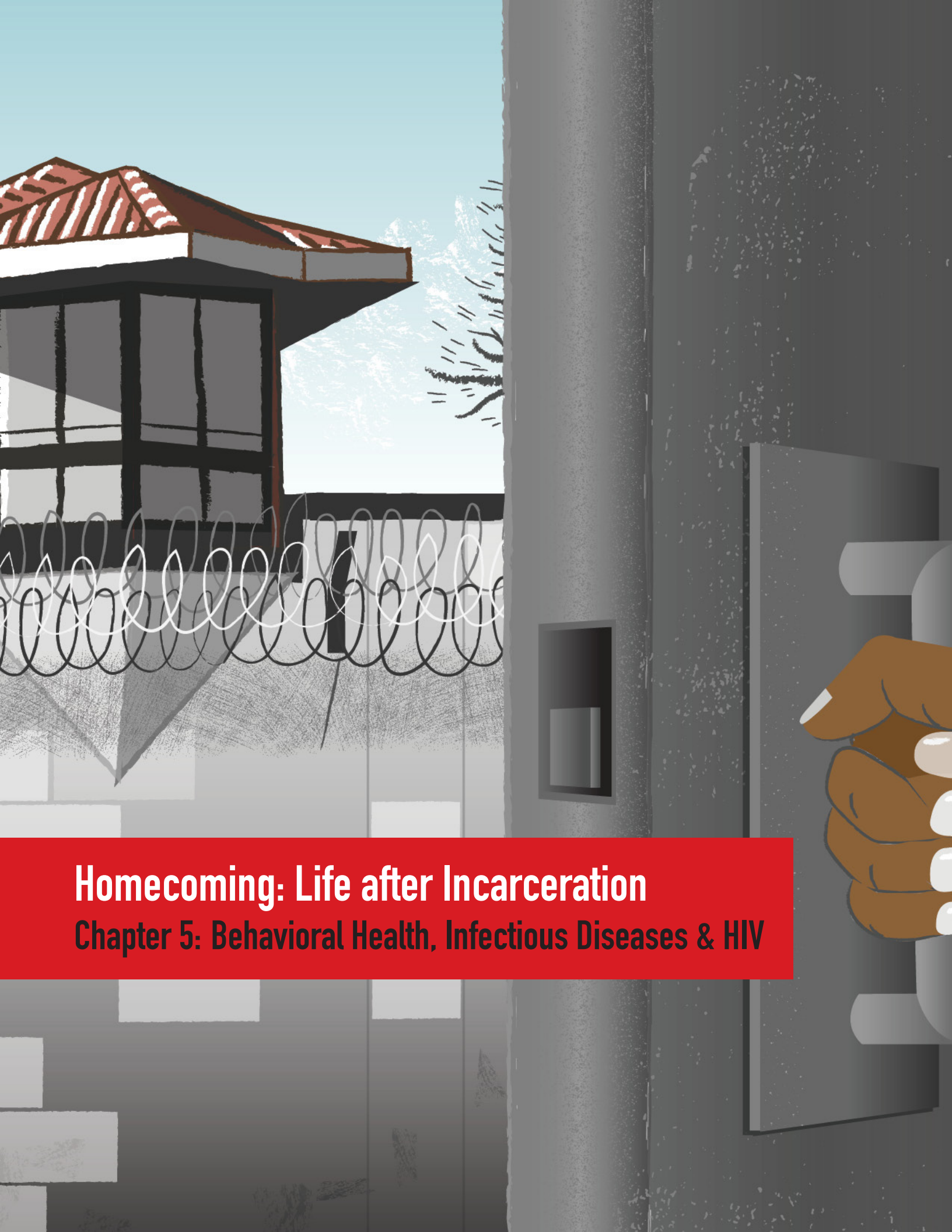

Homecoming: Life after Incarceration

Chapter 5: Behavioral Health, Infectious Diseases & HIV

Homecoming: Life after Incarceration | Supercharging Reentry Success

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HOPWA
HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS

CHAPTER SUMMARY

One	Functions as an introduction to the 'book,' through providing background information, framing topical discussions, and telling the history and context of mass incarceration (and subsequent release for most) in the U.S. from the late 20th century till now. https://files.hudexchange.info/resources/documents/HOPWA-Homecoming-SRS-Chapter-1.pdf
Two	Dives more deeply into the mechanics and broad reach of the U.S. criminal legal system and its impacts on those who spend months, years, and often decades walled off from the outside world. We highlight Innovative Models of successful "in-reach" in jails and prisons in Texas and in-prison educational programming and advocacy in Illinois. https://files.hudexchange.info/resources/documents/HOPWA-Homecoming-SRS-Chapter-2.pdf
Three	Looks at the LGBTQ+ population, cis women, and girls to shed light on the multiple struggles of these underserved and seldom-discussed populations. They are all over-represented in the criminal legal system and susceptible to physical and emotional abuse, stigma, and discrimination inside, as well as homelessness, difficulty finding employment, and other societal challenges outside the walls after their release. https://files.hudexchange.info/resources/documents/HOPWA-Homecoming-SRS-Chapter-3.pdf
Four	Discusses the complexities of family reunification, including common differences between mothers' and fathers' experiences and the importance of family reunification for children, followed by a series of Innovative Models related to family reunification. https://files.hudexchange.info/resources/documents/HOPWA-Homecoming-SRS-Chapter-4.pdf
Five	Examines conditions related to behavioral health and infectious diseases inside correctional facilities; shares several evidence-based innovative models of post-release housing and support services tailored to meeting the needs of those living with mental illnesses, substance use disorders, and/or HIV; and closes with an overview of post-release HIV prevention strategies and the campaign to end the HIV epidemic by 2030. https://files.hudexchange.info/resources/documents/HOPWA-Homecoming-SRS-Chapter-5.pdf
Six	Starts with managing the transition from inside to outside and then describes—and offers examples of—the structure, financing, and delivery options for several different models of housing and services to support the wide range of people being released. https://files.hudexchange.info/resources/documents/HOPWA-Homecoming-SRS-Chapter-6.pdf
Seven	Discusses getting releasees re-established in the community, including the range of "soft" and "hard" skills needed by systems-impacted people to successfully gain employment and effective ways of helping people in reentry learn (or re-learn) skills for managing behaviors and coping with the stresses of life in contemporary U.S. society. https://files.hudexchange.info/resources/documents/HOPWA-Homecoming-SRS-Chapter-7.pdf
Eight	Explores building strong strategic partnerships in your town, city, and/or state to achieve community-wide implementation of the kind of innovative programs and best practices described in prior chapters and to advocate for systems-level change. Chapter Eight closes with highlights from an interview with a provider with more than twenty-five years' experience post-release trifecta of housing development/operations, support services delivery, and systems-level advocacy for formerly incarcerated people and offers selected resources on planning, siting, and developing post-release supportive housing. https://files.hudexchange.info/resources/documents/HOPWA-Homecoming-SRS-Chapter-8.pdf

CHAPTER FIVE: BEHAVIORAL HEALTH, INFECTIOUS DISEASES & HIV

Homecoming: Life after Incarceration – Companion Videos

Also found on the HUD Exchange website is a suite of new documentary films that cover topics similar to those explored in this book but use the unique capabilities of film to humanize and supplement the more detailed discussions of the written text. Each video is 20 - 40 minutes in length and comprises interviews conducted with post-release housing and services clients and providers, as well as researchers and policy makers in the field.

Readers are encouraged to use the videos to supplement the information shared here (and vice-versa) to get a better feel for the dignity, intelligence, life experiences, and humanity of (a small sampling of) the millions of Americans who have been incarcerated and/or are supporting others in their reentry process.

The videos most closely related to the topics covered in this chapter include the list below. All videos can be streamed at: https://www.hudexchange.info/homecoming

Episode V: **For Us, By Us**
Episode VI: **Trauma and Dignity**
Episode VII: **Ending HIV Epidemic**
Episode X: **Money Management Services**

Chapter Five Introduction

In Chapters Three, Four, and Five we have sought to provide an in-depth overview of the intersectionality of gender, race, family dynamics, physical and behavioral health, infectious disease transmission, and the impacts that arrest, incarceration, and release have on all of these.

- Chapter Three focused on certain aspects of cis and transgender women and girls' experiences with the criminal legal system.
- Chapter Four discussed the complexities of family reunification, including common differences between mothers' and fathers' experiences and the importance of family reunification for children.
- Chapter Five looks more closely at conditions related to behavioral health and infectious diseases inside correctional facilities and begins to share evidence-based models of post-release housing and support services tailored to meeting the needs of those living with mental illnesses, substance use disorders, and/or HIV, which happens to be the vast majority of releasees. The chapter closes with an overview of post-release HIV prevention strategies.

Multiple studies have shown that mental illness, trauma, substance use, HIV, and other infectious diseases, especially viral hepatitis and tuberculosis, occur in high numbers among prisoners. The prevalence of each of these conditions, as well as the extent to which they overlap, present a challenge at reentry. In the realm of post-release housing, expertise on each of these issues is essential. In particular, it is important to understand how they manifest and intersect in the carceral environment, as well as the implications each holds for prisoners upon their release.

Quick facts on health and social factors impacting success upon release:

- At least 43% of prisoners experience some form of mental illness;[1]
- 85% have lifetime substance use disorders, and 65% have an active substance use disorder;[2]
- Approximately 15% of all people living with HIV (PLWH) are in contact with the criminal legal system each year;[3]
- 1% to 1.5% of state and federal prisoners in the U.S. were living with HIV (17,150 in 2015);[4] and
- One in seven PLWH in the U.S. has been incarcerated at least once.[3]

1. https://www.prisonpolicy.org/research/mental_health/
2. https://nida.nih.gov/publications/drugfacts/criminal-justice#:~:text=85%25%20of%20the%20prison%20population,overdose%20following%20release%20from%20incarceration
3. Spaulding AC. (2009) *HIV/AIDS among inmates of and releasees from US correctional facilities, 2006: declining share of epidemic but persistent public health opportunity*. PloS one, 4(11), e7558. Available online: https://doi.org/10.1371/journal.pone.0007558
4. https://bjs.ojp.gov/content/pub/pdf/hivp15st.pdf

Glossary of Terms

Criminal legal system: The preferred term for many to describe U.S. police, courts, and corrections systems, because the traditional term ("criminal justice system") inaccurately suggests that "justice" has been a central focus to these institutions when that is far from the case.

Stigma: An attitude of disapproval and discontent toward a person or group because of the presence of an attribute perceived as undesirable.

System-impacted: Refers to the negative collateral effects of having one or more family member(s) incarcerated.

Tenant-based rental assistance: A method of providing housing assistance in which a household is provided a rental subsidy (sometimes referred to as a "voucher') and they are then responsible for finding a suitable unit of their choice in the private rental market that the landlord/owner agrees to rent to them and which meets the requirements of the sponsoring program. The tenant's portion of the rent is typically determined by formula (for many government programs, including HOPWA, this is set at 30% of the household's adjusted gross income), and the subsidy program makes up the difference between the tenant's portion and the amount paid to the landlord/owner.

Undetectable: When copies of human immunodeficiency virus (HIV) cannot be detected by standard viral load tests, a person living with HIV is said to have an "undetectable viral load." Technically, this means fewer than 200 copies of HIV per milliliter of blood (<200 copies/mL), though the target is less than 50 copies/mL.

Viral load: A measure of the amount of HIV in one's blood.

Mental Illness and Its Implications

Mental Illness in Prison

An estimated 56% of the people held in state prisons and 45% of those in federal prisons struggle with mental illnesses.[5] Of these, about 29% are diagnosed with a serious mental illness (SMI). Imprisoned women are more likely to have more severe diagnoses than imprisoned men.[6] According to a study from BMC Public Health, "The mentally ill are overrepresented in correctional settings at estimated rates ranging from two to four times the general population. As result, there are now ten times more individuals with SMI in prisons and jails than there are in state mental hospitals." [7]

Incarceration generally worsens the mental health of those being detained. (Please see the description of Post Incarceration Syndrome (PICS) in Chapter Two.) Some of the biggest contributing factors that diminish someone's mental health include disconnection from family, loss of autonomy, boredom and lack of purpose, unpredictability of surroundings, overcrowding, institutional abuse, solitary confinement, and experiencing or witnessing violence.[8]

Despite the high rates of mental health diagnoses in the prison population, adequate mental health care inside prison is scarce. According to the National Alliance on Mental Illness (nami.org), "Despite court mandates, there is a significant lack of access to adequate mental health care in incarcerated settings. About three in five people (63%) with a history of mental illness do not receive mental health treatment while incarcerated in state and federal prisons. It is also challenging for people to remain on treatment regimens once incarcerated. In fact, more than 50% of individuals who were taking medication for mental health conditions at admission did not continue to receive their medication once in prison. Despite constitutional rights for individuals who are incarcerated to receive medical and mental health care, nearly two-thirds of people with mental illness in jails and prisons do not receive mental health treatment."[9]

When People with Mental Illnesses Exit Jail or Prison

People in prison who are living with mental illnesses are more likely to have been homeless before going into prison than were others.[10] Once inside correctional institutions, they are, illogically, more likely to "max out" their sentences and leave prison unsupervised by parole. They are also more likely to become homeless than their counterparts without some form of mental illness. Once living in the community, research shows they return to prison more frequently, and sooner.[11]

The obstacles to helping people with mental illnesses who have been incarcerated may seem mountainous. The difficulties of continuing their medication and treatment upon release is similar to those

5. https://www.prisonpolicy.org/research/mental_health/
6. Al-Rousan, T. (2017) *Inside the nation's largest mental health institution: a prevalence study in a state prison system*. BMC Public Health 17, 342. Available online: https://doi.org/10.1186/s12889-017-4257-0
7. Ibid.
8. https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/
9. https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Treatment-While-Incarcerated
10. Jeremy Travis, Amy L. Solomon, and Michelle Waul. *From Prison to Home: The Dimensions and Consequences of Prisoner Reentry* (Washington, DC: Urban Institute—Justice Policy Center, June 2001), 29. Available online: https://www.urban.org/research/publication/prison-home-dimensions-and-consequences-prisoner-reentry
11. Ibid, 87.

living with HIV. Furthermore, a lot of community-based organizations have a fear of people leaving prison with mental health issues. The possibility of psychosis, lack of medication, and compliance issues can all be daunting.

Some housing programs have a policy of not serving individuals with a major mental illness. They may consider these conditions too serious for their current staff to handle or lack access to income streams to pay for the level of qualifications and support needed. Yet, what are the long-term housing alternatives for the large group of mentally ill people leaving prison unable to access the housing that has been set aside for the mentally ill? When turned away by supportive housing providers, most will end up in less structured and less service-enriched environments, where, unfortunately, they will most likely do worse. It is therefore recommended that, instead of ruling out mentally ill ex-prisoners, post-release housing providers increase their skill and capacity to respond to the needs and aspirations of these returning community members.

At a Glance 5.01

Preparing to house people exiting prison who experience severe mental illness

- Provide training for staff on major mental illnesses and co-occurring substance use disorders;
- Orient staff to the treatment of mental illnesses and the basics of psychopharmacology;
- Hire a part-time mental health clinician to consult with staff at regular meetings and on an emergency basis;
- Collaborate with mental health services in the community to have new residents assessed and treated;
- Support residents who are resistant to treatment;
- Hire peer workers with lived experience that is comparable; and
- Emphasize the need to assess mental health very early in the relationship.

Innovative Model 5-A

AFC's Scattered-Site Permanent Supportive Housing Programs – Chicago, IL

Overview

AIDS Foundation Chicago (AFC) coordinates collaborative, permanent supportive housing projects for vulnerable homeless individuals and households living with chronic conditions, including HIV, in Chicago and surrounding counties. AFC's Supportive Housing Program (SHP) consists of 12 partner agencies who serve more than 1,000 households annually. SHP case managers provide intensive case management services helping clients achieve and maintain housing stability, access eligible benefits, improve their health, and reach client-directed goals. Over 97% of housing participants maintain stable housing for at least 12 months.

In addition to supportive housing, AFC provides a long-term rental subsidy through its Tenant-based Rental Assistance Program for people living with HIV (PLWH). AFC also coordinates four streams of funding to provide short-term rent, mortgage, and utility assistance to people experiencing housing crises. Finally, AFC oversees the Housing Navigation Program, which provides housing information, unit identification, emergency assistance application, and referral services to low-income PLWH in the community.

Evidence-based Approaches to Serving Multiply-diagnosed Residents

Intensive Case Management services in AFC's housing programs are based on the evidence-based practices of Harm Reduction, Housing First, Motivational Interviewing, and Trauma-informed Care. These models are not used in isolation; together they guide case management services to ensure a client-centered, strengths-based, and culturally appropriate approach.

Harm Reduction (HR) is a non-judgmental, non-coercive approach to service delivery that affirms the client as the primary agent of reducing negative consequences in their lives. AFC's housing program models are based on HR, with the understanding that many who experienced homelessness have—in order to survive—participated in behaviors that put their housing and health at risk, such as the use of illegal substances and needle sharing. Rather than mandating abstinence from these behaviors, AFC case managers work collaboratively with clients to identify ways to reduce the risk of negative consequences, such as by reducing use or accessing needle exchanges.

Housing First (HF) prioritizes providing permanent housing to people experiencing homelessness—and exiting jail or prison—without any preconditions or requirements to participate in services. This approach ends homelessness as quickly as possible and provides a platform from which participants can pursue their goals and improve their quality of life. All of AFC's housing programs take a Housing First approach; there are no barriers to entry or requirement to participate in case management services. As soon as clients are identified and determined eligible, case managers work to move them into a permanent housing unit as quickly as possible, while honoring client choice in unit location and features.

Motivational Interviewing (MI) is a counseling method that helps people resolve their ambivalence about change and build internal motivation to change their behaviors. MI is client-centered and directive in that the counselor works to identify and mobilize the individual's intrinsic values and goals to move toward behavioral change. All AFC case managers are trained in Motivational Interviewing and use this approach to engage clients in conversations around physical and behavioral health, including ways to access and maintain HIV care.

Trauma-informed Care (TIC) is a service delivery approach grounded in an understanding of, and responsiveness to, the impacts of trauma. This model recognizes the high incidence of trauma among homeless and formerly incarcerated individuals and how this experience of trauma impacts the individual's well-being and participation in the program. Through TIC, case managers incorporate an understanding and awareness of trauma into their work by assuming that everyone has experienced some form of trauma and seeking to understand behaviors as adaptations to traumatic experiences. Trauma-informed Care involves opportunities to rebuild control, emphasizing the importance of choice and helping clients to create predictable environments that allow increased self-efficacy and personal control.

