

TRAINING MANUAL



Creating a Jail Linkage Program

September 2013



U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau
Special Projects of National Significance Program



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The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) has developed the Integrating HIV Innovative Practices (IHIP) manuals, curricula, and trainings to assist health care providers and others delivering HIV care in communities heavily impacted by HIV/AIDS with the adoption of Special Projects of National Significance (SPNS) models of care. This IHIP training manual is part of that effort. Additional IHIP materials can be found at www.careacttarget.org/ihip.



INTRODUCTION

ABOUT THIS MANUAL

Public health interventions, from improving continuity of care for HIV-positive prisoners to reducing drug and sexual risk behaviors, have been studied in prison-based settings and shown to be successful.^{1,2} In contrast, only a few interventions have examined jail settings to identify best practices for case finding and linkage to community-based services.^{1,3} Given the number of people living with HIV/AIDS passing through these facilities, and the need to reach them and deliver evidence-based interventions, the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau's (HAB's) Special Projects of National Significance (SPNS) program launched the Enhancing Linkages to HIV Primary Care & Services in Jail Settings Initiative (EnhanceLink). Because most interventions have previously focused on prison-based work,¹ this jail linkages training manual and, indeed, the project itself, fill an important research void.

EnhanceLink ran from 2007–2012 and built upon the HRSA/Centers for Disease Control and Prevention (CDC) jointly funded 5-year Corrections Demonstration Project (findings and case studies accessed from www.hab.hrsa.gov/abouthab/files/openingdoors.pdf). At \$21.7 million, EnhanceLink funded 10 grantees representing 20 separate jail sites as well as an evaluation/technical assistance center.

This training manual synthesizes lessons learned from this federally funded, innovative pilot project and has important implications for HIV testing and procedures in jails across the United States.⁴ The learning objectives of this manual are to

- illustrate the effectiveness of jail linkage work;
- provide information on components of a jail linkage program;
- highlight best practices from successful EnhanceLink grantees so that readers have the necessary information to replicate and implement this work; and
- support the goals of the National HIV/AIDS Strategy (NHAS) by maximizing available resources to reduce HIV incidence, increase access to care and optimize health outcomes, and reduce HIV-related health disparities.

The target audience includes health care provider sites and community partners with an interest and need to work with incarcerated populations, particularly HIV-positive jail inmates and the recently released (otherwise known as “releasees” herein).

This training manual is part of the Integrating HIV Innovative Practices (IHIP) program that promotes replication and dissemination of successful SPNS initiatives. Accompanying this manual is an implementation guide that builds upon the lessons outlined herein and

a pocket guide for easy reference. A training Webinar series is also taking place. All of these materials, including archives of the Webinars, and other SPNS training products, are housed at www.careacttarget.org/ihip.

INCARCERATION IN THE UNITED STATES: AN OVERVIEW

The United States has the highest incarceration rates of any industrialized country in the world.⁵ Approximately 1 out of every 100 people in the United States is in jail or prison;⁶ and, if rates persist, 1 in 15 Americans will have been incarcerated at some point in their lives.⁷

Prisons versus Jails: What's the Difference?

The terms “jails” and “prisons” are often used interchangeably, but they represent different kinds of correctional facilities.⁸ Prisons are operated by State governments or the Federal Bureau of Prisons instead of local municipalities. Most inmates have committed felonies and typically serve terms of at least 1 year. In contrast, jails are locally operated, or are short-term managed facilities for people awaiting arraignment, trial, or sentencing; or who cannot post bail and are serving short jail sentences;

or are awaiting transfer to prison; or have violated the terms of their parole.⁸

There are 3,000 jail systems within the United States (not counting individual facilities within those systems); these vary from rural lockups with just a few cells to large city jail systems with tens of thousands of inmates.⁵ How fast detainees leave jails can vary between individual jails and from individual to individual. On average, nearly one quarter of jail detainees are released within 2 weeks. According to a recent study specifically focused on felony defendants in large urban areas, approximately 50 percent of these individuals were released within 2 days. All are released or transferred within 1 year.

More people pass through jails than prisons.^{2,11,12} In 2006, approximately 85 percent of incarcerated persons were solely in jails.¹³ Each year, there are nearly 13 million jail admissions—representing 9 to 10 million unique persons annually and an average of 760,000 jail inmates—daily in the United States.¹³ This equates to more than 4 percent of the U.S. adult population passing through a jail in a given year.¹⁴

Prisons and jails have their own policies/procedures, so these vary and are not universal. Jail interventions must be tailored to where they're being implemented and for whom.¹



WHY A JAIL INTERVENTION?

Jails concentrate marginalized individuals with a range of social and health problems into one place.^{1,5} Prior to coming into jail, many individuals may have received no health care or such services have been fragmented due to cooccurring health conditions or problems that interfere with access (e.g., substance abuse, mental illness), and due to structural inequalities, including poverty, unstable housing, limited educational attainment, and un- or underemployment.^{15,16} Vulnerable populations are less equipped to address health issues when faced with competing needs related to survival, such as food and shelter.¹⁷ In these communities, health disparities may lead to risky behaviors, which in turn contribute to HIV infection acquisition and to crime leading to arrest.^{18,19}

Behaviors and vulnerabilities that increase risk for HIV are often associated with incarceration, such as substance abuse and high-risk sexual practices, including commercial sex work. Incarcerated persons also have high rates of sexually transmitted infections (STIs), including HIV as well as viral hepatitis, tuberculosis (TB), mental illness, substance abuse, and histories of physical, sexual, and emotional abuse.^{19,5} The intersection between HIV, homelessness, and incarceration is also well documented; in fact, individuals with mental illness are most likely to be homeless prior to and after incarceration.²⁰

Jails represent a chance to test, diagnose, and treat high-risk populations, and offer marginalized people an opportunity for contact with the health care system.^{5,20} Collaboration between public health agencies, community-based organizations, and jails has implications for public health and safety efforts. Working together, linkages promote continuity of care for a highly vulnerable population.^{21,22}

A jail intervention, like EnhanceLink, includes engagement, testing, and linkage coordination, all of which need to occur quickly because jail stays are often brief and the uncertainty around discharge dates presents a shorter window of opportunity to reach people.³ Medical screenings, however, are a part of the intake process and offer an opportunity to implement such interventions, as do booking and intake.^{19,20}

DID YOU KNOW?

The idea that jails and prisons are “breeding grounds” for HIV transmission has been perpetuated over years but is largely unfounded.

Source: Hammett TM. HIV/AIDS and other infectious diseases among correctional inmates: transmission, burden, and an appropriate response. *Am J Public Health.* 2006;96:974–78.

