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HIV Policy Recommendations
New York City
February 2014

Background:

While the tide of the HIV epidemic may have been stemmed by medical advances that have offered new prevention possibilities and lengthened lives, they have also given rise to an ill-deserved complacency. In fact, HIV continues to rage in our city, and to disproportionately impact already marginalized communities: men who have sex with men, young people, and African-American men and women, most notably.

Of the 3,141 new HIV/AIDS diagnoses made in NYC in 2012, 1635 (52%) lived in high or very high poverty areas (20% and higher above the federal poverty level). Further, people of color, particularly people of African descent, face a disproportionate burden: of the 114,926 people living with HIV/AIDS (PLWHA) in NYC, 51,154 (44.5%) were Black, 37,290 (32.4%) were Hispanic, and 23,715 (20.6%) were White. PLWHA living in high poverty areas have poorer survival rates than persons living in low poverty areas, and Blacks with HIV/AIDS have lower survival rates than Whites.[1]

Yet we are, indeed, positioned to bring these numbers down significantly. The past few years have produced numerous game-changers: under the Affordable Care Act, nearly everyone living with HIV will have access to medical coverage; New York State's Medicaid Redesign process created a mechanism through which savings can be invested to fund better services; a major study, HPTN 052, released in August 2011 found that early initiation of treatment not only improves health outcomes for individuals living with HIV, but also that it reduces transmission by nearly 100 percent[2]; and the newly approved pre-exposure prophylaxis (PREP) adds another tool to the prevention arsenal.

[1] New York City Department of Health and Mental Hygiene, HIV Surveillance Annual Report, 2012, http://www.nyc.gov/html/doh/downloads/pdf/dires/surveillance-report-dec-2013.pdf
[2] M.S. Cohen, et. al., "Prevention of HIV-1 Infection with Early Antiretroviral Therapy." *New England Journal of Medicine*; 365:493-505 (August 11, 2011). http://www.nejm.org/doi/full/10.1056/NEJMoa1105243

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In light of these developments, and inspired by community support for a bold plan of action, the New York State Department of Health's AIDS Institute hosted this fall a series of community meetings focused on ending the AIDS epidemic in New York. Pursuit of this bold proposition—that we can end the AIDS epidemic—requires recognition of our current shortcomings.

In fact, we are constantly missing opportunities to diagnose new cases, to connect those diagnosed to care, and to keep those who are connected in care managed and treated so that they can become virally suppressed and, in turn, far less likely to pass on the disease. In New York State in 2011, of the 154,000 estimated cases of persons living with HIV, only 131,000 (85%) of those were aware of their HIV status. Further, only 85,000 people (55% of those infected) had received *any* HIV care during the past year; just 74,000 (48% of those infected) had received continuous care during the year; and 60,000 (39% of those infected) were virally suppressed. Many factors drive these results, but poverty is elemental in the disruption of care and treatment.

Only if we are committed to assigning resources to both connecting people to care, and keeping them in care will we make headway in the fight against HIV/AIDS. Accordingly, we offer the following set of policy recommendations for the coming months and years.

- **Housing**
    - ***Scale up housing for all people living with HIV/AIDS (PLWHA) and recently incarcerated, who are at high risk for HIV.***
    - ***Complete construction of and expedite access to all supportive housing units promised under the NY/NY III agreement***
    - ***Scale up "low threshold", "housing first" housing, which eliminates many of the onerous admissions requirements typical of public housing.***

    HIV and homelessness are intimately connected, and housing status is among the strongest predictors of health status for PLWHA. HIV prevalence among the homeless population is nearly nine times that of the general population.[3] Over 500,000 households in the United States with HIV/AIDS will require housing assistance at some point in their lives.[4] Homeless or marginally housed individuals are more likely to delay treatment, less likely to have regular access to care, less likely to receive optimal drug therapy, and less likely to adhere to their medication than are stably housed individuals—all of which increase the individual's viral load and decrease health outcomes.[5] Also, persons with declining housing status are three times as likely to exchange sex for money or other needed goods, whereas persons with improving housing status reduce their risk behaviors by half.[6] Said differently,