AFC's Re-Entry Housing for Health Partnership

The Re-Entry Housing for Health Partnership (RHHP) is a collaboration developed by AFC to serve individuals living with HIV who would otherwise be homeless upon release from a correctional facility. The program provides stable housing and supportive services to the reentry population. Without support, those who are reentering civic life must cope with the challenges that arise from living on the streets and in shelters; these challenges increase the likelihood of repeat incarceration, transmission of HIV, and poor health.

Housing and case management allow releasees to stabilize and focus on maintaining health. RHHP's program model therefore creates a seamless continuum of care for recently released, HIV-positive incarcerated populations by providing supportive housing and intensive case management services, as well as improving linkages between correctional facilities and community agencies.

AFC, the grantee and lead agency, collaborates with Christian Community Health Center and The Boulevard of Chicago to provide permanent housing and supportive services. AFC also works with the Center for Housing and Health to process rental assistance payments to landlords. In addition to offering client-level services, AFC's model targets re-entry at the system and program levels to strengthen, coordinate, and maintain linkages across housing and service-delivery communities.

RHHP has three main steps that ensure continuity of care for each client: (1) outreach to correctional facilities by program coordinators; (2) collaboration with Illinois Department of Corrections, transitional homes, treatment centers, and other community organizations to maintain communication with clients during transition; and (3) connections to permanent housing.

Once stably housed in a scattered-site, permanent housing unit, clients are provided with case management and access to wraparound services, including referrals to primary care, mental health, substance use, counseling, benefits acquisition, and employment assistance.

AFC's Program Coordinator conducts outreach to, and develops collaborations with, local correctional facilities in order to recruit people before they are released. They also provide programmatic support to case managers at partner agencies as they deliver case management and referral services to clients to help them maintain housing stability, increase skills and income, and achieve greater self-sufficiency. As of July 31, 2020, 33 scattered-site apartments were provided for 33 individuals living with HIV who have been released from a state correctional facility or jail.

For more information, go to: https://www.aidschicago.org/page/i-need/housing

Medicaid Can Support Transitions Back to the Community

As people leave jail or prison, they need health coverage, and many are eligible for Medicaid. Uninterrupted access to healthcare can reduce their risk of recidivism and improve their job and housing prospects, as well as family support. Guidance from the Centers for Medicare and Medicaid Services (CMS) published in 2016 clarified that Medicaid covers services for individuals who are on parole or probation, on home confinement, or in the community awaiting trial.

The guidance also explains that people living in halfway houses, which corrections agencies often supervise, can receive Medicaid-covered services as long as they have freedom of movement and association, and can get health care in the community just as other Medicaid beneficiaries do. Additionally, the guidance explains how states should suspend, rather than terminate, eligibility for beneficiaries while incarcerated and how they can work with prisons and jails to enroll people in Medicaid and connect them to health care services before they reenter the community.[12]

A high proportion of justice-involved individuals have long-untreated chronic health conditions, as well as a high incidence of substance use and mental health disorders. Facilitating enrollment in Medicaid and supporting access to services following incarceration has the potential to make a significant difference in the health of this population and in eligible individuals' ability to obtain health services that can promote their well-being. Such enrollment will also help people with disabilities obtain critical community services to avoid crises and unnecessary institutionalization.[13]

Nineteen states have yet to fully realize Medicaid's ability to support the justice-involved population by expanding Medicaid to cover all adults with incomes below 138% of the poverty line. In those states that haven't expanded Medicaid, among adults under 65 who don't have a disability, only very low-income parents and pregnant women are eligible for Medicaid. This leaves many thousands of people, especially men, without health coverage to help them successfully transition back to the community.[14]

Substance Use Disorder in Prison

Despite high percentages of the prison population suffering with a substance use disorder (SUD), such as opioid use disorder (OUD), access to treatment is lacking. The exact rates of incarcerated people with SUD has yet to be determined, but most recent studies put the estimates at between 65%-85% of the prison population as suffering or having suffered with SUD.[15] This is in stark contrast to the general population, in which only 5% -10% is estimated to be suffering or having suffered with SUD.[16] According to Pew Charitable Trusts (pewtrusts.org), "The most effective therapy for people with opioid use disorder (OUD) involves the use of Food and Drug Administration-approved medications, such as methadone, buprenorphine, and naltrexone. Despite evidence that this approach, known as medications for opioid use disorder (MOUD), reduces relapse and saves lives, the vast majority of jails and prisons do not offer this treatment."[17] A recent National Academy of Sciences report on medications for opioid use disorder stated that only 5% of people with OUD in jail and prison settings receive MOUD treatment.[18]

How do substance use disorders affect a prisoner's chance at success after release? According to the National Institute on Drug Abuse, "During their time in prison, many untreated inmates will experience a reduced tolerance to opioids because they have stopped using drugs while incarcerated. Upon release, many will return to levels of use similar to what they used before incarceration, not realizing

12. https://www.cbpp.org/blog/medicaid-can-support-transitions-back-to-the-community
13. https://www.hhs.gov/guidance/document/facilitate-successful-re-entry-individuals-transitioning-incarceration-their-communities
14. https://www.cbpp.org/blog/medicaid-can-support-transitions-back-to-the-community
15. https://www.drugabuse.gov/publications/drugfacts/criminal-justice
16. https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/opioid-use-disorder-treatment-in-jails-and-prisons
17. Ibid.
18. https://www.drugabuse.gov/publications/drugfacts/criminal-justice

their bodies can no longer tolerate the same dosage levels, thereby increasing their risk of overdose and death. One study found that 15% of all former prisoner deaths from 1999 to 2009 were related to opioids. Insufficient pre-release counseling and/or post-release follow-up are partially responsible for this alarming increase in mortality."[19] With this in mind, treatment for substance use disorders while in prison, and making services available immediately after release to continue that treatment, are essential to prevent sickness, recidivism, and death among people who were formerly incarcerated.

A Little Tolerance for Drugs

Post-release housing programs need to do their best in managing the impacts, if any, from tenants' use of drugs—the impacts on themselves, on their neighbors/roommates, and on the community as a whole. It is an issue of paramount importance. Some providers would prefer to operate a clean-and-sober housing program; it certainly sounds tidy and controlled—but in reality, it is not an easy, or necessarily likely, scenario. Many residents in post-release housing have histories of drug use, and given the circumstances of their lives during reentry, may be prone to relapse. Housing programs with no tolerance for drinking or using drugs (enforced sobriety) may find that adhering to this policy is such a struggle that it limits the impact of their work. Rules that are too strict often cause residents to bounce out of the program, causing disruptions for everyone and undermining the goal of stabilizing and integrating residents in society at large.

Having observed over time the problems other providers have faced in trying to support tenants' housing stability in an environment of zero tolerance, more and more housing programs are now offering more flexibility around the issue of drug and alcohol use. Believing that total sobriety is not always necessary for former addicts to achieve residential stability, their understanding is that residents will necessarily have relapses, and with support, these residents can use short-term returns to substance use—or temporary increases in levels of use—as stepping stones in their progress towards full recovery from addiction.

Such attitudes reflect a harm reduction approach to addiction described above, with the goal of reducing the frequency or degree of potentially negative consequences of substance use, when full elimination of the activity is not an available option.

In practice, harm reduction means different things to different people. This is especially true in the realm of housing. Two housing groups describing themselves as following HR policies will often look and operate very differently. If interested, your organization will have to decide for itself how HR approaches might be incorporated. One recommendation is that if you choose to integrate HR, leave the term itself out of the description of the housing program, as it can create a stigma for the residents who live there. The terms "low threshold" or "low barrier" may be preferable. When the harm reduction approach is applied in a housing setting, it's referred to as "Housing First."

19. Ibid.

At a Glance 5.02

Core principles of harm reduction

- There are no punitive sanctions imposed by the program based on the choice of substances that someone decides to put/not put in their body. When we create punitive sanctions, people will inevitably lie.
- Incremental change is normal, as are setbacks.
- The most appropriate measures of success are residents' quality of life and sense of well-being.
- Tenant engagement—a commitment to ensuring tenants are actively engaged in influencing housing services and shaping their communities—can offer a powerful approach.
- Client-focused services are part of a non-authoritative approach that allows clients to take the lead in discussions so that they will discover their own solutions.
- Motivational Interviewing is used in order to help people resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behaviors.

At a Glance 5.03

Steps to planning harm reduction-based post-release housing

1. Read literature and attend trainings and meetings about harm reduction and housing first;
2. Talk to and visit with service providers with a policy of harm reduction;
3. Sit down with staff and hash out among yourselves what you really mean by HR—have discussions/debates;
4. Determine at what point the program will say "no more" to certain behaviors that impact the community—be clear on what the limits will be;[20]
5. Put your organization's own interpretation of HR in writing. Make sure that everyone on staff understands the policies; know that these policies will evolve over time, once your program is in operation for a while; and
6. Revisit your HR plan frequently and make revisions as needed.

At a Glance 5.04

Ideas for incorporating harm reduction into post-release housing

1. There are no clean-time requirements for admission to the program.
2. Residents are expected to behave as good tenants and uphold the terms of their lease. Eviction from the residence is based on these terms alone.
3. Relapse is perceived as an inevitable and necessary part of the recovery process. Arrangements are made for interventions in the case of relapse.
4. Staff provides support services to residents whether they are straight, intoxicated, or high. Limitations may include when residents are falling asleep or seem threatening.

20. Adolph Grant, interview by Kristina Hals, September 2001, SPAN, Inc., Boston.

5. In the event of relapse in substance use, residents are allowed to seek treatment and return to the residence. If residents are receiving a government rental subsidy, the length of time a unit can be held for them while they undergo residential treatment (or experience a brief incarceration) will be stipulated in the contract.
6. Residents who relapse may remain in the housing program, provided they maintain acceptable behaviors as tenants in good standing.
7. Residents who are not "clean and sober" are encouraged to learn and practice strategies to reduce the harm their addiction causes in their lives, and in the lives around them, such as following regular daily schedules, eating regular meals, using clean needles, using needle exchanges where available, and practicing safer sex.
8. Residents are taught HR techniques, such as needle exchange, cleaning their works, and practicing safer sex.
9. Remember that you may choose to implement any or all of these, and that it's okay to adapt over time as your residential community evolves.

More to Learn

Working in the field of post-release housing will give the staff of any organization much to think and talk about. The daily challenges will undoubtedly keep them interested and engaged in their work. A goal of this book is to prepare those who take on this adventure by exploring a number of the themes and challenges that are likely to arise. Nevertheless, the real learning will come from the daily experience of operating a post-release housing program. Given the complexity of issues, expect that staff will need ongoing education on the many topics that affect residents' lives.

At a Glance 5.05

Websites with up-to-date resources on Harm Reduction and Housing First

- Corporation for Supportive Housing: https://www.csh.org/
- HOPWA Program Fact Sheet on Housing First & Harm Reduction: https://files.hudexchange.info/resources/documents/HOPWA-Factsheet-Housing-First-and-Harm-Reduction.pdf
- National Harm Reduction Coalition: https://harmreduction.org/
- Pathways Housing First Institute: https://www.pathwayshousingfirst.org/

Relapse as a Risk Factor in Recidivism

"If we get someone into housing and they are all messed up, they are going to lose the housing."[21]

Reentry itself is a common risk factor for relapse. For someone recently out of prison, just walking down the street may be enough to set off their addiction. As a brain disease, addiction flares under trigger conditions. Coming back to an old neighborhood and seeing familiar places and former friends

21. Grant, interview.

associated with drug use is particularly likely to increase cravings for drugs and alcohol.[22] Formerly incarcerated people in recovery from addiction are therefore more likely to thrive, and stay clean and sober (if that's their intention), in new territory. Furthermore, depending on the terms of their parole, associating with other former felons may be grounds for re-incarceration, so reentry in a neighborhood that is new to a releasee may be a good idea on multiple fronts.

At a Glance 5.06

Options for addressing addiction in-house

- Substance abuse counseling;
- Relapse prevention groups;
- Cognitive behavior programs; and
- Harm-reduction recovery programs.

At a Glance 5.07

Out-sourced options for addressing addiction – referrals

- Day treatment;
- Individual substance abuse counseling;
- Methadone maintenance;
- Twelve-step programs;
- Rational recovery programs; and
- Collaboration with needle exchange and other harm-reduction programs.

Addiction can be like a hurricane that sweeps through and interrupts recent releasees' progress, and it can leave the morale of housing staff in tatters. Relapses and related behaviors can bring on multiple complications in the lives of residents, including loss of jobs, eviction, mental health and medical crises, and, almost inevitably, re-arrest. Social workers and advocates identify substance abuse as the single most important issue for those in reentry to work on if they are to avoid going back to prison. As one advocate explains, "Out of control substance use is the biggest barrier to success."[23] It will likely to be an underlying issue with almost every incoming resident in post-release housing.

The innovative model that follows, and the others that are based on supportive housing, harm reduction, and housing first principles, offer the best avenues to long-term success for residents, even if it's hard at first for some staff and community members to accept the evidence that supports these approaches.

22. Travis, Solomon, 27.
23. Grant, interview.

Innovative Model 5-B

LSS's Forensic Housing Program – San Francisco, CA

The Forensic Housing Program (FHP) is a permanent supportive housing (PSH) program of Lutheran Social Services of Northern California (LSS), in collaboration with San Francisco City and County programs. The program first ensures that people living with HIV (PLWH) who lack appropriate options upon release from jail or prison have immediate housing access. FHP offers low-barrier, single room occupancy (SRO) housing.

FHP provides all program participants with supportive housing services, including case management support to help stabilize their lives. Additional program services include: optional money management, linkages to HIV prevention, access to benefits counseling, workshops/groups focused on teaching basic life skills, access to medical and oral healthcare, and access to behavioral health services targeting post-incarcerated individuals living with HIV.

The program receives funding from the U.S. Department of Housing and Urban Development (HUD) through a competitive Special Projects of National Significance (SPNS) grant from the Housing Opportunities for Persons With AIDS (HOPWA) program. (See Chapter Six for more information on HOPWA and other funding streams for housing.)

LSS supplements its core staff with the following resources:

- Nursing school interns from the University of San Francisco who provide nutrition education and community activities to improve overall participant health outcomes;
- Resource groups that meet weekly focusing on nutrition, harm reduction, relapse prevention, treatment, and HIV medication adherence;
- Cooking classes specific to creating nutritional meals that can be prepared in small spaces and cooked in a microwave; and
- Access to partner agencies with expertise in income advocacy, employment, healthcare and behavioral health services, and permanent housing search and placement.

The Forensic Housing Program works with individuals living with HIV, post release, in the following areas:

1. **Accessing Health Care:** One of the primary goals of the HOPWA program is to ensure that participants actively engage in primary healthcare with community-based HIV care providers.

2. **Accessing Public Benefits and Money Management:** FHP staff works with social service providers to assist program participants in accessing benefits such as the County Adult Assistance Program (General Assistance), federal Supplemental Security Income (SSI), and optional money management services, which help participants increase their self-sufficiency.

3. **On-Site Services:** All services are offered on a strictly voluntary basis. Case Management is available to help clients cope with reentry by making referrals to various resources in the

community. Residents have a private room furnished with a refrigerator and a microwave and access to use a shared community room and kitchen. On-site meeting spaces are used to host classes, community meetings, and enrichment activities.

Requirements for acceptance into the Forensic Housing Program include:

- Documentation of HIV status and engagement in medical care;
- Homeless certification;
- Release from custody within the past two years and free from any warrants;
- If on parole, applicants must be in compliance with their parole agent (LSS strives to take new clients within the first 24 hours of their release from custody);
- Documentation of more than 72 hours of incarceration;
- Ability to live independently and keep one's room in a livable/safe condition;
- Agreement to follow all program rules;
- Agreement to pay 30% of adjusted gross income in monthly rent.

Learn more about LSS's programs at: https://www.lssnorcal.org/

Prevention of Infectious Disease Transmission in Prison

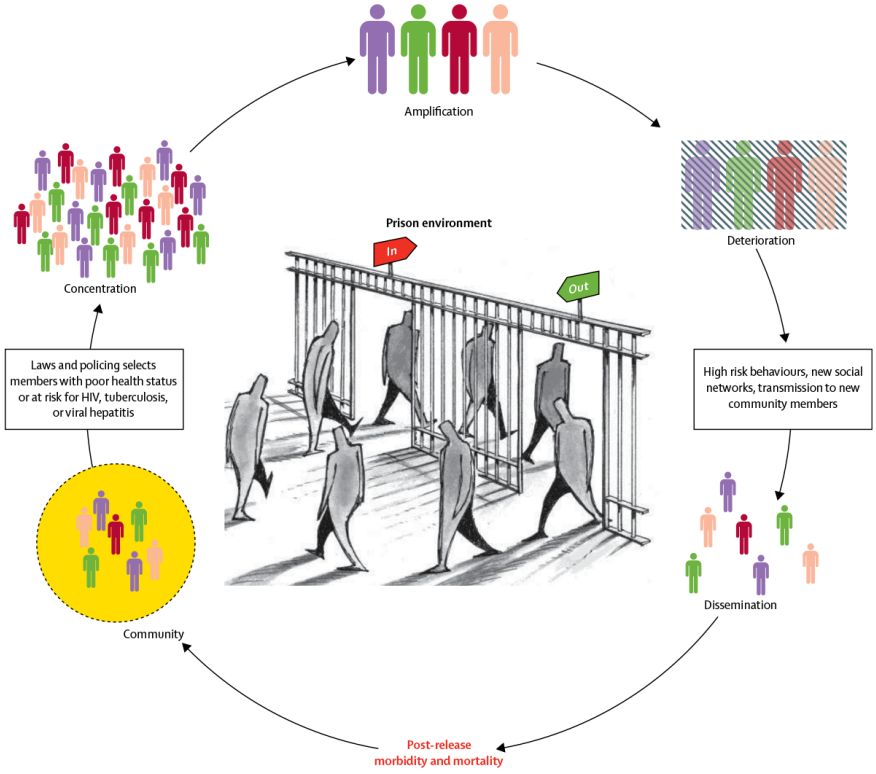
Prisons Serve as an Infectious Disease Concentration Mechanism

Prisons serve as a mechanism for concentrating poor health among the individuals detained there, in part because some of the structural and behavioral factors that lead to poor health are also associated with an increased likelihood of arrest and incarceration.[24] Prisons amplify adverse health conditions as a result of bad physical infrastructure, overcrowding, and restricted access to healthcare and prevention services.