Without linkage interventions, barriers to care that existed prior to jail admission remain upon release. For example, many individuals released from jail are uninsured even if they're eligible for Medicaid or Medicare. Their benefits may have been "turned off" when incarcerated and they may not know how to turn them back on. This barrier is difficult to navigate for many people and impedes access to medication and HIV primary care, both of which are paramount to addressing the HIV epidemic.¹⁷

The EnhanceLink project proved that this work could not only be done within this short window, but could be done successfully and cost-effectively.²³ (See also "Costs" in Chapter 3.) EnhanceLink grantees achieved a successful linkage rate of at least 60 percent.¹⁷

A successful jail intervention can decrease expensive emergency room visits, decrease transmission of HIV, reduce recidivism, and improve quality of life for individuals and, ultimately, for communities.¹⁷ Jail linkage programs offer the linkage and engagement services called for in the Affordable Care Act. If the United States is to achieve the vision of an AIDS-free generation and offer the access to care called for in the NHAS, then the millions of people who cycle through jails each year must be included. (To read more about the NHAS, visit www.whitehouse.gov/administration/eop/onap/nhas and <http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas-fact-sheet.pdf>.)

AN OPPORTUNITY

The CDC strongly recommends jail-based HIV testing.¹⁰ Routine HIV screening in jails is also consistent with the NHAS.¹⁰ Nonetheless, many HIV-positive jail inmates are unaware of their HIV status or are out of care. The majority of detainees pass through jail and never move on to prison but, rather, return to the communities they left.^{13,20} The transition period from incarceration back to the community is known to be a time of particular vulnerability, as well as high risk for cessation of antiretroviral therapy (ART), further underscoring the need for transitional and linkage services.¹⁰ Without assistance, people leaving jails tend to return to the same conditions that they were living in before they were

incarcerated, increasing their risk for recidivism; if they are not linked to HIV primary care, they will contribute to higher community viral loads, leading to poor individual outcomes and increased HIV transmission.

Rapid HIV testing technology is ideal for jail settings, since results can be delivered to inmates so that they are aware of their serostatus. Identification of HIV alone is associated with a three- to fourfold reduction in sexual risk behaviors.^{10,24,25} Identification of HIV-positive individuals provides health departments with the opportunity to notify partners and provide them with testing and referral services, too, all of which support prevention efforts.²⁰

Access to, and provision of HIV testing in jails is inconsistent, underscoring that more can be done to increase rates of HIV testing for those incarcerated in jails. (To review CDC testing recommendations in correctional settings, see www.cdc.gov/hiv/topics/testing/resources/guidelines/correctional-settings/pdf/Correctional_Settings_Guidelines.pdf, and to visit the AIDS Education and Training Centers (AETCs), National Clinician Consultation Center site to review State HIV testing laws, see www.nccc.ucsf.edu/consultation_library/state_hiv_testing_laws/.)

Overall, HIV interventions help reduce transmission in the community by increasing awareness of HIV, offering risk reduction counseling and information about the benefits of ART and the importance of adherence, and linking HIV-positive persons to a primary care provider and to ART.⁸ As such, health departments, local health care providers, and community-based organizations have a vested interest in the provision of HIV testing, treatment, and linkage to care and treatment in jails and upon inmate release. It is useful for health care and correctional staff to view jails as part of the continuum of care rather than independently, since this approach may help encourage strategic and retention-in-care planning.²⁶

The CDC also recommends using "combinations of scientifically proven, cost effective, and scalable"²⁷ prevention interventions. Given that case management for HIV-infected persons has been shown to increase engagement and retention in care and EnhanceLink proved to be cost-effective (see the following section), this jail linkage work should be considered for replication.²³



SPNS INITIATIVE: FINDINGS FROM THE FIELD

*EnhanceLink staff “understand. They don’t judge you. My family judged me right away. They would help me one week and if I relapsed well, ‘The hell with you. I’m tired with you. You’re never going to change...’ See with [EnhanceLink] there is hope. They see potential in me.... [They ask] ‘What do you need?’ Nobody’s ever asked me that! And it’s programs like this that help me get through life.”**

—EnhanceLink Participant

The EnhanceLink project was funded to design, implement, and evaluate innovative methods for linking people living with HIV/AIDS who are in jail settings—or who have been recently released from local jail facilities—into HIV primary medical care and ancillary services. The project was based upon the Framework for Program Evaluation in Public Health²⁸ as well as the Behavioral Model for Vulnerable Populations, which asserts that predisposing and need factors as well as

enabling resources all influence health behaviors and, in turn, health outcomes.²⁹

Overall, EnhanceLink conducted and enrolled the following:

- *HIV tests.* During 877,119 admission events there were 499,131 HIV tests offered with 210,267 inmates agreeing to test.
- *New HIV diagnoses.* Of the 1,312 positive HIV tests, 822 represented newly diagnosed individuals.
- *Participants.* In total, 1,270 HIV-positive participants enrolled in the EnhanceLink study; most were previously diagnosed and out of care.³⁰ To avoid any sense of coercion, individuals could still

*Nunn A, Cornwall A, Fu J, et al. Linking HIV-positive jail inmates to treatment, care, and social services after release: results from a qualitative assessment of the COMPASS Program. *Journal of Urban Health.* 2010;87(6):954–68.

ENHANCELINK PARTICIPATING SITES

Grantees:

- AID Atlanta, Inc.
- Care Alliance Health Center
- AIDS Care Group
- Yale University AIDS Program
- University of Chicago, IL School of Public Health
- Baystate Medical Center, Inc.
- University of South Carolina Research Foundation
- Philadelphia FIGHT
- NYC Department of Health and Mental Hygiene
- Miriam Hospital

Evaluation Center: Emory University Rollins School of Public Health and ABT Associates were subcontractors.

To read more about the initiative, visit www.hab.hrsa.gov/about/hab/special/carejail.html and access the initiative Website: www.enhancelink.org/EnhanceLink/index.html.

Source: de Voux A, Spaulding AC, Beckwith C, et al. Early identification of HIV: empirical support for jail-based screening. *PLoS One*. 012;7(5):1–7.

receive linkage services even if they declined to formally enroll in the study. At a minimum, all sites followed participants for 6 months post-release, although some grantee sites followed jail inmates upon release for longer.^{20,31}

Among EnhanceLink participants, less than one-half had a high school diploma or GED and median lifetime arrests were 15.³² Among previously diagnosed participants, 90 percent had known their HIV status for more than 2 years, and 81 percent had never taken ART medications.³²

Many participants in the study reported past diagnoses of STIs. Hepatitis C was the most common HIV coinfection. In addition, many EnhanceLink participants had histories of depression, and suicidal ideation and attempts; other kinds of emotional distress were also prominent. Only a few participants had a formal mental

WOMEN IN JAIL

Approximately 12 percent of total jail detainees in the United States are women, a number that's grown fivefold since 1985. Incarcerated women often have histories of childhood sexual abuse and neglect, sex work, and intimate partner violence (IPV). HIV-positive women in the EnhanceLink study suffered greater burden of illness, and were more likely to be homeless, less adherent to ART, and had more severe addiction issues. To be most effective, interventions should reflect gender-specific differences and women's experiences of HIV and incarceration.