[3] National Coalition for the Homeless, "HIV/AIDS and Homelessness," (July 2009), http://www.nationalhomeless.org/factsheets/HIV.pdf.
[4] Virginia Shubert and Nancy Bernstine, "Moving from Fact to Policy: Housing is HIV Prevention and Health Care." *AIDS and Behavior* 11: Supplement 2 (2007): S175, http://www.aidschicago.org/pdf/2008/housing_plan_MovingfromFact.pdf.
[5] Richard J. Wolitski, "HIV, Homelessness, and Public Health: Critical Issues and a Call for Increased Action." *AIDS and Behavior* 11: Supplement 2 (2007): S168.
[6] Angela Aidala et al., "Housing Status and HIV Risk Behaviors: Implications for Prevention and Policy." *AIDS and Behavior* 9.3 (2005): 259.

housing works. In a six-month longitudinal study of adherence to HAART (Highly Active Antiretroviral Treatment) regimens in New York City, residents in long-term housing were sixteen times more likely to report strong adherence to their treatment regimens than were unstably housed participants.[7]

In New York City, homelessness remains a monumental challenge. NY/NY III housing for PLWHA is tied to extensive eligibility requirements that make it challenging for contracting social service agencies to fill the available units. The City should work with the State to revise some of the eligibility criteria to allow more needy families access to these needed units. Similarly, new units should be built or designated for PLWHA, both singles and families, and the governing contracts should be sufficiently flexible that the units can be readily filled, including by individuals, including ex-offenders and substance users, who are often excluded from public housing opportunities.

- **Education**
  - ***Continue to support and expand comprehensive, age-appropriate, medically accurate sex education by committing additional resources to teacher training, by codifying Mayor Bloomberg's initiative to require one semester of sex ed in both middle and high school, and by instituting accountability mechanisms to ensure that the mandate is implemented in all schools.***

According to the Centers for Disease Control and Prevention, in 2011, 47% of high school students had had sex at some time. Further, nearly 40% of high school students who had been sexually active during the previous 3 months had not used a condom the last time they had had sex. Accordingly, youth suffer intolerable sexual health outcomes. According to the CDC, almost half of all new STD infections are among youth aged 15 to 24.[8] Further, of the 3,141 new HIV diagnoses in 2012 in New York City, 1214 (38.7%) were among those aged 13-29.[9] Additionally, though we have seen a significant decline in the teen pregnancy rate, we still have 69 pregnancies per 1,000 adolescent females, resulting in more than 17,000 teen pregnancies annually, of which 87% are unintended.[10]

- **Law Enforcement**
  - ***Put an end to the police practice of using condoms as evidence in prostitution convictions.***

[7] Chad A. Leaver et al., "The Effects of Housing Status on Health-Related Outcomes in People Living with HIV: A Systematic Review of the Literature." *AIDS and Behavior* 11: Supplement 2 (2007): S96.
[8] Centers for Disease Control and Prevention, Sexual Risk Behavior: HIV, STD, and Teen Pregnancy Prevention, http://www.cdc.gov/HealthyYouth/sexualbehaviors/
[9] New York City Department of Health and Mental Hygiene, HIV Surveillance Annual Report, 2012, http://www.nyc.gov/html/doh/downloads/pdf/dires/surveillance-report-dec-2013.pdf
[10] New York City Department of Health and Mental Hygiene, Health Department Data Shows Steady Decline in Teen Pregnancy Rate, http://www.nyc.gov/html/doh/html/pr2013/pr012-13.shtml

There is mounting evidence that the practice of police seizure of condoms as evidence of prostitution-related offenses, and introduction of condoms as evidence of prostitution-related offenses in criminal proceedings undermines New York's important efforts to fight HIV and AIDS.[11] New York City's police officers routinely confiscate and enter condoms as evidence in prostitution-related cases, and prosecutors routinely cite seized condoms as evidence of a prostitution-related offense in criminal court complaints. The fear generated by this practice leads some people in the sex trade to carry fewer condoms, and sometimes to engage in sex work without the protection of condoms. In the age of HIV, discouraging the use of condoms, particularly among high-risk and vulnerable groups, can have disastrous public health consequences. A 2011 study in New York City among people who exchange sex for money or other goods found that 14% of the men and 10% of the women were HIV-positive,[12] as compared to a 1.4% HIV prevalence in New York City generally and a 0.6% prevalence in the United States overall.[13] We must ensure that this vulnerable community is not deterred from using condoms.

