BARRIERS TO HIV PREVENTION AND TREATMENT FOR PEOPLE WITH CRIMINAL-LEGAL INVOLVEMENT

by

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BARRIERS TO HIV PREVENTION AND TREATMENT FOR PEOPLE WITH CRIMINAL-LEGAL INVOLVEMENT

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Abstract

This research explores the challenges that individuals with criminal-legal involvement face in accessing HIV prevention and treatment services, particularly pre-exposure prophylaxis (PrEP) and antiretroviral therapy (ART). Individuals with criminal-legal involvement are disproportionately affected by HIV and often experience disruptions in care due to systemic barriers, including stigma, limited resources, and a lack of coordinated services (Murphy et al., 2022; Rowell-Cunsolo et al., 2020). Research also shows that only a small percentage of individuals re-engage in ART treatment for HIV within the first 90 days after release from incarceration, increasing their risk for poor health outcomes (Iroh et al., 2015). This study employs a mixed-methods approach with secondary data to highlight gaps and barriers in the provision of HIV prevention and treatment services. Qualitative and quantitative data from the ACTION Community Needs Assessment in one county site in Texas offered an overview of service availability across criminal-legal and healthcare organizations, while focus groups with agency staff provided in-depth insights into service delivery challenges. The goal of this current study is to identify gaps in the continuum of care—from screening and referral to long-term treatment engagement—and to understand how those gaps affect access to life-saving services. Findings will help inform public health interventions and policy solutions aimed at improving HIV care for this high-risk population.

Understanding HIV Care Access Among Criminal-Legal Involved Populations

HIV prevention and treatment services, such as pre-exposure prophylaxis (PrEP) and antiretroviral therapy (ART), are essential tools in reducing HIV transmission and improving health outcomes. PrEP is a once-daily medication that can reduce the risk of acquiring HIV by up to 99% when taken consistently (Centers for Disease Control and Prevention, 2023). ART, the standard treatment for people living with HIV, effectively suppresses viral load, enhancing individual health and lowering the risk of onward transmission to nearly zero (Eisinger et., 2019). Despite the effectiveness of these interventions, access remains limited among high-risk populations, particularly individuals who engage in intravenous drug use, unprotected sex, or other behaviors that elevate HIV risk, such as inconsistent condom use, lack of regular HIV testing, or having partners with unknown HIV status. Many of these individuals are overrepresented in the criminal-legal system due to overlapping risk factors and systemic inequities (National Institutes of Health, 2010), making them an important demographic in the national HIV response.

Building upon this, people with criminal-legal involvement face an elevated risk of HIV infection, driven by both behavioral and structural factors. Evidence suggests that individuals recently released from incarceration are more likely to engage in high-risk sexual behaviors and substance misuse, which heightens their vulnerability to HIV (Murphy et al., 2022; Epperson et al., 2007). These risks are further intensified by social determinants of health, including unstable housing, poverty, and restricted access to healthcare services. This convergence of individual and systemic challenges underscores the need for targeted public health interventions that are specifically designed to address the complex needs of this population.

Moreover, criminal-legal involvement—defined as individuals who are currently or formerly incarcerated or under community supervision—is associated with a significantly higher prevalence of HIV, as reflected in national data. According to the Bureau of Justice Statistics, approximately 1.2% of male and 1.0% of female prisoners were living with HIV at the end of 2020, a rate far exceeding that of the general U.S. population (Maruschak, 2020). Each year, about one in seven people living with HIV in

the U.S. passes through a correctional facility (National Institutes of Health, 2010; Woznica et al., 2021). Given these disparities, effective HIV care requires a continuous and integrated system that encompasses screening, diagnosis, linkage to care, retention in care, and viral suppression. However, for individuals with criminal-legal involvement, this continuum is frequently fractured. Incarceration often disrupts access to HIV screening, prevention, and treatment services, leading to missed opportunities for early intervention. Upon release, individuals frequently encounter additional structural and social barriers, including housing instability, stigma, and fragmented healthcare systems. These disruptions exacerbate care continuum gaps, resulting in delayed diagnoses, lapses in treatment, and worsening health disparities. For instance, only 28% of formerly incarcerated individuals enroll in HIV care within 90 days of release, increasing their risk of disease progression and further transmission (Iroh et al., 2015).

