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Leveraging the U.S. Criminal Justice System to Access Women for HIV Interventions

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Abstract

The criminal justice (CJ) system can be leveraged to access women for HIV prevention and treatment programs. Research is lacking on effective implementation strategies tailored to the specific needs of CJ-involved women. We conducted a scoping review of published studies in English from the United States that described HIV interventions, involved women or girls, and used the CJ system as an access point for sampling or intervention delivery. We identified 350 studies and synthesized data from 42 unique interventions, based in closed (n=26), community (n=7), or multiple/other CJ settings (n=9). A minority of reviewed programs incorporated women-specific content or conducted gender-stratified analyses. CJ systems are comprised of diverse access points, each with unique strengths and challenges for implementing HIV treatment and prevention programs for women. Further study is warranted to develop women-specific and trauma-informed content and evaluate program effectiveness.

Keywords

HIV; intervention; criminal justice; women; systematic review; implementation science

Introduction

Women in the criminal justice (CJ) system in the United States have been disproportionately impacted by the HIV epidemic (1–4). The U.S. incarcerates more of its citizens, and more women, than any other high income country worldwide (5). One in six people living with HIV (PLH) in the U.S. pass through prisons and jails annually (6), and far more remain under community supervision. Women's experiences of both HIV and incarceration differ in

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important ways from men's. As opposed to men's individualistic drug use patterns, women often have overlapping sex and drug partners that increase exposure to HIV and other sexually transmitted infections (STIs) (7). Within personal networks, relationships are frequently complicated by intimate partner violence (IPV) that reduces women's autonomy to modify drug use behaviors or engage in health promoting activities (8–10). Incarcerated women also experience a higher burden of medical, psychiatric, and substance use disorders (SUDs) than incarcerated men (11). These biological, behavioral, and social factors converge on structural gender-related health disparities, resulting in an HIV prevalence among incarcerated women that is twice that of incarcerated men (12, 13).

Despite experiencing a disproportionate burden of disease, women are less likely than men to have access to HIV prevention or treatment services or access to drug treatment during incarceration (14). CJ-involved women are frequently Black or Latina, experience SUDs including injection drug use (IDU), commercial sex work (CSW), stigma, intimate partner violence (IPV), and confinement in closed settings, making them a key target population for HIV prevention (15, 16). Yet just one of the 33 CDC evidence-based behavioral HIV prevention interventions listed on the "diffusion" website is specific to CJ-populations (17), and this program is limited to sexual risk reduction strategies for men only (18). A condom-focused message, however, is unlikely to effectively curb the HIV epidemic in CJ-involved women whose HIV risk is related mostly to drug injection and other substance use, or who have less autonomy to negotiate condoms.

CJ systems can be potential points of access to women living with HIV. Incarceration can be an opportunity to diagnose HIV and effectively provide antiretroviral therapy (ART) to PLH who might not otherwise access regular sources of healthcare (2, 4, 19–23). In a previous large retrospective cohort of PLH incarcerated in Connecticut, women were significantly more likely than their male counterparts to achieve viral suppression during incarceration (24), though these optimal treatment outcomes are not sustained following transition to communities (25).

CJ systems in the U.S. vary widely in terms of their organization, but essentially are comprised of closed facilities (prisons, jails, detention centers) and community-based supervision sites (courts, probation, parole, transitional housing) (26). Although CJ systems aim to protect the public, punish (and perhaps rehabilitate) offenders for public safety, they also represent opportunities to deliver healthcare and behavioral interventions to populations experiencing health disparities (27). Given the intersecting epidemics of HIV and incarceration and to inform the development of women-specific HIV prevention and treatment interventions, we focus this scoping review on the U.S. CJ system as an access point to women for HIV interventions.

In doing so, we acknowledge and build on the previous work of others. Lichtenstein et al. first systematically reviewed HIV interventions for women prisoners (28). This potentially limited relevance to women incarcerated in closed settings, who comprise just 10% of those who are justice-involved. Underhill et al. reviewed HIV risk reduction interventions for adults (both men and women) in correctional and community settings (29). This comprehensive review included heterogeneous study populations, ranging from people who

use drugs to those with any lifetime history of CJ-involvement (including lifetime history of arrest) and did not address gender-specificity. Azhar et al. reviewed HIV prevention interventions, applying a very broad definition of CJ-involvement (30).

These prior reviews contribute vitally to our understanding of the core components of HIV interventions for women in CJ system, but lack factors integral to intervention development and implementation science: 1) how to make HIV interventions or their evaluations women-specific (and thus meaningful to the target audience); and 2) how to identify potential intervention recipients by using the CJ system as a focal point of contact for a population who may otherwise be challenging to engage in community settings. We designed the current study to focus on the gender-specificity of interventions and to span the full breadth of the CJ system (i.e. closed, community, and other settings) -- issues that have not been adequately addressed previously.

Methods

We undertook a scoping review (31) of the published literature to address the questions: How can CJ systems be leveraged to reach women for evidence-based HIV interventions? How can HIV interventions be adapted to address the specific needs of women who are CJ-involved? Whereas a systematic review pre-defines a specific narrow research question and rates the quality of the evidence (e.g. What is the effect of HIV risk reduction behavioral interventions on condom use among women prisoners?), a scoping review more broadly probes existing literature about a concept or general topic (e.g. using the CJ system to deliver HIV interventions to women) (31). In other words, a systematic review asks “What?” and a scoping review asks “How?” We searched PubMed, Ovid MEDLINE, PsycInfo, Embase, and Google Scholar using the following sets of MeSH terms: 1) HIV *or* AIDS; 2) women *or* gender *or* female; 3) criminal justice *or* prison *or* jail *or* probation *or* parole *or* police *or* court *or* incarcerat* *or* offend* *or* offenses* *or* lock-up *or* lock up *or* transitional housing *or* court *or* criminal* *or* crime*. After combining the 3 term sets, we filtered based on full text or abstract available and clinical trial or review, added relevant citations from systematic reviews, and removed duplicates. Two authors (JM and DM) independently reviewed each abstract to apply the following inclusion criteria: 1) published manuscript or report available in English; 2) included any women; 3) specifically recruited CJ-involved populations or used the CJ system for recruitment or enrollment in the U.S.; 4) described a specific behavioral, social, or biomedical HIV intervention; and 5) measured the effect of the intervention on HIV treatment outcomes or HIV-related risk behaviors. We used the term HIV intervention to encompass both studies that intervened to prevent HIV (e.g. reduce risk behaviors, increase HIV testing) and studies that intervened to improve HIV treatment (e.g. linkage to or retention in care, antiretroviral adherence). We limited our search to U.S. based settings because the CJ system is nation- and state-specific, and we could not sufficiently address global issues by only searching databases in English. We did not exclude based on study methodology (e.g. randomized controlled trial, quasi-experimental, etc.). Studies published any time prior to the extraction date of October 1, 2016 were eligible for inclusion. After discussing and resolving discrepancies in each author’s review (errring on the side of inclusion), 53 unique studies were included in the synthesis phase, as shown in Figure 1, in which we extracted relevant data into Tables according to the PRISMA checklist