- **HASA**

  - ***Reverse recent HRA policy that pays only 50% of brokers' fees.***

As of March 2011, HRA pays only 50% of the fees charged by real estate brokers on behalf of clients, including HASA clients, who are securing new housing. The vast majority of brokers are unwilling to accept this reduced fee, and people living with HIV have been hugely impacted. As a result of the policy, landlords have either stopped working with HASA clients, or have informally asked HASA clients to pay the other half themselves. This shift has made it nearly impossible for HASA clients and their advocates to secure new apartments and has forced many PLWHA to spend long periods of time living in single room occupancies (S.R.O.s), which are both unhealthy and unduly expensive. Further, it has forced many HASA clients to take undue and unhealthy risks to secure money to pay a broker. Brokers play an essential role in placing HASA clients in housing. Cutting their fee by 50% has meant that very few of those brokers who once worked with HASA clients will do so now. But HASA and its clients rely on brokers not just to show apartments, but also to serve as an intermediary between client and landlord, especially with landlords inexperienced in renting to HASA clients. Without brokers to provide that critical level of reassurance to new landlords, the stigma and discrimination so many HASA clients face in their housing search goes unmitigated.

[11] Human Rights Watch, *Sex Workers at Risk: Condoms as Evidence of Prostitution in Four US Cities.* New York: Human Rights Watch, July 2012, available at http://www.hrw.org/reports/2012/07/19/sex-workers-risk-0

[12] Samuel M. Jenness et al., "Patterns of Exchange Sex and HIV Infection in High-Risk Heterosexual Men and Women," *Journal of Urban Health*, vol. 88, no. 2 (2011), pp. 329-341.

[13] New York City Department of Health and Mental Hygiene, New York City HIV/AIDS Surveillance Slide Sets, March 2012, http://www.nyc.gov/html/doh/html/dires/epi_surveillance.shtml (accessed December 3, 2012).

- ***Landlords should be paid their security deposit via check, not voucher.***

Landlords now have further reason to be wary of renting to HASA clients. Recent HRA policy now requires HASA to pay landlords their security deposit in the form of a voucher, rather than a check. In order for landlords to collect on this voucher, they must submit extensive paperwork: documentation of damages, estimates for repair work, and receipts for work done. The prospect of such an onerous process is daunting, and disincentivizes landlords from accepting HASA clients. While the city's attempt to control the loss of un-returned security deposits is understandable, the process that has been established is too burdensome on landlords, and must be revised to ensure that landlords will continue to work with HASA.

Though these new policies were adopted as cost-saving measures, an honest assessment of the new reality shows that in fact they have had an unintended, and costly, impact. The lack of brokers willing to accept just half of their fee, and the disinterest of landlords in accepting the security voucher has left our clients seeking permanent housing with very few options. As a result, many HASA clients are stuck in emergency housing. This is both inefficient and unhealthy. The city pays approximately $55.00 per night for emergency housing at an SRO. That amounts to $1,650.00 per month. By comparison, HASA will pay up to $940 per month for a one bedroom apartment. The math just does not add up.

- ***HASA for All***

The HASA for All Act, introduced in 2008 by City Council member Annabel Palma, would extend HIV/AIDS Services Administration (HASA) benefits, including enhanced rental assistance and other lifesaving services, to *all* poor New Yorkers living with HIV.

Today, only people with an AIDS diagnosis (defined as individuals with a T-cell count of 200 or lower or two opportunistic infections) are eligible for those benefits. That distinction has prompted some poor people to allow themselves to become sick just to qualify for benefits. Additionally, advocates estimate that the HASA for All Act would help at least 7,000 people receive full HASA assistance, including critical housing assistance.