In response to these challenges, it is crucial to examine the multiple barriers that continue to obstruct effective HIV prevention and treatment for this population. Corrections agencies often lack comprehensive HIV services, including access to PrEP and effective linkage-to-care strategies (Rowell-Cunsolo et al., 2020). Disparities between criminal-legal agencies and healthcare providers further impede service delivery. Corrections frequently lack dedicated HIV prevention programs and structured referral systems, while healthcare providers face challenges identifying and engaging individuals transitioning from incarceration. Systemic disconnects between corrections and healthcare systems frequently lead to inefficient screening and referral processes. Additionally, many correctional facilities lack onsite HIV services, hindering individuals' ability to begin or continue treatment while incarcerated (Springer et al., 2022). As a result, care continuity often depends on flawed referral processes characterized by administrative barriers and institutional mistrust. Additionally, stigma remains a powerful deterrent, discouraging individuals from seeking care and contributing to discrimination (Nakigozi et al., 2013; Treves-Kagan et al., 2015; Kemnitz et al., 2017). Fragmented linkages between correctional facilities and community healthcare providers often fail to ensure smooth transitions to ongoing care. (Elkington et al., 2020; Meyer et al., 2011), and structural issues such as underfunded

programs, restrictive policies, and lack of awareness about PrEP and ART further complicate care engagement.

To further understand these systemic obstacles, it is important to note that although some studies have explored HIV treatment in correctional settings, fewer have examined how corrections and healthcare systems coordinate to support care continuity. Limited research exists on the specific roles that providers, funding structures, and interagency communication play in shaping outcomes for this population (Rich et al., 2016).

Exploring these issues in greater depth, this study draws on secondary analysis of data collected through the ACTION Project (Addressing Risk Through Community Treatment for Infectious Disease and Opioid Use Disorder Now). This five-year, multi-site initiative spans six counties—two in Texas and four in Connecticut, aims to enhance linkage-to-care strategies for individuals with criminal-legal involvement. Prior to launching the intervention, the Community Needs Assessment provided important details about available resources and the structural gaps and service breakdowns that affect individuals navigating care after incarceration or under community supervision.

Given this context, understanding and addressing the multifaceted challenges that criminal-legal involved individuals face in accessing HIV care is essential to achieving health equity and ending the HIV epidemic. This study contributes to that goal by examining service gaps, systemic challenges, and opportunities for improved coordination between corrections and healthcare systems. Accordingly, this study seeks to answer two central research questions: What gaps and barriers exist in the continuum of care for people with criminal-legal involvement in accessing HIV prevention and treatment and what systemic and organizational challenges hinder service delivery, including stigma, fragmented referrals, funding limitations, and restrictive policies?

Methodology

This study employed a mixed-methods approach, with a primary emphasis on qualitative data, following the design framework described by Palinkas et al. (2011). The objective was to gain a comprehensive understanding of the barriers and gaps in HIV services for individuals involved in the

criminal-legal system. While qualitative data provided in-depth insights into these challenges, the quantitative data complemented and reinforced these findings, resulting in a more complete understanding of the issue.

Study Design

Data from the ACTION Community Needs Assessment provided quantitative data through surveys and qualitative data through focus group interviews as a foundational step to inform a larger intervention. For the purpose of this thesis, the focus is on data gathered from agencies located in one county in the research site. Emphasis was placed on qualitative insights derived from focus groups to explore the real-world challenges experienced by organizations and service providers. Survey data offered contextual background on existing services and gaps in provision.

