



Mass Incarceration, Housing Instability and HIV/AIDS: Research Findings and Policy Recommendations

a report on the effects of incarceration and
HIV/AIDS on marginalized communities.



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OVERVIEW

Over the past three decades in the United States, overlapping epidemics of mass incarceration and HIV/AIDS have become disproportionately concentrated among economically disadvantaged persons of color. As a result, a substantial proportion of people living with HIV in the U.S. have spent time in prison or jail, including many with co-occurring substance use and mental health disorders that complicate care and contribute to social marginalization. Each year, some 150,000 Americans living with HIV/AIDS are released from a correctional facility. Some are able to return to live with family – but studies show that as many as half of HIV-positive inmates leave prison or jail with no place to call home and no income to meet basic subsistence needs.

Formerly incarcerated persons with HIV/AIDS face unique barriers to housing that contribute to social instability long after return to the community. The resources currently available to support housing stability fall short of real need for all low-income American households living with HIV. The added stigma of criminal justice involvement further blocks access to work and to the private housing market, and punitive public policies restrict the eligibility of formerly incarcerated persons for public housing, income supports and other safety net programs. Stable, appropriate housing is consistently found to be the greatest unmet need of persons with HIV/AIDS reentering the community from prison and jail, and a history of incarceration has been found to double the risk of subsequent homelessness among low-income persons living with HIV/AIDS.

Recent incarceration and a lack of stable housing are both identified regularly in the research literature as potent risk factors for poor HIV health outcomes and ongoing HIV transmission. Homelessness and housing instability are consistently linked to greater HIV vulnerability, inadequate health care, poor HIV health status and early death. For persons with HIV leaving prison and jail, the period following release is often characterized by limited access to

medical care, interruption of antiretroviral therapy, poor virological and immunological outcomes, and behaviors that can transmit HIV infection. These poor individual HIV health outcomes contribute to high community viral load that perpetuates ongoing HIV transmission.

While experts agree that housing instability is a major challenge to successful management of HIV among persons involved with the criminal justice system, increasing evidence points to housing status as an independent predictor of HIV treatment effectiveness and risk behaviors that can be addressed through cost-effective interventions.



Research findings show that housing assistance for homeless and unstably housed people with HIV improves physical and mental health, reduces HIV transmission, and sharply cuts the use of avoidable emergency and inpatient health care – generating savings in averted health care spending that offset the cost of the housing services. These findings suggest that targeted housing supports have the potential to significantly improve HIV health and criminal justice outcomes among formerly incarcerated persons living with HIV/AIDS, particularly during the vulnerable period immediately following release from prison and jail, but also long-term.

The evidence indicates that action to remove post-incarceration barriers to housing and to increase the availability of housing assistance for low-income persons with HIV/AIDS would improve outcomes for individuals involved with the correctional system, lower community viral load, and reduce

the burden of illness in disparately impacted communities of color.

This issue brief synthesizes existing research findings on housing status, incarceration and HIV health; examines the available evidence from housing-based HIV interventions; and offers evidence-based recommendations for action to increase housing stability and improve post-release outcomes for persons living with HIV/AIDS in the U.S. and for their communities.

OVERLAPPING RISKS: INCARCERATION, HIV/AIDS AND HOUSING INSTABILITY

Criminal justice involvement, HIV infection and housing instability are strongly linked risk factors that disproportionately impact minority and low-income Americans and have a cumulative and compounding effect on HIV vulnerability and health outcomes for affected individuals, their families and their communities.

Mass incarceration in the U.S. disproportionately involves people of color

The United States has experienced unprecedented growth in incarceration over the past three decades – an increase attributed primarily to greater reliance on the criminal justice system to deal with a range of social issues including drug use and mental illness. (HRW, 2003). The number of adults under the supervision of Federal, state and local correctional authorities rose from 1.8 million in 1980 to 7.1 million at the end of 2010 (1 out of every 33 U.S. adults) – including 1.5 million persons in prison, 4.9 million on probation or parole, and 749,000 in local jails. (Glaze, 2011). With the largest prison and jail population of any country in the world, the U.S. now accounts for just 5% of the world’s population but 25% of all incarcerated persons. (Pew, 2011).

Since almost all incarcerated persons return to the community, the number of persons discharged each year from prison and jail has also increased dramatically. In 2010, over 708,000 persons were

released from federal and state prisons (Glaze, 2011) and 11.8 million persons cycled through local jails. (Minton, 2012).

The burden of this mass incarceration falls disproportionately on male members of racial and ethnic minorities. Black non-Hispanic males are incarcerated at a rate more than six times that of White males and 2.6 times that of Hispanic males. (Glaze, 2011; Hartney & Vuong, 2009). This disparity cannot be accounted for solely by differences in criminal conduct, but rather reflects disproportionate law enforcement and sentencing practices that adversely affect Black Americans. For example,

while Blacks constitute only 13% of the U.S. population and Blacks and Whites engage in drug offenses

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at the same rates, Blacks constitute 33.6% of drug arrests, 44% of persons convicted of drug felonies in state court, and 37% of people sent to state prison on drug charges. (HRW, 2012). At the same time, while 93% of state and federal prison inmates are male, incarceration is growing at a faster pace among women. (Pew, 2011). Between 1995 and 2007, there was a 68% increase in the number of female incarcerations, compared to a 43% increase in male incarcerations. (West & Sabol, 2009).

The ongoing U.S. HIV epidemic is also concentrated among members of minorities

More than 30 years into the AIDS epidemic, HIV prevention and treatment efforts in the U.S. are stalled, with no decline in new infections in recent years. Nearly half of all HIV-positive persons are outside of regular care, and only an estimated 28% of all HIV-positive persons are receiving antiretroviral therapy that results in viral suppression. (Cohen, et al., 2011; see also

Gardner, et al. 2011). One factor contributing to poor HIV health outcomes is continued HIV stigma and discrimination, including laws that criminalize behaviors by people living with HIV (such as spitting, biting and consensual sex) based on HIV status. Such laws are unsupported by the current scientific understanding of HIV transmission routes, expose HIV-positive persons to criminal justice involvement, and undermine public health efforts to promote HIV screening and treatment. (ONAP, 2010).

The ongoing U.S. HIV epidemic is also increasingly concentrated among marginalized and underserved people of color, especially Black Americans. Racial, ethnic and sexual minorities represent the majority of new AIDS diagnoses, new HIV infections, people living with HIV/AIDS, and AIDS deaths. (Prejean, et al. 2011). Although Blacks represent only 13% of the U.S. population, in 2010 Blacks accounted for 46% of new HIV infections, 44% of people living with HIV disease, and almost half of new AIDS diagnoses. (CDC, 2012; Prejean, et al., 2011). The HIV infection rate among Black women is 15 times the rate of infection among White women, and between 2006 and 2009, young Black men who have sex with men (MSM) experienced by far the greatest increase (48%) in the incidence of new HIV infections. (Prejean, et al., 2011). Latinos likewise bear a heavy burden of the epidemic. Despite making up only 16% of the U.S. population, Latinos accounted for approximately 20% of new HIV infections in 2010. (CDC, 2012).

Disparities in HIV and incarceration overlap for individuals and communities of color

As a result of the intersection of HIV and mass incarceration among marginalized populations, a significant proportion of all people living with HIV infection in the U.S. have become incarcerated. Each year some 155,000 HIV-positive persons – 14% (1 in 7) of all people living with HIV in the U.S. – are released from U.S. prisons and jails. Among HIV-infected Black men, an estimated 22% - 28% pass through a correctional facility each year. (Spaulding, et al., 2009).

Correctional populations in the U.S. have disproportionately high rates of HIV/AIDS and other infectious disease, including viral hepatitis and tuberculosis. (Hammett, 2006). At the end of 2010, state and federal prison authorities reported that 1.4% of male inmates and 1.9% of female inmates were known to have been diagnosed with HIV/AIDS – rates that are 3 to 5 times higher than in the general U.S. population. HIV prevalence in state prisons varies significantly by region, with Florida, Louisiana, Maryland and New York reporting the highest rates of HIV among state inmates. In New York State, 5.2% of male prison inmates and 11.7% of female inmates had an HIV diagnosis at the end of 2010.

(Maruschak, 2012).

Persons detained in local jails bear a similar burden of HIV disease

as prison inmates, although studies show that a significant percentage of HIV-positive persons who pass through jails remain undiagnosed. (de Voux, et al., 2012; Spaulding, et al., 2009). A 2006 blinded serosurvey of persons entering New York City jails revealed an overall HIV prevalence of 8.7% (6.5% of males and 14% of females). Over a quarter (28%) of HIV infections identified through the serosurvey were undiagnosed at jail entry, and only a small percentage (11.5%) of these persons with previously undiagnosed HIV infection were newly diagnosed through routine jail testing during the survey period. (Begier, et al., 2010).