- ***30% Rent Cap***

While most people who live in public and/or supportive housing have their rental payments capped at 30% of their income, and while the federal Department of Housing and Urban Development guidelines require rental assistance recipients to contribute 30% of their income, many New York City residents with HIV/AIDS who live in subsidized housing pay far more of their incomes toward rent. This seeming irregularity dates to years ago when the New York State Office of Temporary and Disability Assistance mandated that HASA clients who receive shelter assistance and have other forms of income, such as SSI, SSDI, veteran's benefits or work, must monthly pay all but $344 of that income toward their rent. This means that these

individuals have less than $12 to spend daily on food, transportation, utilities, toiletries, clothing, laundry and other basic necessities.[14] By forcing these individuals to make impossible choices this policy inevitably results in evictions and subsequent demand for emergency shelter.[15] Though a bill to rectify this injustice was passed by both houses of the state legislature in 2010, it was vetoed by then-Governor Paterson, in response to pressure from then-Mayor Bloomberg.

- **Address Stigma**

  - ***Invest in a social marketing campaign to address HIV stigma***

Although some of the fear and scapegoating that were rampant in the early years of the epidemic have abated, PLWHA are still subject to stigmatizing behavior and attitudes. This maltreatment can occur in the context of work (23% of people report discomfort with an HIV-positive colleague), school (35% of parents express discomfort with HIV-positive teachers), home life (42% of people would not be comfortable with an HIV-positive roommate), and commercial interactions (51% of people distrust a meal prepared by an HIV-positive person).[16] This discomfort leads to concrete actions that deny PLWHA access enjoyed by others. HIV-positive young people have been, even quite recently, denied admission to school, excluded from school activities, or expelled.[17] People living with HIV may be ostracized by their families, lose their homes, or subjected to intimate partner violence, even murder.[18]

The consequences of HIV stigma extend beyond the isolation from family, peers, and the wider community that PLWHA experience.[19] Social rejection, disapproval, discrimination, and even the perception that stigma exists make an HIV-positive individual less likely to seek treatment, attend medical appointments, or adhere to a drug regimen.[20,21] PLWHA who are highly concerned with stigma are three times less likely to adhere to their drug regimens.[22] Stigma can also impede testing efforts.[23]

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[14] Senator Thomas Duane, *Senate Passes Legislation to Cap Rent Share At 30% of Income for Poor New Yorkers with HIV/AIDS,* April 27, 2010, available at http://www.nysenate.gov/press-release/senate-passes-legislation-cap-rent-share-30-income-poor-new-yorkers-hivaids

[15] New York Times, *Housing Subsidy Has High Profile Foe,* April 29, 2010, http://www.nytimes.com/2010/04/30/nyregion/30housing.html

[16] Kaiser Family Foundation, *2009 Survey of Americans on HIV/AIDS: Summary of Findings on the Domestic Epidemic,* April 2009, http://www.kff.org/kaiserpolls/upload/7889.pdf.

[17] Richard Parker., Peter Aggleton., et al, *HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action* (2002), 6, http://pdf.usaid.gov/pdf_docs/Pnacq832.pdf. *See also*: Eric Johnson, *HIV Positive Boy Denied Admission Sues Hershey School,* Reuters, http://www.reuters.com/article/2011/12/02/us-hershey-hiv-school-idUSTRE7B100Z20111202.

[18] Kaiser Family Foundation, *2009 Survey of Americans on HIV/AIDS: Summary of Findings on the Domestic Epidemic,* April 2009, http://www.kff.org/kaiserpolls/upload/7889.pdf.

[19] AVERT, *HIV and AIDS Discrimination and Stigma,* May 2010, http://www.avert.org/hiv-aids-stigma.htm.

[20] *Id.*

[21] Mary Ann Liebert Inc., *Social Stigma Concern and HIV Medical Adherence, AIDS Patient Care and STDs,* 2005, http://www.hawaii.edu/hivandaids/Social_ Stigma_Concerns_ and_HIV_ Medication _Adherence.pdf.

[22] *Id.* http://www.hawaii.edu/hivandaids/Social_Stigma_Concerns_and_HIV_Medication_Adherence.pdf.

People who fear negative fall-out from a positive HIV test often forego testing.[24] An alarming 16% of adults believe people would think less of them if they got tested for HIV.[25] Public education campaigns are essential to disrupting the ignorance and the stigma that continues to threaten our efforts to end AIDS.