Data Collection Procedures

For the quantitative part of the study, the original ACTION research team sent a secure online survey through REDCap, along with an electronic consent form, to staff at healthcare agencies in the research site. These agencies (N=4) included both criminal-legal organizations (such as probation, parole, and correctional health) and community-based healthcare providers. The survey gathered detailed information about available HIV prevention and treatment services, including HIV testing, PrEP and ART access, referral systems, and substance use treatment.

For the qualitative component, two focus groups conducted via Zoom in Fall 2021, involved six participants representing the four organizations in the research site. These organizations included county probation departments and community-based healthcare providers. Participants occupied diverse professional roles, including probation officers, case managers, and healthcare staff. The focus groups were guided by a structured interview protocol grounded in the “continuum of care” framework, covering themes such as service needs, delivery of HIV and substance use treatment, referral processes, and organizational barriers. Each session lasted approximately 100 minutes and was facilitated by trained moderators. Survey data were also obtained from the same agencies involved in the focus groups, allowing for triangulation and cross-validation of findings.

Data Analysis Plan

For the secondary analysis of survey data, basic descriptive statistics were used to summarize agency-level characteristics and service offerings. This included calculating the proportion of corrections and healthcare agencies that provided HIV screening, PrEP, ART, and referrals versus direct linkage to care. These findings served as a contextual framework to assess the structural availability of services across different organizational types.

The qualitative secondary data analysis involved a detailed review of focus group transcripts, which were originally coded by the ACTION research team. The goal was to identify key barriers and facilitators to accessing services. Recurring themes included stigma, policy constraints, challenges in referrals, funding limitations, and documentation intake process. To understand the weight and relevance of these themes across organizations, the analysis considered how frequently and in what contexts they appeared. Participant quotes were included to bring depth to these insights and illustrate the experiences described.

Mixed-Methods Integration

This study followed an embedded mixed-methods design, wherein qualitative focus group data served as the primary analytic component, and quantitative survey data provided supplementary context. The surveys helped outline what HIV-related services were available in criminal-legal and healthcare agencies, while the focus groups explained why gaps existed and how service providers encountered these challenges on the ground. This integration allowed for a thorough exploration of systemic barriers, provider experiences, and organizational shortcomings that influence HIV prevention and treatment for criminal-legal involved populations.

Ethical Considerations

This analysis was conducted under institutional review board (IRB) approval for use of de-identified data. All participants in the original study provided informed consent prior to participating in surveys or focus groups. Data confidentiality was maintained throughout the original data collection and

secondary analysis processes. Focus group transcripts used in this study were de-identified to protect participant privacy and ensure ethical integrity in analysis and reporting.

Results and Findings

One of the most significant themes that emerged from the data was the unequal availability of HIV-related services across different organizational settings. This disparity was particularly noticeable between healthcare agencies and community corrections organizations. Although these systems often serve individuals with intersecting needs, their differing roles, resources, and service mandates contribute to service gaps. These gaps can interrupt the continuity of HIV prevention and care, especially during transitions between health and supervision systems.

Service Availability:

To begin, the analysis of both quantitative and qualitative data revealed a striking disparity in the availability of HIV prevention and treatment services between community corrections and healthcare providers. Services for HIV treatment (Table 1) and HIV prevention (Table 2) illustrate that while 100% of healthcare-affiliated agencies surveyed provided at least one direct HIV-related service—such as HIV testing, PrEP counseling, or ART prescription—these services were largely absent in criminal-legal agencies. Table 1 outlines how criminal-legal and healthcare providers engage in delivering, linking, or referring services like HIV testing and ART, while Table 2 maps a similar pattern for PrEP-related services, including counseling, prescriptions, and medication dispensing.