(32). In addition, we evaluated whether the intervention was “women-specific”, meaning the study only enrolled women, the intervention incorporated gender-responsive or trauma-informed content (i.e. acknowledging specific barriers to accessing or retaining women in care) or if gender was analyzed as a potential mediating or moderating variable. We also extracted data on implementation strengths and challenges to working within CJ systems, as identified by the study authors in the Results or Discussion sections. When multiple manuscripts described the same named intervention, only that describing primary outcomes and intervention efficacy was included in the table, with other associated studies (e.g. those describing adaptation processes, pilot data, or secondary outcomes) referenced within the row. Results were grouped by CJ access point, wherein we briefly described the scope of interventions then focused in on case examples of interventions that were women-specific.

Results

Closed CJ Settings

Table 1 provides an overview of the 26 unique HIV interventions that used closed CJ settings to access the sample population. Closed CJ settings include prisons, which houses inmates generally sentenced to >1 year and are under state or federal jurisdiction; jails or pre-trial detentions, which house inmates who are pre-adjudication or generally under local or state jurisdiction (33). HIV interventions involved psychoeducational risk reduction, intensive case management for discharge planning, HIV testing (34), adherence support (as directly administered antiretroviral therapy (35, 36),) and medication-assisted treatment for substance use disorders (including extended-release naltrexone (37), methadone (37), and buprenorphine (38).) The majority of interventions were related to HIV prevention and testing for selected “high risk” women offenders, although risk (as either an inclusion criteria or a measured outcome) was variously defined. All HIV prevention interventions were psychoeducational or behavioral; none were biomedical.

Though most studies enrolled few female participants or were underpowered for a gender-stratified analysis, 12 enrolled only women or girls. Among these, 4 HIV interventions explicitly included women-specific and/or trauma-informed content (39–42). Project POWER (Providing Opportunities for Women’s Empowerment, Risk-Reduction, and Relationships), for example, was extensively adapted from a CDC evidence-based intervention (EBI) to include HIV disease knowledge, personal risk recognition, evaluation of behavioral change, self-efficacy, and attainment of skills in 9 facilitator-led sessions prior to release (40). Attrition was high post-release but there was still a significant intervention effect on self-reported condom use, knowledge, health-protective communication, and social support compared to a single HIV prevention session as usual. Similarly, Project RRR-HIV (Reducing Risky Relationships for HIV intervention) was a 6-session interventionist-led group that targeted “risky relationship myths” (39). A majority of the intervention group completed all 5 sessions, resulting in significantly decreased reported condomless sex in the intervention group at 90-days post-release compared to an HIV awareness video as usual group. Despite limitations noted in Table 1 (including a lack of measured biological outcomes like STI incidence), these gender-specific studies suggest the success of

interventions that emphasize peer support, self-efficacy and awareness, and trauma-informed content for women and girls during incarceration.

From an implementation perspective, closed CJ settings overall provide highly structured and controlled settings, in which research staff are often able to maintain prolonged continuity of contact with participants and create buy-in from prison staff, even integrating program introductions into standard facility orientations (Table 4). Onsite health and addiction treatment programs also provide a convenient point of contact to individuals with specific health conditions (e.g. HIV, opioid use disorders). These same settings, however, presented challenges to intervention implementation because of highly restricted access, and vulnerability to variability in local/state funding, policy/law, correctional population control (e.g. individuals being moved to or released from facilities), and disease epidemiology. Whereas prisons seem to be optimal settings for multi-session or time-intensive interventions, the rapid turnover in jails and some juvenile detention centers requires time-limited programs or programs focused on transitional care or case management.

Community Supervision CJ Settings

Table 2 summarizes the 7 interventions that used community CJ settings to deliver HIV interventions. Community settings broadly encompass all those that supervise individuals outside of closed facilities. Community settings include probation, in which individuals are under pre-trial supervision or completing a “jail diversion” or “alternative to incarceration” program; parole, in which individuals are supervised regularly following prison-release; mandated supervised community-based drug treatment programs, or transitional housing programs (that are community-based but affiliated with CJ systems of supervision (33).) Interventions involved psycho-educational sessions, integrated care for substance use disorders, and transitional case management programs. All community-based programs related to HIV testing or prevention; there were no studies that described interventions for women living with HIV to promote engagement in care along the HIV care continuum.

Studies generally enrolled few women. A notable exception was Project WORTH (Women on the Road to Health) that enrolled 306 women from community courts and probation sites throughout New York City for an HIV and intimate partner violence (IPV) prevention program focused on risk reduction, negotiation, and empowerment skills (43). Participants in intervention arms received either a facilitator-led program or a multimedia program with similar content. Both intervention arms had increased proportion of protected sex acts at 12-month follow-up compared to controls. Theoretically, the multimedia program has increased sustainability and scalability because it could be delivered in any setting by untrained staff, including probation offices. WORTH is recognized by the CDC as an EBI. These strengths reflect the overall potential for integrating interventions into community correction settings, after addressing the potential pitfalls of a heterogeneous population with high attrition, privacy concerns, and reluctance of staff to make participation seem mandatory (Table 4).

Other or Multiple CJ Settings

In Table 3, we summarize findings from the remaining 9 studies that used other or multiple CJ access points and could not be categorized elsewhere. Sites included a prison visitor

center (44), a work-release program (45), courts and booking sites targeting arrestees on pre-trial release (46), alternative education programs for juveniles (47, 48), a women's reentry center (49), and juvenile drug court targeting adolescents post-plea (50). Two studies partnered with community based organizations (CBOs) that worked with CJ-involved populations at a variety of sites (46, 49). Although the variety of sites enabled program flexibility, it often resulted in heterogeneous study populations with low effect sizes for intervention efficacy (Table 4). As with community-based programs, all interventions were related to HIV prevention or testing; there were no interventions related to HIV care engagement for women living with HIV.