- ***Invest in HIV stigma training for health care workers in city hospitals and clinics***

Ironically, people living with HIV/AIDS often encounter stigma at the doctor's office.[26] Healthcare professionals can be insensitive to concerns about stigma and may not follow appropriate procedures for maintaining patient confidentiality or may lack such procedures altogether. Healthcare providers' own fear of infection may also result in diminished care and services.[27] At its most extreme, discrimination by healthcare providers results in denial of treatment or access to health facilities.[28] High levels of experienced stigma correlate with low access to care, negative mental health outcomes, and suboptimal adherence to drug therapies.[29] By way of redress, health care professionals in Health and Hospitals Corporation facilities must receive training about HIV stigma in order to heighten awareness, and institutions must ensure that staff are aware of and adherent to patient privacy policies and procedures.

- **Ensure City Hospitals Provide Adequate HIV Prevention Services**

  - ***Ensure that Health and Hospitals Corporation (HHC) staff are trained to universally offer an HIV test, as per state law.***

As of September 2010, state law requires that virtually every individual between the ages of thirteen and sixty-four years who receives health services should be offered an HIV test.[30] HHC health care providers should be regularly trained in the law to ensure that opportunities for HIV diagnosis are not missed.

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[23] AVERT, *HIV and AIDS Discrimination and Stigma*, May 2010.
[24] U.S. Department of Health and Human Services Health Resources and Services Administration, *Stigma and Access to Care: Stigma and HIV/AIDS: A Review of the Literature*, May 2003, http://hab.hrsa.gov/publications/stigma/stigma_and_access_to_care.htm.
[25] Kaiser Family Foundation, *2009 Survey of Americans on HIV/AIDS: Summary of Findings on the Domestic Epidemic*, April 2009, http://www.kff.org/kaiserpolls/upload/7889.pdf.
[26] U.S. Department of Health and Human Services Health Resources and Services Administration, *Stigma and Access to Care: Stigma and HIV/AIDS: A Review of the Literature*, May 2003, http://hab.hrsa.gov/publications/stigma/stigma_and_access_to_care.htm.
[27] AVERT, *HIV and AIDS Discrimination and Stigma*, May 2010.
[28] *Id.*
[29] Jennifer N. Sayles, MD, MPH, *The Association of Stigma with Self-Reported Access to Medical Care and Antiretroviral Therapy Adherence in People Living with HIV/AIDS*, http://www.springerlink.com/content/71h5331844161x75/fulltext.pdf
[30] NY Pub. Health Law, Sec. 63.3.

- ***Ensure that HHC medical staff are trained to discuss and offer post-exposure prophylaxis (PEP), and invest in educational and promotional materials about PEP***

PEP is to HIV as Plan B is to pregnancy, and it is an essential prevention tool for those who fear they may have been exposed to HIV. In 2005, the U.S. Centers for Disease Control and Prevention issued guidelines for PEP usage.[31] Yet a 2011 study found that while 63% of men in gay bathhouses had reported unprotected sex in the past 90 days, just over one-third knew about PEP or PrEP[32] (discussed below). Primary care staff should be trained to discuss PEP with their patients so they are aware of its availability, and emergency medical personnel should all be fully aware of PEP, so it can be administered without delay or complication.

- ***Ensure that HHC doctors are routinely offering pre-exposure prophylaxis (PrEP) as appropriate***

PrEP is the latest tool in the HIV prevention arsenal. It is a regimen of a daily pill that is highly effective in preventing infection, generally appropriate for individuals considered to be at high risk of HIV infection. Yet uptake of PrEP has been far slower than anticipated. Data from more than half of retail pharmacies nationwide indicated that only 1,774 people filled prescriptions for Truvada (the indicated medication) for HIV prevention from January 2011 through March 2013, with women accounting for almost half of those individuals.[33] City doctors should be trained in PrEP guidelines to ensure that they are discussing this prevention option with appropriate patients.

- **Increase Funding for Essential Supportive Services**

While support services remain elemental to keeping PLWHA in care, and to reducing risk behaviors, these funds are often the first on the chopping block when HIV funding is tight. PLWHA and their allies have had to fight year after recent year to maintain funding for local case management and nutrition services. Further, the Ryan White Program experienced nearly across-the-board cuts in FY13, resulting nationally in the loss of $143.5 million in funding.[34] The City failed to make up this shortfall. The HIV Health and Human Services Planning Council of New York, which distributes federal Ryan White funds locally, found

[31] Dawn Smith, *Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services*, U.S. Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, January 21, 2005 (54), 1-20, http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm

[32] Mehta, et.al., *Awareness of Post-Exposure HIV Prophylaxis in High-Risk Men Who Have Sex With Men in New York City*, Sexually Transmitted Infections 2011;87:344-348, http://sti.bmj.com/content/87/4/344.short.