Table 1

HIV Overview Services

Services	Corrections Agency			Provider 1			Provider 2			Provider 3		
	I	N	T	I	N	T	I	N	T	I	N	T
HIV risk behavior screening				S			S			S		
HIV testing	L/R			S			S			S/L		
ART prescriptions					S			S			S	
Dispensing ART						S/L			L			L

Note: I = Identification of Treatment; N = Need for Treatment; T = Treatment; L= Linkage of service; R= Referral of service; S= Service of delivery

Table 2

PrEP Overview Services

Services	Corrections Agency			Provider 1			Provider 2			Provider 3		
	I	N	T	I	N	T	I	N	T	I	N	T
PrEP counseling				S			S			S		
PrEP prescriptions		R			S			S			S	
Dispensing PrEP medication			L/R			S						L/R

Note: I = Identification of Treatment; N = Need for Treatment; T = Treatment; L= Linkage of service; R= Referral of service; S= Service of delivery

These structural disparities are further echoed in provider narratives, which reinforces that corrections often function as referral points, with limited capacity to support clients beyond initial risk screening or resource provision. Focus group interviews emphasized this constrained role within the HIV care continuum. A healthcare provider explained that probation staff "are doing case management, they're not doing treatment services... they're just asking basic questions—are you doing this, are you doing

that?" This illustrates how their responsibilities are limited to monitoring rather than actively engaging in medical interventions.

This distinction between community supervision case management and treatment highlights the structural boundaries that prevent corrections agencies from engaging more meaningfully in direct healthcare provision. This is due largely to agency administrative directives. Relatedly, participants described the hierarchical nature of the corrections system as a barrier to initiating care. As a corrections agent noted, "Everything comes from the judiciary, not from us," emphasizing how decision-making power resides with the courts, limiting the autonomy of frontline staff.

In addition to these structural constraints, service availability varies significantly across geographic locations within the corrections system. A corrections agent reflected on the uneven distribution of resources, stating, "we're at an advantage over here because we're at the [LOCAL TREATMENT PROGRAM]. But that's not always a given if you're up at [CITY3]. I mean, they don't have the same services." This disparity points to an uneven playing field in healthcare access, where location—not need—can determine the quality and availability of care. Such disparities suggest that criminal-legal involved individuals' access to healthcare may depend largely on where they are supervised, rather than their clinical needs, reinforcing regional inequities within the system.

Referral Breakdown and Linkage Failures:

Building on the disparity in service availability, another central challenge identified in this study involves the breakdown of referral and linkage systems between criminal-legal and healthcare agencies. While many criminal-legal agencies reported offering referrals to HIV-related services, both qualitative and quantitative data suggest that these referrals often lack follow-through and do not result in effective connections to care. Two major themes emerged from the focus group transcripts: inadequate follow-through on referrals and a lack of interagency awareness that hinders coordination between criminal-legal and healthcare systems.

Most criminal-legal agencies indicated that they provide referrals for HIV-related care; however, these referrals were often described as passive and informal. Rather than accompanying individuals

through the linkage process or ensuring contact with a service provider, referrals were frequently limited to giving clients basic information, such as a name, phone number, or brochure. As one corrections staff member described, "If we refer someone and the connection, the link drops… I tried to call this person… they sent me to someone else… I didn't know where to go, I didn't know what to do." This comment reflects the broader issue of how referrals, though well-intentioned, often do not lead to actual care engagement. The absence of structured referral protocols or patient navigation systems limits continuity, especially during the critical post-release period when individuals face heightened vulnerability to health risks, including HIV transmission. In these moments, even a small lapse in follow-up can result in individuals falling off the care continuum entirely.

The second major barrier to successful linkage lies in the disjointed relationships between criminal-legal and healthcare organizations. Several participants expressed uncertainty about what services were available outside of their own agency, which often made it difficult to know where or how to refer to someone effectively. As one provider stated, "It's just unfortunate that sometimes you don't know what else is going on in the community and who we can have that warm handoff with." This lack of shared knowledge limits the ability of agencies to coordinate care across systems and reinforces service fragmentation. Without formalized communication pathways, referrals often occur in isolation, and clients are left to navigate multiple systems without support. These silos between organizations mean that individuals reentering the community after incarceration are less likely to receive timely and adequate HIV services, despite being at elevated risk.