The higher HIV prevalence among women in correctional settings is attributed to the fact that many women are incarcerated for drug-related and sex work crimes – including sex exchange to meet housing and other survival needs – that put them at risk for acquiring HIV and other sexually transmitted diseases. Indeed, incarcerated women

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experience worse overall health outcomes than male prisoners, including disproportionately high rates of hepatitis C (HCV) infection, gonorrhea, syphilis, Chlamydia infection and cervical cancer. (See, e.g.: Kim, et al., 2011; Springer, et al., 2010).

Many persons with HIV/AIDS involved with the correctional system have co-occurring mental health and alcohol/drug dependence issues that complicate HIV care and contribute to social marginalization. (See Scheyett, et al., 2010). Rates of behavioral health problems are extremely high among incarcerated persons – a result of U.S. dependence upon corrections as a response to mental illness and drug use. Yet relatively few inmates receive behavioral health care while incarcerated. At midyear 2005, more than half of all prison and jail inmates in the U.S. had a mental health problem, yet only about one in three state prisoners with mental health problems, one in four federal prisoners and one in six jail inmates had received mental health treatment since admission. (James & Glaze, 2006). One-half to two-thirds of all inmates in jails and prisons meet standard diagnostic criteria for alcohol/drug dependence or abuse, yet only 7% to 17% of these persons receive substance use treatment while incarcerated, so that most who are released back into the community have not received needed services. (NIDA, 2009).

Incarceration is linked to lack of stable housing among people living with HIV/AIDS

Record levels of poverty and homelessness in the U.S. also disparately impact people of color. Blacks and Hispanics have poverty rates that greatly exceed the average – 27.4% of Blacks and 26.6% of Hispanics were living in poverty in 2010, compared to 9.9% of non-Hispanic Whites. (DeNavas-Walt, 2011). Homelessness is at historic highs, due primarily to a shortage of affordable housing. Nationwide, for every 100 extremely low-income households there are only 32 units of existing affordable housing. (HUD, 2011b). Approximately 1.2 million people across the nation spent at least one night in an emergency shelter or homeless housing facility during 2010. Black Americans, single men

between the ages of 31 and 50, and people with disabilities were all at disproportionate risk of homelessness, compared to their representation in either the U.S. or the poverty population. This is likely a result of poor employment prospects and insufficient income supports to afford housing. (HUD, 2011a).

Access to safe, affordable housing has been one of the chief concerns of Americans living with HIV/AIDS since the beginning of the epidemic. Loss of income, poor health, interruption of intimate relationships, and pre-existing social disadvantage combine to make it difficult or impossible for many persons living with HIV to secure or maintain housing. (Aidala & Sumartojo, 2007). The U.S. Department of Housing and Urban Development (HUD) Office of HIV/AIDS Housing recently reported that 145,366 U.S. households living with HIV (over 12% of all persons living with HIV in the U.S.) have a current unmet housing need. (OHAH, 2012a). Among persons triply diagnosed with HIV, substance use, and mental health issues, a large multistate study found that 43% currently lack stable housing. (Conover, et al. 2009).

A history of incarceration and lack of stable housing are overlapping vulnerabilities for people living with HIV/AIDS. A 2010 Alabama survey of consumers of HIV services found that 47% were unstably housed (including 27% who were homeless), and 50% had a history of incarceration. (Alabama Department of Public Health, 2012). Findings from two representative samples of New Yorkers living with HIV/AIDS likewise revealed high rates of lifetime incarceration (43% to 48%), homelessness or housing instability (54% to 70%) and felony convictions (over 30%), as well as recent incarceration experience (12% to 13%). (Aidala, et al., 2007; Shubert, et al., 2004). A history of incarceration, mental health hospitalization, and substance use issues each, independently, almost doubled the risk of homelessness among a large group of people with HIV. (Shubert, et al., 2004).

Rates of homelessness are high both before and after incarceration

Housing instability has been described as both a cause and an effect of incarceration. Homelessness is thought to increase the risk for imprisonment through shared risk factors such as untreated mental illness and through increased likelihood of arrest. (Metraux, et al., 2008). Studies show that 10% to 20% of all prison and jail inmates are homeless in the period immediately before incarceration. (Greenberg & Rosenheck, 2008; Metraux & Culhane, 2004). Imprisonment can also precipitate homelessness by disrupting family and community contacts and by decreasing income and housing prospects. (Kushel, et al., 2005). Homeless and marginally housed Americans have lifetime incarceration rates as high as 50%. (U.S. Reentry Council, 2011).

For persons with HIV who become incarcerated, studies show that rates of homelessness are extremely high in the time periods both immediately before and after incarceration. A recent multisite study of HIV-positive men entering jail found that 43% of those newly-diagnosed with HIV infection and 44% of those previously diagnosed were homeless at the time that they entered jail. (de Voux, et al., 2012). A study of people with HIV/AIDS being discharged from prison to Connecticut communities found that 25.9% were homeless and an additional 54.4% were “near homeless” upon release. (Saber-Tehrani, 2012).



Housing instability also increases the risk of return to prison

The evidence also shows that persons who become homeless following release from prison are substantially more likely than those with stable housing to be incarcerated again. (Metraux, et al., 2008). Over 11% of all persons who left New York State prisons to return to New York City entered a homeless shelter within two years of release, and a third of the released prisoners who ended up in shelters had returned to prison by the end of the two-year study period. (Metraux & Culhane, 2004). Self-sufficiency after release is key to reentry success for all former prisoners, and those who secure their own housing and those employed for longer times after release are far less likely to return to prison. (Huebner & Berg, 2011; Yahner & Visher, 2008).

A primary measure used to gauge re-entry success is the “recidivism rate” – the proportion of persons returned to custody within a specific time period. The overall rate of recidivism to prison in the U.S. is extremely high, with a recent large-scale study documenting a 62% re-incarceration rate over an eight-year study period. (Huebner & Berg, 2011). Existing studies indicate a lower than average rate of recidivism to prison among persons who have an HIV/AIDS diagnosis upon release – 20% to 27% over three years – however former prisoners with HIV who are Black, who have a major psychiatric disorder and who are released on parole are at significantly increased risk of re-incarceration. (Baillargeon, et al., 2010-b; Springer, et al., 2004).

Mass incarceration undermines the social stability and health of communities

The record movement of individuals in and out of the U.S. correctional system not only affects the lives of incarcerated individuals but also profoundly threatens their families and communities. Most released prisoners return to low-income communities of color in urban centers, and many of these persons cycle back and forth between these communities and correctional settings. (Lynch & Sabol, 2001). Incarceration reduces lifetime employment earnings and long-term

economic mobility and these losses are collectively amplified for minority communities, often already at a disadvantage in terms of broader financial wellbeing. (Pew, 2010). At the end of 2010, one in 12 working-age Black men was in prison or jail, and one in every nine Black children (11.4%) had an incarcerated parent. (Pew, 2011). Incarceration rates are highest for young Black men who are poorly educated and living in poverty – a recent analysis showed that 7.3% of all Black males ages 20 to 34 were incarcerated with a sentence of more than one year, and that more young Black men without a high school diploma or GED were behind bars (37%) than employed (26%). (Pew, 2010).

High rates of incarceration and related economic and social marginalization fuel the increasing burden of HIV and other chronic diseases in these low-income communities of color. (See Adimora & Schoenbach, 2005). Recent research found that poverty – not race – is the most significant predictor of HIV infection among residents of the U.S. urban neighborhoods most heavily impacted by HIV/AIDS, and that homelessness, unemployment and other social determinants further increase HIV risk for community members. (Denning, et al., 2011). As described in the section below, the social instability experienced by many formerly incarcerated persons living with HIV/AIDS, including housing instability, results in disconnection from HIV care and high rates of behaviors that can transmit HIV. In neighborhoods where a significant number of persons living with HIV are involved with the correctional system, poor post-release HIV health outcomes contribute to high community viral load that perpetuates ongoing HIV transmission, further exacerbating HIV health inequities. (See: Blankenship & Smoyer, 2012; Freudenberg, 2011; Freudenberg, 2001).

HOUSING STATUS, INCARCERATION AND HIV HEALTH OUTCOMES

It has been observed that the “criminal justice setting provides vast opportunities for early diagnosis, prevention and treatment of HIV.” (Meyer, et al.,

2011). Highly active antiretroviral therapy (HAART) has transformed HIV into a manageable chronic condition for many, and effective HAART decreases viral load to an undetectable level that significantly reduces transmission of the virus. (Cohen, et al., 2011). More than ever, prisons and jails can provide a critical “public health opportunity to test for HIV, viral hepatitis, and other sexually transmitted infections, provide treatment such as highly active antiretroviral therapy, and link infected persons to longitudinal comprehensive HIV care upon their release for such co-morbidities as addiction and mental illness.” (Beckwith, et al. 2010).

Indeed, because access to HIV care is legally protected in correctional settings but not in the community, prison and

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jails can be the most consistent sites of HIV care for marginalized populations. (Meyer, et al., 2011). Unfortunately, however, any HIV health gains achieved as a result of HIV treatment during incarceration are often lost upon return to the community because of social and economic determinants affecting adherence, including housing instability. For persons with HIV, release from incarceration is strongly associated with interruption of HIV health care, decreased access to antiretroviral therapy, poor virological and immunological outcomes, and high rates of engagement in behaviors that can transmit HIV infection. (Meyer, et al., 2011; Rich, et al., 2011; Beckwith, et al. 2010).