[33] New York Times, *A Resisted Pill to Prevent HIV*, December 30, 2013, http://www.nytimes.com/2013/12/31/health/a-resisted-pill-to-prevent-hiv.html

[34] Carl Schmid for The AIDS Institute, *Funding the Ryan White Program: Now and in the Future*¸ Powerpoint presentation, United States Conference on AIDS, New Orleans, LA, September 10, 2013.

that as a result of these cuts there has been an 18.5% reduction in the local Ryan White caseload overall, with 75% of surveyed grantees experiencing a reduction in the number of clients they can serve.[35]

- ***Food and nutrition programs***

On November 1, 2013 cuts to the Supplemental Nutrition Assistance Program went into effect, impacting families across the nation, and across the city. This cut puts a financial strain on those already most strapped to meet their basic needs. The Ryan White cuts are causing further pain, with nearly 61,000 fewer meals (a 10% reduction) predicted to be served to local PLWHA this year.[36]

Yet good nutrition is a salient concern for PLWHA. By slowing disease progression and reducing complications associated with HIV treatment, nutrition services have the potential to be a cost-saving measure. In fact, while in-home food delivery services average approximately $1,500 per person, per year[37], the average hospital stay for a PLWHA in 2007 was over 13 days, at an average cost of over $2,000 a day in 2006.[38,39] Further, food programs and nutritional counseling can greatly improve physiological health outcomes and treatment compliance. In fact, one study in Atlanta found that food insufficiency was a better predictor of non-adherence to HIV treatment than years of education, employment status, income, housing, depression, social support, and non-alcohol substance use.[40] Consequently, food services have the potential to reduce significantly the need for expensive medical services, and to retain people in care.

- ***Mental health services***

Mental health services took a similar hit with the cuts to Ryan White funds, with a projected 12% reduction in mental health encounters.[41] Yet, PLWHA with mental health conditions experience elevated rates of HIV-related morbidity and mortality.[42]

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[35] HIV Health and Human Services Planning Council of New York, *Service Impacts of the FY2013 Ryan White Budget Reductions*, October 31, 2013. Available at http://www.nyhiv.org/pdfs/planning_council/Service%20Impacts%20of%20the%20FY2013%20Reductions.pdf

[36] HIV Planning Council of New York, *Service Impacts of the FY2013Ryan White Budget Reductions.*

[37] Food Security for Seniors and Persons with Disabilities Project, "A Look at Household Food Security for Seniors and Persons with Disabilities in Seattle's Low-income Housing," February 2008, 17, http://www.solid-ground.org/AboutUs/Publications/Documents/FoodSecurityForSeniors-PersonsW-Disabilities.pdf.

[38] Baligh R. Yehia et. al., "Inpatient Health Services Utilization among HIV-Infected Adult Patients in Care 2002-2007," *Journal of Acquired Immune Deficiency Syndrome* 53.3 (2010):397-404, http://www.ncbi.nlm.nih.gov/pmc /articles/PMC2831106/pdf/nihms153873.pdf.

[39] Kelly A. Gebo, et al., "Contemporary Costs of HIV Healthcare in the HAART Era," *AIDS* 24.17 (2010): 2708.

[40] Seth C. Kalichman et al., "Health and Treatment Implications of Food Insufficiency Among People Living with HIV/AIDS, Atlanta, Georgia," *Journal of Urban Health* 87.4 (2010), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2900577/ pdf/11524_2010_Article_9446.pdf.

[41] HIV Planning Council of New York, *Service Impacts of the FY2013Ryan White Budget Reductions.*

[42] Stephanie Bouis et al., "An Integrated, Multidimensional Treatment Model for Individuals Living with HIV, Mental Illness, and Substance Abuse," *Health and Social Work* 32.4 (2007): 268, http://www.dhs.wisconsin.gov/aids-hiv/PDFdocuments /CMResManual0309/Section%203-%20Mental%20Health/Mental%20Health,%20Substance %20Abuse%20and%20HIV%20 Treatment%20Model%20article.pdf.