Additionally, infectious diseases, malnutrition, and the inhumane attitudes and practices of some custodial officers toward prisoners further contribute to the deterioration of the physical and mental health status of individuals while incarcerated.[25] In the end, more than 95% of the people who have been incarcerated reenter the general community, which increases the risk of spreading infectious diseases into the communities to which they return, and from which the next incarcerated people will be drawn.

24. Ginn, S. (2012) *Prison environment and health*. BMJ (Clinical research ed.), 345, e5921. Available online: https://doi.org/10.1136/bmj.e5921
25. Kamarulzaman, A. (2016) *Prevention of transmission of HIV, hepatitis B virus, hepatitis C virus, and tuberculosis in prisoners.* Lancet (London, England), 388(10049), 1115–1126. Available online: https://doi.org/10.1016/S0140-6736(16)30769-33

The figure below depicts the revolving-door nature of incarceration and recidivism vis-à-vis infectious diseases.



Incarcerated people in the U.S. (and worldwide) have a substantially increased prevalence of HIV, Hepatitis B (HBV), Hepatitis C (HCV), and tuberculosis. A complex interplay of individual, social, and environmental factors before, during, and after incarceration results in an increased risk of these infections and diseases among incarcerated people, particularly sex workers, men who have sex with men, those who inject drugs, and transgender people. Laws that criminalize behaviors such as those involving drug use and unprotected sex, concentrate these key populations, who might already be living with HIV, HBV, HCV, or tuberculosis, in prisons. Some risk behaviors, such as unprotected sex and sharing contaminated injecting equipment, may also continue after incarceration, albeit to a lesser extent.

Paradoxically, in the absence of viable alternatives to incarceration, the time that those living with these diseases spend in correctional settings presents an opportunity for them to re-engage with medical treatment. At the same time, prison medical staff could diagnose those who are unaware of their status, help prevent new infections in those at risk, and establish connections outside the facility so that their patients can continue receiving care when released back into the community.

The authors of the 2016 study cited above conclude their report with the following statement: “Unfortunately, more work is needed to develop effective cooperation and coordination between the criminal justice and public health systems, which are often not aligned in their missions. Ultimately,

reforms in laws and policies that criminalize drug use and sexual behaviors are crucial to reduce prison populations that put large numbers of individuals at risk of potentially life-threatening infections, which can be more effectively prevented and treated in community settings."[26]

We see statements like this over and over again. Basically, putting people whose only "crime" is the use of illicit drugs into prison rather than an effective treatment protocol is both a terrible waste of resources and pretty much a guarantee that their lives will be worse after the intervention, not better. The more we incarcerate drug users, the more we damage them, their families, and the communities to which they return—more traumatized, maybe sicker, and also possibly farther from health stability after each subsequent cycle of arrest, incarceration and release.

The Early Years of COVID-19 Management in U.S. Jails and Prisons

At a Glance 5.08

Quick facts on COVID-19 and prisons

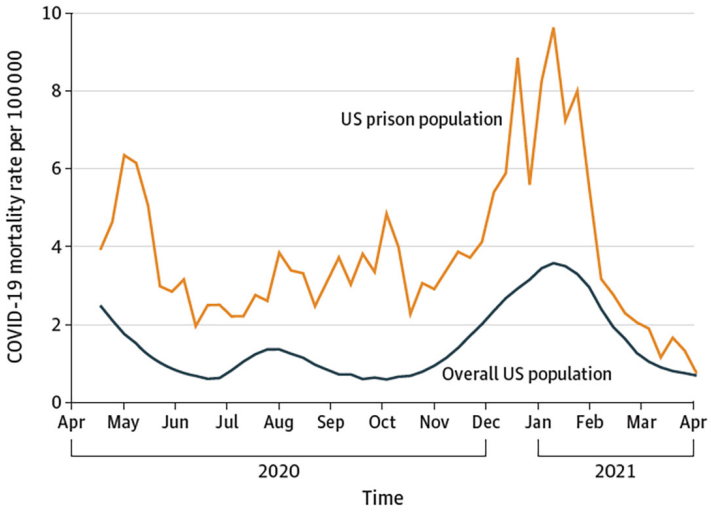
- COVID-19 infection rates in prisons in 2020 were 5 to 6 times that of the general public;
- Prisons operating above 70% (some were at 150%) of their approved capacity had 3 to 5 times more cases than other prisons (2020 data); and
- Prisons are not isolated environments that are completely separated from their surrounding communities. Strong correlations in COVID-19 transmission rates were seen between prisons and communities, and improving safety in one sphere helps to protect the other.

A study encompassing all fifty state prison systems in the U.S. compared COVID-19 cases and deaths to the data of the general U.S. population over the course of one year (May 2020 to April 2021). The researchers found an overall increased vulnerability to COVID-19 for incarcerated people. Despite comprising a younger and more resilient demographic—only 3% of people in prison are over 65 years old, compared to 16% for the general population—COVID-19-related mortality in prisons was overwhelmingly higher. This study found that people are 2.5 times more likely of dying from COVID-19 just by being held in prison, regardless of age or gender.[27]

During the peak of winter 2021, COVID-19 infection rates in federal prisons reached 5 times that of the general population. This highlights the heightened danger of transmission in locked-up communities, despite efforts to contain spreading through the use of personal protective equipment (which were limited in supply), personal hygiene, and social distancing.

26. Kamarulzaman. https://doi.org/10.1016/S0140-6736(16)30769-33
27. Marquez, N. (2021) *COVID-19 Incidence and Mortality in Federal and State Prisons Compared with the US Population, April 5, 2020, to April 3, 2021*. JAMA, 326(18), 1865–1867. Available online: https://doi.org/10.1001/jama.2021.17575

Standardized Mortality Due to COVID-19



This graph compares the overall mortality rates of people in prison versus the general population due to COVID-19 from April 2020 to April 2021, a timeframe roughly equal to the first year of the pandemic in the U.S. Prison overcrowding was strongly associated with increased COVID-19 incidence rates in that period of time.

A Massachusetts study found that for every 10% increase in prison population (as a percentage of total prison capacity), there was a 14% increased risk of COVID-19 contagion. Prisons operating between 70% and 100% of their design capacity and those operating at over 100% of their design capacity had 3-fold and 5-fold higher incidence rates of COVID-19, respectively. The study also found that the strategy of keeping prisoners apart from each other—where possible—helped reduce transmission. For each 10% increase in the percentage of people who were placed in single-cell units, the overall COVID-19 incidence rates across the facility were reduced by 18%.[28]

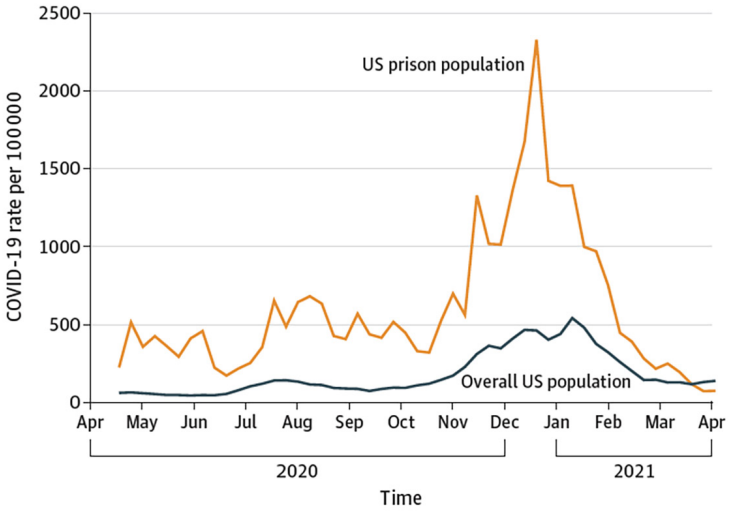
Infections in prison are particularly difficult to eradicate once they become widespread. In the context of a pandemic, this can easily represent a threat to the public as a whole, since prisons become de-facto reservoirs for the virus, posing a major challenge for effective epidemic control. The studies referenced above recommend prison decarceration as a potential immediate remedy to heightened COVID-19 risks, as well as implementing in-home detention practices and an extension of single-cell strategies within all prisons and jails.

Another major factor seen in the U.S. during the first two years of the COVID-19 pandemic was a reluctance among prison guards to meticulously follow safety protocols (wear masks, get vaccinated, avoid super-spreader events, etc.). In addition, staff don't always remember throughout the work day that they will be going home that night, so an accidental workplace exposure can inadvertently (and easily) spread a virus throughout a community quite quickly.

It is worth mentioning that both the national and Massachusetts studies found a direct correlation between COVID-19 levels in the communities that surround prisons and the levels of COVID-19 inside

28. Leibowitz, A. (2021) *Association Between Prison Crowding and COVID-19 Incidence Rates in Massachusetts Prisons, April 2020-January 2021*. JAMA internal medicine, 181(10), 1315–1321. Available online: https://doi.org/10.1001/jamainternmed.2021.4392

Incidence of COVID-19



the prisons. This raises concerns regarding a lack of safety conditions, policies, and protocols that would prevent the transmission of infectious diseases from the outside to the inside of prisons. While the COVID-19 pandemic was an extraordinary situation, prison management would be remiss if they didn't take the chance to improve on that front ahead of any future eventualities. This isn't news to prison enterprises, as there have been extensive reports from the World Health Organization,[29] the United Nations, and other international bodies regarding poor sanitary conditions in U.S. prisons and however that facilitates the spread of infectious diseases. Thus far, however, improvements remain insufficient at both the systems and institutional levels.

Pre-Existing Policies and Procedures Provided Inadequate Protection Against the Spread of COVID-19

At a Glance 5.09

Quick facts on 2020 lockdown and decarceration strategies across the U.S.

- Prison visitation bans were among the least effective COVID-19 related restrictions;
- Large-scale decarceration and changes to pretrial detention policies are likely to prove important for improving U.S. public health, biosecurity, and pandemic preparedness; and
- Minimizing carceral outbreaks and their spill-over into surrounding communities appears to be necessary for both epidemic control and the mitigation of racial health disparities.

An extensive study took place between January and November of 2020, encompassing a total of 1,605 counties across all states, and it identified a correlation between incarceration rates and COVID-19 spread in the surrounding populations. The findings of this study reflect that epidemic control depends not only on emergent responses as a pandemic develops, but also on longer-term policy determinants of public health vulnerability. In other words, curbing risk factors such as excessive incarceration practices before epidemics show up is the best way to prevent harsher impacts down the road.[30]

29. World Health Organization. (2014) Report on Prisons and Health. Available online: https://www.euro.who.int/data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf
30. Malloy, G. (2021) *Effectiveness of interventions to reduce COVID-19 transmission in a large urban jail: a model-based analysis.* BMJ open, 11(2), e042898. Available online: https://doi.org/10.1136/bmjopen-2020-042898

Therefore, if the U.S. aims to be safer for all its citizens, we need to prioritize a sensible, nationwide program of large-scale decarceration with a focus on reentry support. This would not only reduce social and racial inequality but also improve U.S. public health and safety, pandemic preparedness, and biosecurity. In October 2021, the American Public Health Association (apha.org) adopted a policy in support of decarceration as a public health matter, and new research shows the detrimental effect of COVID-19 on all-cause mortality in state prisons. Despite the clear need for smaller confined populations, the data shows that with just a few exceptions, state and local authorities are allowing their prison and jail populations to return to dangerous, pre-pandemic (often over-crowded) levels.

The U.S. Centers for Disease Control and Prevention (cdc.gov) published guidelines for correctional facilities that proposed the establishment a number of policies aimed at mitigating COVID-19 transmission, including: "limiting transfers of incarcerated people between facilities, restricting the number of visitors entering facilities, promoting personal hygiene and environmental sanitization, maximizing the space between those incarcerated (e.g., arranging bunks so that people sleep head to toe), and screening staff for symptoms."

However, these policies proved insufficient in the face of such a contagious pandemic, and it's important to note that they also simply weren't followed. Whether because of the resource limitations that correctional facilities face, a misallocation of available resources, or simply the fact that many of the issues these institutions face fall outside of these guidelines, the reality is that a more thorough action plan for future outbreaks is required—and should be prioritized for all U.S. jail, prison, and detention facilities.

The COVID-19 death rate in prisons at the end of April 2021 stood at a staggering 200 deaths per 100,000 incarcerated people, much higher than the death rate among the general U.S. population of 81 deaths per 100,000.[31] A February 2022 report from the UCLA COVID-19 Behind Bars Data Project revealed that among the 984 prisons publishing COVID-19 data, 72% reported a COVID-19 outbreak in January 2022.[32]

Compassionate Release

People in federal prisons who sought release during the COVID-19 pandemic had two main ways of getting out early. One was home confinement, which allows low-risk prisoners to finish their sentences at home or in a halfway house. They're still considered in custody, and the decision to let them out is entirely up to the Bureau of Prisons (BOP). As COVID shutdowns began in March 2020, Congress expanded the eligibility criteria and then-Attorney General William Barr ordered prison officials to let more people go. As a result, tens of thousands were sent to home confinement, but it is not clear how many, if any, will have to return to prison settings once the pandemic outbreak in prisons ends. The other way some received an early end to their incarceration was through compassionate release. It can be a slow and rejection-filled process. State prisons are filled with people who have what are called "preexisting" medical conditions that put them at a heightened risk for complications from COVID-19.

31. Marquez. https://doi.org/10.1001/jama.2021.17575
32. https://uclacovidbehindbars.org/omicron-surge

As of December 2020, ten months after the start of the pandemic, 40% of state prison systems were still filled to 90% of capacity or higher. Meanwhile, the compassionate-release process functioned so slowly that by the end of April 2021, fourteen months after the start, federal judges had approved only 21% of the compassionate-release requests they received in 2020.

An additional important policy change advocates would like addressed is that in many states people are forced to remain in prison even after they've been approved for parole until they complete certain required programs (such as drug or alcohol treatment). With many of these required programs rendered unavailable in prison during the pandemic due to safety concerns, corrections officials and parole boards should have allowed people to finish these programs outside of prison instead. Clearly that is a policy change that needs to be addressed moving forward.

Some states recognized the inefficiency of case-by-case releases and the necessity of larger-scale programs. In New Jersey, for example, Governor Phil Murphy signed bill S2519 in October 2020, which allowed for the early release of those with less than a year left on their sentences. A few weeks after the bill was signed, more than 2,000 people were released from New Jersey state prisons. In February 2021, North Carolina Governor Roy Cooper announced that a legal settlement had been reached to release 3,500 people in state custody (with 1,500 of those releases to take place within 90 days). The releases were the result of a lawsuit challenging the conditions of North Carolina prisons during COVID-19. The state said that it would release people using discretionary sentence credits (similar to "good time credits"), home confinement, and post-release supervision. But these instances of large-scale release efforts taking place in state prison systems were the exception, not the rule.[33]

Lessons Learned

One of the common threads that weave between incarceration and COVID-19, HIV, and other infectious diseases is the disproportionate impact of each in communities of color. A recent report by the National Academy of Sciences (nasonline.org) surmised that as much as 70% of all health outcomes are due to health access, socio-economic factors, and environmental conditions. The well-documented association between social determinants of health and the greater HIV burden in African-American and other communities of color re-emerged in epidemiological studies of the disproportionate incidence of COVID-19 cases, hospitalizations, and deaths in the U.S.[34]

While the evidence to date (2020-2022) does not suggest that people living with HIV have a higher susceptibility to SARS-CoV-2 infection, higher rates of comorbidities associated with COVID-19 disease severity among PLWH is a concern. COVID-19 restrictions led to decreased access to HIV prevention services and HIV testing, and worsening HIV treatment access and virologic suppression. This had impacts at both the individual and societal level, which could lead to a worsening HIV epidemic in the communities most at risk for both.[35]

33. https://www.prisonpolicy.org/blog/2022/02/10/february2022_population/
34. Millett, G. (2020) *New pathogen, same disparities: why COVID-19 and HIV remain prevalent in U.S. communities of colour and implications for ending the HIV epidemic.* Journal of the International AIDS Society, 23:e25639. Available online: https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.25639
35. Brown, L. (2021) *The interplay between HIV and COVID-19: summary of the data and responses to date.* Current opinion in HIV and AIDS, 16(1), 63–73. Available online: https://doi.org/10.1097/COH.0000000000000659

Susceptibility COVID-19 may increase HIV risk through socio-economic downturn or increased injection drug use	**Testing** HIV testing rates down due to limited hours and accessibility due to COVID-19 restrictions
Prevention Decreased access to pre-exposure prophylactic medication (PrEP) and fewer refills requested	**Treatment** Decreased access to anti-retroviral therapy (ART) and delayed appointments

Not surprisingly, the lessons learned from four decades of managing the HIV epidemic in the U.S. proved invaluable in structuring a coordinated response to COVID-19. Regular testing practices, contact tracing, and clinical trial infrastructure, together with influence networks to rapidly review potential vaccines and treatments for FDA approval, were key in promoting a collective response from administrations and communities all over the country. In spite of all this collaborative knowledge and experience, however, the response to COVID-19 by prison officials and systems was well below what could—and should—have been achieved.

The capacities built in the last 40 years of HIV control more successfully supported public health policy endeavors during the pandemic. In a way, the infrastructure to face COVID-19 was already there, ready to be expanded and repurposed. However, there's a need for these strategies to better reflect the reality of everyday Americans, become de-politicized, and keep everyone impacted in mind so that no one gets left behind by:

- Acknowledging the limits to social distancing in shelters, crowded housing, or for homeless populations;
- Expanding testing within communities at risk, utilizing peer workers to the extent possible;
- Dedicating funding to combat food insecurity and the rise of extreme poverty;
- Adapting HIV-destigmatizing strategies to COVID-19 patients as well as treatments; and
- Tailoring effective policies to the needs of multiply disadvantaged groups.

