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GUEST EDITORIAL

# Jails: The New Frontier. HIV Testing, Treatment, and Linkage to Care After Release

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Jails represent a critical point for public health intervention within the criminal justice system. Characterized by rapid turnover, jails can serve as a window of opportunity for many interventions—including those designed to identify HIV infection among detainees, initiate or re-initiate HIV care and antiretroviral therapy (ART), and provide linkage to care after release. The most vulnerable within our communities pass through jails; incarceration transcends "risk categories". Addressing HIV within jails is not limited to interventions targeting one specific risk group. Men who have sex with men (MSM), high-risk heterosexuals, and those who have a history of injection drug use can all be found within jails, which make jails ideal settings through which to impact HIV within the community as a whole.

An estimated one in seven persons living with HIV/AIDS leave a prison or jail each year [1], and over 11 million persons are admitted to jails annually [2]. While the majority of HIV programs within correctional facilities are based in prisons, as opposed to jails, the vast majority of incarcerated persons each year are detained only in jails and never have access to prison-based programs. Approximately 95 % of inmates are released from jails each year with average lengths of stay often less than 72 h, representing the challenge and importance of intervening within a rapidly closing window.

The papers included in this special issue of *AIDS and Behavior* demonstrate, as a whole, that HIV programming for jail detainees and releases can lead to positive outcomes—enhanced identification of HIV cases, engagement and retention in care, and improved clinical outcomes. The 10 demonstration models funded through the HRSA/SPNS EnhanceLink initiative have shown that successful partnerships can be developed between community-based organizations, correctional systems, and/or health departments. Testing programs can be implemented, treatment can be initiated/reinitiated, and individuals can be linked to care in the community after release. Findings from the multisite evaluation of these models show the overall successes of the initiative, yet also highlight challenges that remain. Overall, these papers describe a population impacted by substance use, mental illness, unstable housing, lower educational attainment, and difficulties with health insurance; many of these factors were found to influence engagement in care and outcomes. However, services provided inside jail and in the community after release can make a difference. Engagement in care and viral suppression are possible and interventions appear to be cost-saving on a societal level. More specifically:

Richard Rapp et al. [3] discuss the limited evidence-base to date and the importance of adapting successful prison and community-based interventions. Alison Jordan et al. [4] provide a useful description of the model of care implemented for Rikers Island in New York City, where over 70 % of HIV-infected persons released to the community are linked to primary care; this serves as an example for other jurisdictions.

Anne Spaulding et al. [5] provide an overview of the EnhanceLink project and demonstrate the feasibility of HIV testing in jail and provision of linkage services to enhance continuity of care. Over 80 % of HIV-infected persons offered linkage and transitional services accepted program services. Matt Stein et al.

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[6] presents the baseline characteristics of the EnhanceLink cohort, highlighting a population impacted by mental illness, substance use, low educational attainment, and extensive involvement with the criminal justice system. Notably, 20 % of male participants self-identified as homosexual or bisexual, and 65 % of the cohort self-identified as African-American, with African-Americans less likely to have health insurance or an HIV provider. Ehsan Chitsaz et al. [7] provide a detailed analysis of baseline substance use among the cohort, finding that polysubstance use is common among participants and that drug use severity is independently correlated with lower likelihood of having an HIV care provider, being prescribed ART, and adherence to treatment prior to incarceration. Ann Avery et al. [8] found that having insurance at baseline was a correlate of being in care and being adherent to care, while recent homelessness and high degrees of substance abuse were correlated with nonadherence to ART and being out of care. Chyvette Williams et al. [9] report that HIV-infected women in jails have a greater burden of illness and greater need. Compared to men, at baseline, women are more likely to be homeless, have more severe addiction problems, more chronic health conditions, and are less adherent to ART.

Jeannia Fu et al. [10] found that nearly one-third of the EnhanceLink cohort was reincarcerated within the 6-month follow-up period, with homelessness, major psychiatric diagnosis, and longer lifetime incarceration history associated with recidivism and health insurance post-release associated with a decreased likelihood of recidivism. Cristina Booker et al. [11] report that approximately three-quarters of those enrolled in the cohort received services in the first 30 days after release. The critical finding is that services provided inside jail matter! Factors associated with linkage included HIV or medication education inside jail, discharge plans completed upon release, and stable housing. As described by Alexei Zelenev et al. [12], transitions from homelessness to more stable housing were closely associated with a number of benefits to overall well-being, including reduction in substance use, decline in addiction severity, and improvements in mental health.

Finally, in two separate papers, Anne Spaulding et al. illuminate the key take-home messages for decision makers—viral suppression is achievable [13] and EnhanceLink interventions appear to be cost-saving [14].

The success of the EnhanceLink initiative should represent the beginning of key program implementation nationwide. Routine HIV testing in jails, particularly in harder-hit communities, makes sense. Improvements in ART are so extraordinary and cost-effective that initiating or reinitiating treatment is a high priority. The time detainees spend in jail is just the beginning, as linking and re-engaging releasees to care in the community is of paramount importance. This is consistent with the National HIV/AIDS Strategy, which includes establishing a seamless system to link people with continuous and coordinated quality care [15].

Although many lessons have been learned from the EnhanceLink initiative, there remain unanswered questions and challenges. "One size fits all" approaches may not work; women are different from men and may require unique interventions to meet gender-specific needs. When dealing with homeless and/or unstably housed persons, treating HIV is very difficult when basic support (such as safe housing) is not in place. The national epidemic of substance abuse is at the root of many of the challenges, and improving substance use treatment within jails is necessary.

Six years ago, when the EnhanceLink demonstration models were first funded, experts believed routine HIV testing, treatment, and linkage to care among jail detainees was impossible due to the chaotic nature of jails, inmates' lives and the environment, and that structural constraints would be an insurmountable barrier for the application of the Seek, Test, Treat, and Retain paradigm within that setting. The following manuscripts demonstrate that this is NOT the case. In fact, these models for HIV testing and care can also be applied to other infectious diseases, including hepatitis C virus and sexually transmitted infections, which also are in need of appropriate intervention. Leaders in public health, HIV medicine, correctional health, and academia need to move forward—together—today—to address these ongoing challenges and improve the overall health of the community.

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