Sources:

Minton TD. Department of Justice. Jail inmates at midyear 2010. Washington, DC.

University of Illinois at Chicago, Community Outreach Intervention Projects, School of Public Health. Enhancing linkages to care for women leaving jail. Final report. 2012. [unpublished.]

Dwyer M, Fish DG, Gallucci AV, et al. HIV care in correctional settings. *Guide for HIV/AIDS Clinical Care*. HRSA, HAB. June 2012.

Tinsley M. HRSA, HAB, SPNS Program. Enhancing linkages to primary care & services in jail settings: a critical HIV/AIDS Bureau initiative. [Presentation.]

Meyer JP, Zelenev A, Wickersham J, et al. Women released from jail experience suboptimal HIV treatment outcomes compared to men: results from a multi-center study. [unpublished]

health diagnosis, despite 54 percent presenting with an Addiction Severity Index (ASI)³³ mental health score of .22 or greater, indicative of severe psychiatric illness.^{3,34} Nearly all participants had histories of substance use; 59 percent had ASI drug scores of at least .16, which represents severe drug addiction.³

Seventy percent of participants were male with an average age of 42 years. Viral load and CD4 counts revealed that 66 percent of participants had uncontrolled viremia (viral load > 400 copies/ml).³⁰

While Blacks represent 46 percent of HIV-positive persons and 40 percent of the incarcerated community, the numbers were even higher among EnhanceLink participants: 65 percent were Black.³² Black EnhanceLink

participants were less likely than other participants to have health insurance upon entering jail, reflecting health inequities that exist within jail subsets, particularly by race.³² Black EnhanceLink participants were also the most likely to identify as homosexual or bisexual, and to have advanced HIV disease.³²

COSTS

The EnhanceLink interventions were deemed cost-effective from a societal perspective with an average cost per client linked at \$4,219; the mean cost per 6-month sustained linkage was \$4,670.²³

Having a case manager work closely with the jail medical staff may reduce costs incurred by the jail, which could be motivation and justification for establishing such a partnership. Cost-cutting is a big selling point in establishing partnerships between community-based organizations, jails, and health departments. For example, the case manager at the University of South Carolina Research Foundation project worked to obtain medical records from community clinicians, thus reducing duplications in lab work and diagnostic evaluations.

Of those previously diagnosed, only 55 percent were on HIV medication leading up to 7 days before incarceration.¹⁰ As the EnhanceLink Evaluation Center summarized, “Jails therefore serve as an opportunity to re-start ART among those who have fallen out of care or some who had discontinued ART due to substance use.”¹⁰

The EnhanceLink project did not identify a substantial increase in pharmacy costs with many detainees initiating ART post-release given their short stay.¹⁰ If a person was pre-trial, some case managers were able to negotiate to have their home HIV medications be given in the jail. This approach was so successful that after completion of the SPNS grant, the jail created a case manager position to continue the effort.³⁴ Another grantee—the NYC Department of Health and Mental Hygiene—was able to direct some of their Ryan White Part A Early Intervention Services funding toward sustaining their jail linkage efforts at Riker’s Island.³⁵

Another cost-effective intervention involved coordination of medical records. In response to a jail medical director’s capacity to treat HIV-positive inmates, one grantee site examined their patient immunology charts. If the inmate had been seen at the community clinic previously, the community HIV doctor would engage in

“Without treatment or consistent care, chronic conditions worsen until individuals are forced to present to emergency rooms for care, ratcheting up costs to the health care system. With proper continuity of care resources in place, much of this cost can be avoided.”

—Hannah Zellman, Philadelphia FIGHT, EnhanceLink grantee

Source: Zellman H. Philadelphia Fight Institute for Community Justice. *Establishing the need for an intervention program*. 2012. [unpublished]

a case conference about the patient with the jail medical director. “This enhancement improved the quality of medical care provided to the HIV positive inmates, while stretching dollars for the facility. This is a cost-effective method in which to provide specialty care in collaboration with the medical team at the jail.”³⁴

SUCCESSFUL OUTCOMES

Findings from EnhanceLink were consistent with the Antiretroviral Treatment and Access Study (ARTAS), supporting the role of case management. Both found that people who participated in case management were more likely to follow up on care referrals.²⁹ Coordinating social services was associated with retention in care;³⁶ one EnhanceLink site found a *ninefold increase in retention in care* when patients were linked to a Ryan White medical case manager in the community at time of release.³⁷

EnhanceLink interventions are beyond the services typically offered within a jail setting. The project illustrates that jail inmates can benefit from these services, and individual morbidity and mortality are reduced.³⁸ Medical treatment adherence increased when HIV detainees were immediately linked to primary care while receiving continuous case management and support services to address their particular psychosocial needs.⁴⁰

Study participants noted that EnhanceLink helped prevent relapse and promoted adherence to ART.³ This is important, since participants with pre-incarceration heroin and cocaine use were more likely to relapse after release, underscoring that addiction is a chronic,

relapsing disorder and that linkage programs must take substance use into account when creating linkage and care services.³⁹

Grantees found that they could improve health care outcomes and recidivism by addressing—through the inclusion of substance abuse treatment, intensive psychosocial support, prevention education, and self-esteem building—underlying factors that cause people to fall out of care and become repeat offenders.⁴⁰ For example, individuals receiving community-based services within 30 days of release were more likely to be engaged in HIV primary care. Those released with stable housing were also more likely to be linked to care,⁴¹ as housing has been tied to a more stabilized lifestyle, reduction in drug use, and increased health care utilization.³

Treatment adherence is associated with reduction in recidivism,⁴² improved health behaviors, and enhanced secondary HIV prevention.³ Significant factors associated with decreased patient viral load include attending the first case manager meeting, assessing patient needs for HIV-related medical services, having health insurance at time of incarceration, and having a copy of one's medical record at time of release. Not surprisingly, the number one predictor of success was attending a meeting with one's HIV care provider within 30 days of release.³⁸

*Overall, the patients in the EnhanceLink study achieved clinical care engagement rates comparable to those in other clinical settings. This is important to underscore, given the transient nature of jails, and the high rates of psychosocial issues among those released from jail.*³⁸ Participants would recommend the program to others and credit it with successful transition back into the community.⁴⁰

BEFORE YOU GET STARTED: LAYING THE GROUNDWORK

Before community-based organizations get started on this work, it is important to examine existing programs and other organizations operating within the jail in order to avoid duplication of effort or starting an intervention program without the capacity to complete it. For program evaluation, it is also important to pre-determine how to collect and store data, how data will be analyzed, and questions to be documented and answered.³⁶ Prior to outlining project specifics, it is imperative to understand the culture of corrections, what may or may not be

permissible within these environments, and implications to your proposed program.