At a Glance 5.10

The Bail Project's recommended responses to COVID-19

In 2020, as the COVID-19 pandemic began to spread through overcrowded jail environments, The Bail Project (see Innovative Model 2-A) stepped forward with recommendations to reduce the risk of rampant spreading of COVID-19 among incarcerated populations, jail staff, and the broader community. They urged jails to undertake all possible avenues for limiting that peril. The sensible steps outlined on the next page will help to protect the public from outbreaks, while continued mass detention will not:

- **Release people on personal recognizance.** Exposing people to potential infection because they cannot afford a cash bond threatens the safety of the community by exacerbating a growing pandemic. Going forward, judges should consider that factor and release on personal recognizance all people charged with misdemeanors and low-level felonies. Judges should also reconsider custody status for anyone whose incarceration will make them vulnerable to infection.

- **Cite and release people charged with misdemeanors and gross misdemeanors.** To preserve resources and prevent infection, sheriff's deputies should issue citations and a notice to appear for everyone charged with misdemeanors or gross demeanors.

- **Prioritize immediate release for people who are most vulnerable.** Older adults and those with serious medical conditions and fragility face a higher risk for infection. The conditions that can increase one's risk of infection include diabetes, heart disease, asthma, lung disease, and HIV. These conditions are more common among those who are incarcerated than the general population. Releasing these vulnerable groups from jail immediately will avoid the need to provide complex medical care within the jail or transfer people to hospitals where capacity may be stretched thin.

- **Reduce release conditions and restrictions.** Courts must consider whether the conditions set for a person's release will interfere with their ability to seek necessary medical screening and treatment, as well as their ability to protect and care for any loved ones who may be impacted or vulnerable. No one should be forced to choose between violating a release condition or protecting their health and the health of others. Judges should also ensure that people released are not required to appear in person for check-ins and non-essential court proceedings where infection could spread.

- **Protect meaningful access to legal counsel and other pretrial support**. Jails must avoid any restrictive measures that interfere with a person's ability to obtain legal and other support to advance their case. For example, The Bail Project's staff conducts interviews with people detained in jail before providing bail assistance in their case. Restricting this access will mean that more people will remain detained on unnecessary cash bail, increasing their risk of infection. If visitor and legal access to the jail is in any way restricted or endangered, the jail should take steps to release people who cannot afford their bail amount.

- **Ensure care and hygiene for people who remain incarcerated.** The jail must follow changing public health protocols and coordinate with public health experts to communicate with staff and people in custody about preventative measures; provide adequate access to hygiene; and provide immediate testing and treatment to those who exhibit signs of infection. Access to care and hygiene must be made free, without commissary fees.

Meanwhile, the American Public Health Association (apha.org) recommends: "Moving toward the abolition of carceral systems and building in their stead just and equitable structures that advance the public's health by:

- Urgently reducing the incarcerated population;
- Divesting from carceral systems and investing in the societal determinants of health (e.g., housing and employment);
- Committing to non-carceral measures for accountability, safety, and well-being;
- Restoring voting rights to formerly and currently incarcerated people; and
- Funding research to evaluate policy determinants of exposure to the carceral system and proposed alternatives."

HIV and Its Implications in Incarceration and Reentry

The Scope of the Challenge for Successful PLWH Reentry in the U.S.

As of 2022, approximately 90,000 people living with HIV (PLWH) in the U.S. pass through the correctional system each year, resulting in a prevalence of HIV among people in prison that is three to four times higher than that of the general population.[36] For most PLWH in prison, especially those who are inside for a long time, their overall HIV health improves—sometimes dramatically. But reentry to the community is typically characterized by a significant decline and/or absence of adequate healthcare.[37]

Poor health outcomes after release result from the myriad of obstacles that people returning home face upon reentering the community, including homelessness, lack of medical insurance, untreated mental illnesses, a return to drug and alcohol use, and lack of employment. Given the prevalence of HIV within incarcerated populations, assuring continuity of care throughout incarceration and during the first months of community reentry is particularly important in reducing both HIV morbidity and mortality among releasees.[38]

HIV in Prison

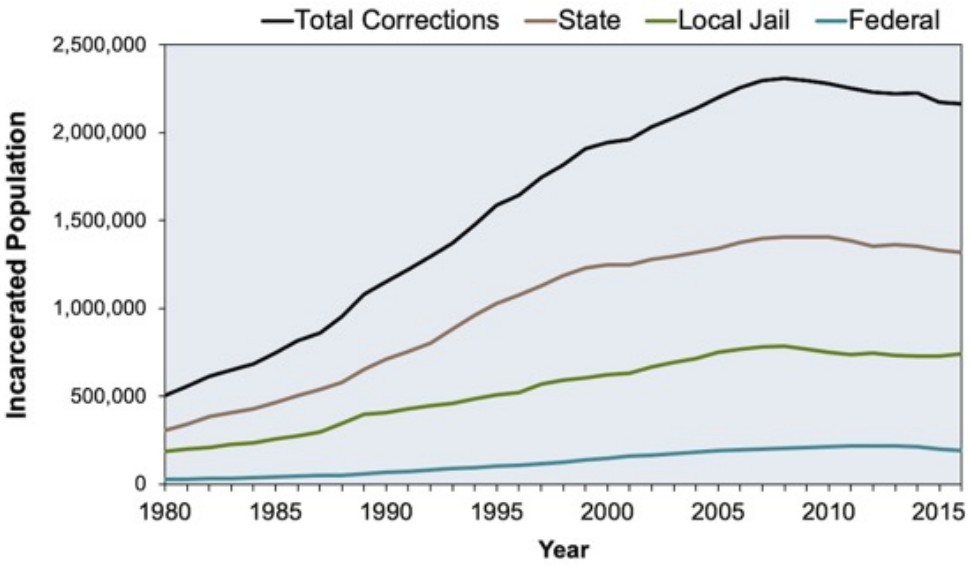
The elevated HIV seroprevalence among people held in correctional facilities is primarily a result of the political and criminal legal structures in the U.S. that penalize groups who already face multiple HIV-related vulnerabilities, including sex workers, individuals who inject drugs, and sexual/gender minorities. Some people know their status when entering jail or prison, while others do not.

36. Springer, S. (2011) *Public health implications for adequate transitional care for HIV-infected prisoners: five essential components.* Clinical infectious diseases: an official publication of the Infectious Diseases Society of America, 53(5), 469–479. Available online: https://doi.org/10.1093/cid/cir446
37. Copenhaver, M. (2009) *Adaptation of an evidence-based intervention targeting HIV-infected prisoners transitioning to the community: the process and outcome of formative research for the Positive Living Using Safety (PLUS) intervention.* AIDS patient care and STDs, 23(4), 277–287. Available online: https://doi.org/10.1089/apc.2008.0157
uw.edu/go/key-populations/hiv-corrections/core-concept/all#epidemiology-prevention-hiv-correctional-setting
38. Booker, C. (2013) *Linkage to HIV care for jail detainees: findings from detention to the first 30 days after release.* AIDS and behavior, 17 Suppl 2, S128–S136. Available online: https://doi.org/10.1007/s10461-012-0354-3
.

Nowadays, virtually all correctional facilities offer HIV testing as a routine practice. And, in most correctional systems, it is provided on an "opt-out" basis, which means that unless someone specifically refuses to get tested, all incoming detainees will be tested. As a result, the percentage of people who are tested for HIV is quite high. Although transmission of HIV within jails and prisons is, in fact, quite low, the principal routes of transmission include unprotected anal sex, injection drug use, and tattooing.

The number of PLWH held in state and federal prisons declined steadily from 1998 to 2015 (the most recent data available). From a high of 25,976 in 1998 it dropped to a low of 17,146 in 2015—15,920 were men and 1,226 were women. The prevalence of HIV among all incarcerated people in 2015 was 1.3%, which is markedly higher than the 0.3 to 0.4% HIV prevalence in the general population.[39]

The graph below shows the growth in overall incarceration numbers from 1980 to 2015, broken out by type of correctional institution. More than half of all incarcerated people are held in local (county) jails. Roughly one-third are in state prisons; and the smallest percentage are in federal prisons. Each system has different policies and procedures related to HIV prevention and care, though since 2018, federal Ryan White HIV/AIDS Program (RWHAP) funds can help pay for HIV medications and treatment in all states and across all carceral systems, including in juvenile facilities.



HIV Testing Practices Vary by Type of Facility and Location

The policies and practice of testing for HIV in jails and prisons differ, based on local, state and institutional priorities. Best practices include opt-out testing for all incarcerated persons at intake and prior to release. Most jails and prisons conduct a health screening for all new prisoners, but this may take up to two or three weeks, so those who are only in jail overnight or for a short duration may not be offered HIV testing. The benefit of offering HIV testing on an opt-out basis is that most people know their status. In some carceral systems, the testing is on an opt-in basis, which means that it is more often refused—so fewer people know their status.

39. Health Resources and Services Administration. *National HIV Curriculum.* Available online: https://www.hiv.gov

Among prison admissions in 2015, about a third (34%) were admitted in states that conducted mandatory HIV testing and an additional 31% were admitted in states with opt-out HIV testing during intake. Because a prison system is responsible for providing healthcare to its entrants over a period of years, aggressive opt-out testing for HIV is important, so that appropriate medical care can be delivered, HIV transmission inside the prison is reduced, and incarcerated people living with HIV can maintain optimal health and wellbeing.

Life Behind Bars with HIV

Certain prison subpopulations are more likely to have HIV than others. Incarcerated women, for example, have been found to be up to twice as likely as incarcerated men to be living with HIV. In the general population, these rates are reversed.[40] Being transgender puts a person at a higher risk of experiencing incarceration due to many factors, including discrimination in policing. Transgender women are also 49 times more likely to have HIV than the general population.[41]

Racial disparity is also significant, with HIV much more prevalent among incarcerated Black, indigenous, and people of color (BIPOC) and Latinx people than White people. In jails, Latino men have the highest rate of all prisoners testing positive for HIV.[42] Regional variation is also a factor.

The biggest disease today is not leprosy, [HIV] or tuberculosis, but rather the feeling of being unwanted, uncared for, and deserted by everybody.[43]

The HIV positivity rate is as low as one percent in some states, and as high as 20 percent in others.[44] Whether looking at gender, race, or location, HIV is clearly concentrated in distinct population subgroups in jails and prisons. Given that these are essentially the same people who are targeted by racism, adding the stigma of living with HIV can be traumatizing.

Many people in prison would prefer to not disclose their HIV status with their cellmates or others whom they meet inside. This desire for privacy is not well accommodated in prison. The visibility of PLWH varies, in part, with the manner in which medications are dispensed. Some facilities require that prisoners stand in a public line to receive HIV medication, which makes prisoners with HIV an easy target for discrimination. On the positive side, thanks to the wide-spread availability of federal RWHAP funding for HIV care and treatment inside correctional facilities, most who do disclose their HIV status in prison receive regular HIV care, although it can vary in quality and consistency. Nevertheless, while

40. https://www.hiv.uw.edu/go/key-populations/hiv-corrections/core-concept/all#epidemiology-prevention-hiv-correctional-setting
41. Erickson, M. (2019) *Women, incarceration and HIV: a systematic review of HIV treatment access, continuity of care and health outcomes across incarceration trajectories.* AIDS (London, England), 33(1), 101–111. Available online: https://doi.org/10.1097/QAD.0000000000002036
42. https://www.beintheknow.org/understanding-hiv-epidemic/community/hiv-and-transgender-people
43. Valera, P. (2017) *HIV risk inside U.S. prisons: a systematic review of risk reduction interventions conducted in U.S. prisons.* AIDS care, 29(8), 943–952. Available online: https://doi.org/10.1080/09540121.2016.1271102
44. AIDS Action Committee. *What Works in HIV Prevention for Incarcerated Populations* (Washington, DC: AIDS Action Committee, 2001), 2. (No longer available.) For more recent information, visit: https://aac.org/aachealth-library/prison-inmates-ex-offenders-hiv-and-viral-hepatitis/

their medical needs are covered, HIV+ ex-prisoners may not be particularly well informed about the progression of their disease or the specific medications they are taking.

A 2015 review of multiple studies related to PLWH in prisons found that with regard to viral suppression, nearly half of those whose HIV status was known had received some HIV treatment prior to incarceration, but only 27% of them had an undetectable viral load upon entry to jail or prison. However, the majority of people who receive HIV treatment while incarcerated do achieve viral suppression (52% of the total and 65% of those on anti-retroviral medication), and their suppression rates are higher with longer durations of incarceration. The average adherence during incarceration (58%), however, is not as high as adherence among the general population (83%), which suggests a need for in-prison education and medication adherence counseling.[45]

Those who are living with HIV and not virally suppressed upon release have high HIV-transmission risk factors when they reenter society, and any formerly incarcerated individuals who did not have HIV in their first incarceration are more likely to have an HIV diagnosis if, or when, they return to incarceration. (As noted previously, the average recidivism rate in the U.S. is 66%.) As they move through this risk cycle, prisoners may also pick up other infectious diseases as well, such as Hepatitis B, Hepatitis C, and tuberculosis, as discussed earlier in this chapter.

At a Glance 5.11

Infectious and chronic diseases among people exiting prison.[46]

- One study that looked at the impact of infectious diseases on previously incarcerated people as a proportion of everyone in the U.S. infected with that disease determined that 13% of HIV, 15% of Hepatitis B, 24% of all sexually transmitted infections (STIs), 29% of Hepatitis C, and 35% of tuberculosis in all Americans is present in people exiting jails and prisons.[47]
- Twenty-one percent of prison detainees and 14% of jail detainees reported ever having tuberculosis, Hepatitis B or C, or other STDs (excluding HIV or AIDS).
- An estimated 40% of people in state and federal prisons and jail detainees in 2012 reported having a current chronic medical condition, while about half reported ever having a chronic medical condition. About 66% of people in prison and 40% of jail detainees with a current chronic condition reported taking prescription medication.
- High blood pressure was the most common chronic condition reported by prisoners (30%) and jail detainees (26%).
- The majority of prisoners (74%) and jail detainees (62%) were overweight or obese.

45. Iroh, P. (2015) *The HIV Care Cascade Before, During, and After Incarceration: A Systematic Review and Data Synthesis.* American journal of public health, 105(7), e5–e16. Available online: https://doi.org/10.2105/AJPH.2015.302635
46. Maruschak, L. (2016) *National Survey of Prison Health Care: Selected Findings.* National health statistics reports, (96), 1–23. Available online: https://pubmed.ncbi.nlm.nih.gov/27482922/
47. Hammett, T. (2002) *The burden of infectious disease among inmates of and releasees from US correctional facilities, 1997.* American journal of public health, 92(11), 1789–1794. Available online: https://doi.org/10.2105/ajph.92.11.1789

Innovative Model 5-C

Medical Support Services for PLWH Who Are Incarcerated – State of Kentucky

The State of Kentucky Dept. of Public Health (KDPH) became an in-prison HIV healthcare leader through its pro-active implementation of Policy Clarification Notice 18-02 (PCN 18-02). This policy allows state and local Ryan White HIV/AIDS Programs (RWHAP) to provide care and medications for incarcerated persons and those living in half-way houses after release. Prior to that time, all Ryan White Programs in Kentucky, as all across the country, were prohibited from providing HIV care or medications to anyone held in federal or state prisons and local jails and half-way houses, if there was a reasonable expectation that another source of funding would be available to cover those costs. Considered the "payor of last resort," RWHAP funds could not be used to pay for a service when other federal funding or payments from state governments to support prisons and jails was available.

It had always been known that most local Kentucky jails do not receive federal funds and that the state and local funds they do receive are not typically used to pay for medications or clinical care. HIV medications have likewise been considered to be "too expensive" for many local jails to provide. This Notice clarified that, based on statute, "local payers, such as local jails, are not subject to the payor of last resort provision, and RWHAP funds may be the primary payor." After the new policy was implemented, approximately 60 local or county detention centers in Kentucky had formed agreements with KDPH RWHAP to provide short-term and transitional HIV care services for incarcerated PLWH by 2020. These jails went on to provide services to 59 people in 2021.

In releasing the state's PCN 18-02 implementation plan, Todd Hurst, Kentucky AIDS Drug Assistance Program (KADAP) Administrator, said, "We want to make sure that any person with HIV who is incarcerated has access to adequate HIV care. Where there is a shortfall in a facility, we want to be able to step in and work with that facility to make sure that we're supporting them with whatever—whether it be case management ... or medical care and medication for those who have already tested positive." Hurst encourages subrecipients who work directly with local jails to come to an agreement of what they can provide and what they cannot provide, especially because different facilities have different budgets. "It's really a collaboration between those local subrecipients and that local facility to make sure that they're meeting the needs of those folks [living with HIV]."

PCN 18-02 authorizes the "time-limited provision of appropriate core medical and support services for the purpose of ensuring linkage to and continuity of care" for incarcerated PLWH who will be eligible for RWHAP services upon release, when such release is imminent. The time limitation is generally 180 days or fewer, however it may be extended based on individual circumstances. Federal RWHAP administrators recognize that "in some instances, the time limitation will be commensurate with the duration of incarceration." Approved services include:

- AIDS Drug Assistance Program (ADAP) treatments;
- Early Intervention Services (EIS);
- Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (in the case that a person that is working in a community-based program and has employer-based health insurance coverage);
- Linguistic Services; and
- Medical Transportation.

The Kentucky Ending the HIV Epidemic Strategic Plan for 2021–2026 specifically describes linkage-to-care activities, with a focus on incarcerated populations and collaborating with the criminal legal system to increase HIV treatment for incarcerated PLWH using RWHAP services. The strategic plan also includes a review of the linkage-to-care and case management processes for incarcerated PLWH, with the goal of increasing the efficiency and timeliness of services when possible. In addition, the strategic plan indicates that KDPH will strive to ensure linkage navigation services for incarcerated PLWH prior to their release from jails and prisons to ensure that they continue to receive HIV care as they return to and settle in the community.

Link to Kentucky Ending the HIV Epidemic Strategic Plan for 2021–2026

When People Living with HIV Are Released from Prison

Although most people know their HIV status when leaving incarceration, many do not. It is important, therefore, to understand how and when state and county correctional systems test for HIV. Depending on where a housing program is located, residents arriving from both jail and prison could easily be unaware of their HIV status. Although no systems require HIV testing at discharge, approximately 41% of those released in 2015 were in one of the twenty-one jurisdictions that offer HIV testing at discharge upon request.

