

Triple Threat: Addiction, Incarceration and HIV/AIDS in the African American Community

-- Gil Gerald

Nearly three decades since it first came to public attention in the U.S., the HIV/AIDS pandemic is a continuing and increasing health crisis for African Americans in California. Among those knowingly or unknowingly living with HIV infection, or living with a diagnosis of full blown AIDS, African Americans are disproportionately impacted by the disease as demonstrated in epidemiologic data which shows African Americans, both men and women, as having the highest HIV and AIDS incidence rates in the state. (Krawczyk, C).

The interplay between behavioral risk factors for HIV/AIDS and other interconnected socio-economic factors responsible for the overall health disparities among African Americans have created a *syndemic* -- *'two or more afflictions interacting synergistically, contributing to excess burden of disease in a population'* (NASTAD, 2007). Risk factors, such as drug use and addiction, increase vulnerability to HIV infection due to related high risk sexual and needle sharing behaviors. These behaviors are associated with high HIV incidence rates in poor and mostly urban African American communities (CAPS, 1999).

African American Californians who have become ill or died as a consequence of HIV/AIDS are overwhelmingly male (the incidence rates of HIV/AIDS among African American males, are greater than the incidence rates for men or women in any other racial or ethnic group), and the majority became infected through unprotected sex with other men (54%), or through the sharing of infected needles (8%) while injecting drugs (Krawczyk, C). Men in the at-risk and affected Black community may describe themselves as men who have sex only with other men, or with both men and women. This group also includes individuals who identify as transgender individuals, and some

biologically male transgender individuals self-identify as female.

African American women are so disproportionately impacted by the virus that AIDS is the NUMBER 1 cause of death among African American women, ages 25-44! Poverty, lack of education, employment and housing often places African American women in positions in which they are forced to engage in *survival sex* to support themselves and their families (i.e. trade sex for money, food, shelter, drugs, etc). As with African American men, unprotected sexual intercourse with an infected male partner (74%) and the sharing of infected syringes (24%) account for the majority of reported cases among African American women (ibid).

In addition to socioeconomic factors, health care can be interrupted by several other factors which lead to chaotic and isolated lives. Addiction to one or more substances, mental illness, criminal prosecution and incarceration for drug-related crimes, joblessness, lack of affordable health coverage, and homelessness often complicate the ability of African Americans to successfully cope with HIV and/or take advantage of new life saving/life enhancing treatment. Many are also isolated from the support systems that might otherwise be available from the African American community through faith based organizations, family ties and significant others. This isolation is due primarily to the stigma attached to HIV/AIDS, to sex between people of the same gender, to transgender individuals, to addiction, and to criminal behavior. The stigma and isolation experienced by African Americans living with HIV/AIDS damages communities as well as individuals because they inhibit the community-level interventions and individual action/responsibility needed to successfully stem the further spread of HIV.

HIV/AIDS and Incarceration

A significant number of African Americans with HIV/AIDS are stigmatized and isolated even more because they are incarcerated or have been in jail or prison. The disproportionate impact of HIV and incarceration on African Americans in California is well-documented. While African Americans make up less than 7% of the state's population (Census Bureau, 2007), 18% of all annual HIV Diagnoses in Californians are African American (Krawczyk, C).

A disproportionate share of the African American community is also institutionalized in California's prisons, county and municipal jails. In 2007, African American prisoners made up nearly one-third (28.9%) of the state's 171,444 prison population (CDCR, 2007). African American males were 28.9% of male inmates and African American females were 28.7% of female inmates (ibid). This pattern of overrepresentation in California's correctional facilities is also true at the county and municipal level. In Los Angeles, for example, in 2002 more than one out of every three men (36%) who were in county jails were African American, and more than four out of ten (44%) among jailed females were African American (County of Los Angeles, 2004). By comparison, African American people represent only 9.5% of the total Los Angeles County population.

High incarceration rates in the African American community also affects HIV risk, as incarceration decreases the number of men in the community, which disrupts stable partnerships and promotes higher-risk *concurrent partnerships* (having more than one sexual partner in a given period and going back and forth between them). Since the ratio of

men to women is much lower among African Americans than any other ethnic group and African American women are less likely than other women to date men outside of their race (McNair, I., et al 2004), women with seemingly low-risk behaviors may end up involved with men who engage in high risk behaviors (Aral SO, et al 2008). For example, in Sacramento County a large percentage of new HIV infections are African American women who are not considered high-risk (i.e. sex workers, or IV drug users).

Among African Americans who are vulnerable to HIV infection, there is evidence that they are also likely to have been in jail. In one jurisdiction, up to 63% of African American men who have sex with men (MSM) and living with HIV/AIDS reported having been incarcerated in their lifetime, and 26% were incarcerated within the past two years (County of Los Angeles, 2004). The disproportionate impact of HIV in African Americans is also reflected in populations being released from prison or jail. The State's Transitional Case Management Program (TCMP) serves inmates living with HIV/AIDS who are in the process of paroling out of state prison. While the TCMP did not have an accurate number it could report in December 2009, an estimate was provided to this author indicating that more than 30% of the 1,050 parolees it served between July 1, 2007 and June 30, 2008 were African American (Gerald, G). This number represents only a small portion of the total number of African American individuals with HIV or AIDS who are being released in any given year out of all correctional facilities in California including State prisons, county and municipal jails, as there is no routine policy in place that tests prisoners prior to release. Within this group, most are in need of treatment for addiction to one or more substances, and many also have co-occurring mental illness.