Barriers to Accessing Care:

These challenges in service provision and interagency communication ultimately feed into larger barriers that affect care access. Individual-level stigma, organizational inefficiencies, and system-wide funding and policy constraints intersect to make HIV prevention and treatment difficult to sustain for people with criminal-legal involvement.

At the individual level, stigma, fear, and limited awareness were key deterrents to accessing care. Participants emphasized that some individuals avoid engaging with public health systems due to

anticipated judgment or community backlash. As one healthcare provider shared, "It's stigmatizing for folks to walk into the doors of the [PUBLIC HEALTH DEPARTMENT]," indicating how internalized and externalized stigma can powerfully shape care-seeking behaviors among people with criminal-legal involvement. Beyond stigma, basic administrative requirements often create challenges for those trying to re-engage in care post-incarceration. Another healthcare provider noted, "We hear from patients that documentation is a barrier." Even when services are technically available, these seemingly small requirements—such as producing identification or proof of residence—can delay or derail care, particularly for individuals experiencing homelessness or instability after release.

Several providers identified bureaucratic intake procedures and redundant documentation as major barriers to care at the organizational level. These processes often frustrate clients and interrupt engagement with services. One provider explained, "We require all the things. I mean, proof of income, residency… it's so much." Another highlighted how repeated paperwork across agencies complicates navigation: "They might need to go to another agency for support services… and so, then guess what? When they go to those doors, it's the same documentation sometimes again… centralized intake would be phenomenal." The lack of unified intake systems often shifts the burden of coordination onto the individual, leading to duplication, delays, or disengagement.

Even when providers are eager to help, their ability to act is constrained by systems-level barriers and fragmented infrastructures. One provider explained, "I could help, but I'm funded under a grant that just takes care of people who are HIV negative." This quote underscores how narrowly defined funding criteria can exclude individuals in need of care. Another participant described the disconnect among agencies, stating, "We're just working in our silos and not knowing the folks who are doing the work in other agencies." Such fragmentation contributes to a fractured service landscape for people seeking care post-incarceration, underscoring the need for improved cross-agency collaboration and policy reform.

Impact on the Continuum of Care:

These access issues ultimately culminate in significant disruptions across the HIV care continuum. Ideally, individuals would transition smoothly through each stage—screening,

diagnosis, linkage to care, treatment initiation, and long-term retention. However, when services are fragmented, referrals lack follow-up, and agencies operate in silos, this continuum becomes fractured.

The findings from this study reveal that people with criminal-legal involvement are frequently referred to services without sufficient support or guidance. In many cases, referrals consist only of basic contact information, leaving clients to navigate a complex and unfamiliar system alone. As one corrections staff member put it, "I tried to call this person… they sent me to someone else... I didn't know where to go, I didn't know what to do." This quote encapsulates the disorientation and frustration that often accompanies reentry and care-seeking.

Without coordinated efforts or warm handoffs between criminal-legal agencies and healthcare providers, individuals easily fall through the cracks. Some never initiate care, while others disengage prematurely due to administrative burdens, stigma, or mistrust of institutions. These missed opportunities undermine both prevention and treatment efforts, leading to delayed diagnoses, unmanaged viral loads, and increased risk of ongoing transmission. Ultimately, the failure to support individuals throughout the continuum of care reinforces existing disparities and hinders the success of public health interventions targeting HIV in criminal-legal populations.

Discussion

This study examined systemic gaps in HIV prevention and treatment service delivery for individuals with criminal-legal involvement, using mixed-methods data from the ACTION Community Needs Assessment. The findings highlight a critical disconnect between criminal-legal systems and healthcare providers—two sectors that serve overlapping populations but operate with limited coordination. This divide disrupts continuity of care, especially during transitions from incarceration or supervision to community-based services.