Housing instability and poor HIV health are common following release from prison

Although prison and jail inmates still face barriers to effective HIV treatment (see AMFAR, 2008), many prisoners infected with HIV are diagnosed, initiate HAART and adhere to treatment regimens while

incarcerated, and HIV treatment in prison settings, when offered, has been demonstrated to be highly



successful. (Meyer, et al., 2011). After release from prison, however, many persons with HIV fall out of care. One study examined health care utilization by all inmates (2,115) who were receiving HIV antiretroviral treatment at the time of release from Texas prisons over a four-year period. Only 28% made an appointment with an HIV clinic in the 90 days following release, only 5% of those eligible for free medications through the Ryan-White funded AIDS Drug Assistance Program (ADAP) filled their prescriptions within the 10-day window to obtain a free supply, and only 30% had filled a prescription for antiretroviral medication 60 days after release. (Baillargeon, et al., 2010-a; Baillargeon, et al., 2009). Not surprisingly, the group of these persons who were re-incarcerated within three years (27%) showed a significant decrease in mean CD4 count and increase in viral load upon return to prison. (Baillargeon, et al., 2010-b).

The period immediately after release from prison is a highly vulnerable time for all persons, characterized by high rates of recidivism, homelessness, relapse to drug use, and premature death. (Lim, et al., 2012; Visser & Travis, 2011; Binswanger, et al., 2007). For persons with HIV, housing instability following release is a potent factor contributing to poor HIV health care access, utilization and outcomes. Compared to stably housed peers, persons living with HIV who lack stable housing are more likely to delay HIV care, have poorer access to regular care, are less likely to receive and adhere to optimal antiretroviral therapy, and have lower CD4 counts

and higher viral loads. (Wolitski, et al., 2007; Aidala, et al., 2007; Kidder, et al., 2007b). Significantly, housing status has been found to be a more significant predictor of HIV health care utilization and outcomes than demographics, drug use, mental health or other individual characteristics more commonly associated with treatment effectiveness. (Kidder, et al., 2007b).

Non-adherence to HIV therapy, loss of viral suppression and declines in CD4 cell counts are commonplace following discharge from prison. (Stephenson, et al., 2005; Springer, et al., 2004). Among North Carolina men who successfully used HAART while in prison, those who were released and re-incarcerated during a two-year period had significantly worse HIV health status upon return to prison than a matched group who had remained continuously incarcerated. (Stephenson, et al., 2005). A large Connecticut study found that 59% of all prisoners who received HAART during incarceration had an undetectable viral load by discharge, but the rate of return to prison was high (27%) and was associated with poor HIV outcomes. (Springer, et al., 2004). Incarceration events have been found to have a “dose effect” upon HIV health outcomes following return to the community, with a strong relationship noted between the number of incarcerations and being unable to adhere to HIV treatment. (Milloy, et al. 2011).

Jail stays are also linked to homelessness and inadequate HIV care

While this paper is focused primarily on the challenges faced by men and women living with HIV who are re-entering the community from state and federal prisons, it is also important to mention the thousands of persons with HIV who pass through local jails each year. Many of the same issues and approaches are relevant, but there are differences in the jail setting and population that present unique barriers to stability and HIV treatment.

Each year in the U.S. there are an estimated 12 million admissions to local jails. (Minton, 2012). Many persons repeatedly cycle through jails, shelters

and other institutional settings as a result of lack of employment or income, housing instability, drug and alcohol dependence, mental illness and chronic health issues including HIV/AIDS. (Metraux & Culhane, 2010; Solomon, et al., 2008). The steep increase since the late 1980's in the number of people incarcerated in jails, high rates of HIV infection, and the concentration of both HIV and incarceration among already disadvantaged low-income, Black, and Latino populations, have led some to describe urban jail systems as the “epicenter of the epicenter” of the HIV epidemic in the United States. (Freudenberg, 2011).

Jail stays provide a critical opportunity to diagnose and treat HIV infection among high-risk, transient populations with limited access to medical services. However, since most jail stays are less than one month and many are just a few hours or days, there is little opportunity for discharge planning or to address social or health issues. (Solomon, et al., 2008). Most people with HIV/AIDS incarcerated in jails return to the community with co-occurring problems related to housing and substance use, and the overall instability in their lives hampers their ability to attend to HIV-related health care needs. (Fontana & Beckerman, 2007). One study examined outcomes of antiretroviral therapy (ART) in a cohort of HIV-positive persons going in and out of a county jail over a nine-year period. Even intermittent antiretroviral therapy conferred some medical benefit, but a large majority of the inmates (76%) interrupted ART after being released from jail and only a small number (15%) managed to stay on medications over time. (Pai, et al., 2009).

Housing instability before and after a jail stay is strongly linked with poor HIV health outcomes. A multisite study of 743 HIV-infected jail detainees prescribed or eligible for ART found that persons who were homeless in the week before incarceration were significantly less likely than those who were housed to be engaged in healthcare using any measure – less likely to have an HIV provider, to be taking ART, and to be adherent to prescribed ART. (Chen, et al., 2011). Among 177 HIV-infected

inmates who were released and then re-incarcerated in the San Francisco jail system in a 12-month period, more than half were homeless in the month preceding re-incarceration, 59% of those with a history of antiretroviral use were not taking HAART, and HAART discontinuation was independently associated with homelessness. (Clements-Nolle, et al., 2008).

The evidence shows that improved discharge planning and post-release housing supports are an urgent public health priority not just for persons with HIV/AIDS who are re-entering the community from prison but also for persons living with HIV at the point of discharge from jail. The Urban Institute’s Elected Official’s Toolkit for Jail Reentry provides information and resources for local elected officials interested in launching a jail reentry initiative. (Urban Institute, 2010).

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Incarceration and housing instability heighten the risk of HIV infection

Both homelessness and a history of incarceration are strongly associated with high HIV prevalence and increased risk of ongoing HIV transmissions. The rate of HIV infection was 11% in a large sample (1,426) of homeless and marginally housed adults interviewed in San Francisco, and persons who reported a history of incarceration (25% of the sample) were significantly more likely than those who had not been imprisoned to be HIV infected (14.9% versus 10.1%), and to report psychiatric hospitalizations, drug use, and multiple sexual partners. (Kushel, 2005).

People coping with homelessness and housing instability face enormous day-to-day challenges

that affect their ability to limit exposure to HIV or to reduce behaviors that can transmit HIV to others. Homelessness and unstable housing are strongly associated with increased rates of unsafe sex and drug use behaviors, after controlling for other factors that influence HIV risk such as demographics, substance use, mental health issues and access to services. (Kidder, et al., 2008; Wolitski, et al., 2007; Aidala, et al., 2005). Compared to stably housed persons with HIV with the same individual and service use characteristics, persons with HIV who lack stable housing are two to three times more likely to engage in sex exchange, to have unprotected sex with an unknown status partner, to use drugs and to inject drugs. (Kidder, et al., 2008). Rates of new HIV diagnoses among homeless persons have been found to be as much as 16 times the rate in the general population. (Kerker, et al., 2005; Robertson, et al., 2004). Housing instability magnifies HIV risk among already-vulnerable populations, including street-involved youth, transgendered persons, injection drug users and men who have sex with men (Marshall, et al., 2009; Wilson, et al., 2009; Kipke, et al., 2007), and is a barrier to proven risk reduction strategies such as needle exchange and counseling. (Des Jarlais, et al., 2007; Elifson, et al., 2007). Even in communities of concentrated poverty and high HIV seroprevalence, the rate of new HIV infections is almost twice as high (1.8 times) for persons with a recent experience of homelessness, compared to those with stable housing. (Denning, et al., 2011).

A history of incarceration likewise amplifies the risk of acquiring or transmitting HIV infection. The evidence suggests that while some HIV transmission may occur in prison, the greatest risk for individuals and their communities occurs during the periods just before and just following incarceration. (Gough et al., 2010; Epperson, et al., 2010). Due to difficulty in accessing services to meet basic needs, including housing, many persons recently released from prison or jail use drugs or engage in sex for drugs, money, or transportation early in the community reentry process. (Luther, et al., 2011). Incarceration may also contribute to viral transmission by disrupting stable partnerships and promoting high-risk partnerships.

(Khan, et al., 2011). Recent findings from the HIV Prevention Trials Network (HPTN) 061 multi-site longitudinal study of Black men who have sex with men (BMSM) in the U.S. show a high prevalence (60%) of prior incarceration among BMSM, suggesting that incarceration may be one factor that contributes to high HIV infection rates among BMSM. (Brewer, et al., 2012).

Unmet housing needs undermine reentry initiatives to improve HIV health

Communities have employed a range of HIV-specific case management and discharge planning services to target persons leaving prison and jail and connect them to HIV care. Targeted federal initiatives include the HIV/AIDS Health Improvement for Re-entering Ex-Offenders (HIRE) program, a demonstration project established in 2009 by the Office of Minority Health (OMH) in the U.S. Department of Health and Human Services. The program funds provider networks in five U.S. communities that work collaboratively to improve connections between the reentry population and community-based, minority-serving organizations that provide HIV/AIDS-related services and transition assistance.