Co-occurring HIV, Substance Abuse, Physical and Mental Health Disorders

HIV prevalence rates for incarcerated individuals have been shown to be higher than those among the general population, and are closely associated with co-occurring substance abuse and mental health disorders. For example, one study documented a 21.6% HIV positive rate upon intake among incarcerated MSM who inject drugs (San Francisco Department of Public Health, 2004). Additionally, the prevalence of other diseases for those who have been released has been shown to be considerably higher than in the general population: four times higher for TB; nine to ten times higher for hepatitis C, and three to five times higher for schizophrenia and other psychotic disorders (Davis, Lois and Pachiana, S). So it would be safe to assume that the prevalence rates for HIV/AIDS would also be higher among this group. Eighty-three percent of all incarcerated people living with HIV/AIDS exhibit an addiction to one or more substances at the time of incarceration (ibid), and the TCMP reports that practically all of the *parolees* it serves need some level of substance abuse treatment upon release (Gerald, G).

Mental illness is also prevalent among people living with HIV as well as persons who have a substance use disorder. The results of a study published in the *Archives of General Psychiatry* (Bing, E.G., et al 2001) revealed that nearly half of HIV positive individuals assessed for mental illness presented with depression, dysthymia, generalized anxiety disorders, or panic attacks. In another study published in the *Journal of Psychoactive Drugs*, co-morbidity with psychiatric illness and substance abuse was found to be prevalent among HIV-positive persons and men who have sex with men (MSM) in Los Angeles

(Galvin, F.H. et al, 2003). Substance use disorder is considered to be the most common and clinically significant co-morbidity among persons with severe mental illnesses (Mueser et al, 2003).

Barriers to Care

Many local jurisdictions and the State of California as a whole have documented that post-incarcerated individuals with HIV/AIDS experience significant barriers to care and are among the most underserved populations in the state (California, 2006). Significant numbers of parolees living with HIV/AIDS have trouble finding housing (38% in San Diego County), which is significant because the literature provides ample evidence that an individual released from prison or jail who returns to a shelter upon release will predictably return to prison or jail. More suitable drug-free transitional or permanent housing must be identified and secured prior to release as part of the case management plan (Kushel et al 2005, and Rodriguez and Brown 2003).

Post-incarcerated individuals with HIV/AIDS also lack knowledge of available services (County of San Diego, 2005, Inland Empire, 2008) and many do not trust the health care system. Much of this lack of trust is related to their experience of stigma, discrimination, and lack of cultural competency in the provision of services by the system. Transgender individuals in particular experience the more extreme consequences of systems and services that are unresponsive to their needs (California, 2006).

To help prevent the further spread of HIV among African Americans in California, and to improve the quality of life for those already infected, federal, state and local resources must *holistically* address co-occurring conditions and

other complex needs confronting African American incarcerated and post-incarcerated individuals; taking into consideration the issues of racism, discrimination and poor socioeconomic conditions. It cannot be overemphasized that this population includes some of the most marginalized people in society; such as persons who are homeless upon release, mentally ill, in need of medical care, in need of alcohol and/or other drug treatment, lacking marketable job skills, and ostracized or discriminated against because of race, criminal history, sexual orientation, gender, gender identity or gender expression. All of this is a certain prescription for recidivism. All of these needs must be thoroughly addressed as they have implications for access to jobs, education, health care, and all of the assets necessary to build resiliency against HIV. Additionally, if primary prevention is not provided to post incarcerated individuals, their families, significant others and sexual or drug using partners, there is significant risk that new HIV infections in the African American community will continue to occur.

Complex Needs Requiring Appropriate Services in the Community

While many reforms are needed to improve conditions in the prisons and jails, once a person has been released, the treatment setting in the community can make a big difference in prolonging and improving the quality of life of those infected, as well as in preventing the further spread of HIV in the African American community. Comprehensive, treatment services addressing the complex needs of the re-entry population offer the opportunity to decrease isolation by bringing together the persons recently released from jail with family significant others when appropriate, with community groups including faith-based

organizations, with substance abuse counselors, with mental health and medical professionals, and with other resources to support treatment/recovery and enhance physical and mental health.

For post incarcerated individuals, priority service needs include: case management; benefits assistance; housing; medical and mental health care; transportation (San Francisco, DPH, 2004; County of Los Angeles, 2002), and assistance with food and nutrition (County of Los Angeles, 2002). HIV prevention is also very important. Prevention is warranted both in and out of jail or prison, given the fact that in one study 15% of African American mothers had an incarcerated partner, especially single women and women under 35 (Cummings et al, 1997). Sero-discordant couples (when one partner is HIV positive and one is HIV negative) also need support to maintain safer sex behaviors over time. Several jurisdictions that receive direct federal funding for HIV prevention, including Orange, Riverside and Los Angeles counties, have noted high and unmet HIV prevention needs in the re-entry population and have prioritized post-incarcerated individuals for these services as part of their HIV Prevention Plans.