A key finding is the absence of direct HIV services within criminal-legal agencies. These agencies typically function as referral hubs, lacking the infrastructure or mandate to offer clinical care such as PrEP or ART. In contrast, healthcare providers surveyed offered a broader array of HIV-related

services. However, without active collaboration, neither system is fully equipped to support this high-risk population. This structural separation echoes earlier research pointing to poor interagency communication as a persistent barrier to HIV care continuity (Meyer et al., 2011; Rich et al., 2016).

Referral and linkage breakdowns emerged as a recurring theme. Although criminal-legal agencies often report making referrals, these are frequently passive—limited to contact information with no follow-up. Participants described confusion, minimal guidance, and a lack of support when trying to access services. Without structured handoffs or navigation systems, individuals—many of whom are facing housing insecurity, unemployment, or stigma—must navigate complex systems alone. These conditions increase the likelihood of disengagement and missed care opportunities, as supported by Rowell-Cunsolo et al. (2020).

This study also uncovered multi-level barriers. At the individual level, HIV-related stigma and fear of judgment deter care-seeking. Basic administrative requirements like ID or proof of residence further complicate access, particularly for people lacking stable housing. Organizationally, intake processes across healthcare agencies were described as redundant and burdensome, delaying care and frustrating clients. At the systems level, rigid funding guidelines and siloed operations hinder flexibility and collaboration. These findings are consistent with national research (Nakigozi et al., 2013; Kemnitz et al., 2017; Springer et al., 2022) emphasizing the role of structural barriers in limiting access to care for people with criminal-legal involvement.

Together, these factors fracture the HIV care continuum. Ideally, this continuum progresses from testing and diagnosis to linkage, treatment, and viral suppression. However, this study reveals disruptions at nearly every stage. For instance, some individuals are tested in custody but receive no follow-up. Others are referred post-release without clear pathways to care. These lapses can delay treatment, contribute to unmanaged viral loads, and elevate transmission risk—especially during the high-risk post-release period (Epperson et al., 2007; Murphy et al., 2022). From an implementation science perspective, this study shows how evidence-based interventions like PrEP and ART lose impact when care systems are disjointed. Cross-sectoral interventions that emphasize coordination, client navigation, and continuity are

crucial. Peer-led linkage programs, centralized intake models, and cross-training between sectors may offer pathways to improve service access and engagement. Addressing these gaps will require not only improved referrals but also stronger coordination across sectors, better provider training, and more flexible funding streams to meet individuals' needs holistically.

In conclusion, this research underscores how criminal-legal involvement intersects with health system vulnerabilities to shape HIV care access. While these challenges are longstanding, addressing them is essential to meet national HIV reduction goals. Improving interagency collaboration, building responsive referral networks, and centering trauma-informed approaches will be critical to advancing equity in HIV prevention and treatment for this marginalized population.

Limitations

Several limitations should be acknowledged when interpreting the findings of this study. The sample size was relatively small, particularly on the qualitative side, with only two focus groups conducted involving six participants across four organizations at the county site in Texas. Although the insights generated were rich and informative, they may not fully capture the experiences of other regions or broader systems engaged in HIV service delivery. Additionally, because this study relied on secondary data, the research questions and themes were shaped by the existing dataset rather than being designed specifically for this thesis. This constrained the ability to explore certain topics in greater depth or to follow up on emerging insights through additional data collection. The survey data also relied on self-reports from agency representatives, which introduces the possibility of social desirability bias or inaccuracies based on participants' interpretations of their organization's services. Finally, the study's geographic focus on a single county site in Texas may limit the generalizability of findings to other jurisdictions with differing policies, service models, or resource availability.

Future Studies

While this study offers insights based on secondary data from the ACTION Community Needs Assessment, future research should build upon these findings by collecting primary data

directly from individuals with criminal-legal involvement. Engaging with people who are currently or formerly incarcerated or under community supervision could offer more nuanced perspectives on barriers to accessing HIV services. Their lived experiences would provide essential context for understanding both system-level challenges and personal obstacles to care.