Understanding the “Culture of Corrections”

Jails have close proximity to their surrounding communities and can vary dramatically in size and scale, from small county lockups to large city jail facilities. Policies can also vary by facility, region, and State. The practices outlined in this training manual and its associated implementation and pocket guides may need to be modified based on the regulations applicable within your specific jail setting.

A single city or county typically operates a jail and most receive little or no supplemental support from State or Federal funding to expand services beyond their critical core mission of promoting public safety.²³ Motivation for jail administration to participate in public health interventions comes from informed jail leaders, a demonstration of cost-effectiveness and value to society, and the development of a trusting collaboration with a community health partner.²³ It is also helpful to plan your intervention through the “eyes of the jail administrator” and anticipate any concerns related to implementation—such as security, space or costs—and address those concerns up front.²⁴³

It is important to recognize that inmates may distrust clinical care providers due to poor experiences in the past, or attitudes of fatalism;³⁴ racial, ethnic, and class differences between inmates and corrections staff can add to this distrust. Effectively working within the jail thus requires a high degree of cultural competency. Minimizing staff turnover will help maintain continuity of relationships with inmates and newly released individuals. As one grantee summarized, “None of this can be accomplished without the central goal of developing trust and rapport with the client—no small feat in a jail environment that often feels unsafe, especially for individuals living with HIV.”⁴³

It is difficult to adhere to Health Insurance Portability and Accountability Act (HIPAA) regulations to offer privacy and confidentiality when working with inmates. In addition, State-specific statutes may apply to HIV matters of confidentiality. Additional steps may be necessary to safeguard HIV status, and community-based health providers should discuss this issue with jail administrators.⁴³ Providers should also clarify with inmates how

their health information may be used, as well as how it is being safeguarded.

Navigating through policies, and the administrative, procedural, organizational, and security measures within a jail facility can be difficult and requires clear communication by all parties.⁵ Community-based organizations and health providers need to understand the jail environment in which they are working—one where safety and security are top priorities. This means that lockdowns may occur, and that community-based providers may not be allowed in on a given day; that some traditional supplies (e.g., paper clips or pens) may not be suitable or allowed in jail; that even cellphones may be considered contraband. In some settings, visitors are not permitted to bring anything with them into the jail setting, including food (although this varies from jail to jail), but, if permissible, food may encourage the development of relationships. As one grantee expressed, “Nothing brings people together like food,” and her organization as well as other grantees found providing food to jail staff to be a nice, nonthreatening way to foster good will.^{37,44}

Any person entering a jail needs authorization from the jail to be admitted. However, hiring and clearance policies between the community-based provider and the jail could differ. A person who passes a background check with the community-based site may not necessarily be cleared to work in the jail. A system should be established between the jail, corrections administrator, jail health provider, and community partners for identifying and assessing eligible patients, communicating regularly, pre-release planning, and sharing health information in ways that ensure HIV confidentiality.⁴⁵

As you develop your program, and determine its scope and the requisite steps for implementation, also focus on protocols, processes, and procedures, and obtain feedback while the program or intervention is being implemented.

The scope and range of services offered inside jails should be individualized to fit the needs of inmates who require a range of medical and mental health care and social support. No “one-size-fits-all” model will work for patients or programs, and some adaptability may be necessary. However, specific interventions planned to outside groups must receive approval from jail administration, and this may limit the range of intervention available. However, a record of community groups being

allowed access to inmates within jails for purpose of conducting an intervention may eliminate the need for outside groups to “prove themselves” before an expanded range of interventions is permitted.⁴⁶

Securing Buy-in and Creating Partnerships

In building relationships with corrections staff, community-based providers should engage the entire staff (e.g., medical staff, warden, corrections officers). Given the hierarchical structure of jails, it is effective to first target high-level decision makers in proposing intervention. Senior leadership at meetings will increase the likelihood for success.⁴⁷

In some cases, jail officials who are not part of the medical staff may seek to learn the HIV status of inmates. Protecting patient confidentiality is of utmost importance, and education sessions with corrections administrators about HIV will help enforce this.⁴⁸ These sessions can address misconceptions, provide information about transmission, explain post-exposure prophylaxis policies, and underscore the importance of patient confidentiality.^{43,64} By educating county probation and parole staff about your project and goals, you will improve communication, which may also enhance patient followup.^{31,43} High staff turnover within correctional settings may necessitate the frequent jail staff trainings.⁴³ Similarly, community-based providers will benefit from security orientation sessions by corrections administrators.³¹

Collaboration and coordination with outside agencies may be necessary, and finding key supporters will help you spread the word. Opinion leaders in the community may be Ryan White Planning Council, consortia, or consumer advisory board members. Involving them in early discussions will improve programming and help you gain buy-in. In facilities both large and small, local health departments can often provide support as well.²⁰

Sharing information and goals up front enhances partnerships by allowing all parties to have a voice. For more formal partnerships, memorandums of understanding (MOUs, for both community-based organizations and jail facilities) will facilitate documenting services, relationships, and reportorial structures. Team-building activities may also be useful, especially those that involve the development of universal forms that can

be shared by jail and community providers to streamline enrollment and reduce duplication of efforts.⁵

EnhanceLink grantees underscored, however, that an MOU must be backed by support; sincere buy-in from collaborating partners and community stakeholders is essential. As one grantee explains, “People think you get an MOU and that’s it, but it’s not it. It’s just the beginning.”⁴⁹ For some EnhanceLink sites, the research grant functioned as a kind of MOU, where partner roles were outlined in the grant application itself. MOUs can be helpful in jumpstarting communication but ongoing conversation and collaboration are necessary.

Sites tailored their linkage programs to their communities and the jail settings with whom they partnered. For grantees with a strong safety net of community services, the majority of their activity was focused on work within the jail, while providers with less developed referral networks allocated more time to the post-release phase.²³ Multiple sites found it helpful to have the case manager position split their time between the jail and the community as a way to better nurture community partnerships and connect patients to services post-release. Success in jails for community-based providers requires their flexibility and adaptability.



GETTING STARTED

“I don’t do doctors; I don’t do appointments; I don’t do court. Nothing! If it didn’t have to do with from the block of my house to the block where the drug dealer was, I did not go . . . I had my own little circle of life . . . if it wasn’t for [EnhanceLink staff member] or anyone I wouldn’t have anything that I have right now. And I have a lot . . . I have another appointment. My doctors do want to keep track of me because it’s the beginning. She said for the first couple of months she wants to see me every month, and I think that’s to see how I’m getting along emotionally, how I’m coping.”