This may be due in part to the fact that mental illness reduces an individual's ability to mount an effective immune response against the virus,[43] increases the likelihood of engaging in risk behaviors as a way to mitigate stress, and negatively affects motivation to alter risk behaviors or take other positive steps to increase quality of life.[44,45] Further, the particularly strong correlation between HIV and domestic violence[46] amplifies the need for and benefits of mental health care for HIV-positive women. Mental health interventions have been shown to be effective in this context. In a 2004 study of women with a history of sexual violence, those who participated in an intervention examining their sexual histories and linking these experiences to their current decision-making were 150% more likely to reduce risky sexual behaviors (such as unprotected sex) than women who did not receive the intervention.[47]

Mental health interventions have the demonstrated potential to increase treatment adherence and to help reduce risk-taking behaviors, thereby slowing transmission of HIV. In a study published in 2007, HIV-positive participants in a mental health treatment program achieved decreases in the use of drugs and alcohol, as well as improvements in mental health.[48] Individuals in the study also demonstrated improved capacity to manage their disease progression, including increased usage of both antiretroviral and appropriate psychiatric medications.[49] One study found that, overall, clinics that employed a mental health professional had fewer missed appointments, and other research found that substance abuse services had a similar effect.[50]

- ***Legal services (including legal services for housing and immigration)***

Legal services suffered the largest projected loss within the various service areas as a result of the cut to Ryan White funds, facing a 15% reduction, equal to nearly 4,500 fewer legal service hours provided to PLWHA.[51] Further, Ryan White funds for legal services are severely restricted and do not cover many essential areas of legal practice, including housing and immigration. Yet provision of legal services has been shown to have distinctly positive effects, including improved individual health, on the lives of people with HIV/AIDS. A 2002 study reviewed the need for, availability of, and impact of legal services for PLWHA and determined that "[Legal] services improve access to health care, housing, and support services through education,

[43] Dalmida, "Spirituality, Mental Health, Physical Health," 187.
[44] Heidi E. Hutton et al., "Depression and HIV Risk Behaviors among Patients in a Sexually Transmitted Disease Clinic," *American Journal of Psychiatry* 161 (2004): 912-14, http://ajp.psychiatryonline.org/data /Journals/AJP/3760/912.pdf.
45 Ibid.
[46] U.S. Dept. of Health and Human Services, HRSA CARE Action, "Intimate Partner Violence," (September 2009): 1, http://hab.hrsa.gov/newspublications/careactionnewsletter/sept2009.pdf.
47 Wyatt, "The Efficacy of an Integrated Risk Reduction Intervention," 459-60.
[48] Bouis, "An Integrated, Multidimensional Treatment Model," 268.
[49] Ibid., 277.
[50] Elizabeth Horstmann et al., "Retaining HIV-Infected Patients in Care: Where Are We? Where Do We Go from Here?," *Clinical Infectious Diseases* 50 (2010): 755, http://cid.oxfordjournals.org/content/50/5/752.full.pdf.
[51] HIV Planning Council of New York, *Service Impacts of the FY2013Ryan White Budget Reductions.*

empowerment, and enforcement of legal rights."[52] It found that these services were especially effective in guaranteeing access to and the maintenance of health care services[53] primarily by addressing issues that would otherwise compete with these priorities.[54] A 2007 survey by LegalHealth in New York City assessed the impact of legal services on individuals with cancer. Of the respondents, 83% said legal assistance helped reduce their stress, and 51% reported that it had a positive effect on their financial situation.[55]

The need for access to legal services is arguably even more urgent for people living with HIV, given the strong association between poverty and HIV status, the historical stigma associated with the disease,[56] the heightened risk of discrimination in employment, housing, and other contexts, and the negative health outcomes associated with stress and anxiety for PLWHA.[57] Studies show that individuals perceiving higher levels of cumulative negative life burden and stress-inducing circumstances have viral loads twice as high as those with lower levels of negative life burden, controlling for adherence to HAART.[58] Furthermore, higher levels of stress are associated with faster disease progression.[59] The resolution of legal cases, including housing, immigration, and benefits matters, is essential, therefore, in diminishing stressors and ensuring stability.