Most reentry programs have not been rigorously evaluated, however, and those that have been examined show only limited success connecting discharged persons to HIV care. (Freudenberg, 2011; Meyer, et al., 2011; Springer, et al., 2011). Even case management programs that have successfully linked released prisoners to medical services have failed to confer stability in HIV treatment outcomes over time. (Wohl, et al., 2011). Reentry case management interventions examined to date have not demonstrated reductions in either recidivism or long-term health benefit, “leaving only a limited evidence base to guide policy and resource allocation.” (Freudenberg, 2011).

Housing instability appears to be a major factor contributing to this lack of success. Qualitative findings from a large HIV reentry initiative revealed that stable housing and access to mental health

services were the primary unmet needs of the returning prisoners served by the program. (Nunn, et al., 2010). Project Bridge, a federally funded demonstration project, provides intensive case management for HIV-positive persons returning to the community from prison. During the first three years of the Project Bridge program, re-incarceration happened at least once for 48% of participants. (Rich, et al. 2001). An evaluation of the program showed that participants had high rates of substance use issues (97%) and mental health issues (34% on medication) and that 86% reported living in unstable housing at baseline. Housing was identified as greatest unmet need of participants, and the most difficult to address – only half of project clients achieved stable housing during an 18-month study period, primarily through the federal Housing for People with HIV/AIDS (HOPWA) program. (Zaller, et al. 2008).

HOUSING INTERVENTIONS TO IMPROVE HIV HEALTH FOLLOWING REENTRY

Incarceration, housing instability, poor HIV health and increased risk of transmission are strongly associated in the period immediately following release from prison or jail and remain linked long after reentry. Among a large cohort of homeless and unstably housed persons living with HIV in three urban centers, 68% reported a history of incarceration, 32% had spent more than one year incarcerated, and a history of incarceration was significantly associated with detectable viral load. (Courtenay-Quirk, et al., 2008).

Housing status is increasingly identified as a “strategic” point of intervention to address HIV/AIDS and the overlapping vulnerabilities associated with both HIV infection and incarceration, including race and gender, extreme poverty, mental illness, chronic drug use and histories of exposure to trauma and violence. (Aidala & Sumartojo, 2007). A pilot study of HIV-positive men and women leaving prison found that living in the same place as before incarceration and rating housing “comfortable” or

“very comfortable” were significant predictors of engagement with post-release primary care. (Harzke, et al. 2006).

Housing assistance is HIV health care and prevention

A now-substantial body of research evidence supports housing assistance as an evidence-based HIV health care intervention for homeless or unstably housed persons living with HIV/AIDS. Systematic review of the research literature reveals a significant positive association between increased housing stability and better health-related outcomes in all studies examining housing status with outcomes of medication adherence, utilization of health and social services, HIV health status and HIV risk behaviors. (Milloy, et al., 2012; Aidala, et al., 2012; Leaver, et al., 2007).

Housing status is one of the strongest predictors of accessing HIV primary care, maintaining continuous care, receiving care that meets clinical practice standards, and entry into HIV care among those outside or marginal to the health care system. (Aidala, et al., 2007; Kidder, et al., 2007b). Over time, receipt of housing assistance is independently linked to improved HIV health care outcomes after controlling for other factors associated with treatment effectiveness, including demographics, drug use, health and mental health status, and receipt of other services. (Aidala, et al., 2007, see also Knowlton, et al., 2006). A randomized controlled trial found that homeless persons with HIV who received a housing placement upon hospital discharge were twice as likely to achieve an undetectable viral load as a matched comparison group that continued to rely on the “usual care” available to homeless persons in the community. (Buchanan, et al., 2009).

Stable housing provides a baseline to address not only HIV, but also the mental health and substance use issues that often accompany and complicate HIV infection. A large scale study of housing and health among persons living with HIV in three cities found that improved housing status led to dramatic

reductions in avoidable emergency and acute care, and that receipt of a federal housing voucher was associated with significant improvements in access to mental health services, depression, perceived stress and overall mental health status. (Wolitski, et al., 2010).

Improved housing status is also a proven HIV prevention strategy. A large, multi-state study found that homeless/unstably housed persons whose housing status improved over time reduced their risk behaviors by half, while persons whose housing worsened over time engaged in increased risky behaviors. (Aidala, et al., 2005). Women who received federal housing assistance were half as likely to engage in sexual risk behaviors as a matched group of very-low-income women who were homeless. (Wenzel, et al., 2007). Perhaps most importantly, housing assistance improves access and adherence to antiretroviral medications, which can lower viral load to an undetectable level, reducing the risk of transmission to a sexual or drug-using partner by as much as 96%. (NIAID, 2011).

In fact, there is evidence that housing status is perhaps the most important factor in determining an HIV-positive person's access to health care, their health outcomes, and how long they will live. The San Francisco Department of Public Health found that over a five-year period entry into supportive housing was independently associated with an 80% reduction in mortality among persons who were homeless at the time of AIDS diagnosis. (Schwarcz, et al., 2009). Two recent studies by Riley, et al., empirically ranked factors that affect the health status of HIV-infected homeless and unstably housed women and men. Unmet subsistence needs (i.e., food, hygiene, shelter) had the strongest effect on overall physical and mental health – more significant even than antiretroviral treatment. (Riley, et al., 2011; Riley, et al., 2012). The authors observed, “Impoverished persons will not fully benefit from progress in HIV medicine until these barriers are overcome, a situation that is likely to continue fueling the US HIV epidemic.” (Riley, et al., 2012).

Housing-based HIV interventions improve health and reduce public spending

Recent findings from large scale intervention studies not only link housing assistance to improved health outcomes for homeless and unstably housed persons living with HIV, but also show that public dollars spent on housing produce net savings for communities.

The Housing and Health (H&H) Study was conducted by the Centers for Disease Control and Prevention (CDC) and the HUD Housing Opportunities for People with AIDS (HOPWA) program to assess the impact of immediate access to a HOPWA housing voucher on physical health, mental health and HIV risk behaviors among people living with HIV/AIDS who were homeless, unstably housed or doubled-up with another household. (Kidder, et al., 2007a). At the end of the 18-month study period, 82% of study participants who received a HOPWA voucher were stably housed and improved housing status resulted in substantially better health outcomes, including a 35% reduction in people reporting one or more emergency room visit, a 57% reduction in the number of hospitalizations, and significantly improved mental health status. (Wolitski, et al., 2010). H&H analyses included a comparison of health outcomes of study participants who continued to experience homelessness during the follow-up period with outcomes for participants who had no time homeless during the study. After controlling for socio-demographic variables, substance use, and physical and mental health status, those who experienced homelessness were 2.5 times more likely to use an emergency room, 2.8 more likely to have a detectable viral load, reported significantly higher levels of perceived stress, and were more likely to report unprotected sex with a negative/unknown status partner. (Wolitski, et al., 2009).

H&H researchers also considered the cost implications of HIV-specific housing, using statistically significant housing-related health outcomes to calculate the “cost-utility” of H&H housing assistance as a health care intervention.

Cost-utility, expressed as the cost per quality-adjusted life year saved (QALY), is the measure used by health economists and policy makers to compare the “value-for-money” of health care interventions. The cost-utility of the H&H intervention was calculated as a function of the cost of the services provided, HIV transmissions averted, medical costs saved, and quality-adjusted life years saved. Findings show that housing is a cost-effective HIV health care intervention, with a cost per quality-adjusted life year (QALY) in the same range as widely accepted health care interventions such as kidney dialysis and screening mammography, and far below (about one-fifth) the cost per QALY of HIV pre-exposure prophylaxis (PrEP). (Holtgrave, et al, 2012).

The Chicago Housing for Health Partnership (CHHP) is an integrated system of housing and supports for individuals with chronic medical illnesses who are homeless upon discharge from hospitalization. An 18-month random control trial compared health outcomes and public costs for over 400 chronically ill homeless persons discharged from hospital stays: half randomly assigned to supportive housing placement and half discharged to “usual care” in the community. (Sadowski, et al., 2009). Among one third of study participants living with HIV/AIDS, those who received a supportive housing placement were twice as likely as those assigned to usual care to have an undetectable viral load at 12 months. (Buchanan, et al., 2009). Cost analyses compared the total annual cost of publicly funded medical/health, legal, housing (including the supportive housing intervention), and social services used per homeless adult in the intervention and usual care groups. Compared to members of the usual care group, the intervention group generated an average annual public cost savings of \$9,809 for each chronically homeless person living with HIV/AIDS and \$6,620 for non-chronically homeless PLWHA. Stated another way – for every 100 chronically homeless PLWHA housed with case management services, there was a net savings of almost \$1 million annually in avoidable publicly funded health and crisis care costs. (Basu, et al., 2012).