—EnhanceLink participant

The intervention strategies recommended for jail settings include increasing HIV case-finding through additional or expanded testing; effectively engaging HIV-infected persons into care (in-reach); providing ART treatment (either directly or through community health system linkages); improving continuity of and retention in care post-release; and initiating secondary prevention interventions.^{5,50}

The EnhanceLink evaluation center identified some strategies for building a strong and successful program. “[M]any administrative issues are involved in implementing programs. Appropriate and effective information sharing is critical to successful linkage programs, including:

- Having appropriate space for the program in the jail;

- Coordinating the new program with existing services;
- Authorizing community-based organizations, public health departments, and other outside organizations to work in the facility; and
- Meeting facility security requirements.”⁵¹

Characteristics that may influence a jail program design include prevalence of HIV in the community and within the jail; average daily jail population; and mean and median length of stay.⁵¹

OVERVIEW OF A JAIL LINKAGE PROGRAM

Major components of EnhanceLink activities will be described in more detail in the following pages. To

provide context of what a jail linkage program looks like at a glance, some common steps were taken by EnhanceLink grantees, including:

- HIV testing or inmate self disclosure, and mental health and substance abuse screenings;
- Recruitment (including informed consent) and enrollment into the program;
- Pre-release intensive case management intervention (typically, within 24 hours and at least within the first 48 hours) and individualized discharge plans;
- Medical care and HIV education, including risk reduction, ongoing while in jail; and
- Post-release intensive case management (continuity of care) linkages to address mental health and substance abuse treatment needs, HIV primary care, and basic survival needs.³¹

Staffing

Having nonjudgmental, culturally competent staff that both want to be engaged in jail work and with inmates is integral to a successful program.³¹ Specific positions may vary by the size of the jail population being served and the community-based organization's internal capabilities. At some grantee sites, roles included different titles or persons were charged with multiple roles. While titles for staff varied across grantee sites, many of the responsibilities to perform the steps outlined above were similar.

All EnhanceLink participants were HIV-positive so they were either initially engaged by an HIV tester or they self disclosed. If HIV testing is taking place and being administered by jail medical staff, an effective referral system between medical or testing staff and the community-based organization is essential.⁴³ In some grantee sites, the jail medical staff included persons who split their time between the site and a community clinic where inmates would be referred upon release. This approach assisted with continuity of care but was not always feasible. In sites where jail medical staff (i.e., no outside facility staff) performed HIV testing, inmates with a positive result were promptly referred to an individual to discuss medical needs. In some cases this person was called a medical case manager or a patient care coordinator. (See also "[Linkage Services](#).") At EnhanceLink sites where mental health staff and housing counselors existed within the jail, these onsite staff members

SPNS GRANTEES AND AIDS EDUCATION AND TRAINING CENTERS (AETCS) TEAM UP

Some sites utilized their local AIDS Education and Training Center (AETC) to provide training and additional support while implementing their jail initiative. The South Carolina local performance site of the AETC, for example, provided onsite and distance-based HIV education training sessions to jail medical staff.

The Pennsylvania/MidAtlantic AETC provided technical assistance in the development of this manual and the associated implementation and pocket guides.

Source: University of South Carolina Research Foundation. The South Carolina linkage program for inmates (SCLPI). Final report. 2012. [unpublished.]

were brought in as inmate needs dictated. Patient educators or health educator/risk reduction counselors offered health education to inmates.³¹ (See also "[Risk-reduction Education](#).”)

The following information may be helpful to those who wish to establish and evaluate a jail program, EnhanceLink grantees had a principal investigator or program evaluator; some of the larger sites had research assistants and data managers as well. In some cases, the principal investigator also served as the head of the entire grantee project, while other sites differentiated management of the project and oversight of the data and evaluation.³¹ Requirements for maintaining confidentiality may differ—and be more difficult—for research than for clinical management. Evaluation and proof of a program's effectiveness helps facilitate community support and aid in sustainability efforts.⁴³

Discharge nurse, facility coordinator, linkage coordinator, or resource coordinator were varying titles for the person responsible for beginning the process of coordinating care upon release.³¹ At many sites, the same staff person met the participant in jail and then initiated followup post-release.⁴³ Community-based individuals accompanied releasees to appointments to ensure connection to care while care outreach workers were responsible for seeking individuals who fell out of care.⁵² (See

also “Discharge Planning.”) Some sites, like Philadelphia FIGHT, added additional support in the form of faith and community-based mentors and peers.⁴³

Some EnhanceLink grantees had capacity to create a health liaison or court advocate position, and those that did not expressed a desire to add this service to further bolster support for those they serve. In the case of Riker’s Island, the court advocate was a key position that sometimes prevented an individual from being placed in jail and, instead, helped broker an agreement with the courts for the individual to go into hospice, inpatient substance abuse treatment, or an alternative site. As one EnhanceLink participant at AIDAtlanta summarized, “I met with an [EnhanceLink] case manager several times. The court advocacy was very significant. I probably would have gone to prison without it. The program played a valuable part in me getting off the streets. We put a plan together to help me get out, also an individual service plan and counseling. It gave me hope to think I had an opportunity.”⁴⁰

The role of the court advocate was to develop relationships with courts, and assist nonviolent detainees, including those on parole violations to be admitted into behavioral health treatment programs, mental health treatment programs, residential substance treatment programs, or specialized medical care (e.g. nursing home, hospice) in lieu of detention. This advocacy work requires patient consent and entails contact with attorneys, prosecutors, and court liaisons as well as acceptance from health care providers. The court advocate brings health and social service program acceptance letters and electronic health record reports to court. Confidentiality continues to be a concern and the patient/inmate needs to give informed consent and be an active participant in the planning. Not all justice systems or judges have the same approach or views; however, some EnhanceLink grantees did have success with a court advocate approach. As one grantee summarizes,

A unique and important part of these efforts has been advocacy in the criminal justice system. Clients are often treated more favorably in court when there are representatives from a program accompanying the client. The criminal justice ‘system’ views involvement with a ‘program’ as a positive step—and particularly when the program can offer help with housing, transportation and supportive ‘wraparound’ services that include transportation to probation and parole and court hearings.⁵

HIV Testing

According to the EnhanceLink Evaluation Center,

“Many public health interventions—such as the administration of tests, as well as delivery of results and medical treatment—require multiple days to complete. Given how many persons exit jails rapidly, the provision of interventions during the initial days of incarceration may be challenging. One notable exception is HIV testing.”¹

The CDC Rapid HIV Testing in Jail Demonstration Project, funded from 2004–2006, demonstrated feasibility of rapid HIV testing in jails. Many findings from the study can be used to target services and testing; for example, one finding of particular importance is that 39 percent of newly identified HIV cases were among inmates whose only disclosed risk factor was heterosexual sex. Programs that target inmates for HIV testing based solely on reported risk factors may have omitted these individuals, leading the CDC to recommend routinized testing to better identify HIV infection and to reduce stigma.⁴

Identification of HIV infection is a critical first step in ensuring HIV-positive individuals are linked to appropriate care and services.⁴ Jails often provide HIV testing although it is less common and less systematic than in prisons.⁵¹ Regarding testing time and costs, the EnhanceLink Evaluation Center summarized