"There is a crumb of discharge planning for people with HIV/AIDS and almost nothing for everyone else."[48]

Interestingly, those who know they are living with HIV are often better prepared for release than are those who are either HIV-negative or don't know their status. This is because pre-release planning inside institutions, where it exists, often focuses first on this population. Unfortunately, it rarely goes beyond offering the names and phone numbers of social services agencies and government sponsored health centers that people returning home are expected to contact themselves. For most releasees, a lot more help is needed. Many PLWH have only just recently learned of their status and need considerable orientation on how to find help.

Although insufficient, the level of pre-release planning typically offered inside institutions is useful, and it does create an easier link for outside housing and services groups to gain access to those who are about to be released. By collaborating with the staff responsible for this pre-release planning inside institutions, and coordinating with the agencies that commonly receive referrals, organizations can build the next steps of support through the reentry process and into housing. (See the Montrose Center's prison in-reach program in Chapter Two as an example.)

From the perspective of those leaving jails and prisons, HIV is often not their biggest, or first, concern. In fact, they are usually more concerned about the in-your-face problems of daily survival. Many states discharge people directly to the street or, if lucky, to emergency shelters, both of which are potentially disastrous for those with a compromised immune system. In addition, shelters rarely have staff with

48. JoAnne Page, interview by Kristina Hals, October 2001, New York City.

expertise in HIV or the resources needed to manage living with HIV, such as refrigeration for medications and secure storage and delivery. Thirty-one percent of PLWH estimated to be experiencing homelessness in 2020 were unsheltered, while 48% were in emergency shelters. Only one in five (21%) had been able to access some kind of short-term, transitional, or supportive housing.

Yet, despite releasees' fixation on other issues, the stigma of HIV and the physical effects of both the virus and anti-retroviral treatment (ART) can create immediate problems during reentry. Many leave prison without a sufficient supply of their HIV medications—typically only two weeks' worth, if any. When a person living with HIV interrupts their routine of schedules and regimens for taking medications, health and treatment problems will result. These difficulties stem from the chaos of reentry and the lack of counseling on how to obtain insurance, such as Medicaid, and connect with medical providers and the state's RWHAP AIDS Drug Assistance Program (ADAP).

> **"What we have found is that for HIV-positive ex-prisoners, the issues around housing become bigger and bigger. Family members often do not accept them home as readily as if they were not HIV-positive, or sometimes if they do, it is with the attitude that—here is your cup, spoon, and plate, please don't kiss the kids."[49]**

Furthermore, many coming out of prison and living with HIV just do not know that much about their illness or treatment. In addition, inside correctional institutions, medication lines, regular clinic schedules, and standardized meals are so highly structured that a fair number have not learned how to take care of themselves, or even what medications they are taking. Thus, comprehensive discharge planning should occur, beginning several weeks prior to release, based on a holistic and multidisciplinary approach that includes medical, social service, housing, and behavioral health at a minimum. Assuring continuity of treatment and educating releasees about HIV and how to successfully live with it should be primary goals.

Unfortunately, the clinical benefits of in-prison treatment that so many enjoyed are quickly lost if PLWH end up discontinuing treatment after release. Therefore, among a PLWH's first needs on the outside is connection with an HIV service organization or social or health worker with that specialty. Observational studies of individuals transitioning from incarceration to community settings have identified a variety of barriers to retaining engagement in HIV care, including poor or non-existent pre-release planning, systematic removal of healthcare benefits from incarcerated individuals, high-intensity drug and alcohol use in the immediate post-release period, and homelessness or housing instability.[50]

One 2014 study compared the expectations of incarcerated PLWH with the reality of their lives after release. The fact that they would face numerous barriers to successful community reentry and to accessing healthcare has been well documented. However, little was known at the time regarding the outcome expectations of PLWH after release, how their post-release lives would align with their

49. Focus group with organizations in New York City housing formerly incarcerated residents, conducted by Kristina Hals at Bailey House, November 2001.
50. Milloy, M. (2014) *Incarceration of people living with HIV/AIDS: implications for treatment-as-prevention*. Current HIV/AIDS reports, 11(3), 308–316. Available online: https://doi.org/10.1007/s11904-014-0214-z

pre-release expectations, and how any discrepancies might impact their engagement in HIV care following release. Before leaving prison, most participants felt confident that they would be able to manage their HIV effectively. Upon release, however, many experienced intermittent or prolonged periods of antiretroviral nonadherence, largely due to substance use relapse or delays in care initiation. Their substance use was precipitated primarily by stressful life experiences, including stigma, lack of stable housing, and contact with drug-using social networks.

Study participants were more likely to anticipate living with family or friends and needing income assistance post release. Most were taking antiretrovirals prior to release and anticipated needing help securing health benefits and medications. Given high recidivism rates among incarcerated populations in general and poor HIV-related outcomes for PLWH after release, a fundamental disconnect was found between an individual's expectations of life and the actual outcomes after release. The researchers suggest that this disconnect may be due to the difficulty of "exerting self-influence over the competing pressures of the reentry environment and changing personal circumstances."

Taken together, the study's findings highlight the challenges that PLWH face upon release and the need for multi-component HIV linkage and care programming that begins pre-release and extends into post-release and addresses:

- Stigma and discrimination;
- Evidence-based substance use disorder treatment;
- Environmental factors that precipitate relapse, such as homelessness and lack of income/employment;
- Outcome expectation management between pre-release expectations and the realities of release; and
- Practical problem-solving and skill development.

In addition, the researchers cited a need for future research that "explores the conscious and sub-conscious effects of layered stigma on engagement in HIV care among PLWH post incarceration and ways to minimize the corrosive effects of stigma on successful community reentry and well-being. The attainment of these goals has the potential to enhance not only the well-being of PLWH releasees, but also that of the communities to which they return."[51]

At a Glance 5.12

Maintaining continuity of treatment for HIV

- Request a medical summary, after-care letter, and/or service referral from the releasing authority. Make sure it is complete and accurate.
- Request that the institution put aside a 30-day supply of medication in the prison pharmacy in advance of when someone will be discharged, so that it can be quickly obtained upon release. (Several states already do so as standard policy.)

51. Haley, D. (2014) *Multilevel challenges to engagement in HIV care after prison release: a theory-informed qualitative study comparing prisoners' perspectives before and after community reentry.* BMC public health, 14, 1253. Available online: https://doi.org/10.1186/1471-2458-14-1253

- Arrange for at least one month's supply of medication to leave with the person exiting prison, or at least enough to last until the first medical appointment on the outside, and make sure releasees have an up-to-date list of the medications they're currently taking, including dosage and regimen.
- Arrange referrals and appointments with local HIV service providers, including housing providers in advance of release.
- Find out if your state's AIDS Drug Assistance Program (ADAP) routinely provides enrollment cards to PLWH upon release. (In some areas, a referral to a doctor can be made without an ADAP or Medicaid insurance card.) Certain clinics will submit applications themselves and defer payment for their services until post-release enrollment is completed. Other providers can apply for payment under a state's charity pool of emergency Medicaid funds. In yet other areas, there is no option but to wait until a payment mechanism is in place.[52]
- Make a plan for both the storage of medications and compliance with drug regimens. Offer pill boxes, refrigerators, calendars, and watches with alarms—whatever is needed to maintain compliance.

At a Glance 5.13

Creating a bridge between incarceration and community – Hampden County, MA

Many barriers exist between correctional facilities and community providers, which affects the care and services incarcerated people receive both while in the facility and during their reentry process. In some service models, clinicians are dually based in correctional facilities and community health centers to help ensure that essential linkages are made and treatment is not interrupted. Below are strategies for improving HIV treatment and care during reentry developed by Hampden County, MA:

- Ensure a warm handoff (same clinician [dually based], clinician to clinician [face-to-face meeting before transfer], or establish a relationship with a new provider [via telephone]);
- Employ peer specialists to support re-entry (e.g., navigator, addiction coach, reentry coach);
- Ensure that insurance, Medicaid, and ADAP enrollment are in place upon release;
- Ensure that the first appointment with a new clinic is in place on release; follow up with patients to the extent possible;
- Connect patients with essential services, especially housing; schedule intake appointments and prearrange transportation, if possible;
- Link patients to harm-reduction organizations, especially overdose prevention for the newly released;
- Help HIV-related community-based organizations connect with correctional facilities and organizations that serve incarcerated individuals;
- Educate correctional facilities about RWHAP; and
- Engage formerly incarcerated PLWH in the RWHAP planning process.

52. Steven Nesselroth. *Hitting the Bricks: Working with Recently Released Former Prisoners Living with HIV/AIDS (monograph)* (Washington, DC: National Minority AIDS Council, 2002), 7. (No longer available.)

Innovative Model 5-D

Whitman-Walker Community Health Center – Washington, D.C.

Since 1973, Whitman-Walker Health (WWH) has been a place where people can just be themselves without fear of judgement or retribution. It began in 1971, operating as The Gay Men's VD Clinic, part of the Washington Free Clinic, in the basement of the Georgetown Lutheran Church. In 1978, Whitman-Walker Clinic received its first government funding from the D.C. Dept. of Human Resources, and in 1983 after Acquired Immune Deficiency Syndrome (AIDS) was identified and named, Whitman-Walker launched an AIDS Education Fund to provide information, counseling, and direct services to people living with AIDS in the District of Columbia. In 1984, WW Clinic opened an AIDS Evaluation Unit, the first gay, community-based medical unit in the country devoted to the evaluation and diagnosis of AIDS symptoms.

The subsequent decades reflected steady growth and unsteady financial standing until the 2010's, when the clinic was consistently operating in the black and it officially launched its new name, Whitman-Walker Health (WWH), emphasizing its role as a full-service health center for the metro D.C. community and a provider of the highest quality of care for its patients. WWH serves more than 15,000 patients, and administers about 10,000 free HIV tests each year. Whitman-Walker Health also offers primary medical care, dental, mental health care, addictions treatment, legal services, and a range of supportive services. WWH's mission is to offer affirming community-based health and wellness services to all, with a special expertise in LGBTQ and HIV care.

In fulfilling its mission, Whitman-Walker Health works to create a healthcare home where everyone will be treated with the dignity, respect, and love they deserve, seeing the person first and empowering everyone to "live healthy, love openly, and achieve equality and inclusion." Through multiple locations throughout metro D.C., WWH provides stigma-free care to anyone who walks through the door. They are "proud and honored" to be a place where the gay, lesbian, bisexual, transgender, and queer communities, as well those living with or affected by HIV, feel supported, welcomed, and respected. WWH's core healthcare services include:

- Medical Care and Community Health
- Gender-affirming Care and Services
- Behavioral Healthcare
- Dental Health

Additional services tailored to meet the needs of the Whitman-Walker Health community include:

- **Insurance Navigation:** WWH has a team available to speak with patients about their health insurance options and any problems they might have regarding their insurance or the cost of care, including meeting with patients who don't have insurance to see what they qualify for and to help them enroll. As a DC Health Link enrollment center, WWH also helps District residents with their health insurance options. WWH Insurance Navigators can help eligible patients enroll in health insurance programs and get information on ways to keep healthcare costs low.
- **Legal Services:** WWH legal team provides assistance with breaking through legal barriers to achieve improved health and wellness outcomes. WWH specializes in working with

patients who are living with HIV and/or members of the LGBTQ and Intersex communities. All services are provided free of charge and include:

- Consumer/Debtor Rights;
- Disability Insurance;
- Discrimination;
- Immigration;
- Insurance and Benefits;
- Name and Gender Change; and
- Wills and Powers of Attorney.

- **Youth & Family Services:** WWH staff help youth feel safer and healthier through a wide variety of services, including education, prevention, and health programs tailored to young people ages 13–24. The youth programs are designed to create a safe space where all youth feel respected and welcome to be themselves.

For more information go to: https://www.whitman-walker.org/

Housing's Positive Impact on Outcomes for PLWH

A strong body of research findings, including an analysis conducted by the Centers for Disease Control and Prevention (CDC), shows that housing status is a stronger predictor of HIV health outcomes than such individual characteristics as gender, race, age, drug and alcohol use, mental health issues, and the receipt of social services.[53] As noted by the CDC researchers, "this is an important finding, as it indicates that housing itself may improve the health of PLWH."[54]

On the flip side, folks experiencing homelessness are at heightened risk of acquiring HIV, with rates of new infections as high as 16 times the rate in the general population.[55] Even after accounting for other factors, such as substance use, mental health, and access to services, the condition of homelessness is independently associated with increased rates of behaviors that can transmit HIV and other infectious diseases.[56]

One study conducted by Columbia University revealed that at least half of Americans living with HIV experience homelessness or housing instability following a positive HIV diagnosis.[57] Data gathered

53. Leaver, C. (2007) *The effects of housing status on health-related outcomes in people living with HIV: a systematic review of the literature.* AIDS and behavior, 11(6 Suppl), 85–100. Available online: https://doi.org/10.1007/s10461-007-9246-3
54. Kidder, D. (2007) *Health status, health care use, medication use, and medication adherence among homeless and housed people living with HIV/AIDS*. American journal of public health, 97(12), 2238–2245. Available online: https://doi.org/10.2105/AJPH.2006.090209
55. Kerker, B. (2005) *The health of homeless adults in New York City: A report from the New York City Departments of Health and Mental Hygiene and Homeless Services*. Available online: https://www1.nyc.gov/assets/doh/downloads/pdf/epi/epi-homeless-200512.pdf
56. Kidder, DP. (2008) *Housing status and HIV risk behaviors among homeless and housed persons with HIV*. Journal of acquired immune deficiency syndromes (1999), 49(4), 451–455. Available online: https://doi.org/10.1097/qai.0b013e31818a652c
57. Aidala, AA. (2012) *Housing status and the health of people living with HIV/ AIDS: A systematic review*. Presented at the XIX International AIDS Conference, Washington, D.C., July 2012; Aidala, A. A. (2005) *Homelessness, housing instability and housing problems among persons living with HIV/AIDS*. Paper presented at the NAHC National Housing and HIV/AIDS Research Summit I.

by the U.S. Dept. of Housing and Urban Development (HUD) showed that on a single night in January 2018, across all states and territories, 111,122 persons with severe mental illness, 86,647 with chronic substance use, and 10,064 with HIV were unsheltered or living in emergency shelters or transitional facilities.[58]

The combination of HIV and homelessness is especially challenging because homeless people are less likely to take the anti-retroviral therapy (ART) medications needed to improve health outcomes.[59] In addition, when ART is prescribed, adherence can be particularly difficult for those experiencing homelessness because of the necessity of focusing on meeting their daily challenges for securing food, shelter, and clean clothing.[60]

According to the 2020 Ryan White HIV/AIDS Program (RWHAP) report on client-level data, the percentage of clients with stable housing increased from 82% in 2010 to 88% in 2020. In 2020, 7% of clients had temporary housing and nearly 5% had unstable housing. The highest proportions of clients with temporary or unstable housing, by age group, were among those 20–24 years old (10% and 6%, respectively), 25–29 years old (9% and 7%), 30–34 years old (7% and 9%), and 35–39 years old (9% and 7%). It's worth noting that those with unstable and temporary housing continue to have disparately lower levels of viral suppression compared to those with stable housing: 77%, 84% and 90% respectively reached viral suppression.[61]

In study after study, research continues to demonstrate that housing stability significantly increases PLWH entry into and retention in care, and it increases their adherence to complex HIV treatment regimens, which result in both improved health outcomes and reduced HIV transmission. A 2011 study in Los Angeles of 14,875 RWHAP clients who had at least one medical outpatient visit found that those who were living in unstable housing (homeless or transitional housing) were 1.4 times more likely to fall out of care than those with permanent housing.[62]

People living with AIDS (not HIV more broadly) and experiencing homelessness who were subsequently able obtain supportive housing were shown to have had a lower risk of death than those who did not obtain housing.[63] Another study found that PLWH in supportive housing were 63% more likely to be alive and have an intact immune system (one measure of disease progression) than were those in the control group.[64]

58. https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/
59. Buchanan, D. (2009) *The health impact of supportive housing for HIV-positive homeless patients: a randomized controlled trial.* American journal of public health, 99 Suppl 3(Suppl 3), S675–S680. Available online: https://doi.org/10.2105/AJPH.2008.137810
60. Kirst, M. (2015) *The impact of a Housing First randomized controlled trial on substance use problems among homeless individuals with mental illness*. Drug and alcohol dependence, 146, 24–29. Available online: https://doi.org/10.1016/j.drugalcdep.2014.10.019.
61. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/data/rwhap-annual-client-level-data-report-2020.pdf
62. Los Angeles County Department of Public Health (2011). *Los Angeles County Enhanced Comprehensive HIV Prevention Plan (ECHPP).* (No longer available.)
63. Schwarcz, S. (2009) *Impact of housing on the survival of persons with AIDS*. BMC public health, 9, 220. Available online: https://doi.org/10.1186/1471-2458-9-220.
64. Buchanan, D. (2009) *The health impact of supportive housing for HIV-positive homeless patients: a randomized controlled trial.* American journal of public health, 99 Suppl 3(Suppl 3), S675–S680. Available online: https://doi.org/10.2105/AJPH.2008.137810

In fact, housing with linked services (supportive housing) achieves much greater stability than does case management services without coordinated rental assistance.[65] Residents' stability in supportive housing is similar to the level achieved in more segregated housing and service models like group homes and nursing homes, but tenants highly prefer supportive housing.[66] This success seems to hold for a range of disabilities; people living with physical disabilities, chronic illnesses, and HIV all fare well in supportive housing,[67] as do people with severe mental illness and substance use disorders.[68]

Given the fundamental role of stable housing in promoting positive health outcomes, it became apparent to RWHAP staff that focused efforts and partnerships were needed to address the healthcare needs of low-income PLWH who access services. The program has, therefore, embarked on a number of activities to make housing services more accessible to RWHAP clients that include aligning federal partnerships and leveraging resources, addressing policies to increase use of housing services, and funding initiatives to better understand how to address the housing needs of PLWH.