The H&H and CHHP studies add to the growing evidence base on the potential of housing interventions to end homelessness and reduce public systems involvement and costs among persons with chronic health conditions, serious mental illness and substance use problems. (Culhane & Byrne, 2010; Flaming, et al., 2009; Larimer, et al., 2009; Culhane, et al., 2002). Among the initiatives are attempts to address homelessness among people released from incarceration and redirect public resources from unproductive crisis care and correctional systems costs to more appropriate and cost-effective uses. (Roman, et al., 2009; Metraux, et al., 2008).

Outcomes of HIV-specific reentry housing interventions are promising
While there are no published

The evidence suggests that while some HIV transmission may occur in prison, the greatest risk for individuals and their communities occurs during the periods just before and just following incarceration.

results from housing interventions specifically targeted to serve formerly incarcerated persons living with HIV/AIDS, available information from housing-based programs is encouraging. For example, the City of Dallas’ Project Reconnect Housing program has successfully employed HOPWA and Dallas Housing Authority resources to fund non-profit organizations to address reentry challenges for people with HIV/AIDS through permanent tenant-based rental assistance coupled with intensive case management to ensure that persons placed into housing are connected to HIV care and maintain housing. (HUD, 2012).

A HOPWA-funded New York City program assists formerly incarcerated individuals with HIV-related illness to secure permanent housing in the private market using locally funded rental assistance. The program places homeless participants in immediate transitional housing, provides assistance with permanent housing placement (helping participants to locate affordable units, apply for the rental

subsidy, and pay security deposits and brokers' fees), and links participants to health care and supportive services. Program results show high rates of housing stability and that only 8% of program participants were re-incarcerated in prison or jail during a one-year period. (Quattrochi & Arzola, 2010).

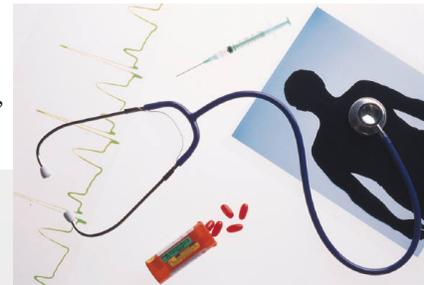
A 20-unit transitional residence in New York City is funded through Ryan White to serve women living with HIV/AIDS who are homeless upon exit from prison or jail. Same-day placement in a studio apartment is combined with case management, access to HIV health care and other community-based supports. The program employs a low-threshold approach that does not require sobriety as condition of either obtaining or maintaining housing. Initial results indicate significant impact on improved viral load and CD4 counts six months from program entry, increased enrollment in behavioral health care and a reduction in self-reported substance use. Program participants have also been substantially more successful securing permanent housing than members of a comparison group of recently released women receiving case management only. Findings indicate that immediate housing placement may be an effective strategy to address the myriad challenges women face upon reentry, including histories of sexual and physical violence, and that when housed, mandatory abstinence from substance use may not be required for persons living with HIV/AIDS to be adherent to antiretroviral medication. (Ali, et al. 2011).

RECOMMENDATIONS FOR IMPROVING HOUSING AND HEALTH OUTCOMES FOR FORMERLY INCARCERATED PERSONS WITH HIV/AIDS

Any recommendations to improve outcomes following release from prison or jail must be placed within the larger context of the individual, community and societal harm caused by our nation's culture of mass incarceration. We can never adequately address the overlap of homelessness, incarceration and HIV vulnerability until our nation

reforms its criminal justice systems and takes a "broader view of public safety that is not produced by punishment alone." (Western & Pettit, 2010). The devastating social, political, and economic implications of mass incarceration have been largely invisible to the public, but even the popular press has begun to acknowledge that the "scale and the brutality of our prisons are the moral scandal of American life." (Gopnik, 2012).

Efforts are underway to better understand and address mass incarceration, weighing concerns about crime control, rehabilitation, and more fundamental issues of social justice. Better approaches to public safety will require attention to systems responsible for education, employment, social protection, physical and behavioral health care, as well as more effective responses to problem drug and alcohol use and curtailing unnecessary custodial sentences. There is also growing recognition that our criminal justice system - like other government systems - must be evidence-based, meet clear performance measures and withstand the scrutiny of fiscal, cost-benefit and racial impact analyses. One interesting multidisciplinary task force examining these issues was a group of scholars convened by the American Academy in 2008. (See Deadalus, 2010).



For persons with HIV leaving prison or jail, a recent review of the literature on incarceration and HIV health outcomes identified four major challenges to successful management of HIV: "relapse to substance use, homelessness, mental illness, and loss of medical and social benefits." (Meyer, et al. 2011; see also, Springer, et al., 2011). As the authors explain, each of these challenges constitutes a competing priority upon release that demands immediate attention and diverts time, energy, and valuable resources away from engagement in care and adherence to HAART.

Preexisting poverty, lack of education and employment opportunities, disruption of social supports, and high rates of untreated substance use and mental health problems have already been mentioned here as formidable obstacles for many people reentering the community from prison and jail. Those living with HIV/AIDS must also contend with the combined stigma of incarceration and an HIV diagnosis.

Outlined below are resource limitations, policies and practices that restrict access to post-release housing and services for persons with HIV/AIDS, along with recommendations for change proposed by researchers, service providers and advocates.

Recommendation 1: Make appropriate, affordable housing available to all low-income people living with HIV/AIDS

As already mentioned, many persons living HIV/AIDS in the U.S. find it difficult or impossible to secure and maintain a stable, appropriate place to live. Housing is consistently cited as the greatest unmet need of people with HIV across the country. (NAHC, 2011). While stigma, co-occurring behavioral health issues and other factors contribute to housing instability for low-income households living with HIV, affordability is by far the most significant barrier. The most recent HUD data show that 41% (7.1 million) of very low income renter households have “worst case housing needs” defined as severe rent burden, inadequate housing, or both, and that the number of households with worst case needs has almost doubled over the last decade. (HUD, 2011b). Even persons disabled by HIV who receive Social Security or Veterans benefits are shut out of the housing market, since there is not a single county in the US where a person who on relies on federal disability benefits can afford even an efficiency apartment. (NLIHC, 2012).

Low-income people with HIV/AIDS leaving prison or jail and those with a history of incarceration face additional obstacles to stable housing. (Roman & Travis, 2004). The stigma of criminal justice

involvement further blocks access to the private housing market, as many landlords conduct background checks of criminal history, income, employment, credit history, and rental history – all of which present very real challenges for individuals with a history of justice involvement. (Solomon, et al., 2008). As explained below, punitive post-incarceration policies also restrict eligibility for public housing and homeless housing assistance.

Successful strategies to improve housing and health outcomes for formerly incarcerated people living with HIV/AIDS will require additional resources, policy changes and new housing approaches.

Recommendation 1-a: Scale up targeted HIV/AIDS housing resources to meet real need

Efforts to make appropriate, affordable housing available to all low-income households living with HIV in the U.S., including supportive housing for those who need it, must start with increased funding for targeted HIV housing assistance. Current HIV housing resources are highly effective but can meet only a fraction of actual need.

The U.S. Department of Housing and Urban Development (HUD) Housing Opportunities for People With AIDS (HOPWA) program is the only designated federal housing program for households living with HIV/AIDS. The HOPWA program funds local communities and projects to provide emergency, transitional and permanent housing assistance and related support services for low-income persons with HIV. Most HOPWA funds are distributed as non-competitive allocations to localities or regions that demonstrate significant HIV/AIDS prevalence. Local administrative agencies have a great deal of discretion in how this formula HOPWA funding is used, and some localities have made housing for formerly incarcerated persons a priority. HOPWA Special Projects of National Significance (SPNS) program grants are awarded directly by HUD to non-profits that can demonstrate innovation in terms of program concept or population served. HOPWA SPNS funds

have been used in Baltimore, Dallas, New York and other cities to develop or expand supportive housing opportunities for formerly incarcerated persons living with HIV/AIDS. (OHAH, 2012b).

The HOPWA program achieves high rates of housing stability, reporting in 2011 that 95% of households receiving permanent housing assistance remained stably housed, 96% of households receiving short-term rent, mortgage, and utility assistance were stable or had reduced risk of homelessness, and 79% of those receiving other short-term or transitional support were stable or had reduced risk of homelessness. (OHAH, 2012a & 2012b). Recent research found HOPWA housing vouchers to be a cost-effective health intervention to improve HIV outcomes and reduce ongoing transmission among homeless and unstably housing people living with HIV. (Holtgrave, et al., 2012; Holtgrave, et al., 2007). Since program services are available to individuals at the point of release from incarceration, HOPWA funding has been particularly useful in the creation and operation of reentry housing programs. However, the HOPWA program is currently funded to serve less than 30% of households living with HIV that have a housing need, and among the many HOPWA housing programs in the U.S. only a handful target persons leaving prison and jail.

Ryan White CARE Act Title I Funds have also been used effectively in some communities to provide emergency and transitional housing for formerly incarcerated persons living with HIV/AIDS. Ryan White Title I funds are allocated by the federal government to local planning councils, who determine priority uses of the funds. As one example, New York City's local planning council supports transitional housing programs that target persons recently released from incarceration. (Public Health Solutions, 2012). However, since housing is classified under the Act as a supportive rather than a health service, communities may use only a fraction of Ryan White dollars to fund housing interventions. Now that substantial research findings demonstrate the role of housing assistance as an evidence-based HIV health care intervention for homeless and

unstably housed persons living with HIV/AIDS, it is time for a shift in paradigm – to view housing as a core component of HIV health care rather than an ancillary service.