Five programs in Table 3 enrolled only women or incorporated women-specific, trauma-informed content. The HOME (Health Options Mean Empowerment) intervention, for example, was a peer-educator based educational program about HIV risk reduction (44). Women were recruited from a prison visitor center, trained to be peer-educators, and invited to group sessions timed with their prison visits. The program also partnered extensively with CBOs to provide health fairs in the prison visitors' parking lot on a weekend visiting day. While there was a significant intervention effect on HIV testing compared to an unexposed cohort, the convenience sample was heterogeneous and included sisters, mothers, and friends in addition to sexual partners of male inmates. HOME was subsequently adapted for community-based delivery (Project HAPPEN; Health Access Program for Prevention, Empowerment and Networking for Women (49).) HAPPEN was feasible and acceptable in part because of its flexibility and patient-centered focus but again was limited by accrual, attrition, and heterogeneity of the study sample. Another major gender-specific intervention referred HIV uninfected women from multiple CJ sites (jail, parole, probation) and enrolled those eligible in partnership with a county HIV prevention program (51). The HIV and IPV risk reduction intervention was based on motivational interviewing techniques and found to successfully and sustainably reduce condomless sex, needle sharing, and IPV compared to controls. A major drawback to this study was its time-intensiveness, which could limit replicability in other settings.

Discussion

We performed a scoping review of the published literature to evaluate CJ settings as points of access to women for HIV prevention and treatment interventions. The 42 unique studies that met inclusion criteria for synthesis represented a broad range of intervention types and sampling techniques. Instead of using the CJ "system" as a massive umbrella term, we sought to disaggregate the various components within it, comparing the strengths and challenges of each from an implementation science perspective (Table 4). In doing so, we uncovered the strengths and weaknesses of each type of CJ setting (jail, prison, probation, parole, courts, etc.) in terms of being an access point for intervention. For example, an HIV testing intervention that involves large populations with high turnover might best be implemented in a jail; a resource-intensive educational program might best be operationalized in a prison; or a broad outreach program might benefit from the flexibility and centrality of a probation office. Capacity-building within different CJ sectors is key to optimizing health outcomes for people who are CJ-involved (52).

The most successful interventions overall were those in which research staff had established rapport within the CJ site, either because they were more informed about the needs of the target population or because they were able to best align the program focus with the priorities of the CJ site. For example, an HIV psychoeducational program for probation/parole officers and onsite HIV testing was facilitated because one of the researchers was also a probation officer (53). It is often perceived as a conflict when researchers serve dual roles of researchers and interventionists, in which case close partnerships between academic and correctional centers can be highly effective (54).

Women comprise 25% of PLH in the U.S. (55, 56). Countless more women are at high risk of acquiring HIV because of transactional sex, injection and non-injection drug use, underlying psychiatric disorders, interpersonal violence exposure, and overlapping sex and drug use networks (57). Yet women who could most benefit from evidence-based HIV prevention and treatment interventions are frequently isolated from systems of care and support (58). In the absence of women-specific HIV behavioral or biomedical prevention strategies, women face multilevel barriers to care engagement and continue to experience disparate health outcomes with attendant morbidity and mortality, acquire HIV, and may transmit HIV to sex and drug use partners. Evidence-based effective HIV prevention and treatment interventions are thus critical to women's health but hinge on being able to effectively reach high-risk women.

Women, who are a minority in the intertwined epidemics of HIV and incarceration, were still relatively under-represented in the CJ interventions synthesized here. Even fewer interventions incorporated women-specific and/or trauma-informed content, but those that did achieved more compelling intervention effects on HIV-related outcomes. This finding reflects known gender differences in the medical, psychiatric, and social service needs (11, 59), longitudinal HIV treatment outcomes during and following incarceration (60, 61), and HIV risk behaviors (14, 57) of CJ-involved populations. To be gender-specific (and thereby culturally competent) for target audiences of CJ-involved women, interventions should incorporate HIV risk reduction strategies that center on achieving self-efficacy or empowerment and acknowledge relational factors like IPV that contribute to women's HIV risk and care engagement. At a minimum, larger studies of HIV interventions for CJ populations can evaluate gender as a mediating and moderating factor that significantly influences outcomes.

Women who are CJ-involved often experience extraordinary stigma related to their incarceration, substance use, commercial sex work, and other risk behaviors (14). Stigma can exacerbate health disparities to negatively affect health outcomes and also restrict access, limiting the potential for intervention delivery (62). Because women comprise a minority of CJ-involved persons, they are often absent from interventions despite their markedly elevated HIV risk. This represents important areas for future research as HIV prevention efforts expand globally, especially since women who use drugs or engage in commercial sex work, like many CJ-involved, are identified by the World Health Organization as a key target population for intervention (63).

From an implementation science perspective (64), “access points” for HIV prevention and care and related intervention delivery have in common several key factors: 1) a population who stands to benefit from the intervention routinely interacts with the site/system; 2) the site can sustainably support research staff (e.g. in terms of cost, space, technology); 3) the priorities of the site’s organization align with the missions of the intervention; and 4) there are few structural barriers to entry (e.g. in terms of location, hours of operation, cost). Examples of access points for health interventions include emergency departments, clinical care sites, community-based organizations, addiction treatment programs, and others. Women involved in CJ systems may face serious challenges when they access care in these healthcare settings if they do not address women’s specific needs or lifestyles, counter stigma (e.g. stigma associated with HIV, substance use, or CJ involvement), or are not supported by public policies that enable access.

While this scoping review was intended to be exhaustive, it is not without limitations. CJ settings may have other HIV prevention and treatment programs in place for women that have not been rigorously tested or described in the published literature, though we sought to describe only evidence-based interventions. We focused our search on the U.S. CJ system, the organization and conduct of which is distinct from other settings globally. Inclusion was also limited to studies that accessed sample populations through CJ settings as ports of entry, thereby missing interventions for CJ populations in other settings. Notwithstanding these limitations, this is the first systematic review to examine CJ settings as points of access to women for HIV interventions.