Co-occurring substance abuse and mental health disorders require trained and specialized staff that is able to diagnose and treat these conditions simultaneously. Co-occurring conditions require the services of community-based organizations with the capacity to provide coordinated care and services across systems and disciplines – i.e. medicine, substance abuse treatment, and mental health services. Having resources or strong linkages to supportive services in the areas of housing, vocational and educational assistance is also desirable, along with strong case management capabilities.

A number of treatment models, such as the *Integrated Dual Diagnosis Treatment Model* have demonstrated effectiveness in promoting good treatment outcomes for individuals with co-occurring mental illness and substance abuse disorders (Drake, R, et. al, 2001). Key factors in the effective applications of the model include: 1) approaching treatment in stages; 2) employing assertive outreach; 3) employing motivational interventions; 4) providing counseling; 5) assisting the client in developing social support; 6) understanding recovery as a long-term, community-based process; 7) comprehensively addressing mental health and substance abuse together; and 8) providing culturally sensitive and competent services. More of these comprehensive approaches must be made accessible to the re-entry population, as well as other high-risk, underserved segments of the African American community.

Complexity of Care Needed in the Community

The State of California and several counties with large urban populations provide programs involving pre-release and post-release services. These services must continue and be further developed to build sufficient capacity to meet the need. Comprehensive pre-release planning and post-release services must effectively address the need to:

- Provide treatment for co-occurring mental illness and substance abuse disorder
- Provide for placement of post incarcerated individuals in drug-free, safe and sanitary transitional or permanent housing immediately upon release
- Provide for uninterrupted HIV medical care and medications

- Provide for medical care to address co-morbid HIV, Hepatitis C, or TB
- Provide staff that is culturally competent in serving African American same gender loving individuals, African American transgender individuals, and African American heterosexual men and women
- Provide for the development of social supports in light of the stigma and isolation that are based on HIV status, sexual orientation, gender identity or expression, substance use history, or a combination of two or more of these factors
- Provide the necessary benefits assistance, educational and vocational assistance to promote sustainability in the community
- Provide evidenced-based criminogenic assessment and rehabilitation services which according to an Expert Panel Report are seriously lacking in California's Prison and Parole System (CDCR Expert Panel, 2007).

Opportunities for Change and Improvement

African American community education, involvement and mobilization are of paramount importance as resources become more constrained by cutbacks in health and social services as well as by increasing case loads, which are attributable not only to continuing new infections but also to improvements in treatment for HIV—people are living longer.

African American community involvement is needed to develop resources within the African American community to address the issue of the stigma and other barriers to care experienced by African American post-incarcerated individuals, and to increase African American participation in HIV

community planning which determines how available public resources for HIV are spent.

Staff in behavioral healthcare settings must receive the training and technical assistance needed to provide services that are culturally competent in serving African Americans and culturally responsive in serving individuals from this community who are different in terms of their sexual and gender identity. Expanded and increased institutional/community partnerships are imperative in addressing the environmental issues that contribute to recidivism, inhibit persons from being welcomed back into the community, and from entering and remaining in recovery from substance abuse and mental health disorders.

Comprehensive and coordinated care - medical, behavioral health, and housing services under one roof, is often difficult to find, yet alcohol and drug counselors, medical and mental health, professionals and other providers of services to this population, must find effective ways to increase the integration and coordination of services, so as to decrease the barriers to receiving and remaining in care. Determining and strengthening provider *capacity*, as well as *capability* is a key step in

improving access and retention of clients in treatment.

The HIV and AIDS incidence rates among African Americans are unacceptable! And they will only get worse unless prevention and care efforts are effectively designed for and delivered to the most vulnerable and underserved. During these times of financial duress, when the State is contemplating the elimination of all HIV Prevention Services, a comprehensive response is required from all sectors – government officials, policy organizations, service providers, and the community. We must build a strong and shared resolve to develop the necessary services and resources in our communities to end the pandemic of HIV among African Americans in California.

Whatever else it may be, our community must be a good and loving community that embraces and cares for its own, especially the most vulnerable among us—the ill and aged, the children, the disabled and the poor.

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As a co-founder of the National Minority AIDS Council, he served as the incorporating officer and the first Secretary of the Board. He has also served as Executive Director of the Minority AIDS Project-Los Angeles, on the Board of Directors of AIDS Project-Los Angeles, and Director of Development for the Black Coalition on AIDS.

Mr. Gerald contributed a chapter in the groundbreaking publication “In the Life: A Black Gay Anthology” (Beam J. ed, Alyson Publications, 1986), and has been published in several periodicals, including the “Journal of the National Medical Association” and “Point of View: the Magazine of the Congressional Black Caucus Foundation.”

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