Rapid test kits are administered on site and do not need a special license or extensive training. All types of rapid tests take 20 minutes or less from start to finish. This allows inmates to get their results immediately rather than requiring jail staff to track them down later. Most commonly, an oral swab or finger stick is done rather than a blood draw. Any reactive test still needs further testing but negative tests do not. . . . The costs of rapid and traditional HIV testing may vary by region and institution but generally the costs are less than \$20, and perhaps less than \$10, per test depending on the type of test performed.²⁰

Traditionally, early detection and case finding have not sufficiently linked inmates with community-based services upon release;⁵³ intake into and discharge from jail present opportunities for these activities.^{53–56} For the EnhanceLink project, “HIV-infected persons were offered and enrolled in linkage services at each of the

grantee sites. Some of the referrals came from the jail-based testing programs, where some individuals may have learned of their HIV status for the first time. Others had a previous diagnosis confirmed by testing during the current jail stay. Still others had a previous HIV diagnosis, often occurring during a previous incarceration, and entered the initiative without HIV testing on the new jail entrance.”⁵⁷

Nearly all EnhanceLink grantees were already engaged in HIV testing within jail facilities before the SPNS initiative grant. Before EnhanceLink, however, grantees did not have much capacity to do linkage work or did not have data to show which linkage activities were most effective. EnhanceLink funding enabled grantees to increase the amount and intensity of case management and linkage services to those found to be HIV positive and, in some cases, to bolster testing efforts. There were a few sites where HIV testing and jail intervention programs were being started. The implementation guide that accompanies this manual outlines steps for both new and expanding programs.

Timing of Services and Interventions

As mentioned earlier in this manual, community-based organizations need to identify what services are currently taking place within the jail, including HIV testing, which often varies from jail to jail. Medical examinations that include HIV testing may occur at different places—during pre-booking, booking, post-arraignment, at their first medical encounter, or at other points.⁵¹ Due to short average length of inmate stay, however, EnhanceLink grantees conducted HIV testing within 24 hours of intake if possible, or at least within the first 48 hours.^{50,58} The majority of testing took place at intake, although many sites created multiple opportunities for HIV testing through either medical visits, med lines, or self-referral sick call.^{30,43}

Community-based organizations must understand their State laws surrounding HIV testing and the type of informed consent required. Opt-out strategies have resulted in greater rates of testing than opt-in strategies.¹⁹

“HIV testers need to be well trained . . . as well as being compassionate and skilled in working with clients with low literacy and comprehension of the [lesbian, gay, bisexual, transgender] LGBT communities.”⁴³ HIV testers also need to be aware of safety issues and confidentiality.⁴⁴

IMPORTANT QUESTIONS WHEN ESTABLISHING HIV TESTING IN JAILS

For community-based organizations not readily involved in HIV testing within jails but looking to initiate such a program, the Yale University School of Medicine EnhanceLink grantee created a valuable guide, available in full here: <https://careacttarget.org/content/jail-time-testing-institute-jail-based-hiv-testing-program-training-manual>. Some important questions they recommend considering include:

- “Is there a medical exam at intake or shortly after?”
- Is there an opportunity to discuss HIV testing at orientation?
- Are there programs that inmates routinely participate in individually or in groups where they can be reached?
- What is the best shift within the jail environment?
- Are there policies that would impede your ability to implement a new way of doing testing?
- Is there space to do the testing and to store supplies?
- Who will do the testing? Who will collect and process confirmatory testing? Is there staff buy-in? Who will do the paperwork?
- Is it necessary to provide financial support to the institution?
- Who will feel threatened by what you are doing? What can you do to minimize the sense of threat?
- Who are your champions? Who are your allies and who can help push your mission?
- How and where will inmates get their results?
- Will results become part of the jail medical record?
- What is the procedure for a reactive rapid test?”

Source: Altice FL, Sylla LN, Cannon CM, et al. Jail: time for testing. Institute a jail-based HIV testing program. Yale University School of Medicine. n.d. Available at: <https://careacttarget.org/content/jail-time-testing-institute-jail-based-hiv-testing-program-training-manual>.

With maximum privacy, inmates can use a “request to see” form at any time to request an appointment. The form requires only the name and/or position of the person they would like to meet; it does not disclose the reason for the visit. This is available to all inmates regardless of HIV status to ensure confidentiality. In addition, all data, forms, and documents are kept *without individual identifiers*. Discussions with patients must be confidential—something difficult to achieve in a jail setting. Determining locations to provide HIV test results and conduct assessment is an important point to negotiate with jail administration.

In working with inmates, staff will have more success if they are warm and friendly; inmates greatly appreciate receiving basic items from grantees (e.g., toothbrushes and toothpaste, clean socks, clean underwear) if permitted. For example, in Riker’s Island, grantee staff found that allowing inmates to take a shower and have some basic hygiene materials went far in increasing client willingness to participate in an HIV test. It is important, however, that testing be voluntary, and community-based providers must avoid the appearance of coercion by giving inmates anything in return for engagement in HIV testing. If one inmate receives items, all inmates should receive the same items.

Always ask patients about their HIV status before offering testing, because some may self disclose, as was the case for many EnhanceLink participants. Individuals who self disclose should be asked about whether or not they are on treatment, if they have notified their partners, and whether they have an HIV or primary health care provider.

Treatment and Adherence

“I thought, why live? I’m still going to die. That was the way I was thinking. I didn’t want to take medication . . . So all those years I was with no medication so I got really sick . . . Now I want to go through medication and I think I do want to live. I want to take my medications. I want to go to the doctor. [EnhanceLink] brightened up my spirits a little bit . . . Really when I got locked up, and I met [EnhanceLink staff member] and went [in] to the program, and being clean, I guess made me just want to keep on living . . . I’ve been on my medication for 2 months now and I feel much better . . . I’m loving it.”³

—EnhanceLink Participant

Inmates often have unmanaged HIV and other untreated infectious diseases when they enter jail.⁷ Without linkage-to-care programs, many individuals being released do not connect to HIV primary care and begin HIV treatment.⁵⁹ Inmates already prescribed ART seldom continue it after jail release, and virological and immunological outcomes worsen.⁶⁰ In order to achieve viral suppression, ART must be taken as directed once started. Data from the HIV Prevention Trial Network study (HPTN 052) demonstrates the benefit of ART in preventing HIV transmission,⁴¹ and jails linkage work continues this effort.

Five factors contributing to treatment outcomes for releasees include:

1. “adaptation of case management services to facilitate linkage to care,
2. continuity of [combination] ART,
3. treatment of substance use disorders,
4. continuity of mental illness treatment, and
5. reducing HIV-associated risk-taking behaviors as part of secondary prevention.”⁶⁰

If a patient is placed on ART, complex regimens with large pill burdens should be avoided if possible. A patient’s other prescriptions should be examined prior to administering ART and discussed with patients and medical providers to avoid drug-drug interactions. Because jail stays are short, many EnhanceLink participants were not placed on ART until after they were released and connected to care. Pre-release patient education about ART, however, was offered. For releasees on ART, many sites provided a small supply of medications and/or a prescription for medication.