- ***Services for foster care and runaway youth***

The City must ensure that youth in foster care receive essential HIV prevention programming. These services must be given by trained staff and with sensitivity to the range of sexual orientations and gender identities of young people in the foster care system. Efforts to improve prevention programming also must work to tackle the institutionalization of sexphobia, homophobia, transphobia and heterocentrism in that system.[60]

Homeless youth, many of whom have aged out of foster care, are at high risk for HIV infection. While it is estimated that the rate of HIV among homeless youth is 5%, one study reported a rate as high as 17% among street youth in San Francisco. This alarmingly high rate is likely attributable, at least in part, to the prevalence of survival

[52] John-Manuel Androite & R. Bradley Sears, *Ensuring Access to Health Care for People with HIV/AIDS: The Role of Legal Services (A Ryan White CARE Act Policy Study)* (April 2000): 6.
[53] Ibid., 12.
[54] Ibid., 11.
[55] David I. Schulman et al., "Public Health Legal Services: A New Vision," *Georgetown Journal on Poverty Law and Policy*, 15(2008): 729, http://lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=1219&context=lsfp.
[56] Ronda B. Goldfein and Sarah R. Schalman-Bergen, "From the Streets of Philadelphia: The AIDS Law Project of Pennsylvania's How-To Primer on Mitigating Health Disparities," *Temple Law Review* 82 (2010): 1208-13.
[57] Adam W. Carrico et al., "Psychoneuroimmunology and HIV," in *Comprehensive Textbook of AIDS Psychiatry*, ed. Mary Ann Cohen and Jack M. Gorman (New York: Oxford University Press, 2008), 28.
[58] Ibid.
[59] Ibid.
[60] The Center for HIV Law and Policy, *Sexual Health Advocacy for Youth in Foster Care and Detention Facilities, Legal and Policy Outline*, available at http://www.hivlawandpolicy.org/resources/sexual-health-advocacy-youth-foster-care-and-detention-facilities-legal-and-policy-outline

sex, reported as high as 43% in one study of street youth in Los Angeles.[61] Accordingly, it is imperative that the City boost its investment in programs that offer prevention services, housing, and other supports to this vulnerable population.

- **HIV and Intimate Partner Violence**

  - ***Fund services that address the connection between HIV and intimate partner violence.***

Regardless of gender, half of HIV-positive patients who seek treatment have been affected by intimate partner violence (IPV) or childhood sexual abuse.[62] But despite the co-incidence of IPV and HIV, fewer than 10 percent of HIV providers routinely screen for IPV.[63] Because past or current IPV increases transmission risks and negatively affects health outcomes,[64] improved awareness of IPV can facilitate HIV prevention and risk reduction, as well as improve health outcomes for PLWHA.[65]

Accordingly, HHC should incorporate IPV screening into all healthcare and social work encounters with PLWHA, and transgendered individuals, who are additionally at high risk, and ensure that staff are trained to provide necessary referrals, resources, counseling, or strategies for safety planning. Further, the City must continue to invest in legal and social services for survivors of intimate partner violence. Finally, the City must increase the supply of temporary and permanent housing for survivors of IPV, and ensure that housing is available for survivors regardless of their family status, sexual orientation, gender, gender-identity and/or HIV/AIDS diagnosis.

[61] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Understanding the Healthcare Needs of Homeless Youth*, available at: http://bphc.hrsa.gov/policiesregulations/policies/pal200110.html
[62] U.S Dept. of Health and Human Services, HRSA CARE Action, *Intimate Partner Violence*, (September 2009): 1, http://hab.hrsa.gov/newspublications/careactionnewsletter/sept2009.pdf.
[63] U.S Dept. of Health and Human Services, *Intimate Partner Violence*, 1.
[64] Karen A. McDonnell, et. al, "Abuse, HIV Status and Health-Related Quality of Life among a Sample of HIV Positive and HIV Negative Low Income Women," *Quality of Life Research* 14.4 (May 2005): 945-957.
[65] U.S Dept. of Health and Human Services, HRSA CARE Action, *Intimate Partner Violence*, (September 2009), http://hab.hrsa.gov/newspublications/careactionnewsletter/sept2009.pdf.