Additionally, incorporating longitudinal approaches could track individuals over time, helping to identify which interventions promote sustained engagement across the HIV care continuum. This type of research would be especially valuable in shaping reentry programs and public health initiatives aimed at reducing HIV transmission and improving long-term outcomes for criminal-legal populations.

Conclusion

This study highlights the critical role that service coordination, provider communication, and structural support play in ensuring effective HIV prevention and treatment for people with criminal-legal involvement. By analyzing both quantitative and qualitative data from the ACTION Community Needs Assessment, the research uncovered clear disparities in service availability, inconsistent referral and linkage processes, and multiple barriers at the individual, organizational, and systems levels. Together, these factors contribute to significant disruptions across the HIV care continuum.

Criminal-legal affiliated agencies often lack the resources or authority to deliver direct HIV services, instead relying on referrals that frequently fail to result in care engagement. Healthcare providers, though better equipped to offer services like PrEP and ART, face challenges in connecting with individuals' post-incarceration due to siloed systems and restrictive policies. Without intentional strategies to bridge these gaps, individuals continue to face high risk for HIV transmission and experience unequal access to treatment.

Improving outcomes requires greater collaboration between the corrections and healthcare systems, as well as the development of streamlined referral mechanisms, funding structures that support integrated care, and interventions tailored to the needs of this high-risk population.

Strengthening these connections will be essential for reducing disparities, supporting reentry efforts, and ultimately advancing public health goals related to HIV prevention and care.

References

Browne, F., Washio, Y., Zule, W., & Wechsberg, W. (2023). HIV-related risk among justice-involved young African American women in the U.S. South. Health & Justice, 11(1). https://doi.org/10.1186/s40352-023-00228-7

Centers for Disease Control and Prevention. (2023). PrEP for HIV prevention. https://www.cdc.gov/stophivtogether/hiv-prevention/prep.html

Eisinger, R. W., Dieffenbach, C. W., & Fauci, A. S. (2019). HIV viral load and transmissibility of HIV infection: Undetectable equals untransmittable. JAMA, 321(5), 451–452. https://doi.org/10.1001/jama.2018.21167

Elkington, K., Jaiswal, J., Spector, A., Reukauf, H., Tesoriero, J., Nash, D., … & Remien, R. (2016). Can TasP approaches be implemented in correctional settings?: A review of HIV testing and linkage to community HIV treatment programs. Journal of Health Care for the Poor and Underserved, 27(2A), 71-100. https://doi.org/10.1353/hpu.2016.0047

Elkington, K., O'Grady, M., Tross, S., Wilson, P., Watkins, J., Lebron, L., … & Cohall, A. (2020). A study protocol for a randomized controlled trial of a cross-systems service delivery model to improve identification and care for HIV, STIs and substance use among justice-involved young adults. Health & Justice, 8(1). https://doi.org/10.1186/s40352-020-00121-7

Elkington, K., Robertson, A., Knight, D., Gardner, S., Funk, R., Dennis, M., … & DiClemente, R. (2020). HIV/STI service delivery within juvenile community supervision agencies: A national survey of practices and approaches to moving high-risk youth through the HIV care cascade. AIDS Patient Care and STDs, 34(2), 72-80. https://doi.org/10.1089/apc.2019.0157

Epperson, M., El-Bassel, N., Gilbert, L., Orellana, E., & Chang, M. (2007). Increased HIV risk associated with criminal justice involvement among men on methadone. AIDS and Behavior, 12(1), 51-57. https://doi.org/10.1007/s10461-007-9298-4

Iroh, P. A., Mayo, H., & Nijhawan, A. E. (2015). The HIV care cascade before, during, and after incarceration: A systematic review and data synthesis. American Journal of Public Health, 105(7), e5–e16. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2015.302635