Important topics to cover with inmates when discussing treatment include:

- the benefits of HIV medication: its value in preventing progression to AIDS and reduction in HIV complications, including opportunistic infections;
- addressing misconceptions about treatment;
- how medications work;
- integrating regimens into daily life;
- importance of adherence and consequences of nonadherence and treatment interruptions;
- common side effects and suggestions how to manage them;
- dosing and names of medications; and
- any food requirements and the effect of nutrition in medication absorption.

Risk-reduction Education

Jails offer an opportunity to provide HIV risk reduction education to those at high risk for infection but who have little knowledge of HIV or do not view themselves at risk.^{19,61} Grantees must be cognizant of detainees' health literacy levels when providing education.^{20,62} Providing pre-release risk reduction information is important since "the time immediately following release from incarceration imparts great risk for engaging in high-risk behaviors, including relapse to drug use and unprotected and/or transactional sex,"²⁹ which is yet another reason to include risk-reduction discussions with inmates.

EnhanceLink grantees also provided education on additional HIV and health-related topics. Although these varied according to the population within each jail, these basics were covered:

- HIV, STI, hepatitis, and TB overviews,
- Prevention strategies and negotiating safe sex,
- Techniques to deal with fear, fatigue, pain, depression, grief and loss, isolation, and anger management,
- Communication strategies for talking with health care providers and family,
- Conflict resolution,
- Nutrition information,
- Symptoms evaluation,
- Relapse prevention (including post acute withdrawal syndrome),
- Advance directives,
- Job training, including mock interview/role playing, and
- Overall wellbeing, including exercise, journaling, and spiritual needs.^{34,36}

Community-based organizations may also want to consider counseling regarding legal issues that surround HIV, such as nondiscrimination and criminalization or enhanced punishment due to infection (e.g., prostitution, reckless endangerment for unprotected sex).

As one EnhanceLink participant stated, "For people that are HIV [positive], their main issues, their emotional issues, their soul issues, their spiritual issues...to me, from my experience and from what I see, [these] are the most critical things."³

Some grantee sites formalized their curriculum while others incorporated HIV and risk reduction education into broader support groups open to the entire

jail population. In no cases did EnhanceLink grantees limit their educational classes to only HIV patients due to concern around confidentiality and stigma. This enabled patients to feel safe and, in some cases, spurred inmates who had opted out of testing to opt in after learning more about HIV infection. One grantee site operated a family member/loved one support group within the jail and open to all inmates; they advertised this by putting up flyers and sending out letters as well as reaching out to after-incarceration support systems to recruit participants.³¹

It is important to consider that jail stays may be short when scheduling presentations as discharge can happen quickly. Because of this, several grantee sites condensed their educational topics into fewer sessions in an effort to cover more topics before inmates were discharged.

Discharge Planning

Discharge planning involves pre-release enhanced/intensive face-to-face case management,⁶³ and retention strategies need to be embedded into it from the beginning.⁴³ It is important to talk with both jail staff and detainees about a possible discharge date, recognizing that this is made difficult based on jail settings' unpredictability.³¹

The more interaction with transitional services prior to release, the better the chance for connection to care and, therefore, viral suppression.³⁰ However, because discharge within jails can be unpredictable, case managers should act as if each session is their last (as there may be time for only one meeting).^{17,30}

The case manager should listen closely to inmate stories and concerns, including perceived challenges to care, as well as fears about release and HIV status (particularly if newly diagnosed), and try to address these. Release from jail represents a vulnerable time for individuals; therefore, it is important to discuss triggers associated with poor decisionmaking and risktaking. EnhanceLink case managers were often familiar with stages of change and used motivational interviewing techniques⁴⁵ (which include precontemplation, contemplation, preparation/determination, action/willpower, and maintenance or relapse).⁶⁴

Two discharge plans were drafted. One for the inmate who remains incarcerated and moves on to prison, the other for the inmate who is released into the community. The latter should "document when the patient was last in care prior to incarceration, the patient's sources of

social support and housing options, and potential obstacles to appropriate post-release care, along with strategies to address these obstacles.³⁰ Each identified need should be documented and a plan established to address those needs. When the release date is known, application for public health insurance (as applicable), such as Medicaid, Medicare, and/or ADAP coverage, should be completed.

Some grantee sites provided inmates with a copy of their discharge plan; however, grantees and inmates need to be careful with paper plans—that they do not create inadvertent disclosure. In all cases, inmates should be notified when and if changes are made to it, upon which they should be given a copy of the new plan. Some EnhanceLink participants found it helpful to be given a “to do” list as part of their discharge plan to help them remember important tasks, and a list of community resources, including STD clinics, syringe exchange programs in the community, and a list of partnering community-based organizations along with relevant contact names and numbers.⁴⁰

“The goal of initiating social services at the point of discharge is to appropriately link multiple service providers to a client to achieve successful reintegration into the community; maintain healthy behaviors, including adherence to HIV care; reduce risky behaviors; and reduce recidivism.”²⁰

It is important to collect multiple and varied ways of reaching clients after they have been released into the community since housing and phone numbers may change. Grantees collected emergency contact information including the person’s support system as well as information about where the person hangs out, their “street name” or nickname, and any identifying tattoos or other markers.³¹

Linkage Services

Linkage services include post-release referrals to care coupled with intensive case management and followup. Having a consistent advocate (whether a case manager or navigator) can create a sense of trust and rapport. In instances where an inmate is being linked to another provider, “soft handoffs” or “warm transitions” are very important.⁴³

Poor retention in HIV primary care is associated with increased mortality.⁶⁵ Because former inmates face many competing needs, engaging in—and retaining—HIV

care may be low among their priorities.²⁹ After jail inmates are released, basic needs, such as food, clothing, safe housing, and even drug treatment and mental health support, often take precedence over HIV care. The most successful interventions recognized this and promoted access to and linkage in programs that meet these needs. Maslow’s hierarchy of needs provides an important framework for a successful linkage-to-care program.^{4,60}

Linkage services provide a continuum of care from jail to the community; the goal is to do so with as little interruption as possible. To be effective and link jail releasees to the vast array of services they may need in the community means formulating or strengthening relationships with partnering organizations, knowing what community resources are available, and creating supportive relationships between jail- and community-based staff. Community partnerships varied from site to site in scope, involvement, and past working history. Collaborations included health care facilities, housing, social services, mental health, substance abuse treatment and, where possible, transportation assistance, food services, legal services, employment services, and support groups.⁴⁵