Synthesis and Future Directions for Research

Several major themes emerged from this scoping review: 1) CJ-based HIV interventions are most effective when research is aligned with the priorities of the CJ system, stakeholders are involved, and research methods are adapted to suit the structure of the CJ setting; 2) Women are underrepresented and under-evaluated in CJ-based HIV interventional research; and 3) Successful CJ-based HIV interventions for women incorporate women-specific content, including building self-efficacy. Most HIV interventions addressed prevention and focused on psychoeducational or behavioral approaches. Missing from the literature is any description of biomedical interventions for HIV prevention, including HIV pre-exposure prophylaxis (PrEP) or treatment of sexually transmitted infections (STIs), which is clearly needed to push the field forward and align with scientific developments. Although most studies focused on HIV risk behaviors as outcomes, risk behaviors were inconsistently defined- a deficiency that could be addressed through measure harmonization (65). Despite a wealth of new point-of-care and rapid testing technologies, there is also limited data on HIV testing for CJ-involved women. We could not identify any studies that addressed the HIV care continuum for women living with HIV and interfacing with community-based or other CJ supervision sites, perhaps because it is more difficult to measure the HIV care continuum in community settings where care is more widely dispersed. Future work is needed to address the specific health needs of women who interact with the multiple diverse components of CJ systems, with attention to SUDs, CSW, IPV exposure, and psychiatric disorders that often affect women’s healthcare engagement. While we intended to inform implementation science and subsequent development of women-specific HIV interventions,

most included studies focused on intervention efficacy rather than real-world effectiveness. The literature has not sufficiently addressed implementation factors that may help or impede the use and dissemination of HIV evidence-based intervention in CJ real-world settings. More research needs to be conducted and funded in this area.

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Figure 1.
Study Flow Diagram

Table 1

Interventions Delivered in Closed Settings (Prison or Jail)

1 st Author Year	Study Sample	CJS Access	Intervention	Women Specific?	HIV Outcomes	Major Findings	Limitations
<i>HIV Prevention and Testing</i>							
Bryan A 2009(1)	Denver, CO N=484 detained adolescents n=84 girls	3 Juvenile detention facilities	Combined alcohol and sexual risk reduction counseling vs. sexual risk reduction counseling vs. HIV/STI prevention info only (all single sessions lasting 2–4 hours)	Yes Randomized by gender. Gender of intervention leader matched to participants	Condom use Frequency of intercourse while drinking Alcohol- related problems	At 3,6,9,12 months: Both active interventions (combined alcohol and sexual risk reduction group and sexual risk reduction only group) more successful but no added benefit of alcohol risk reduction group	Limited effect on alcohol use outcomes Did not measure other substance use Social desirability bias 30–40% attrition Possible protective effect of incarceration on substance use Single session
Diclemiente R 2014(2)	Atlanta, GA N=188 African American adolescent girls in juvenile detention	Juvenile detention facility	Project Imara (HORIZONS): intervention sessions (3 individual counseling sessions, 4 phone sessions, expedited partner testing) vs. usual care (STI testing, treatment, counseling)	Yes Girls only	Condom use self- efficacy HIV/STI knowledge Condom use skills	At 6 months: Significantly increased knowledge, skills, self- efficacy among intervention group No difference in condom use, # partners, STI incidence	Time/labor intensive Did not assess motivation to change Not blinded for follow-ups
El-Bassel N 1995(3)	New York, NY N=145 incarcerated women with recent drug use	Jail	Skills building and social support enhancement (16 × 2-hour group sessions over 8 weeks) vs. informational group sessions	Yes Women only	Condom use Perceived vulnerability to HIV Sexual self- efficacy Coping skills HIV knowledge Emotional support	Implementation feasible in jail High participation rates Group membership had no significant effect on any measured outcome	Pilot study Attrition due to unplanned release or facility transfers Few IDU Self-reported drug use Non-random sample
Fogel C 2015(4)	North Carolina N=521 women	2 Prisons	Project POWER* (Adapted EBI; 8 × 1.5 hour facilitator-led groups over 4 weeks + pre- release booster;	Yes Women only Gender specific content	Bacterial STI incidence Sexual risk behaviors 3.6 m post-release Illegal drug use Employment status	At 3, 6m post- release: ↑ condom use with main male and secondary partners	No significant effects on incident STIs Potential issues with self- reporting behavior (social desirability bias) 12.8% intervention participants did not attend a single session Low retention post-release No true placebo

1 st Author Year	Study Sample	CJS Access	Intervention	Women Specific?	HIV Outcomes	Major Findings	Limitations
			see also(5, 6) vs. TAU (single session STI prevention)			↑ HIV knowledge ↑ health-protective communication ↑ social support	
Kavasery R 2009(7)	CT N=323 women	Prison/jail	Routine opt-out rapid HIV testing: on entry vs. 1 day later vs. delayed (within 7 days of intake)	Yes Women only	% consenting to and completing testing	Testing acceptance associated with early testing, younger age, higher bond	Generalizability
Knudsen H 2014(8)	CT, DE, KY, RI N=444 women with pre-incarceration drug use within 6 weeks of release	Prisons, jails	RRR-HIV [*] : 5 group sessions with 1 booster session post-release (see also(9, 10)) + HIV awareness video vs. HIV awareness video alone (TAU)	Yes Women only Gender-specific content	Condomless sex	At 90d post-release: ↓ condomless sex with intervention after adjusting for study site 77% of intervention group completed all 5 prison-based sessions	\$20 honorarium for participation during incarceration (coercion?) Self-reported outcomes Heterogeneous study sample Brief follow-up
Myers 2005(11)	CA N=238 state prisoners n=108 women	3 Prisons	Centerforce: prevention case management × 2 months pre-release and 3 months post-release Demonstration project	No	HIV risk behaviors	Most received multiple services; more likely retained in program and not re-incarcerated if received comprehensive health services Pre- vs. post-intervention: ↑ condom use ↓ sex while intoxicated	Small sample (127 in evaluation component, only 51 completed 10w follow-ups) Self-reported risk
Needels 2005(12)	New York, NY N=1410 jail detainees (adolescent males, adult females) n=704 women	Jails	Healthlink: Intensive discharge planning and community case management × 1 year post-release (see also(13)) vs less intensive discharge planning and no	Gender-stratified analysis	HIV risk behaviors Re-arrest Drug use Engagement in drug treatment programs Linkage to healthcare	↑ Use of drug treatment programs in intervention, especially among women ↓ drug use per self-report + hair analysis in intervention, mostly marijuana in	Program had limited access to inmates No true control group