RWHAP demonstration initiatives are testing innovative models for assisting PLWH to attain and maintain health and housing stability. Some now underway include programs that:

- Engage unstably housed PLWH by providing services that have a low threshold for easy accessibility, e.g., drop-in hours and on-site access to vital housing and support services;[69]
- Merge RWHAP and housing data to better identify clients who are unstably housed and not retained in medical care;[70] and
- Integrate employment programs and housing subsidies into HIV care and treatment sites.[71]

In addition, some states now use Medicaid funds for various preventive measures, including housing-related services that help individuals find and stay in housing. For example, California allows hospitals and social service organizations to collaboratively treat PLWH experiencing homelessness; Medicaid funds can be used for housing services, and local and state monies can be applied directly to housing payments. North Carolina has launched pilot projects to use Medicaid funding for one-time security deposits and first month's rent.[72,73]

65. Rosenheck, R. (2003) *Cost-effectiveness of supported housing for homeless persons with mental illness*. Archives of general psychiatry, 60(9), 940–951. Available online: https://doi.org/10.1001/archpsyc.60.9.940.
66. Leff, H. (2009) *Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness*. Psychiatric services (Washington, D.C.), 60(4), 473–482. Available online: https://doi.org/10.1176/appi.ps.60.4.473
67. Sadowski, L. (2009) *Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial.* JAMA, 301(17), 1771–1778. Available online: https://doi.org/10.1001/jama.2009.561
68. https://shnny.org/uploads/The_Culhane_Report.pdf
69. Dombrowski, J. (2018) *The Max Clinic: Medical Care Designed to Engage the Hardest-to-Reach Persons Living with HIV in Seattle and King County, Washington*. AIDS patient care and STDs, 32(4), 149–156. Available online: https://doi.org/10.1089/apc.2017.0313
70. Health Resources and Services Administration. *Addressing HIV Care and Housing Coordination through Data Integration to Improve Health Outcomes along the HIV Care.* Continuum, 2015–2018. Available online: https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-data-integration
71. Health Resources and Services Administration. *SPNS Initiative: Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services*, 2017–2020. Available online: https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-initiative-improving-hi
72. https://shelterforce.org/2019/02/19/medicaid-dollars-for-housing/
73. Centers for Medicare and Medicaid. *Accountable Health Communities Model,* 2019. Available online: https://innovation.cms.gov/initiatives/ahcm

The closing line of the 2020 article cited above on the role of RWHAP in addressing health and housing disparities for low-income PLWH states, "As the U.S. looks toward ending the HIV epidemic over the next 10 years, addressing the housing needs of people with HIV will play a critical part in meeting those bold goals. Alongside these housing needs are the concomitant issues of mental health, substance use, and financial instability, which will also need to be prioritized and addressed. In order to effect significant gains, new partnerships with public and private stakeholders in the housing arena, listening to people living with HIV who are experiencing homelessness, and funding innovative strategies that address housing needs are needed." Partnerships with carceral facilities and the criminal legal system will also be very important as we work to eradicate HIV.

Housing for Formerly Incarcerated People Living with HIV

In some communities, living with HIV means that a releasee will actually be more likely to secure stable housing. Funding is available in every state and U.S. territory for housing assistance for low-income PLWH and their families through two federal programs: the Housing Opportunities for Persons With AIDS (HOPWA) Program and the Ryan White HIV/AIDS Program (RWHAP). The only federal eligibility criteria for accessing these resources are being HIV+ and low income (defined by HUD as 80% of Area Median Income for HOPWA and by HHS as 300% of Federal Poverty Level for RWHAP).

...strategies to reduce as many barriers to housing as possible for renters with histories of arrest and/or incarceration.[74]

PLWH releasees are eligible for assistance through these programs regardless of the nature of their crime or sentence, and the agencies that receive these funds are encouraged to implement local programs that work to assist the most vulnerable in each community. However, within federal program guidelines, more stringent requirements may be implemented at the local level. Housing and service providers may ultimately adopt policies that are more restrictive than necessary due to a variety of factors, including lack of information, bias, prior negative experiences, fear of community push-back, or other reasons. The guidance issued by HUD Secretary Marcia Fudge in 2021, however, explicitly encourages providers to thoroughly rethink their program designs and implementation strategies to reduce as many barriers to housing as possible for renters with histories of arrest and/or incarceration.[74]

In practice, most housing programs that serve extremely low-income households, people experiencing homelessness, and/or PLWH have already had residents with histories of incarceration living there. But few conduct active outreach to those leaving prison, and not all will accept those just recently released from institutions. Housing options for PLWH on their way out of correctional institutions can be limited in two respects:

- By virtue of being newly released, they cannot always immediately access programs dedicated to serving PLWH because those programs may not have any openings or they may screen out people with felony convictions. This practice is most often related to confusion and

74. https://www.hud.gov/press/press_releases_media_advisories/HUD_No_21_105

misinformation about federal program guidelines, and the Biden administration's push to expand access to HUD programs aims to reduce this problem.

- Meanwhile, because of stigma associated with their HIV status, they may not be welcome elsewhere, such as in homes of family members or even in apartments rented in the private market. While discrimination in housing based on race, gender identify, sexual orientation, family composition, religion, disability and other factors is illegal, enforcement of the federal Fair Housing Act and other state and local anti-discrimination statues varies by jurisdiction. HUD's renewed focus on fair housing enforcement may yield positive developments nationwide.

The services typically offered in post-release housing may also need modification for PLWH. There is a need to prioritize emergency and transitional housing, as these resources are scarce for all people leaving prison; and the alternatives, such as shelters, are frequently unsafe environments. They may also lack some or all of the resources that will help stabilize residents' housing and health status.

Additionally, PLWH residents benefit from working with specialized HIV case managers. Another consideration is the mixed demographic of people living with HIV who were incarcerated. Housing programs that accept recent releasees should seek to understand the social dynamics among the various subgroups within that demographic—and their mutual tolerance for one another—so that those coming in will feel welcome to live in that housing and secure among the other residents who were formerly incarcerated.

Innovative Model 5-E

DESC's Site-Based Housing First Model – Seattle, WA

Program Overview and Population Served

Downtown Emergency Service Center (DESC) has operated a former office building as permanent supportive housing (PSH) in the Pioneer Square neighborhood of downtown Seattle since 1997. Originally funded through a federal Housing Opportunities for Persons With AIDS (HOPWA) construction grant, it targets vulnerable people experiencing homelessness whose multiple disabilities, disorders, and conditions have prevented them from succeeding in conventional low-income housing. DESC's primary goals for the project are to promote residents' housing success/longevity and clinical/social stabilization. In order to achieve these goals, intensive support services are offered on-site, and the building is staffed 24 hours per day.

DESC serves single homeless men and women who are living with HIV, behavioral health disorders, and/or substance use disorders. At least two of these conditions are required to qualify for residency in the building, along with being homeless and having an income below 30% of the area median. DESC is committed to providing homes to no fewer than 48 PLWH (75% of the building's 64 units) at any given time.

Typical service-enriched housing is not set up to serve those who suffer not only from HIV but also from other serious disabilities, such as behavioral health and substance use disorders, or other physical

disabilities. Likewise, those striving to house the most vulnerable homeless people are often overwhelmed by the health difficulties and vigilance HIV requires. It is an effective and unique response to this convergence of need, providing a critical housing resource for individuals living with co-occurring disorders and HIV who are experiencing homelessness.

As with all its PSH programs, DESC seeks to house those who have failed in conventional housing and those who face the greatest risk to personal health and safety while homeless. Many have histories of eviction and criminal backgrounds, which limit their housing options. Also, beyond the direct struggles associated with living with HIV, trying to manage multiple medical and behavioral health conditions while experiencing homelessness can be very challenging. DESC's staffing level and flexible, individualized approach allows the organization to effectively support clients' efforts and unique set of challenges.

DESC screens all residents to determine eligibility for public benefits. Some residents are eligible for Washington State's Foundational Community Supports (FCS) to cover the cost of the services being delivered by Clinical Support Specialists. DESC ensures that FCS is billed for eligible services and that the Ryan White HIV/AIDS Program is the payor of last resort.

Program Philosophy and Amenities

The chaos and disruptions associated with long-term homelessness are most commonly characterized by chaotic or disorganized living; untreated medical and behavioral health symptoms; food insecurity; frequent and repeated use of crisis intervention systems (EMTs, detox, police, hospital emergency rooms); and an inability or unwillingness to take care of primary health care needs and/or meaningfully engage in community support programs. Once in the building, residents are able to begin the slow process of social, medical, and psychiatric stabilization, which can be sustained over the long term with appropriate support services.

The services available to residents include 24-hour crisis management, behavioral health and substance use disorder treatment planning, one hot meal each night, one-on-one and group counseling, assistance in securing entitlement income and other financial resources, coordination of healthcare services, money management, and medication monitoring. DESC's PSH programs all demonstrate, as does research on PSH and Housing First, that once the chaos of homelessness is eliminated from a person's life, clinical and social stabilization occur more quickly and are more enduring.

A mix of both private and common areas within the building allows residents to feel secure without feeling isolated. Most have experienced chaotic, homeless situations before moving in. Each apartment is furnished with a bed, dresser, table, and two chairs. The comfort provided by having a private, secure space allows a resident to shift their focus beyond immediate survival needs and onto other problems that led to and/or exacerbated their homelessness. The availability of common areas for relaxation, socialization, eating and activities gives residents the opportunity to form meaningful relationships while gaining additional skills. Additionally, adequate private meeting space in staff offices and group rooms is crucial to conducting the individualized service planning and delivery needed by residents with co-occurring disabilities.

Integrated Services and Staffing Model

Staff is available to residents around the clock. The team is led by a Project Manager (PM), who is responsible for property management and on-site service delivery. The rules and structure of the residential program are designed to complement the provision of individual client support services. This integration creates a comprehensive service model rather than one fragmented by the separation of building management from support services. To achieve this goal, a three-part approach is utilized:

1. **Case management services:** Comprehensive assertive case management services are provided to residents through a combination of efforts by on-site Clinical Support Specialists (CSSs), a Housing Stabilization Specialist (HSS), case managers from DESC's and other licensed clinical programs, Residential Counselor staff, and additional resources that can be brought to bear. CSSs develop and maintain individualized service plans (ISPs) for each resident they serve, identifying service needs including assistance with basic needs, diagnostic and treatment services, crisis assistance, and assistance with the development of meaningful activity and a social support network. Services are designed to be low barrier and outreach-oriented.

   The individualized service plan provides a way for the resident to understand why prior housing situations were unsuccessful. It identifies steps they may take to make their experience with DESC different. It also identifies any outstanding needs and gaps in services the resident may be experiencing and provides a plan for how they might obtain those services. These functions of the ISP provide the tailored, pragmatic, creative, and client-centered approach that has the best chance of fostering housing success. ISPs are reviewed regularly and updated at least annually.

2. **24-hour on-site supportive services:** In addition to case management, much of which happens during daytime hours, a team of Residential Counselors (RCs) are available to residents in milieu areas at all times. RC involvement with residents is less structured than the work done by CSSs, but RCs provide a critical level of support to residents. RCs are familiar with the contents of the ISPs for each resident and interact with residents in ways supportive of the plan's objectives. Having the 24-hour RC staff involved in the service delivery in this way allows case managers to remain in better contact with their clients and increases coordination of services.

   The presence of knowledgeable and trained RC staff around the clock also allows for effective crisis intervention when the need arises. Residential Counselors are supervised by an RC Supervisor who is responsible for overseeing all aspects of milieu coverage and RC staffing and supervision.

3. **Flexible program structure:** In addition to individual resident services, the structure of the program itself is designed to promote housing success. The rules and structure of the program are clear and understandable, and designed to assist residents with making positive choices. The 24-hour coverage by staff familiar with each resident's needs and ISP helps residents feel secure and provides greater certainty that crisis situations will be resolved quickly. Rules are designed to promote the safety and comfort of all residents and attempt to foster a high level of self-determination. Behavioral problems are dealt with in a collaborative manner with

residents, within program guidelines. Staff discusses the nature and causes of the problem with residents, and residents have a role in developing plans to achieve more stable and cooperative living in a way that avoids future rules violations and preserves housing.

Program Goals and Philosophy

DESC's goal in managing behaviors is to be consistent in responding to problems, though not necessarily to respond in the same way for each resident. Staff strives to treat each resident individually, gearing their intervention to the specific strengths and needs of the resident. DESC believes that an individualized intervention is the only way to successfully address behavior and preserve housing because it addresses the social and psychiatric problems that underlie the behavior in question. Resident participation in social and therapeutic activities is encouraged but optional. In all interactions, the residents' right to make choices based on perceived needs and desires is respected, even if the choices being made by a resident seem non-productive to staff. However, when residents make unproductive decisions, staff will make continual efforts to engage the client and not cease engagement efforts in the face of a resident reluctant to accept services.

The integrated model that DESC uses helps to create an atmosphere of trust with residents. Ideally, clients come to understand that the primary goal of all the staff in the building, including the Project Manager and the staff at the front desk, is ultimately to help them keep their housing. This is different from other models of special needs housing where staff roles are often more rigid and where residents may see the manager as a person who might evict them, front desk staff as the enforcers, and the social service staff as the "good guys" who are there to help them. In DESC's model, all staff are aware of individual clients' needs and issues and are able to provide support and the most clinically appropriate response to problematic behaviors.

Regular community meetings are held and facilitated by staff. Topics of discussion include announcements of changes in building rules or staffing and notices of and planning for upcoming activities and events. The meetings also provide an opportunity for residents to offer input on building policies, raise issues of concern to residents (e.g. safety concerns and complaints about the neighborhood or building), comment on general operations of the building, and make suggestions for activities, services, or equipment to be provided on site. Emphasis is placed on consensus building and collaborative problem solving that encourages residents' involvement.

DESC has cooperative service agreements in place with 17 different case management agencies that may refer clients for housing. This coordination benefits residents by providing them with "wrap-around" support services upon move-in. DESC's experience with this clientele has shown that when the efforts of housing staff and case management staff are combined, the residents are much less likely to fall into the kind of crises that result in the loss of their housing.

For more information on DESC and its programs, go to: htpps://www.desc.org

Preventing HIV Transmission after Release

Multiple studies have demonstrated that people entering correctional facilities, especially those under age 35, have a high prevalence of sexually transmitted infections (STIs); for some, this will include HIV and/or viral hepatitis. Risk behaviors for acquiring HIV and other infections transmitted through intimate contact, such as having condomless sex, having multiple sex partners, injecting drugs, and engaging in commercial, survival, or coerced sex, are common among those who become incarcerated. Before their incarceration, many had very limited access to medical care. In addition, other social determinants of health, such as insufficient social and economic support or living in communities with high local STI prevalence, are common.

As noted previously, most PLWH leaving prison or jail acquired HIV prior to their incarceration. HIV transmission in correctional facilities is no longer common. For that reason, our examination of the social dynamics of HIV transmission will focus on the routes of HIV transmission in the specific subpopulations that are most vulnerable to HIV acquisition before and after incarceration. In the final pages of this chapter, we'll also look briefly at those elements of the National HIV/AIDS Strategy that relate specifically to providing assistance to people coming out of jails and prisons.

HIV Transmission in the U.S. Is Tied Primarily to the Behaviors of Men

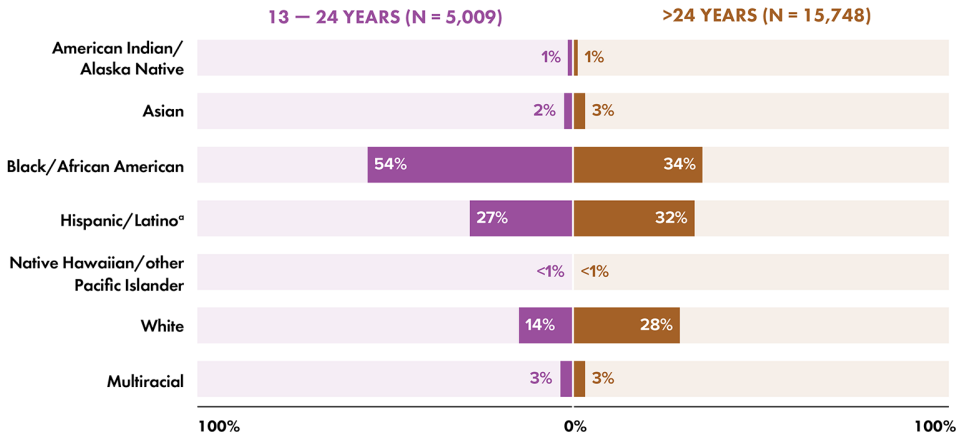
A much higher proportion of gay and bisexual men are living with HIV compared to all other groups in the U.S. The estimated lifetime risk for acquiring HIV among men who have sex with men (MSM) is one in six, compared with heterosexual women at one in 253 and heterosexual men at one in 524. These disparities are further exacerbated by race and ethnicity, with Black and Latino MSM having a one in two and a one in four lifetime chance of acquiring HIV, respectively. In 2019, MSM accounted for 69% of the 36,801 new HIV diagnoses in the U.S. From 2015 through 2019, among all MSM, White men accounted for 30% of new diagnoses annually, while Black men accounted for 36%, and Latino men accounted for 22%.[74]

Given that a substantial number of MSM are unaware of their HIV status, especially those under the age of 25,[75] the risk of acquiring HIV through shared needles and unprotected sex is further increased. Thus, gay and bisexual men have an increased chance of having a sex partner and/or person with whom they might share a needle who is living with HIV, either knowingly or unknowingly. Further, those who do not know that they are living with HIV cannot take advantage of HIV care and treatment, and if they have an elevated "viral load" may unwittingly pass HIV on to others.

It is here—where knowledge, attitudes, and behaviors related to HIV come into play as new releasees rejoin the broader community—that those of us who are concerned with both promoting their individual health and attaining the goal of ending the HIV epidemic (EHE) can make a substantive contribution. We can first inform ourselves and then help formerly incarcerated men and women protect themselves, and their intimate partners, against HIV transmission.

75. https://www.cdc.gov/hiv/group/msm/msm-content/diagnoses.html
76. https://www.cdc.gov/std/treatment-guidelines/msm.htm#:~:text=HIV%20Risk%20Among%20Men%20Who,one%2in%20253%20(191)

The graph below depicts new HIV diagnoses in 2020 among men who have sex with men, by age group and race/ethnicity.



Young Latino MSM, recent Latinx immigrants, and transgender Latina women are significantly affected by HIV. New HIV diagnoses among Latinx gay and bisexual individuals have increased by 30% since 2010. At least one in three new diagnoses among Latino men in 2017 were among those born outside the U.S., while an estimated 25% of transgender Latinas are living with HIV.