Finally, despite the fact that housing assistance is a proven evidence-based prevention strategy, we are not aware of any U.S. housing programs funded explicitly as primary HIV prevention for vulnerable persons. For street involved adolescents, young urban men of color, transgender persons and other extremely vulnerable persons, the evidence shows that criminal justice involvement and homelessness are overlapping risks that are strongly associated with acquiring HIV infection, exposure to violence and other negative outcomes. (Ramaswamy & Freudenberg, 2012; Wilson, et al., 2009). It is time to fund housing assistance as a primary HIV prevention strategy for HIV-negative persons at highest risk who are homeless and become engaged with the criminal justice system.

The National HIV/AIDS Strategy (NHAS) highlights the importance of HIV-related housing services as a key part of a comprehensive HIV service delivery package, states that federal agencies should consider additional efforts to support housing assistance to enable people living with HIV to obtain and adhere to HIV treatment, and sets specific goals and metrics for measuring progress on improved housing status for persons with HIV. (ONAP, 2010). Unfortunately, to date no new federal HIV housing resources have been made available to meet these NHAS housing goals.

To bring federal HIV housing resources to scale to meet the real housing needs of all income-eligible persons living with HIV, including formerly incarcerated persons:

- Increase HOPWA allocations to address the disparity between available resources and real housing needs, and scale up successful HOPWA-funded models of post-release housing for persons with HIV/AIDS.

- Introduce HUD-sponsored legislation, as directed by the NHAS, to update the distribution of HOPWA formula funds to align with current HIV incidence rather than cumulative AIDS morbidity, and to include factors that take into account local poverty rates and housing costs.
- Preserve and expand the role of Ryan White funded housing supports for homeless persons with HIV/AIDS, including persons leaving prison and jail, as part of the 2013 reauthorization of the Ryan White CARE Act.
- Fund housing as a primary prevention strategy for persons whose homelessness upon release from incarceration places them at highest risk for HIV infection, violence and other negative outcomes, such as street youth, young urban men of color and transgender people.

Recommendation 1-b. Allow formerly incarcerated persons appropriate access to a full range of federal housing programs and homeless assistance

Even with increased funding, targeted HIV housing resources cannot meet the needs of all formerly incarcerated persons with HIV/AIDS. Expanding housing options post-incarceration will also require policy changes to remove barriers to “mainstream” federal programs that provide subsidized low-income housing and homeless housing assistance.

In many communities, persons leaving prison or jail face significant barriers or total exclusion from federally funded public housing and voucher programs administered by local Public Housing Authorities (PHAs) – subsidized housing that is the federal government’s major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing. (LAC, 2009).

While it is widely believed that persons convicted of a crime are barred from living in public housing, in fact PHAs have great discretion in determining their

admissions and occupancy policies for federally subsidized housing and voucher assistance. Federal law allows PHAs to exclude persons with criminal convictions altogether or subject them to restrictive admissions policies, but PHAs are required to ban only persons convicted of methamphetamine production on the premises of federally assisted housing and those subject to lifetime registration as a sex offender. PHAs are authorized to make individual determinations in every other case. For example, applicants who have been evicted from federally assisted housing as a result of drug-related criminal activity within the last three years are ineligible for public housing and voucher programs unless the PHA determines that the evicted household member has successfully completed

There is evidence that housing status is perhaps the most important factor in determining an HIV-positive person’s access to health care, their health outcomes, and how long they will live.

rehabilitation, or the circumstances leading to the eviction no longer exist (e.g., the offending household member has died or is imprisoned). (U.S. Reentry Council, 2012; LAC, 2009).

Although most persons convicted of a crime continue to satisfy federal eligibility requirements for subsidized housing, restrictive PHA tenant screening policies and procedures are a significant obstacle. Only a few PHAs completely bar formerly incarcerated persons, but many PHAs initially deny applications for housing based on criminal backgrounds for all households, relying on appeal procedures to allow for a case-by-case review of circumstances, including evidence of rehabilitation. Most harmfully, these policies can prevent persons living with HIV/AIDS from returning to federally subsidized housing to live with family after release from prison or jail. In June 2011, the Secretary of HUD sent a letter to PHA executive directors, describing the laws and policies regarding screening

potential tenants based on criminal activity and encouraging PHAs to modify policies to enable more formerly incarcerated persons to reunite with family members who live in public housing or receive voucher assistance – noting that in order to give persons a “second chance” we must help them “gain access to one of the most fundamental building blocks of a stable life – a place to live.” (HUD, 2011c). The Secretary sent a similar letter in 2012 to private rental property owners of HUD-assisted properties. (HUD, 2012). Some PHAs have begun lowering barriers faced by tenants and applicants convicted of a crime, including innovative programs that link housing to necessary support services. (Wilkins & Burt, 2012). However, most communities continue to employ policies and practices that effectively bar formerly incarcerated persons, including persons with HIV/AIDS, from mainstream federally subsidized housing.

HUD regulations explicitly exclude homeless persons reentering the community from prison or long jail stays from entering mainstream federal homeless assistance programs upon release from incarceration. The McKinney-Vento Homeless Assistance Program (reauthorized and updated in 2009 by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act) funds the primary programs providing supportive housing for homeless persons, including the Supportive Housing Program, the Shelter Plus Care Program and the SRO Program. These programs are a vital resource for persons living with HIV/AIDS who require housing linked to support services. The HUD definition of homelessness that is used to determine eligibility for these programs specifically excludes persons leaving a prison or jail stay that lasts 90 days or more.

To make all federal housing and homeless assistance available to meet the housing needs of formerly incarcerated persons, including people with HIV/AIDS:

- Change local Public Housing Authority policies and decision-making processes to lower barriers

to federally subsidized housing for persons with a criminal conviction – most importantly to enable people leaving prison or jail to reunite with family members who live in public housing or receive federal voucher assistance.

- Expand eligibility for McKinney-Vento Homeless Housing Programs authorized by the HEARTH Act to include persons who are homeless at the point of discharge from a criminal detention facility.

Recommendation 1-c: Incorporate housing as a critical element of new HIV health care systems

Evidence that housing assistance is a cost-effective HIV health care intervention necessitates new investments in housing as a core component of HIV health care delivery models.

HIV treatment advances and treatment as prevention strategies present exciting opportunities to improve individual and population level HIV outcomes. Housing insecurity, however, is a powerful impediment to HIV treatment effectiveness. As HIV prevention and care systems evolve in the U.S., it is critical to ensure that housing strategies are viewed and funded as an essential component of health care delivery.

Implementation of the Affordable Care Act (ACA) in the U.S. presents a unique and particularly important opportunity to expand supportive housing for people with HIV. One of the ACA’s most important provisions is the option for states to significantly expand Medicaid eligibility for low-income Americans, including those with HIV/AIDS, without requiring a disability designation. ACA provisions also offer the potential to couple stable affordable housing with Medicaid-funded supports for persons with HIV and other chronic health challenges, connecting them to a network of comprehensive primary and behavioral health services that can help improve health, increase survival rates, foster mental health, reduce harmful alcohol and drug use, and generate health care savings through reduced dependence on expensive

emergency and acute care. (CHCS, 2012). In the case of HIV/AIDS, stable housing also produces substantial cost savings by lowering rates of ongoing HIV transmissions, since each averted HIV infection saves an estimated \$400,000 in lifetime health care costs alone. (Schackman, et al., 2006).

To realize the full potential of the Affordable Care Act for homeless and unstably housed people with HIV/AIDS, including formerly incarcerated persons living with HIV, each state should:

- Fully implement the Affordable Care Act and exercise the option to widely expand Medicaid coverage.
- Promote models of care for persons with HIV/AIDS and other chronic illnesses that incorporate housing supports as a core health service.
- Track health care savings realized through improved housing status and re-invest those savings in housing supports for chronically ill persons.

Recommendation 1-d: Promote “low-threshold” housing policies and models for persons with complex needs

Meeting real housing need among formerly incarcerated people with HIV will require housing approaches that lower barriers posed by behavioral health issues and restrictive eligibility criteria.

HIV-positive persons with a history of incarceration and active drug use face the additional barrier of combined “stigma against drug users, people with HIV infection and those involved in the criminal justice system.” (Freudenberg, 2011). Public Housing Authorities may deny federal housing assistance to current drug users and those who abuse alcohol (although they may also consider mitigating circumstances such as access to support services in determining a final course of action). (LAC, 2009). Even within HIV and homeless service systems, many non-profit housing providers exclude persons

with active drug and mental health issues and/or histories of incarceration – either as a matter of policy or through tenant selection. Staff members of social support organizations report that housing is one of the most difficult services to obtain for HIV-positive clients transitioning from corrections, in large part due to housing program restrictions associated with previous incarceration and substance use – and that some clients choose re-incarceration because of the lack of services following release. (Robillard, et al., 2011).