1 st Author Year	Study Sample	CJS Access	Intervention	Women Specific?	HIV Outcomes	Major Findings	Limitations
			community services			women No difference in re-arrest, HIV risk	
Rich 2015(14)	RI N=223 inmates on MMT at time of arrest n=50 women	Prison	Randomized to: Continued MMT during incarceration vs tapered methadone withdrawal (usual care)	No	IDU Engagement in MMT post-release Adverse events Opioide use Re-incarceration Cost	Intervention arm more likely to engage in MMT at all and within 1m post-release No difference in serious adverse events ↓opioide use in intervention arm ↑IDU in usual care ↓post-release medical costs in intervention	limited generalizability (excluded HIV+, inmates incarcerated >6m) Several participants released before completing forced withdrawal
Roberts on 2011(15)	MS N=246 newly admitted adolescent females	Prison	Health education program (60 minute × 60 minute session vs. time-equivalent skills-based HIV/STI risk reduction program (sequential cohorts with interim washout periods)	Yes Women only enrolled	HIV risk reduction skills (health knowledge ; condom application, social competency HIV risk behavior	↑ condom application and social competency skills in skills-based program Equivalent change in perceived barriers to condom use ↓ sex while intoxicated in both arms post-interventions No reduction in STI incidence	Cross contamination Similarity between 2 arms Self-reported behavior
Sacks J 2012(16)	Denver, CO N=468 women requiring addiction treatment	Prison	Randomized to: Challenge to Change therapeutic community program (community activities 4h/day, work 4h/day, 5d/week × 6m) vs. cognitive behavioral intensive outpatient program 2hr sessions, 3 times/week × 16w	Yes Women only enrolled Gender-responsive, trauma-informed content	Recidivism Drug use Mental health Trauma HIV risk behavior	At 6, 12m post-release: Improved outcomes across all domains for experimental arm vs. control Longer time to re-incarceration for experimental arm vs. control Effects on mental health unsustained	Control arm may have had earlier access to community-based services Effect may be due to intensity rather than treatment type

1 st Author Year	Study Sample	CJS Access	Intervention	Women Specific?	HIV Outcomes	Major Findings	Limitations
Schlapman 2000(17)	Howard County, IN N=196 "male to female ratio is balanced"	Juvenile detention center	4 peer-based interactive sessions pre-release over 7 months on sexual risk facilitated by "HIV Prevention Center"	No	Session attendance HIV knowledge Commitment to change behavior	66% completed all 4 sessions Pre- vs. post-intervention: Improved recognition and labeling of high-risk behaviors No change in commitment to change behavior	Low retention (146 completed pre-test, 69 completed post-test; unanticipated facility transfers) Self-reported outcomes Risk behaviors not measured
Schmiege 2009(18)	Denver, CO N=484 adolescents N=84 girls	3 Juvenile detention facilities	Theory-based intervention (single 3hr session) vs theory-based intervention + alcohol risk reduction (single 3-4 hr session) vs control (single 2 hr information session) (see also(19))	Yes Same-sex groups Gender evaluated as mediator and moderator	HIV sexual risk Attitudes towards condoms Norms for condoms Self-efficacy for condoms Intentions to use condoms	↑ sexual risk behavior in info group at 3 months but no change in any intervention groups	Self-reported outcomes Intervention with most effect confounded by being the longest session
Scott 2012(20)	Cook County, IL N=480 women in county jail addiction treatment program	Jail	Recovery Management Checkups (monthly meetings for motivational interviewing, linkage to drug treatment, ongoing engagement, risk reduction counseling) vs TAU	Yes Women only	HIV risk behavior Post-release drug relapse Recidivism	At 30, 60, 90d post-release: 69% overall relapsed to drugs in 30d post-release (no difference in arms) Intervention group returned to treatment sooner, No difference between arms in HIV risk behavior or recidivism	Generalizability (time/resource intensive) Short follow-up period
St. Lawrence J 1997(21)	MS N=90 women	Prison	HIV education based on social cognitive theory and skill training (90 min. once weekly × 6 wk) vs. sessions based on theory of gender and power (unstructured discussion)	Yes Women only enrolled Gender-specific content	HIV risk reduction skills HIV knowledge	Arms had equivalent improvement from baseline in HIV knowledge, attitudes towards prevention, perceived vulnerability to HIV, self-	Possible cross-over between experimental conditions Did not measure impact on post release behavior

1 st Author Year	Study Sample	CJS Access	Intervention	Women Specific?	HIV Outcomes	Major Findings	Limitations
Vigilant e 1999(22)	RI N=78 women "high risk" for HIV	Prison	Discharge planning program with longitudinal therapeutic relationships (physician, social worker, peer counselor pre and post release) vs. discharge planning as usual vs. historical control (352 women released prior to discharge planning)	Yes Women only enrolled	HIV risk behavior Recidivism IDU Crack use CSW	efficacy, condom intention, condom communication frequency Effects maintained at 6m post- intervention	High turnover of peer counselors Attrition Small study Historical control significantly different than intervention group at baseline No true randomization-assigned by discharge planning board
HIV Treatment and Care							
Di Paola A 2014(23)	CT, MA N=65 opioid dependent, HIV+ inmates who received at least 1 injection	Prisons and jails	Project NEW HOPE Extended release naltrexone (XR-NTX) vs. placebo; both with 5 total injections given every 28 days (See also(24))	No	HIV VL, CD4 Retention in HIV care HIV risk behaviors Drug use outcomes Acceptability of XR-NTX	Modest acceptability of XR-NTX	Preliminary pilot data while study still recruiting
Kim J 1997(25)	RI N=41 HIV+ incarcerated women	Prison	Prison Release Program (pre- release counseling by HIV nurse for 30 min. sessions × 5; linkage to community care) vs. historical control of HIV+ women vs. control of matched HIV- women	Yes Women only	# successful post- release referrals for medical care, financial assistance, drug treatment, housing programs	Significant effect of intervention on re-incarceration within 12 months (17% intervention vs. 39% historical controls vs. 37% HIV-women)	Generalizability Non-random sample
MacGowan R 2015(26)	California N= 75 HIV+ inmates	Jail, prison (including prison medical facility)	Positive Transitions (POST): 4 × 90	No	HIV risk behaviors STI diagnoses	Changes from baseline to 3m post-release; No	High attrition post release No control group