Kemnitz, R., Kuehl, T., Hochstatter, K., Barker, E., Corey, A., Jacobs, E., … & Westergaard, R. (2017). Manifestations of HIV stigma and their impact on retention in care for people transitioning from prisons to communities. Health & Justice, 5(1). https://doi.org/10.1186/s40352-017-0054-1

Maruschak, L. M. (2020). HIV in prisons, 2015 – Statistical tables. Bureau of Justice Statistics. https://bjs.ojp.gov/content/pub/pdf/hivp20st.pdf

Medina-Perucha, L., Family, H., Scott, J., Chapman, S., & Dack, C. (2018). Factors associated with sexual risks and risk of STIs, HIV and other blood-borne viruses among women using heroin and other drugs: A systematic literature review. AIDS and Behavior, 23(1), 222-251. https://doi.org/10.1007/s10461-018-2238-7

Meyer, J., Chen, N., & Springer, S. (2011). HIV treatment in the criminal justice system: Critical knowledge and intervention gaps. AIDS Research and Treatment, 2011, 1-10. https://doi.org/10.1155/2011/680617

Murphy, M., Sosnowy, C., Rogers, B., Napoleon, S., Galipeau, D., Scott, T., … & Chan, P. (2022). Defining the pre-exposure prophylaxis care continuum among recently incarcerated men at high risk for HIV infection: Protocol for a prospective cohort study. JMIR Research Protocols, 11(2), e31928. https://doi.org/10.2196/31928

Nakigozi, G., Atuyambe, L., Kamya, M., Makumbi, F., Chang, L., Nakyanjo, N., … & Gray, R. (2013). A qualitative study of barriers to enrollment into free HIV care: Perspectives of never-in-care HIV-positive patients and providers in Rakai, Uganda. Biomed Research International, 2013, 1-7. https://doi.org/10.1155/2013/470245

National Institutes of Health. (2010). Unprecedented effort to seek, test, treat inmates with HIV. https://www.nih.gov/news-events/news-releases/unprecedented-effort-seek-test-treat-inmates-hiv

Palinkas, Lawrence A., et al. “Mixed Method Designs in Implementation Research.” *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 38, no. 1, 22 Oct. 2010, pp. 44–53, pubmed.ncbi.nlm.nih.gov/20967495/, https://doi.org/10.1007/s10488-010-0314-z.

Rich, J. D., Chandler, R., Williams, B. A., Dumont, D., Wang, E. A., Taxman, F. S., … & Western, B. (2016). How health care reform can transform the health of criminal justice–involved individuals. Health Affairs, 35(3), 390–397. https://doi.org/10.1377/hlthaff.2013.1133

Rowell-Cunsolo, Tawandra L., et al. ““It’s like I Was out There by Myself”: The Receipt of Reentry Support among HIV-Infected Formerly Incarcerated Individuals in New York City.” *Health & Justice,* vol. 8, no. 1, 10 Mar. 2020, https://doi.org/10.1186/s40352-020-00108-4. Accessed 21 June 2020.

Springer, S. A., Nijhawan, A. E., Knight, K. R., Kuo, I., Paola, A., Schlossberg, E., … & Davis, F. (2022). Study protocol of a randomized controlled trial comparing two linkage models for HIV prevention and treatment in justice-involved persons. BMC Infectious Diseases, 22(1). https://doi.org/10.1186/s12879-022-07354-x

Swan, H. (2016). A qualitative examination of stigma among formerly incarcerated adults living with HIV. Sage Open, 6(1). https://doi.org/10.1177/2158244016629524

Treves-Kagan, S., Steward, W. T., Ntswane, L., Haller, R., Gilvydis, J. M., Gulati, H., … & Lippman, S. A. (2015). Why increasing availability of ART is not enough: A rapid, community-based study on how HIV-related stigma impacts engagement to care in rural South Africa. BMC Public Health, 16(1). https://doi.org/10.1186/s12889-016-2753-2