Low-threshold “housing first” models prioritize housing placement and do not require either abstinence from drugs or alcohol or behavioral health treatment compliance as a condition of becoming or staying housed. Increasing evidence indicates that housing first approaches improve quality of life, achieve stability and HIV health outcomes that are comparable to more traditional abstinence-based housing models, and are far less expensive than the cost of habitual shelter stays and emergency medical services that are often the alternative for chronically ill homeless people. (Hawk & Davis, 2012; Tsai, et al., 2010; Wolitski, et al., 2010; Larimer, et al., 2009; Sadowski, et al., 2009; Caton, et al., 2008; Martinez & Burt, 2006). Seventy-two percent (72%) of those admitted to a low-threshold housing program for persons with active substance use and mental health disorders achieved housing success (retention in stable housing for 2 years or more), and program participants with a history of incarceration were as stable in housing as persons with no criminal record. (Malone, 2009).

Formerly incarcerated persons with HIV infection may also be excluded from existing housing resources based on restrictive admission criteria that require advanced HIV disease, a source of income to contribute towards rent, or proof of legal immigration status. Each community must work to minimize barriers to housing and to identify and allocate available resources to meet the varied and complex circumstances of all homeless and unstably housed persons with HIV.

To meet the housing needs of all persons with HIV/AIDS, it is necessary to adopt a public health approach to housing delivery that will:

- Lift housing exclusions based solely on active drug use or mental health issues.
- Incentivize the development of low-threshold, harm reduction housing interventions that enable persons with active drug use and mental health issues to establish stability, improve HIV health outcomes, and reduce HIV risk behaviors.
- Ensure the availability of housing resources and placement assistance to overcome barriers to housing access and stability that are related to behavioral health, HIV disease stage, lack of income, immigration status or other unique circumstances.

Recommendation 2: Remove post-incarceration barriers to subsistence income and health insurance

Lack of employment, income and public assistance contribute to housing instability and poor health outcomes for formerly incarcerated people with HIV and their families. Many persons leave prison or jail with no source of ongoing income and no medical insurance to cover HIV treatment and behavioral health services in the community.

There are numerous barriers, both formal and informal, for ex-inmates who seek work. Lack of education and work experience limit employment opportunities, formerly incarcerated people can be prohibited by state law from working in certain industries or obtaining occupational licenses, and applicants are often required to reveal criminal justice histories early in the job application process, limiting chances. (LAC, 2009). Providing education, job training opportunities and work supports to incarcerated persons, both before and immediately after their release from prison or jail, has been shown to help individuals secure employment and break the cycle of recidivism. (Pew, 2010). However, job-training opportunities in prison are limited, and some states such as Alabama and South Carolina segregate

HIV-positive inmates, thereby excluding them from available education and job-training programs. (HRW, 2010).

Persons who rely on Social Security disability or Veterans benefits often experience a reduction or gap in benefits upon release from prison or jail. Supplemental Security Income (SSI) and Social Security Disability Insurance Disability (SSDI) benefits are suspended when a person is held in prison or jail for more than one month, and if the stay lasts more than 12 consecutive months SSI benefits are terminated and the disabled individual must begin the application process over again. Veterans benefits may be reduced or terminated for persons convicted of a crime. Proper pre-release planning and procedures, when offered, can enable persons whose SSI, SSDI or Veterans benefits are suspended or reduced to have benefits reinstated and checks restarted upon release. A change in federal law will be required to allow for suspension rather than termination of SSI benefits during prison or jail stays longer than one year. (See Burt & Wilkins, 2012).

Formerly incarcerated persons may also face barriers to public assistance to support themselves and their dependent children. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (which instituted the Temporary Assistance for Needy Families (TANF) Act) stipulates that anyone with a drug conviction can be barred for life from obtaining food stamps and TANF benefits, unless a state modifies or eliminates this prohibition. As of 2009, 24 states did end TANF and Food Stamp benefits permanently for persons with drug convictions and another 17 states imposed requirements before TANF benefits can be restored, such as successful completion of a drug or alcohol treatment program. Although TANF-funded housing subsidies are currently subject to federal lifetime benefit limits, both the TANF and Food Stamp programs are critical sources of assistance for extremely low-income families. Action is needed at federal and state levels to eliminate restrictions on

income supports and benefit programs for persons convicted of drug-related crimes. (LAC, 2009).

Finally, many persons with HIV who are eligible for the Medicaid program leave prison or jail without the active health coverage necessary for continuous care and uninterrupted treatment. The Medicaid law prohibits federal payment for services furnished to anyone in jail or prison, but does not require that incarcerated individuals lose their Medicaid eligibility. Nevertheless, most states terminate rather than suspend Medicaid benefits upon incarceration, and reestablishing eligibility following release can take weeks. Federal regulations that govern the impact of incarceration on Medicaid coverage are complex and intertwined with SSI and other federal benefit programs. However, the regulations provide states with the flexibility to ensure that almost all eligible low-income persons are enrolled in Medicaid upon release from prison or jail. Unfortunately, many states simply fail to take advantage of available strategies to facilitate access to Medicaid coverage and services in the community. (See Bazelon Center, 2009).

To improve the ability of formerly incarcerated people with HIV/AIDS to meet basic subsistence and health needs for themselves and their families:

- Reduce barriers to employment opportunities by removing questions about convictions from initial job applications, shielding non-violent convictions from public view past a certain time, incentivizing businesses to hire and train those with criminal records, and expanding pre- and post-release educational and job-training programs to assist individuals with criminal records.
- Change federal law to allow for suspension rather than termination of Social Security and Veterans disability benefits during incarceration, and ensure that all correctional institutions have agreements in place with the Social Security Administration to facilitate reinstatement of suspended benefits upon release.

- Eliminate restrictions on income supports, food stamps and other benefit programs for those convicted of drug-related crimes and encourage states to remove barriers to education, job training programs and employment programs based on criminal justice involvement.
- Suspend rather than terminate Medicaid for inmates during incarceration and provide prescreening of inmates prior to release so that Medicaid coverage for each eligible person is active upon discharge.

Recommendation 3: Improve pre-release discharge planning for inmates with HIV/AIDS to meet housing and other essential needs

Discharge planning, transitional services, and continuity of care programs are essential for the vast majority of inmates who are released and return home, and may be particularly important for inmates living with HIV/AIDS to ensure uninterrupted HIV treatment and reduce the risk of ongoing HIV transmission upon return to the community. Even something as basic as identification can require planning prior to release. For example, many persons leaving prison do not have a current driver's license or a social security card, and/or lack copies of birth certificates or other official documents necessary to obtain state-issued identification required for job applications, to establish eligibility for public benefits, or to rent an apartment.

Despite increased focus on reentry and innovative demonstration projects, discharge planning and other transitional supports remain unavailable to many inmates facing release from prison, and few institutions offer assistance to secure stable housing prior to release (e.g., counseling, search assistance, referrals to local housing providers, applications for rent vouchers, renter education, etc.). (Mettraux, et al., 2008). Adequate planning for discharge from jail is even more limited, given the volume of persons cycling through local jails each year and the short length of many jail stays. (Solomon, et al., 2008).

To improve post-release outcomes for each person living with HIV/AIDS who is leaving prison or a substantial jail term, provide comprehensive discharge planning services prior to release that will:

- Connect individuals to Medicaid, disability benefits, food stamps, and other public benefits that will be activated immediately upon release.
- Schedule appointments with community health and social service providers, including a post-release appointment with an HIV care provider in the community and referrals to behavioral health care programs as needed.
- Provide an adequate supply of medications to ensure continuous treatment of HIV-infection and other physical and behavioral health issues until community-based health care is in place.
- Identify available employment options and/or collaborate with community service providers to connect individuals to case management, job training and other supports.
- Provide comprehensive housing assistance (e.g., counseling, search assistance, referrals to local housing providers, applications for rent vouchers, renter education, etc.) that secures a placement in stable, affordable and appropriate housing on the day of release.

Recommendation 4: Evaluate the effectiveness of housing-based interventions for formerly incarcerated people with HIV/AIDS

Despite the substantial co-occurrence and harmful impact of housing instability and incarceration among HIV-positive persons, there is limited research specifically examining the overlap of these vulnerabilities on health or criminal justice outcomes, or evaluating the impact of housing-based interventions that target formerly incarcerated people with HIV.

A better understanding will first require regular collection and analysis of data on housing status. All federally-funded providers or health care and services for persons living with HIV should be required to regularly monitor housing status along with health care engagement, viral load and other HIV health indicators in a patient-centered non-coercive manner. The CDC should collect and analyze data on housing status as a routine part of HIV surveillance. Finally, data sharing and collaboration among federal agencies, including the CDC, HUD, and the U.S. Department of Health and Human Services (HHS), would facilitate analysis of the role of housing as HIV prevention and health care intervention to inform the U.S. HIV response. In July 2012 HHS took a significant step towards these goals by including housing status as one of seven common core indicators adopted by the HHS Secretary for monitoring HHS-funded HIV prevention, treatment, and care services. (HHS, 2012). Housing status is also identified as a core indicator of HIV care in a recent Institute of Medicine (IOM) report commissioned by the White House Office of National AIDS Policy (ONAP) to develop tools for assessing progress the U.S. HIV response. (IOM, 2012).