1 st Author Year	Study Sample	CJS Access	Intervention	Women Specific?	HIV Outcomes	Major Findings	Limitations
	n=5 women n=4 trans-women		min individual counseling sessions pre-release, 2 sessions post-release on HIV prevention/care + TCM vs. TCM only (TAU)		Receipt of HIV care Taking ART	significant difference between groups on any outcome measure	Self-reported outcomes Drew study sample from cohort already receiving HIV care and TCM in facilities
Pomeroy 1999(27)	Orange County, CA N=139 HIV+ and HIV-(but "affected") women	Jail	Group psychoeducational program on HIV, social/emotional support, CBT sessions (1.5 hours twice weekly × 5 weeks) vs. waiting list comparison group Not randomized	Yes Women only	Anxiety Depression Trauma symptoms	At 5 weeks post-intervention: ↓ anxiety in intervention group ↓ depression in intervention group ↓ trauma symptoms with very small effect size of intervention	"Affected by HIV" not well defined self-selected-potential sampling bias social desirability bias short follow-up
Reznick 2013(28)	CA N=151 HIV+ inmates in male facilities within 90 days of release n=17 identifying as female, transgender female, or gender other than male	2 prisons and 1 jail	Ecosystem-based intervention with group family counseling (2 sessions pre-release, up to 6 sessions in 4 months post release) vs individually focused intervention All received a 45 min HIV education session prior to randomization	No	HIV transmission risk behaviors ART adherence	↓sexual risk behavior in both arms ↑ART adherence both arms (more in control vs. intervention arm) Re-incarceration more likely in intervention group	Cross-over because limitations in accessing family/friends to participate in intervention arm Self-reported behavior.
Saber-Tehrani 2011(29)	CT N=154 HIV+ prisoners within 90 days of release n=18 women	Prison and jail	Randomized 2:1 DAART vs SAT × 6 months post-release All received standardized ART adherence training	No	HIV viral suppression change in VL, CD4 from baseline ART adherence retention in care HIV risk behaviors	Description of trial protocol. At baseline DAART arm had significantly more depression, otherwise two arms similar	No outcomes published (reported elsewhere(30))
Springer 2010(31)	CT N=23 HIV+ prisoners with opioid use disorders,	Prison	Preference study of those with opioid use disorders: MMT	No	Feasibility Acceptability % viral suppression Mean CD4 count	At 12w post-release 17 (74%) retained ↓ opioid craving score	Small study Non-randomized Limited follow-up

1 st Author Year	Study Sample	CJS Access	Intervention	Women Specific?	HIV Outcomes	Major Findings	Limitations
	transitioning to community within 90d and enrolled in RCT(29), opting for BPN in preference trial n= 5 women		vs. BPN for 12 weeks			↓ opioid and cocaine + Utoxex Few adverse effects CD4, VL relatively unchanged from baseline	
White 2015(32)	NC N=43 HIV+ prisoners on ART n=6 women	11 prisons	SAT with monthly allotment of ART vs DOT After week 24, all could receive ART adherence counseling	No	ART adherence (by MEMS, pill count) HIV VL CD4	At 24, 48 weeks: No significant differences between 2 arms in ART adherence, change in CD4 count, % with viral suppression, change in VL from baseline	Small sample size (underpowered) Possible selection bias because clients could refuse randomization
Wohl 2011(33)	NC N= 89 HIV+ prisoners within 1-3 months of release n=24 women	Prison	Bridging case management (net every 2 wks prior to release; twice weekly × 1wk post release; then weekly ×2-3wks, then every 2 weeks for up to 6 months) vs. Standard discharge planning with HIV outreach nurse and referrals (meet 3 times in 3-6m pre-release)	No	Linkage and retention in medical care Hospitalization	Post-release: No difference between 2 arms in linkage to care, hospitalization s, social service use, recidivism Marginal dose dependent relationship between intervention (contact hours w/counselor) and number of medical visits	Potential Hawthorne effect of trial enrollment on care engagement Small sample size 50% of medical visits self-reported No measures of clinical outcomes
Zaller 2008(34)	RI N=59 HIV+ prisoners within 90d of release n=17 women, 1 transgender woman	Prison	Project Bridge: Intensive case management with eco-behaviorism and motivational interviewing techniques (weekly contact × 12 weeks, then monthly for 18m total)	No	Engagement in HIV medical care	At 6, 12m post-release: Description of demographic and social/medical needs of the program participants, barriers to linkage/engagement in a	Small sample size Excluded participants who were re-incarcerated Generalizability

1 st Author Year	Study Sample	CJS Access	Intervention	Women Specific?	HIV Outcomes	Major Findings	Limitations
						particular service	

ART= antiretroviral therapy; BPN= buprenorphine; CA= California; CJS=Criminal Justice System; CSW= commercial sex work; CT= Connecticut ; DAART= directly administered antiretroviral therapy; DOC= Department of Corrections; DOT= Directly Observed Therapy; DE= Delaware; EBI= evidence-based intervention; HORIZONS= a group-level, gender- and culturally tailored STD/HIV intervention for African American adolescent females seeking sexual health services; KY= Kentucky; IDU= injection drug use; MEMS= medication electronic monitoring system; MS= Mississippi; MMT= methadone maintenance therapy; NEW HOPE= Need Extended-Release Wellness Helping Opioid-dependent People Excel; nPEP= non-occupational post-exposure prophylaxis; NY= New York; POWER=Providing Opportunities for Women’s Empowerment, Risk-Reduction, and Relationships; RI= Rhode Island; RRR-HIV= Reducing Risk Relationships for HIV intervention= SAT= self-administered antiretroviral therapy; STI=sexually transmitted infection; TAU= treatment as usual; UTtox = Urine toxicology; VL= viral load; XR-NTX= extended-release naltrexone

* HORIZONS - a group-level, gender- and culturally tailored STD/HIV intervention for African American adolescent females seeking sexual health services

* NEW HOPE= Need Extended-Release Wellness Helping Opioid-dependent People Excel

* POWER=Providing Opportunities for Women’s Empowerment, Risk-Reduction, and Relationships= knowledge of disease transmission, recognition of personal risk, perception of costs/benefits of behavioral change, self-efficacy, attainment of skills

* RRR-HIV= Reducing Risk Relationships for HIV intervention= targets “risk relationship thinking myths”

Table 2

Community Supervision Settings (Court, Probation and Parole)

