than English at home (http://bit.ly/1Q4mqeW).

Steady, Incremental Communication

Finally, effective public health communication strategies require exposing individuals to appropriate messages multiple times over an extended period as opposed to one-time communication efforts. Changing attitudes, behaviors, and social norms are often slow and, thus, a commitment to a steady, incremental process of communication over time is necessary. In this regard, building positive relationships with local reporters by providing not only evidence-based information but also real-life stories can help shape media coverage (http://bit.ly/2kD3oAa).

In summary, the ACA is a complex law that has affected Americans in different ways over the past seven years. Translating health policy issues to the American public is an important responsibility of public officials. For this very reason, public health communications continues to be a core leadership skill for public health practitioners. AJPH

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The Missing Link: HIV, Corrections, and Public Health

See also Eastment et al., p. 717.

In a country like the United States, which disproportionately locks up the poor, persons of color, and men, looking in correctional facilities for persons with a disease like HIV that in the United States disproportionately affects the poor, persons of color, and men should be obvious. There are very little published data about the fraction of Black men of Generation X without a high-school diploma who go to jail or prison, but preliminary data from a study we are conducting show that a majority are incarcerated in their lifetime. This same demographic is heavily affected by HIV. Nevertheless, efforts to re-engage people living with HIV/AIDS (PLWHA) lost to medical follow-up have rarely partnered with the criminal justice system as a strategy to enhance engagement in HIV management. The article in this issue of *AJPH* by Eastment et al. describes first steps to reverse this lack of coordination between public health and corrections for King County, which encompasses Seattle, in the state of Washington.[1]

THE SEATTLE STUDY

The authors explored the outcomes of the 3% of Seattle residents living with HIV who passed through the King County Correctional Facility and the King County Regional Justice Center in 2014. By contrast, our team previously estimated that, nationally, 17% of all PLWHA in 2006 spent part of the year in a correctional facility and 14% of PLWHA are represented in the cohort of all persons released from such facilities that year.[2] The percentage of the HIV epidemic represented by correctional populations has been falling from proportions seen in the late 1990s.[3]

Nonetheless, traffic through jails, or other short-term facilities, is only one portion of the criminal justice system. On a given day, one third of incarcerated adults reside in jails. The remaining two thirds dwell in state or federal prisons, both of which are long-term facilities for sentenced persons.[4] The analysis did not address individuals who went directly from the street to the state prison system, bypassing jail, the journey that a violator of conditions of prison parole, or a newly sentenced felon not detained before court, may take. It also failed to account for King County residents in prison who were continuously incarcerated—only one third of persons in prison are released annually. In any given year, most persons in prison did not pass through a local jail that same year.

AN OUTLIER

Furthermore, Washington State is an outlier: it lacks the enthusiasm to incarcerate that states elsewhere in the country demonstrate. High incarceration rates in the South drive the extraordinarily high national rate, which results in the United States having the largest prison population in the world. The 2015 national incarceration rate, 860 per 100 000 adults and 666 per 100 000 for citizens of all ages, is 150% of the figure for countries such as the Russian Federation.[4,5] In the same year, Washington State had an adult incarceration rate of 530 per 100 000, which trails the rates in some of the states hardest hit by the HIV epidemic. Florida, Georgia, and Louisiana had incarceration rates in 2015 of 940, 1140, and 1370 per 100 000, respectively.[4] These three states combined were home to 15% of the US HIV epidemic in 2015; Washington is home to only 1%. Although the authors of the

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article studied just 3% of PLWHA in their county, patterns they identified pertain to a large portion of the HIV epidemic nationwide.

AN EXEMPLARY COMMITMENT TO CARE

Eastment et al. rightly points out that, for a country that incarcerates early and often, working with the criminal justice system can bring dividends for community-wide efforts to engage HIV-infected persons in care. For PLWHA who enter Seattle jails, University of Washington HIV providers at Harborview Medical Center can recommend antiretroviral therapy. One of the coauthors, Lara Strick, has been providing care within the state of Washington's prison system for years. Although PLWHA passing through the Washington State and local criminal justice systems were less controlled than average, the exemplary commitment to care by Seattle–King County Public Health and University of Washington HIV physicians, even when patients were incarcerated, may be a reason why the region enjoys above-average levels of community viral suppression.

The authors advocate increased coordination and communication between jails and community partners entrusted with HIV management. Linking data from jail and the electronic HIV registry, as has also been done in New York City,[6] is a commendable, initial step to monitor the quality of linkage. But more than communication is needed. The high-quality care that everyone deserves in this country must accompany the communication. In addition, voluntary, rapid HIV testing at the jailhouse door should be included in areas of high prevalence of undiagnosed HIV, such as Atlanta, Georgia, where more than 0.1% of tests of jail entrants result in new HIV diagnoses.[7] Communication alone will not solve the disengagement from care that is often seen when PLWHA leave jail.

LET'S GO TO JAIL

Willie Sutton robbed banks because "that's where the money was." In the United States, HIV and incarceration are intertwined epidemics. Public health needs to go to jail—that is where the disengagement occurs. A focus on better linkage of the two systems might result in progress toward keeping PLWHA in care and new infections rare for society as a whole. AJPH

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No Mission Too Difficult: Responding to Military Sexual Assault

Building an effective response is central to the systemic change necessary to prevent sexual violence.

See also Rosellini et al., p. 732.

Each year, approximately 1 in 100 men and 5 in 100 women are sexually assaulted while serving on active military duty.[1] Over the past decade, the Department of Defense has invested substantial efforts to address the problem, such as improvements in reporting procedures, surveillance, and primary prevention interventions. However, the high burden of sexual assault-related mental health conditions and disability documented among our nation's veterans highlights the important but understudied issue of early intervention. Experiences in the early aftermath of assault are critical to long-term well-being. "Secondary victimization" owing to victim-blaming responses from law enforcement or health care providers exacerbates mental health sequelae.[2] Provision of high-quality, evidence-based mental health care can address mental health conditions before they become chronic, potentially mitigating the long-term health impact and maintaining the occupational capabilities of service members.

THE VALUE OF ADMINISTRATIVE DATA

In this issue of *AJPH*, Rosellini et al.[3] investigate mental health

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