Experts also call for empirical research focused specifically on the needs of HIV-infected prisoners and those released from prison, including intervention research that incorporates evidence-based solutions into the criminal justice setting. (Meyer, et al., 2011; Rich, et al. 2011)). Evidence-based responses to improve post-incarceration outcomes will require targeted research to examine housing status as an independent determinant of HIV treatment effectiveness and risk behaviors, access to behavioral health care, recidivism to prison or jail, and the public cost implications of housing interventions for people living with HIV/AIDS, their families and their communities.

To better understand the impact of housing status on post-incarceration HIV health outcomes, and to inform the development of evidence-based HIV prevention and care interventions for individuals

involved with the criminal justice system and their communities:

- Require all federally-funded providers who deliver health care and services for persons living with HIV to regularly monitor housing status, engagement with HIV health care, viral load and other HIV health indicators in a patient-centered non-coercive manner.
- Gather information on housing status as a core indicator of HIV health as part of routine data collection by HHS, the CDC, HUD and other federal agencies involved in HIV prevention and care.
- Promote interagency data sharing and analysis to determine real housing need among people with HIV in the U.S., to evaluate the impact of housing status on HIV treatment effectiveness and prevention strategies, and to monitor and inform the U.S. HIV response.
- Conduct empirical research focused specifically on the needs of persons with HIV/AIDS involved with the criminal justice system, including intervention research to test the effectiveness and public cost implications of models of housing support that serve formerly incarcerated people with HIV.

OPPORTUNITIES FOR PROGRESS: THE FEDERAL POLICY LANDSCAPE

The current federal policy landscape provides important opportunities for action to improve housing and health outcomes for formerly incarcerated persons living with HIV/AIDS, their families and their communities.

Over the past decade there has been a mounting reaction to the corrosive effects of mass incarceration on individuals and communities – due in large part to the enormous public expense required to maintain the U.S. correctional system and address the worsening health of incarcerated populations. One focus has been the development of reintegration initiatives for returning prisoners designed to

reduce high rates of recidivism to prison and jail by stabilizing and improving the lives of justice-involved individuals, families and communities.

Ambitious new federal initiatives to expand health insurance, renew and coordinate the U.S. response to HIV/AIDS, and address homelessness likewise create unique and important opportunities to improve the social stability and health outcomes of low-income people living with HIV in the U.S., including formerly incarcerated persons, and to reduce the disparate burden of HIV disease borne by individuals and communities of color.

Outlined below are several of these federal initiatives.

The Second Chance Act

In 2008 the federal Second Chance Act (Public Law 110-199) was signed into law as the first legislation designed to address the needs of people reentering communities from incarceration. Administered by the U.S. Justice Department, Second Chance Act programs are intended to help state and local agencies implement programs and strategies to reduce recidivism and ensure the safe and successful reentry of adults and juveniles released from correctional facilities. The legislation established the National Reentry Resource Center as a project of the Council of State Governments Justice Center (CSG), and authorizes federal grants to government agencies and nonprofit organizations to provide employment assistance, substance abuse treatment, housing, family programming, mentoring, victims' support, and other services that can help reduce recidivism. Congress appropriates federal grant funding for these reentry efforts and program initiatives are underway at the Departments of Justice, Veterans Affairs, Health and Human Services, and Labor. (U.S. Reentry Council, 2011). The National Reentry Resource Center also provides useful guides to reentry planning, including available housing options. (National Reentry Resource Center, 2011; CSG, 2010).

The Federal Reentry Council

In January 2011 the Justice Department convened the Federal Reentry Council, which brings together 20 federal agencies to remove federal barriers to successful reentry. Reentry Council agencies are charged with taking concrete steps to reduce recidivism and lower the direct and collateral costs of incarceration through action to “improve public health, child welfare, employment, education, housing and other key reintegration outcomes.” (U.S. Reentry Council, 2011).

The National HIV/AIDS Strategy

The first U.S. National HIV/AIDS Strategy (NHAS), released in 2010, sets ambitious goals for reducing HIV incidence, lowering the HIV transmission rate, increasing linkage to care for persons living with HIV/AIDS, reducing health disparities, and improving service coordination. The NHAS highlights the importance of HIV-related housing services as a key part of a comprehensive HIV service delivery package, specifically states that federal agencies should consider additional efforts to support housing assistance and other services that enable people living with HIV to obtain and adhere to HIV treatment, and sets goals and metrics for measuring progress on improved housing status for persons with HIV. NHAS provisions direct HUD to reconsider the allocation formula for HOPWA grant funding to better align the program with current need, and to date HUD’s NHAS implementation activities have been focused primarily on this goal. Unfortunately, no new federal HIV housing resources have been made available as yet to meet the housing goals of the NHAS.

Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness

Opening Doors, the 2010 Federal Strategic Plan to Prevent and End Homelessness also recognizes housing as an evidence-based HIV prevention and health care intervention for homeless/unstably housed persons. The plan notes that HIV housing assistance coupled with health care has been shown to decrease overall public expense and make better use of limited public resources, which is relevant

to achieving objective Nine of the plan, to “[a]dvance health and housing stability for people experiencing homelessness who have frequent contact with hospitals and criminal justice.” As yet, however, federal homeless assistance programs are unavailable to persons who are homeless upon exit from prison, including persons with HIV/AIDS, and no specific initiative or funding targets persons with HIV experiencing homelessness and criminal justice involvement. (Interagency Council on Homelessness, 2012).

The Affordable Care Act

The Affordable Care Act (ACA) introduced health care reform in the U.S. with three basic principles – to increase access to care; increase the quality of care; and lower health care costs. One of the ACA’s most important provisions is expansion of Medicaid eligibility to all individuals under the age of 65 with incomes below 133 % of the federal poverty level. The recent Supreme Court’s ruling on the ACA made the expansion of Medicaid eligibility an option states could accept or decline. The optional expansion presents states with a significant opportunity to secure federal funding for health care for low-income Americans, including almost all homeless persons and all low-income persons with HIV/AIDS. As noted above, ACA provisions also offer the potential to couple stable affordable housing with Medicaid-funded supports for persons with HIV and other chronic health challenges. Each state will make a number of critical policy decisions regarding the Medicaid expansion over the next several months and years. These decisions will have a profound impact on health systems and the people who use them, including people living with HIV/AIDS. (See Bazelon Center, 2012).

Ryan White Care Act Reauthorization

Looking ahead, the reauthorization of the Ryan White CARE Act will provide another important opportunity to address homelessness and poor health outcomes following incarceration. Ryan White Title I Funds have been an important, if limited, federal source of funds used effectively to provide emergency and transitional housing

as a supportive service for formerly incarcerated persons living with HIV/AIDS. Given the substantial evidence base linking housing status and HIV prevention and treatment effectiveness, it is time to view housing supports as a core component of HIV health care rather than an ancillary service. As the 2013 reauthorization of the Ryan White CARE Act is considered, it is important to preserve and expand the role of Ryan White funded housing supports for homeless persons with HIV/AIDS who are leaving prison and jail.

CONCLUSION

Dr. Robert Fullilove has observed that “homelessness, housing conditions, incarceration and the concentration of poverty in communities of color are more than just ‘complicating factors’ for people being treated for HIV/AIDS. They are the forces that produce marginalized communities and marginalized people.” (Fullilove, 2006).

Experts agree that progress in HIV prevention and care will require action to address structural factors such as incarceration and homelessness that impede effective treatment, and that housing supports are a proven and cost-effective structural HIV health intervention. (Auerbach, 2009; Gupta, et al., 2008; Purcell & McCree, 2009). As stated in a CDC report on HIV-related health inequities, “new approaches are needed to reduce the impact of poverty, unequal access to health care, incarceration, lack of education, stigma, homophobia, sexism, racism, and other factors that result in disproportionate health impact.” (CDC, 2010).

The need to achieve better health outcomes for HIV-infected persons involved with the correctional system is an urgent individual and public health priority. Alternative approaches to criminal justice and incarceration would likely result in profound public health benefits. The focus of this paper is on the more proximate issue of housing status for persons reentering the community from prison and jail – a factor that is shown to be amenable

to intervention with a significant impact on HIV health outcomes. Housing assistance is an evidence-based HIV prevention and care strategy to mitigate the disadvantage associated with HIV/AIDS and criminal justice involvement, and by doing so to reduce the impact of poverty, unemployment, intergenerational deprivation, mental illness, harmful substance use and other infectious diseases such as TB.

We call on the HIV/AIDS, housing, public health and criminal justice sectors to alleviate the overlapping burden of HIV infection and incarceration on individuals and communities by taking immediate steps to improve housing status among former prisoners living with HIV/AIDS and their families. Though much is likely to be eliminated or deferred during these difficult budget times, the failure to fund and bring to scale these proven and critically-needed housing resources will end up costing much more than it saves.

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