1 st Author Year	Study Sample	CJS Access	Intervention	Women-specific?	HIV Outcome s	Major Findings	Limitations
<i>HIV Prevention and Testing</i>							
Alemagno S 2009(35)	Urban Ohio N=163 "more males than females"	Probation, 2 addiction addiction agencies	Brief Negotiation Interview (20 minute single- session, computer based) vs. TAU (HIV prevention pamphlet)	No	HIV testing HIV risk behaviors	At 2 months: ↑↑AIDS awareness" in experimental group Risk behaviors ↓both groups	Single session (sustainability?) Social desirability bias Generalizability ? No recent IDUs
Brown R 2013(36)	Madison, WI N=15 jail diversion program participants with opioid dependence n=7 women	2 Jail diversion program s: Drug addiction court and addiction alternative program	SBX through primary care vs. SBX through specialty treatment facility vs. MMT through specialty facility (over 12 months)	No	Ongoing drug use by timeline follow-back HIV risk behaviors	↓HIV risk behaviors in specialty groups vs. primary care group	Small pilot study 3 subjects terminated by the court before 6 month follow-up but retention still 80% ? coercion Drug testing not collected randomly Could not distinguish between SBX or MMT
El-Bassel N 2014(37)	New York, NY N=306 women on community supervision	Community courts, Probation	Traditional WORTH* (90- 120min facilitator- led group sessions weekly × 4wk) vs. multimedia WORTH (4 computer sessions) vs. Wellness Promotion control (4 facilitator-led groups; see also(38)	Yes Women only Gender-specific and trauma - informed content	# and % protected sex acts	At 12 months: Participants in both WORTH arms had ↑ % protected sex acts vs. control arm	14% HIV+ at baseline Non-random sampling Self-reported outcomes (social desirability) Limited details available on recruitment/referral process
Gordon M 2013(39)	Baltimore, MD Providence, RI N=697 probationers, parolees n= 130 women	Probation, parole	Rapid onsite HIV testing vs. referral offsite to community HIV testing clinic	No	Completion of HIV test Receipt of results	Onsite testing more likely to be completed after controlling for city No difference between 2 groups in terms of receiving results	Linkage to care for positive results? Self-reported baseline HIV status Selection bias
Lichtenstein B 2016(40)	Tuscaloosa County, AL N=335 "new" and "current offenders" n=50 women	Probation, parole	On-site HIV services: 2 education at HIV sessions for officers, 4 education at HIV sessions for new offenders,	No	Uptake pretest counseling Uptake HIV testing Officer knowledge and attitudes	31% of new offenders sought HIV testing (n=8 women) Positive qualitative feedback from officers	Generalizability ? Replicability? Small pilot Privacy concerns

1 st Author Year	Study Sample	CJS Access	Intervention	Women-specific?	HIV Outcome s	Major Findings	Limitations
			onsite testing during 4 half-days				
Nydegger 2013(41)	CA N=143 "nonviolent drug offenders" n=40 women	Drug diversion sites with mandated outpatient drug education classes	HIV prevention education (1hr interactive group session) vs wait-list control	No	HIV knowledge condom use intention	↓HIV misconceptions in intervention arm ↑implementation intention in intervention arm	Relatively small study Did not measure behaviors and low correlation between intention and behavior Short follow-up
Prendergast 2011(42)	4 states N=812 parolees n=195 women	Parole-based conditional drug addiction program	Strengths-based Transition al Case management and outreach (2 sessions pre-release weekly, then weekly for 3m post release, then monthly × 3) vs standard parole services (referral to community-based treatment)	No	HIV risk behaviors Engagement in drug treatment	At 3, 9m: No difference in arms in receipt of drug treatment, social services, drug use, crime, HIV risk behaviors Some demographic differences in 2 arms at baseline (intervention arm with more white participants)	Broad exclusion criteria limited generalizability Intervention had longer length of participation, number of visits Selection bias

IDU= injection drug use; SBX= suboxone; MMT= methadone maintenance treatment; TAU= treatment as usual

Table 3

Other or Multiple CJ Access Points

1 st Author Year	Study Sample	CJS Access	Intervention	Women -specific ?	HIV Outcomes	Major Findings	Limitations
<i>HIV Prevention and Testing</i>							
Grinstead Reznick O 2011(43)	Northern CA N=319 women visiting a prison	Prison visitor center	Cycling cohorts: HOME* (community building activities, general health workshops, community referrals, individual counseling) vs. no intervention; see also(44)	Yes Women only Gender-specific content	Frequency of unprotected penetrative intercourse (UPI) (but not necessarily with incarcerated partner)	77–85% follow-up rate for 30d post-release interview Significant intervention effect on HIV testing post-release No significant effect of intervention on UPI rate (interaction with baseline UPI rate)	Intervention and comparison groups not concurrent-cohort effect? Convenience sample Heterogeneous group of visitors (sisters, mothers, friends, sexual partners) Only 25% of intervention group attended at least 1 HOME activity (indirect exposure?)
Kelly P 2007(45)	Bexar County, TX N=539 girls	6 sites of a Juvenile Justice System (probation, first offender programs, detention center, treatment center, alternative school)	Cycling cohorts: Girl Talk-2 (6-hour single session peer-led group) vs. video/lecture	Yes Girls only Gender-specific content	Knowledge, attitudes, practices pre-, immediately post- and 6m post-intervention	Significant intervention effect on condom use, communication skills to diffuse potential violence 89% completed follow-up (low attrition)	Self-reported outcomes No true control group (both arms received same information but in different formats) Did not control for study site in models
Mahoney M 2013(46)	San Francisco, CA N=184 women	CBOs targeting women with substance use disorders, CJ involvement (Women's Reentry Center, family reunification program, residential drug treatment program)	Adaptation of HAPPEN (6×90 min sessions, weekly; health access program for prevention, empowerment and networking for women (based on HOME*))	Yes Women only Gender-specific content Gender-responsive elements embedded	Acceptability, feasibility, fidelity to protocol	Highly flexible program-patient-centered	Dropouts from programs=dropouts from study Adaptation continued during piloting phase Slow accrual
Mallory 2013(47)	Midwest U.S. N=74 women	2 jails, 2 community addiction treatment centers, 2 public health clinics	Women First! (HIV educational program; 6×2hr session, weekly) vs attention-only	Yes Women only Based on theories of gender and power	HIV risk behavior	At baseline, 3, 6m: High rates of condom use at baseline in both groups	Underpowered (estimated sample size was 80) Self-reported behavior High attrition (81%) resulting in

1 st Author Year	Study Sample	CJS Access	Intervention	Women -specific ?	HIV Outcomes	Major Findings	Limitations
			comparison group (time matched, general health)				highly selected sample
Martin 2008(48)	DE, KY, VA N=343 n=49 women	Work release, prison, jail	DVD-based peer-delivered intervention (individual counseling) vs. standard HIV intervention (individual counseling) vs. HIV education video TAU. All received 1 booster session and HIV, HCV testing.	No	Condom use	At 30, 90d: ↓sexual risk behaviors in DVD arm vs. other 2 arms in multivariate analysis Longer time in prison and less education associated with ↓condom use	Data still being collected for the study Self-reported behaviors Small n in each arm
Rhodes 1997(49)	Washington, DC Portland, OR N=1369 arrestees on pre-trial release n=356 women	CBOs working with arrestees, located near courts and booking sites	Case management ("average" 2 face-to-face and 2 telephone contacts/month) + referral guide + video vs. single counseling session + referral guide + video vs. referral guide + video only (control)	No	Risk behavior IDU Needle sharing Condom use	↓Needle use, needle sharing, drug use, criminal behavior, jail time in case management arm vs. other 2 arms Variable intervention effect on condom use and sexual risk	Self-reported data (only some corroborated and only at some sites) Social desirability bias
Straub D 2007(50)	South Florida N=165 adolescents n=114 girls	6 Alternative education and juvenile detention facilities	Single 2-hour education session on HIV/STI prevention vs historical control	No	HIV testing intention and uptake HIV knowledge	↑participation in VCT No change from baseline in HIV knowledge, risk self-assessment, intention for STI/HIV testing	Pre and post-test only given to small subset of participants
Toulou-Shams M 2011(51)	Northeast U.S. N=57 court-involved youth post-plea in treatment	Juvenile drug court	Parents and Teens for Health Program (PATH): HIV	No	Condom use Condom self-efficacy HIV testing Sexual	At baseline, 3m: Slight overall ↑ in % sexually active (no difference between arms) Slight ↓ substance use during sex in intervention arm ↑HIV testing in control arm ↑ smoking over time overall	Small pilot study No true control arm Self-reported data