Case managers responsible for linkage services went beyond the traditional tenets of case management to offer more intensive and individualized services. Activities varied based on the capacity of each EnhanceLink grantee site and the resources available within their communities. In addition, some EnhanceLink sites focused their grant monies on those areas of need hardest to meet in their jurisdictions, such as housing. All EnhanceLink sites linked releasees to HIV primary care, substance abuse and mental health treatment, and public medical insurance, and sought to address basic survival needs as much as possible. Some sites also connected releasees to legal support (e.g., child support). A big issue for many releasees is securing identification (e.g., Social Security card, birth certificate, driver’s license, or other government identification), which EnhanceLink grantees either helped assist with or connected releasees with Ryan White case managers at partnering sites for assistance.^{3,4}

Transitional care coordination may also include providing a copy of a patient’s laboratory results, processing ADAP or Medicaid (or other) insurance applications, and identifying ways to share health information between providers (with patient consent).³⁰ “Many jail settings provide mechanisms for medication continuity

of care, including providing the medication that remains in a prisoner's prescriptions, or pharmaceutical programs through which 30 days of medication can be ordered upon discharge and delivered to the service provider in the community. Community-based medication support/subsidies for gaps in insurance coverage, such as Ryan White 'emergency medication,' were frequently accessed to minimize treatment interruption. Local Ryan White-funded case management agencies will be aware of the existence of such resources."⁴³

Factors that may enhance linkage include extent of HIV testing within jail; timeliness in delivering HIV test results; capacity to provide health services; extent of coordination with community service organizations; and program involvement to facilitate favorable court treatment.³⁰ Some strategies for supporting inmates upon release include

- listening to their stories and concerns.
- asking open-ended questions.
- being nonjudgmental and encouraging patients to be honest about behaviors.
- understanding where patients are "coming from" and their priorities.
- providing transportation services where possible.
- providing referrals to necessary services, such as health care, food, housing, and clothing.
- scheduling a meeting with a case manager at the time of release, if possible.
- accompanying patients to their first medical appointment.
- supporting patients in meeting parole and probation requirements.^{8,41}

Whenever possible, case managers should meet releasees at the gate and transport them to critical service appointments, and continue to follow patients post-release.⁶³ (Note, the time for this activity varied among grantees as staff capacities allowed.)

When possible, EnhanceLink grantees offered transportation assistance and, in some cases, provided transportation from the jail gate to transitional housing, as

well as to releasees' first medical appointment. When this was not feasible, grantees offered bus tokens or other transportation assistance within their capacity.

For releasees with substance use issues, linkage coordinators should consider discussing the risks of sharing needles and injection equipment, as well as overdose prevention and, in particular, should link them to substance abuse treatment. EnhanceLink grantees connected individuals with a range of substance abuse therapy, from inpatient to outpatient to sober homes (which sought to address drug use and unstable housing issues simultaneously). "Without appropriate diagnosis and treatment, drug relapse upon release exceeds 85 percent, which contributes to poor health outcomes."³⁹ Left untreated, this vicious cycle of relapse and of recidivism will continue.³⁹

Several EnhanceLink grantees had previously established opioid substitution treatment with buprenorphine at their community health clinic sites or had worked with community partners who offered such a service. As grantee Yale University School of Medicine summarized, "By identifying [people living with HIV/AIDS] PLWHA before jail release, we could identify prisoners with DSM-IV criteria for opioid dependence and get them started on buprenorphine BEFORE relapse to drug use."⁶⁶ (To learn more about how to integrate buprenorphine into HIV primary care and access training materials, visit www.careacttarget.org/ihip.)

When patients failed to attend medical appointments, EnhanceLink grantees made phone calls or sent letters, but ensured they had permission to do so and, for confidentiality reasons, did not disclose patient HIV status. For many sites, checking reincarceration was a first step in looking for a lost-to-followup client; shelters, drug and alcohol facilities, mental health facilities, hospitals, and coroner's offices were also checked when patients could not be found.⁴³ Followup may take the form of neighborhood and street outreach, where workers attempt to find the releasee by going to where they live or hang out (depending on information shared and what followup they consented to).³¹

RECOMMENDATIONS FROM THE ENHANCELINK EVALUATION CENTER TO ADDRESS RE-INTEGRATION OF JAIL INMATES INTO THE COMMUNITY:

1. “All released detainees are assessed for individualized treatment plans and linked to providers that offer a continuum of services under the observed and coordinating leadership of a deployed case manager.
2. The program model would be designed so that foreseeable barriers are minimized or eliminated to the point that is fiscally feasible and possible when linking systems with conflicting missions (e.g., corrections systems and public health initiatives).
 - Transportation is provided from the jail on day of release to transitional housing within the community that provides substance abuse treatment.
 - Utilize a nonjudgmental staff trained in cultural sensitivity to minimize and eliminate [insensitivity and enhance inclusiveness].
3. Primary medical care is combined with dentistry and ophthalmology, two essential unmet needs of the target population.
 - a. Coordination of care is used to promote easy access for consultation on complicated medical histories, helping to expedite treatment planning.
 - b. Programs should be efficient with minimal waiting time for all appointments.
4. Case managers collaborate with service providers to help keep all client records up to date and to ensure continuing access to care.
5. The care settings [should be] chosen based on their level of service, and commitment and sensitivity to the community.
6. There is coordination of care by the case managers to ensure that their services are available during the reintegration process.
7. Treatment plans [should be] designed to improve the patient’s HIV medical status and address social service needs.
8. Intense relapse prevention efforts should be utilized through the use of consult/liaison psychiatry and substance abuse counseling.
9. The case managers and outreach workers, [when possible should] meet clients on their turf to ‘sell the service.’
10. The project administrators and educators market their program to other providers, including known collaborating agencies. Medical and dental society meetings; informational gatherings; AETC lectures; local AIDS consortia; social service agencies; and religious groups should all be targeted to disseminate information about the available services.”

Source: Emory University Rollins School of Public Health. Enhancing linkages to HIV primary care and services in jail settings initiative: linkage to social support services. *Policy Brief*. Spring 2010;1(2):4.



CONCLUSION

Jail linkage interventions help address continuity of care issues as inmates are released from jail into the community. As the EnhanceLink study found, many releasees have undiagnosed mental illness, are unaware of their HIV serostatus or out of care at time of incarceration, and suffer from a plethora of health disparities. Community-based providers working with vulnerable populations at risk for or infected with HIV should look into the feasibility of replicating this work within their organization and local jail(s).

Jail interventions cannot be successfully developed independently—partnerships with jail administrators

are essential. This is a CDC recommendation, and HRSA has been underscoring the importance of linkage to care efforts in reducing and addressing health disparities as called for in the NHAS and the Affordable Care Act. While every grantee site in the EnhanceLink study had to adapt to their State requirements and the jail setting with which they were working, important lessons from this initiative can be used to inform others considering this work. Found to be cost effective¹⁷ with medical linkage rates six times the national average,²³ the EnhanceLink study—and its findings—have important public health implications.



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