At a Glance 5.14

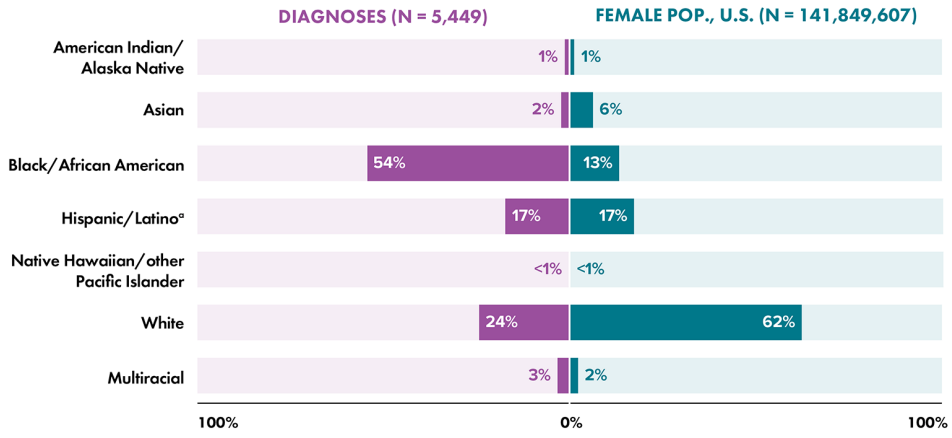
Factors that put men who have sex with men (MSM) at greater risk of acquiring HIV

- Stigma, homophobia, and discrimination affect the health and well-being of gay and bisexual men and may deter or prevent them from seeking and receiving high-quality health services, HIV treatment, HIV testing, and other prevention services.
- Socioeconomic factors, such as limited access to health care, lower income and educational levels, and higher rates of unemployment and incarceration may place many gay and bisexual men at higher risk for HIV.
- Individual factors also put gay and bisexual men at higher risk for HIV, including having condomless anal sex with PLWH who do not have an undetectable HIV viral load. Among all sexual activities, unprotected anal sex has the highest likelihood of transmitting HIV, and a receptive anal sex partner is 13 times more likely to acquire HIV than an insertive partner is.
- MSM are also at increased risk for other sexually transmitted infections (STIs), such as syphilis, gonorrhea, and chlamydia. Having another STI can greatly increase the chance of getting or transmitting HIV.

HIV Diagnoses among Women and Youth

Among women who only have sex with women, the chance of acquiring HIV remains low. For women who have sex with both women and men, however, the risk of acquiring a range of STIs, including HIV, is comparable to that of women who only have sex with men. In 2019, 7,000 women (19% of the total) were diagnosed with HIV. Eighty-four percent (5,863) resulted from sex with men; the remaining 16% was due to injection drug use. Because women may be unaware of their male partner's risk factors for HIV (such as injection drug use or having sex with men), they may not use a condom or prophylactic medicine to prevent HIV.[77] Concurrent sexually transmitted infections increase the risk of HIV transmission, and some of the highest STI rates are among youth aged 20 to 24, especially youth of color. Women's increased risk is also related to their exposure to gender inequalities and the social and economic pressures of poverty.[78]

The infographic below shows the percentages of HIV infection diagnoses and share of the general population among women and adolescent girls in the U.S. by race and ethnicity in 2020. The disproportionate impact among African American women is striking: 55% of new HIV diagnoses among 13% of the general female population.

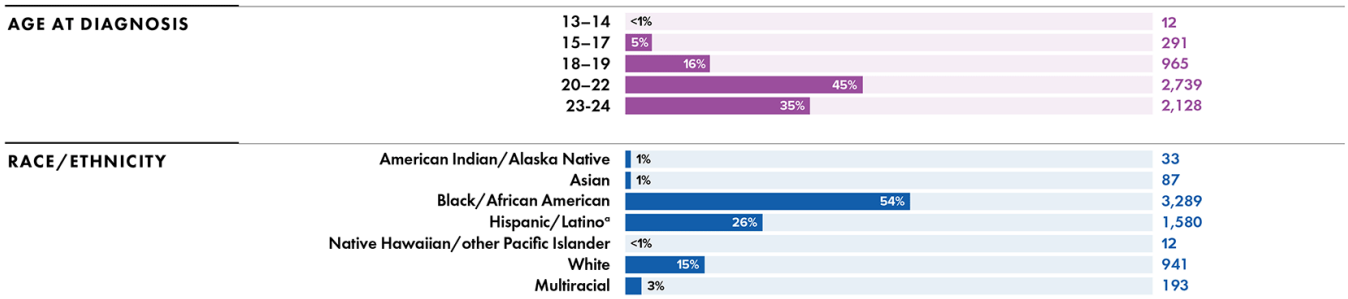


Youth aged 13 to 24 represented one in five (21%) of all new HIV diagnoses in the U.S. in 2019, and 81% of them identified as gay or bisexual males. Lesbian, gay, and bisexual high school students (4%) were more likely to have injected illegal drugs than heterosexual students (1%).[79] An estimated 60,300 young people aged 18 to 24 were living with HIV, and of these, more than half (31,000) had not been diagnosed—the highest rate of people who don't know that they are living with HIV of any age group. In 2016, 84% of youth aged 15 to 24 reported that there is a stigma around HIV, which could mean that they are not comfortable discussing their status with others or speaking with their sexual partners regarding ways to protect themselves from HIV and other STIs. Meanwhile, condom use among sexually active high school students decreased from 61% in 2009 to 54% in 2019. Yet only 9%

77. https://www.cdc.gov/hiv/group/gender/women/prevention-challenges.html
78. Mahathir, M. (1997) *Women at greater risk of HIV infection*. Arrows for change, 3(1), 1–2. Available online: https://pubmed.ncbi.nlm.nih.gov/12292992/
79. https://www.cdc.gov/healthyyouth/youth_hiv/hiv-information-and-youth.htm

of high school students in 2019 had been tested for HIV.[80] There is clearly a great need for effective education on HIV prevention and care among youth and young adults, including for those coming out of juvenile facilities and adult jails and prisons.

The infographic below shows new HIV diagnoses in 2020 by age range and race/ethnicity among individuals aged 13-24 years old. Please note that those aged 20-24 are twice as likely to contract HIV as are 18-19 year olds and Blacks are 13 times more likely than Whites to receive an HIV diagnosis.[81]



PEP, PrEP, and HIV Prevention

PEP is post-exposure prophylaxis, which means taking a medicine to prevent HIV transmission after a possible exposure. It is meant for unexpected exposures, whether during consensual sexual contact (if the condom broke, for example); a medical workplace exposure; through sharing needles, syringes, or other equipment to inject drugs; or in the case of sexual assault/rape. If taken within 72 hours after possible exposure, PEP is highly effective in preventing HIV. However, PEP is not the right choice for people who may be exposed to HIV frequently, and it is not a substitute for regular use of other HIV prevention approaches.[82]

Pre-exposure prophylaxis (PrEP) for HIV prevention is the use of medications for preventing an infection before exposure. Studies have demonstrated that a daily oral medication is effective in preventing HIV transmission, specifically among MSM. Both men and women who are currently HIV negative and have sexual intercourse with someone who is HIV+ can benefit from PrEP. Risk-factor indicators for using PrEP include condomless sex with a partner with HIV whose HIV-RNA level is detectable or unknown, recent sexually transmitted infections (STI's), or injection drug use. When taken as prescribed, PrEP provides greater than 90% protection against acquiring HIV.[83]

PrEP use among Black and Latinx people, especially MSM, remains low. In 2021, while Black people represented 42% of new HIV diagnoses, they represented only 14% of PrEP users. The pattern is similar for Latinx people—they represented 27% of new HIV diagnoses but only 17% of PrEP users. In comparison, White people represented only 26% of new HIV diagnoses but 65% of PrEP Users.[84] Unfortunately,

80. https://www.cdc.gov/healthyyouth/youth_hiv/hiv-information-and-youth.htm
81. https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-33/content/special-focus-profiles.html
82. https://www.cdc.gov/hiv/basics/pep/about-pep.html
83. https://clinicalinfo.hiv.gov/en/guidelines/perinatal/prep
84. https://aidsvu.org/prep-use-race-ethnicity-launch-22/

the disparity in use of PrEP between groups based on race, ethnicity, and region of the U.S. has grown wider in recent years. More targeted and effective initiatives to connect with and engage community members are needed to help assure more equitable PrEP uptake and use.

Until 2022, the only method for taking PrEP was a once-a-day pill; however, many people don't want the hassle of remembering to take a daily pill. Other factors, such as substance use disorders, depression, poverty, and efforts to conceal medication also can impact adherence. The impacts of institutional racism in medicine are also a factor among communities of color.[84]

That changed, however, in December 2021 when the U.S. Food and Drug Administration (FDA) approved an injectable form of PrEP. Debra Birnkrant, M.D., director of the Division of Antivirals in the FDA's Center for Drug Evaluation and Research stated at the time: "Today's approval adds an important tool in the effort to end the HIV epidemic by providing the first option to prevent HIV that does not involve taking a daily pill. This injection, given every two months, will be critical to addressing the HIV epidemic in the U.S., including helping high-risk individuals and certain groups where adherence to daily medication has been a major challenge or not a realistic option." [85]

Transmission Clusters among Certain Subpopulations

Given the low rates of HIV transmission in prisons and the fact that most PLWH maintain low viral loads while incarcerated, making PrEP available inside may not be a high priority. However, making PrEP available to MSM—and others for whom a specific risk of HIV acquisition has been identified—when they are released is a very good idea. One possibility would be make available, on request, a prescription for the two-month, injectable form (and the first dose) just prior to release.

Many young MSM face the multiple challenges of HIV-related stigma: language barriers, mistrust of health systems, and lack of culturally appropriate care. The Centers for Disease Control and Prevention (CDC) has identified HIV transmission "clusters," which comprise loose networks of young Black and/or Latino MSM who are connected socially, sexually, and/or through drug use. HIV transmission is occurring at up to 33 times the national average in some clusters. Most of the young MSM who are being released from jails and prisons across the U.S. return to such networks upon release. Addressing their needs—and thus helping to end the HIV epidemic—requires teamwork, education about the risks of HIV transmission after release and the efficacy of PEP and PrEP, and connecting folks to appropriate health resources.

Among transgender people, racism, stigma, and discrimination seem to increase HIV risk-related behaviors and lead to health disparities in HIV. Issues associated with racism and discrimination—including limited access to health care, employment, and housing—can increase the risk for HIV and affect the health and well-being of transgender people.

- Findings from the CDC's 2020 National HIV Behavioral Surveillance show that most transgender women have experienced some form of abuse or harassment because of their

84. https://aidsvu.org/prep-use-race-ethnicity-launch-22/
85. https://www.fda.gov/news-events/press-announcements/fda-approves-first-injectable-treatment-hiv-pre-exposure-prevention

gender identity or presentation. This may negatively impact their success in accessing HIV testing, care, and treatment.

- Transgender youth are more likely to miss HIV care appointments if they did not feel supported through medical gender affirmation or had been treated negatively because of their gender identity. Thus, access to gender-affirming medical treatment may be essential to improving their uptake of HIV treatment and prevention.[86]

Housing as an Intervention to Improve Health and Reduce HIV Transmission

In 2015, a team of researchers led by Angela Aidala at Columbia University examined 152 studies representing 140,000 PLWH in the U.S. and Canada. In the conclusion to one peer-reviewed article they state, "With rare exceptions, across studies in all domains, worse housing status was independently associated with worse outcomes… Lack of stable, secure, and adequate housing is a significant barrier to consistent and appropriate HIV medical care, access, and adherence to antiretroviral medication, sustained viral suppression, and risk of forward transmission."[87]

The researchers found that PLWH experiencing homelessness or who had other unmet housing needs were less likely to be engaged in care than their counterparts who had no housing challenges. Multiple studies targeting substance using, recently incarcerated, or other socially marginalized PLWH found that poorer housing status was universally associated with lack of regular visits for HIV primary care. Conversely, several studies found that receipt of housing assistance or other services that improved housing was significantly associated with routine use of primary health care services.[88] A few additional examples of findings related to housing's impacts on PLWH follow:

- Adherence to anti-retroviral therapy (ART) medication is crucial for the health of PLWH. Twenty-four of the 30 studies reviewed that looked at the link between housing status and ART adherence reported significantly lower adherence among those who were experiencing homelessness or were unstably housed:[89]
- In one multisite study of HIV+ injecting drug users who were accessing primary care, those with stable housing had double the odds of ART medication adherence than did those in care but without stable housing.[90]
- In a San Francisco study based on all cases of AIDS reported between 1996 and 2001, the individuals were followed through 2006. Those who had been experiencing homelessness at the time of their diagnosis were significantly more likely to delay or never initiate ART.[91]

86. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-27.pdf
87. Aidala, A. (2016) *Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review.* American journal of public health, 106(1), e1–e23. Available online: https://doi.org/10.2105/AJPH.2015.302905
88. Ibid.
89. Spire, B. (2002) *Adherence to highly active antiretroviral therapies (HAART) in HIV-infected patients: from a predictive to a dynamic approach.* Social science & medicine (1982), 54(10), 1481–1496. Available online: https://doi.org/10.1016/s0277-9536(01)00125-3
90. Knowlton, A. (2010) *Antiretroviral use among active injection-drug users: the role of patient-provider engagement and structural factors.* AIDS patient care and STDs, 24(7), 421–428. Available online: https://doi.org/10.1089/apc.2009.0240
91. Arnold, M. (2009) *Race, place and AIDS: the role of socioeconomic context on racial disparities in treatment and survival in San Francisco*. Social science & medicine (1982), 69(1), 121–128. Available online: https://doi.org/10.1016/j.socscimed.2009.04.019

- In a large survey conducted in 19 geographic areas across the country, PLWH experiencing homelessness had significantly lower odds of viral suppression than did those who were housed; and housing status was a significant predictor of their most recent viral load.[92]
- In a large-scale behavioral survey of 8,000 recently diagnosed PLWH, those experiencing homelessness had higher rates of both drug use and behaviors associated with getting or transmitting HIV than did those who were housed. Homeless PLWH respondents who were sexually active reported a greater number of sexual partners in the past year, were more likely to have exchanged sex for money or drugs, and were nearly twice as likely to have engaged in unprotected anal or vaginal sex with an unknown status partner.[93]
- One study that pooled data from 16 programs nationwide (over 2,000 clients) found that the odds of recent drug use, needle use, or sex exchange were 2 to 4 times higher among unstably housed PLWH than for those with stable housing. In follow-up after 9 months, those whose housing status improved significantly reduced their risks of drug use, needle use, needle sharing, and unprotected sex by 50% compared with those whose housing status had not improved. For those whose housing status worsened, the odds of recently exchanging sex for money were more than 5 times higher than for clients whose housing status had not changed.[94]

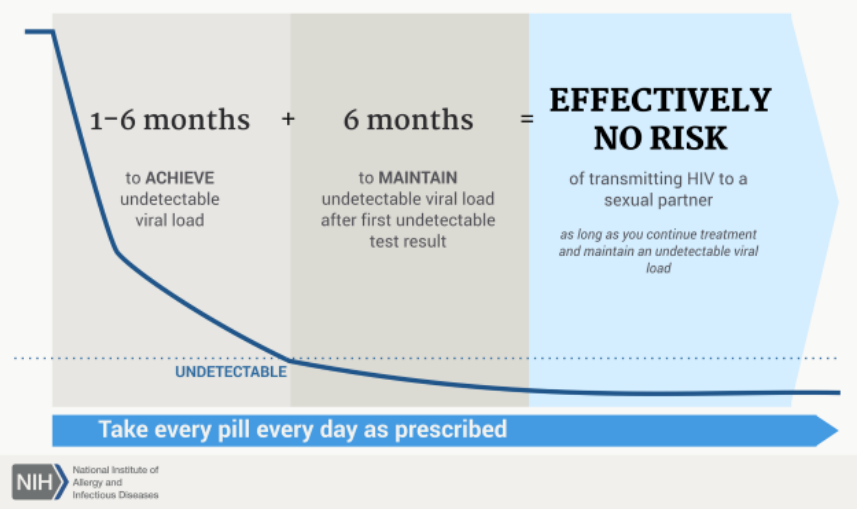
Undetectable = Untransmittable

In recent years, an overwhelming body of clinical evidence has firmly established as scientifically sound the U=U concept. "Undetectable equals untransmittable" (U=U) means that people with HIV who achieve and maintain an undetectable viral load—the amount of HIV in the blood—by taking antiretroviral therapy (ART) daily as prescribed cannot sexually transmit the virus to others. Thus, effective treatment of HIV is a powerful tool in HIV prevention.

A person's HIV viral load is considered "durably undetectable" when all viral load test results are undetectable for at least six months after the first undetectable test result. This means that most people will need to be on treatment for 7 to 12 months in order to achieve a durably undetectable viral load. As with PrEP, it is essential to take every pill every day to maintain a durably undetectable status. The infographic on the next page shows this decrease in viral load over time through taking ART medications as prescribed.

If ART therapy is interrupted, one's viral load will rebound, and the risk of transmitting HIV to a sexual partner in the absence of other prevention methods returns. Stopping and re-starting treatment can cause drug resistance to develop, making that treatment regimen ineffective and limiting future

92. Kidder, D. (2007) *Health status, health care use, medication use, and medication adherence among homeless and housed people living with HIV/AIDS*. American journal of public health, 97(12), 2238–2245. Available online: https://doi.org/10.2105/AJPH.2006.090209
93. Kidder, https://doi.org/10.1097/qai.0b013e31818a652c
94. Aidala, https://doi.org/10.1007/s10461-005-9000-7



treatment options. Further, as viral load increases, then U=U goes away and the risk of HIV transmission increases dramatically.[95] So one can see that there are multiple benefits to releasees in knowing both their own HIV status—as well as the status of any potential partners they may be connecting with—prior to release. And then, as previously noted, it is of utmost importance that PLWH releasees quickly and securely connect with HIV care, medications, and prevention coaching, as needed.

U.S. National HIV/AIDS Strategy (2022-2025)

In December 2021, President Biden released an updated *National HIV/AIDS Strategy* (NHAS) that proposes the goal of ending the HIV epidemic in the U.S. by 2030. Achieving this benchmark includes reaching a 75% reduction in new HIV infections by 2025 and a 90% reduction by 2030. The NHAS offers clearly articulated goals, objectives, and strategies to prevent new infections, treat people with HIV to improve health outcomes, reduce HIV-related disparities, and better integrate and coordinate the efforts of all partners.