1 st Author Year	Study Sample	CJS Access	Intervention	Women -specific ?	HIV Outcomes	Major Findings	Limitations
	program, completing 3m of program n=6 girls		prevention through affect management skills vs general health promotion intervention with teaching		activity Substance use during sex		
Weir 2009(52)	Multnomah County, OR N=530 HIV- women with past-year history of incarceration, probation or parole	Referred from Jail, parole, probation, community; enrolled through county HIV prevention program	Randomized to: HIV risk reduction intervention (up to 12 individual sessions in 3mo with MI) vs. HIV and IPV risk reduction (time matched, MI) vs. control (no sessions). All groups received HIV, HCV, STI testing and handbook of community services	Yes Women only enrolled Trauma - informed content	Condomless sex Needle sharing IPV	At 3,6,9m: ↓ condomless sex in intervention groups vs. control ↓ needle sharing in intervention groups at 9m ↓ IPV in all arms	Selection bias because of broad exclusion criteria Self-reported data Difficult to tease out what component of intervention correlated with effects Resource intense intervention Generalizability

CBO=community-based organization; EBI=Evidence-based intervention; MI=motivational interviewing; VCT=voluntary counseling and testing; IPV=intimate partner violence; UPI=unprotected penetrative intercourse

Table 4

Implementation Strengths and Challenges for Each CJS Access Point

Criminal Justice Access Point	Target Audience	Strengths	Challenges
Prison (closed setting) <i>Including detention centers</i>	Sentenced inmates generally > 1 year Visitors(43)	-Low population turnover(8) -Highly structured setting -Highly controlled setting(53) -Able to maintain continuity of contact between research team and participants(3, 29) -Can create buy-in from prison staff (staff to help recruit participants)(1-4, 8) -Integrated medical care-point of contact for certain conditions (e.g. HIV, Hepatitis C)(32, 33) or continuity of care with dually based prison-community providers(11, 25, 34)	-Logistical: cost, staffing, structural support, technological, time(23) -Ethical: potential for coercion -Multiple IRB approvals often required(23, 54) -Adapting to changes in policy, state funding, environmental disasters(15, 22, 23, 26) -Adapting to resulting changes in HIV epidemiology (accrual)(23) -Women may be released to areas across the state or country(4) -Gaining access to facilities(54) -Hard to involve family/support networks in interventions -Potential for cross-over in densely populated environment(15, 21)
Jail (closed setting)	Pre-sentenced inmates Inmates sentenced <1 year	-High risk population -Volume -Local population, highly concentrated(12) -Program introduction built into standard orientation sessions(12) -May include residential addiction treatment components(20)	-High population turnover: timing, release prior to receiving full intervention(7, 14, 27) -Varying jurisdictional control -Ethical: potential for coercion (study supplies as a status symbol), payment?(27) -Multiple IRB approvals often required -Gaining access to facilities
Juvenile detention programs (closed setting)	Detained youth	-Highly structured setting -Highly controlled setting	-Need to obtain parental consent(1) -High population turnover(1) (attrition) -Ethical: potential for coercion -Study may need to be approved by juvenile court(54) -Gaining access to facilities
Probation (community setting) <i>May include jail diversion programs (Alternatives in the Community) or transitional housing programs</i>	Probationers, women under pre-trial supervision	-Community-based population, interventions easily scalable(37) -More flexibility to accommodate different interventions -Coordinate research visits with mandatory reporting days(35, 45) -Low turnover -Highly motivated population (trying to stay out of jail) -Some programs designed for women and children-more gender-responsive/aware -Intervention delivery onsite(35, 39, 41) -Integrate program referral into baseline assessment(36) -Involving probation officers in trainings(40)	-Jurisdictional control -Ethical-distinguishing voluntary participation in intervention from mandatory reporting requirements -Reluctance of probation officers to participate -Privacy concerns(40) -Intervention may be redundant with mandated programming -Heterogeneous population(38)
Parole (community setting)	Parolees post-release	-Community-based population -Can access pre- or post-release through parole -Involving parole officers in trainings(40)	-Generally parole sentences shorter than prison/jail/probation sentences -Jurisdictional control -Ethical-distinguishing voluntary participation in intervention from mandatory reporting requirements(42) -Reluctance of probation officers to participate

Criminal Justice Access Point	Target Audience	Strengths	Challenges
Court (community setting)	All presenting for adjudication	-Diverse population: many first time offenders(51) -“Teachable moment” for intervention(51) -Diversity of courts: specialized (drug, mental health, veteran, juvenile), criminal, community	-Minimal infrastructure to support health interventions research -Distinguishing voluntary participation from mandatory requirements of the court
Police departments (community setting)	Arrestees	-Breadth of population accessing -High risk -Volume	-Rapid high turnover -Jurisdictional control -Minimal infrastructure to support health interventions
Other community-based organizations serving justice-involved populations (community setting) <i>e.g. Support services for family members of incarcerated, reunification program, residential drug treatment programs, county HIV prevention clinic</i>	Varies	-Highly flexible, accommodating, patient-centered(46) -Potentially less perceived coercion because not affiliated with CJ system (strengthens rapport with clients)(49) -Peer programs may alleviate stigma, isolation(44) -Low cost, promotes sustainability(44) -May embed intervention into existing activities(46) -Can expand harm reduction techniques that might be prohibited in CJS(49)	-Requires extensive collaboration -Program dropouts= study dropouts(46); sustainability?(52) -Heterogeneous population(47) -High rates of attrition in some studies(47)