> In describing the conditions facing people experiencing incarceration, the Strategy's authors assert: People involved in the justice system face a confusing/disparate system of prevention and care services, often for short time periods. These individuals experience a disproportionately high risk of HIV, as well as risk factors associated with under-utilization of prevention and treatment options, including substance use, mental health issues, and poor access to care. Improving HIV prevention and management among justice-involved people requires innovative approaches to integrating care. HIV programs must work with state and local [correctional] facilities to ensure that care services are provided throughout the justice system, particularly to people upon release back to their communities. Pre- and post-transition planning is critical to decreasing barriers to care.[96]

95. https://www.niaid.nih.gov/diseases-conditions/10-things-know-about-hiv-suppression
96. https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025, p.26

A study conducted in 2014 found that only 19% of prison systems and 35% of jails provide opt-out HIV testing. Additionally, fewer than 20% of prisons and jails conform to the CDC's recommendations regarding discharge planning services, which the CDC indicates should include: "making an appointment with a community healthcare provider, assisting with enrollment in entitlement programs, and providing a copy of the medical record and a supply of HIV medications."[97]

In the section titled Missed Opportunities for HIV Diagnosis, the *National HIV/AIDS Strategy* states:

> The Centers for Disease Control and Prevention (CDC) recommends that HIV screening be provided upon entry into—and before release from—correctional settings and that voluntary (opt-out) HIV testing be offered periodically during incarceration. Studies have shown that opportunities for HIV diagnosis, and linking HIV-positive individuals with justice system involvement to community care after release, are being missed in the majority of prison systems and jails.[96, 97]

Continuing, the NHAS authors suggest:

> Developing and expanding partnerships between providers of HIV specialty care and other providers (such as primary care and other health care providers as well as community organizations, health departments, community-based substance use and harm reduction programs, jails and prisons, and others) can leverage existing resources, allowing for seamless transitions between each step of the continuum from diagnosis to achieving and maintaining viral suppression.[98]

Under Goal 3: Reduce HIV-Related Disparities and Health Inequities, the NHAS offers a range of action steps, including two that specifically relate to people exiting jail and prison and experiencing housing instability after release:

> **#3.4.4:** Develop and implement effective, evidence-based and evidence-informed interventions that address social and structural determinants of health among people with or who experience risk for HIV including: lack of continuous healthcare coverage, HIV-related stigma and discrimination in public health and healthcare systems, medical mistrust, inadequate housing and transportation, food insecurity, unemployment, low health literacy, and involvement with the justice system.
>
> **#3.4.6:** Develop new and scale up effective, evidence-based or evidence-informed interventions that address intersecting factors of HIV, homelessness or housing instability, mental health and violence, substance use, and gender, especially among cis- and transgender women and gay and bisexual men.[99]

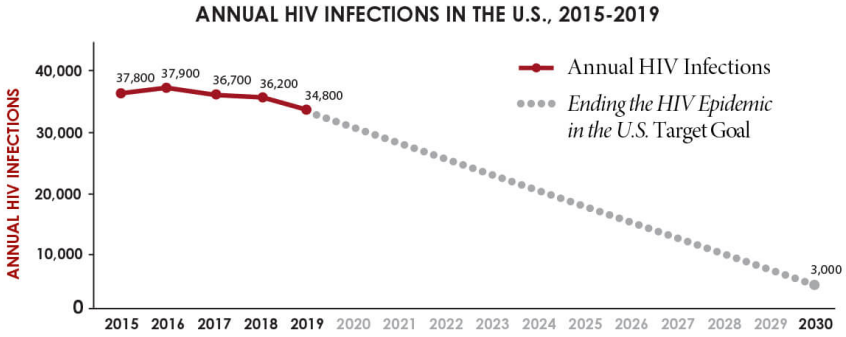
The Strategy's goal of reducing HIV transmission by 90% by 2030 is huge, but not impossible. The rate of HIV transmission in the U.S. has already been decreasing; it is estimated that new HIV infections declined 8% from approximately 37,800 in 2015 to 34,800 in 2019 after a period of relative stability. The rate of infection was highest for people aged 25-34. The highest rates of infection were 42 (per 100,000)

97. Solomon, L. (2014) *Survey finds that many prisons and jails have room to improve HIV testing and coordination of post-release treatment*. Health affairs (Project Hope), 33(3), 434–442. Available online: https://doi.org/10.1377/hlthaff.2013.1115
98. https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025, p.38
99. Ibid, p.7.

for Blacks, 22 for Latinx, and 18 for people who identify as mixed race. The largest percentages of HIV infections were attributed to male-to-male sexual contact (81% of new infections among men and 66% overall).[100]

The infographic below shows the projected decrease needed throughout this decade in order to achieve the 2030 target of a 90% decrease in new HIV infections in the U.S. (from the 2019 level).

NEW HIV INFECTIONS FELL 8% FROM 2015 TO 2019, AFTER A PERIOD OF GENERAL STABILITY



In the NHAS section titled "Implementing the Strategy," after outlining the tremendous amount of work assigned to the Office of National AIDS Policy and its federal partners, the authors state:

> But federal activity alone can't end the HIV epidemic. That is why the strategy is a national one, not just a federal one. The NHAS is a call to action for stakeholders from all corners of society. Achieving its goals will require the engagement of stakeholders from all sectors in a more coordinated, re-energized, national response to HIV. This includes the collaborative efforts of people living with and at risk for HIV; public health professionals; healthcare providers; those working in state, tribal, and local government; staff of faith-and-community-based organizations; educators; advocates; researchers; and people leading and working in private industry.

For more information on the National HIV/AIDS Strategy, go to: https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025

In late 2022, the USA Panel of the International Antiviral Society released a set of updated recommendations on the use of "Antiretroviral Drugs for Treatment and Prevention of HIV Infection in Adults."[101] This well-researched and timely guide provides the most current recommendations for prevention and treatment of HIV, as well as an up-to-date discussion of important comorbidities and coinfections in PLWH related to the use of antiretroviral therapies (ART). On Dec. 13, 2022, JAMA also published an opinion piece titled "Ending the HIV Epidemic: We have the tools, do we have the will?"[102] We encourage readers to download and reference both to help bolster your local EHE efforts' success.

100. https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics#:~:text=New%20HIV%20infections%20declined%208,distributed%20across%20states%20and%20regions

101. Gandhi RT, Bedimo R, Hoy JF, et al. *Antiretroviral Drugs for Treatment and Prevention of HIV Infection in Adults: 2022 Recommendations of the International Antiviral Society–USA Panel.* JAMA. 2023;329(1):63–84. doi:10.1001/jama.2022.22246

102. Haddad M, Person AK, Tookes HE. *Ending the HIV Epidemic: We Have the Tools, Do We Have the Will?* JAMA. 2022;328(22):2207–2208. doi:10.1001/jama.2022.22569s

At a Glance 5.15

HUD's Statement on the Release of the Federal Implementation Plan for the National HIV/AIDS Strategy

In a press release dated August 29, 2022, HUD Secretary Marcia L. Fudge stated:

> Access to safe, stable, and affordable housing is a critical social determinant of health. The launch of the Federal Implementation Plan for the National HIV/AIDS Strategy marks an important step forward in our ongoing efforts to end the HIV epidemic in the United States by 2030, and I am proud of the role that HUD will play to expand access to HIV education and testing, prevent discrimination against people living with HIV, and, ultimately, reduce stigma.

In her message, Secretary Fudge also committed HUD to a range of actions in support of NHAS goals, including:

- Distributing HIV prevention information to people who reside in HUD-assisted housing, as well as those who administer the programs;
- Partnering with the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) to identify and disseminate best practices and expand local coordination in HIV "clusters" and "outbreaks" where homelessness or unstable housing have been identified as compounding factors;
- Undertaking efforts to ensure racial and LGBTQ+ equity in access to housing and services funded by HOPWA;
- Incentivizing communities to appropriately address inequities with the goal of achieving positive housing and service outcomes for people who are Black, Hispanic (non-white), Indigenous, and LGBTQ+, and increase the level of engagement in program planning among people with lived experiences of HIV, homelessness, and housing instability; and
- Coordinating on a targeted initiative for youth in HUD-assisted housing programs to:
  - Increase access to age-appropriate prevention tools and information regarding HIV, STIs, and unplanned pregnancies; and
  - Enhance participants' awareness of both personal risk and prevention options, as well as regarding their motivation and skills in implementing effective prevention behaviors.

For more information on the NHAS Implementation Plan's release, go to: https://www.hiv.gov/blog/white-house-publishes-federal-implementation-plan-national-hivaids-strategy

Closing Thoughts

With this chapter, we have completed our survey of background information on systems, people, and a wide range of conditions, factors, and circumstances that all shape the experiences of those who have been incarcerated and are now headed back into society. In Chapter Six we'll first explore the process of transitioning from inside to outside and then describe the complicated world of permanent supportive housing (PSH)—its paradigms, financing, siting, and operations. So, we leave you here with a few ideas for ongoing staff education in post-release housing:

1. Have staff look at visual art and creative writing by prisoners to help them absorb the experience of incarceration;
2. Circulate books, videos, and podcasts about prison life among staff and encourage group discussions;
3. Visit your local parole office with staff to learn more about how that system works;
4. Have an attorney speak to staff about the laws and regulations that affect ex-prisoners, such as: exclusions from forms of public housing, job sectors, food stamps, voting, etc.;
5. Have mental health clinicians teach staff about what kinds of behaviors, expectations, and needs to expect to find among residents with mental health issues;
6. Have an HIV specialist provide an HIV 101 training for staff—also cover other STIs/infectious diseases, such as Hepatitis B, Hepatitis C, and tuberculosis;
7. Conduct trainings about substance use, relapse, and overdose prevention;
8. Teach staff methods of self-preservation that will prevent burnout and help staff realize that your program probably cannot help certain ex-prisoners who need to grow out of some of their problems—some may even need to go back to jail over and over;
9. Teach staff nonviolent techniques for de-escalating potentially volatile situations between residents and help them plan responses to angry and threatening behavior; and
10. Regularly check in with both staff and residents to discover what they're interested in learning about.

Discussion of Chapter Five

Points to Remember – Mental Illness

- Prisoners have five times the rate of mental illnesses than does the general population. It co-occurs with substance use 90% of the time.
- Mentally ill prisoners experience the most mistreatment, from peers and guards alike, of any incarcerated group. Their frequent experiences in isolation units may worsen their symptoms and cause disease progression.
- Mentally ill prisoners are more likely to "max out" their sentences, leave incarceration unsupervised by parole, and therefore experience sudden, unstructured reentry.

- As mentally ill prisoners are commonly undiagnosed, community groups who serve them after release are challenged with sorting out confusing behaviors and obtaining accurate and complete diagnoses.
- Homeless ex-prisoners with mental illnesses are sometimes declined from housing when their needs are considered too severe. Ironically, these individuals often end up in less structured and supportive environments, such as unstaffed single room occupancy housing and emergency shelters, where they may fail to thrive.

Points to Remember – Substance Use Disorders

- 70% to 85% of all people held in prisons or jails experience substance use disorders, but only one in six receives treatment inside their correctional institutions.
- Since reentry is a common risk factor for relapse, the consistent implementation of strategies to address SUD in post-release housing are pivotal to the success or struggles of both the program and its residents.
- The adaptation of harm reduction principles to stably house people with histories of substance use, mental illness, chronic homelessness, and/or incarceration that is called Housing First is a widely used and proven best practice.

Points to Remember – Infectious Diseases

- Prisons are not isolated environments that are completely separated from their surrounding communities. They can function as revolving doors for the transmission of infectious diseases, including COVID-19, Hepatitis B & C, HIV, and tuberculosis.
- Strong correlations in COVID-19 transmission rates were seen between prisons and their surrounding communities, so improving safety in one sphere also helps to protect the other.
- Compassionate release for people with compromised immune systems and certain medical conditions proved helpful in savings lives during the early months of the COVID-19 pandemic, but there is still much work to do to improve the speed with which applications are processed and to normalize the policies into general practice.
- Large-scale decarceration and changes to pretrial detention policies are likely to prove important for improving U.S. public health, biosecurity, and pandemic preparedness.

Points to Remember – HIV

- Those with the highest rates of HIV in prison come from the subpopulations most at risk of HIV transmission:
    - Men who have sex with men (MSM), including those who don't identify as gay or bisexual;
    - Black and Latinx women who have sex with men; and
    - People who live in certain jurisdictions and/or certain social networks.

Reentry complicates management of HIV disease by:

- Interrupting drug treatment;
- Ending consistent medical care;
- Suddenly giving the ex-prisoner responsibility for care; and
- Exposing the ex-prisoner to environments that threaten their health.

Points to Remember – HIV Prevention

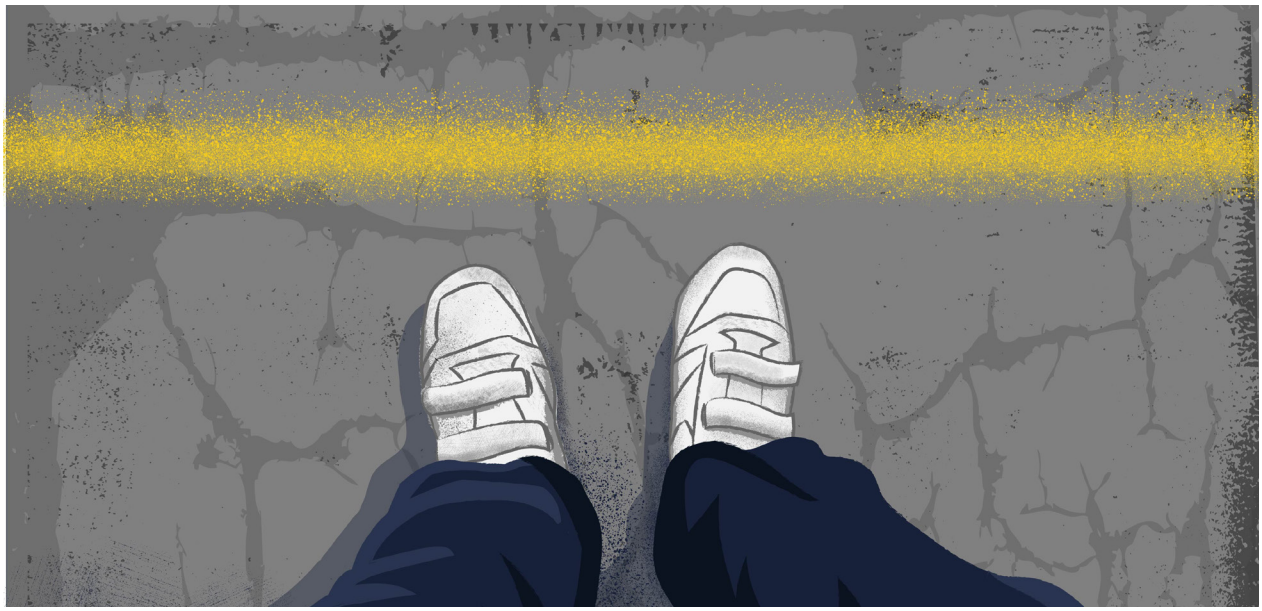
- Less than 50% of youth and young adults living with HIV know their status—fewer than any other age group.
- HIV stigma and distrust of institutions keep young people away from testing, care, and prevention services.
- Men who have sex with men (MSM) have the highest likelihood of HIV transmission, and it's even higher for MSM of color. The primary vector for HIV transmission in women of color is through sex with an HIV+ man.
- Pre- and post-exposure treatments are very effective, easy to administer, and available at low cost or free.
- Having an undetectable HIV viral load means that the virus cannot be transmitted through bodily fluids.
- Stable housing is a proven intervention that both reduces HIV transmission and increases participation in healthcare and other services.
- HIV transmission can be reduced or prevented through several pathways:
  - Avoiding situations likely to transmit HIV, such as unprotected anal or vaginal sex and the sharing of injecting equipment;
  - Accessing PEP and PrEP (for those who are HIV-) and maintaining an undetectable viral load (if living with HIV); and
  - Maintaining housing stability and connections to HIV care and services.

Discussion Activities

- Staff at the Open Doors Housing Program is concerned about a resident who exhibits erratic and sometimes paranoid behavior. His medical summary from prison mentions depression as his only mental health issue. Although he has not done anything threatening, staff is afraid of his combative manner. The Program Director is considering a new rule that anyone with mental health issues not be admitted to the program in the future and, instead, be referred to the state's mental health department. She feels conflicted and has come to you for advice. What, if any, are her other options?
- Develop a list of the range of methods and treatments, both formal and informal, that exist for treating addiction and preventing relapse. Then develop a plan for how each method could possibly be integrated into a post-release housing program. Which one(s) would be most appropriate for the population your organization will serve?
- Create a fictional name and identity for a female prisoner in your state's correctional system. She is clinically diagnosed with bipolar personality disorder, post-traumatic stress disorder, addiction to heroin and alcohol, and advanced HIV disease.

    1. Develop a simple life story that explains the sequence and correlation of these illnesses.
    2. Describe how each illness will impact her ability to adjust to life outside of prison.
    3. About which of her problems do you think she will concern herself the most at reentry?
    4. What services in post-release housing would be most important to make available to her?

- What explains the dramatically different pace of the spread of HIV among people who have been (or are) incarcerated versus the general population? Why would transmission "clusters" form, and what strategies might you employ to diminish the disparate impact these folks encounter?



Homecoming: Life after Incarceration – Companion Videos

Also found on the HUD Exchange website is a suite of new documentary films that cover topics similar to those explored in this book but use the unique capabilities of film to humanize and supplement the more detailed discussions of the written text. Each video is 20 - 40 minutes in length and comprises interviews with post-release housing and services clients and providers, as well as researchers and policy makers in the field. All videos can be streamed at: https://www.hudexchange.info/homecoming

Readers are encouraged to use the videos to supplement the information shared here (and vice-versa) to get a better feel for the dignity, intelligence, life experiences, and humanity of (a small sampling of) the millions of Americans who have been incarcerated and/or are supporting others in their reentry.

Episode I:	**Release**
Episode II:	**Housing**
Episode III:	**Employment**
Episode IV:	**Health, Wellbeing and HIV**
Episode V:	**For Us, By Us**
Episode VI:	**Trauma and Dignity**
Episode VII:	**Ending HIV Epidemic**
Episode VIII:	**Federal Housing Policy**
Episode IX:	**The Cost of Incarceration**
Episode X:	**Money Management Services**