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Elaine Johnson (SAMSHA) [Substance Abuse and Mental Health Services Administration] - November 19, 1993

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[3] From: Ben Merrill 11/17/93 8:22AM (1261 bytes: 22 ln)
To: Kristine Gebbie, Steve Lee
cc: Carlos Velez, Ben Merrill
Subject: SAMSA STRATEGIC FLAWS
---------- Message Contents ----------

On Friday, November 19th at 3:00 pm you meet with Elaine Johnson and Myron Belfer to discuss the SAMHSA Strategic Plan for HIV/AIDS.

Carlos called this morning to report the following serious flaws in the plan:

1) Although the plan acknowledges that 62% of reported US cases are of gay men, the plan fails to address any strategic planning to reach this community. It says that its highest priority will be women's and children's communities.

2) Although the plan SAYS it is culturally sensitive, it is silent with regard to gay men and women of color.

3) The plan is absolutely silent on needle exchange as a way of stopping the spread of the disease through those means and it does not acknowledge a substance abuse problem among gay and lesbian adults nor does it address the substantially recognized substance abuse problem within gay adolescent communities.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Substance Abuse and Mental
Health Services Administration
Rockville MD 20857

OCT 7 1993

to Carlos
Bess / fyi -
& comments

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator
750 17th Street, N.W., Suite 10-60
Washington, D.C. 20503

Dear Ms. Gebbie:

Please find enclosed a copy of the Substance Abuse and Mental Health Services Administration AIDS Strategic Plan. This document provides a framework for AIDS planning and program implementation in SAMHSA, and for our collaborative work with other agencies. A copy of this Plan was previously provided to Mr. Warren Buckingham for his use in developing planning documents for your office.

I look forward to the opportunity to meet with you to discuss AIDS related activities in SAMHSA.

Sincerely yours,

Elaine M. Johnson

Elaine M. Johnson, Ph.D.
Acting Administrator

Enclosure

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

STRATEGIC PLAN FOR HIV/AIDS

Submitted by Elaine M. Johnson, Ph.D.
Acting Administrator
Substance Abuse and Mental Health Services Administration

U.S. Public Health Service
U.S. Department of Health and Human Services
August, 1993

C:AIDSPLAN.818

Table of Contents

I. INTRODUCTION

"Strong positive leadership is needed to overcome entrenched ignorance and fear, as well as to rectify the serious flaws and deficits in care and prevention strategies. We are witnessing an expanding national disaster, and there is greater urgency than ever to mobilize against the scourge of AIDS."

AIDS: An Expanding Tragedy
Final Report of the National Commission on AIDS
June, 1993

The Substance Abuse and Mental Health Services Administration (SAMHSA) plays a critical role in providing federal leadership in the response to the HIV epidemic. Following the establishment of SAMHSA in the fall of 1992, the agency recognized that HIV/AIDS would be a priority issue because of its significant impact on populations targeted for prevention efforts and services supported by SAMHSA. An agency-wide strategic planning process for addressing HIV/AIDS was initiated with the formation of SAMHSA. On January 6, 1993, SAMHSA issued an interim report on the development of the strategic plan. This report outlined SAMHSA's history, programs and issues relevant to the development of the plan. This report had the benefit of input from a significant number of groups involved with the national response to the HIV/AIDS epidemic. The report set forth the timeline and the process for developing the final plan. This document is a product of that process.

SAMHSA recognizes that the high risk populations they serve are not only in need of individual treatment services, but also an array of preventive interventions and other actions. The epidemic has disproportionately affected individuals with or at risk for developing mental illness and addictive problems. In addition to these populations, SAMHSA provides services to Gay and lesbian individuals, adolescents, and criminal justice populations. These are populations not only disproportionately affected by HIV/AIDS, they have unique issues regarding access to services as well as prevention programs. Accordingly, SAMHSA recognizes a special responsibility to address forthrightly and comprehensively the needs for HIV prevention and treatment activities in its current programs and to delineate plans for the future based on need and evolving knowledge.

This plan examines the trajectory of the HIV/AIDS epidemic in relation to key target populations served by SAMHSA. It describes SAMHSA's organizational and programmatic responses to the epidemic and articulates nine principles which guide SAMHSA's

ongoing HIV-related efforts. Conclusions are made concerning the epidemic and SAMHSA's role in leading the response to the epidemic.

II. THE TRAJECTORY OF THE AIDS EPIDEMIC

HIV will continue to spread in the foreseeable future. Every year an additional 40,000 to 80,000 people become infected with the HIV. It is projected that by January 1995 120,000 people will be living with AIDS. The total number of AIDS cases reported to the CDC as of March 31, 1993 was 289,320 (CDC, 1993b). By the end of 1994 the number of cases may reach 390,000. Approximately 1 million individuals are carrying the AIDS virus. Of that 1 million, only about one half are aware that they are carrying the virus.

Geographically, the epidemic is becoming more diffuse. While cities on both coasts continue to have the highest number of AIDS cases, there is an increasing number of cases in the central region of the country.

Gay and Bisexual Men

- AIDS continues to affect Gay and bisexual men more than any other group. Approximately 62% of the AIDS cases reported since the beginning of the epidemic are among men who have sex with men. While HIV transmission among older Gay men has dropped sharply, a great number of younger Gay men are not taking precautions to decrease chances of transmission.

Injecting Drug Users

- The second largest infected group are individuals who are IV drug users or who have sex with IV drug users. This group accounts for approximately 32% of the cases.

Non-Injecting Drug Users

- While injecting drug use has always been associated with HIV transmission, other drug and alcohol use is playing an increasingly important role. Use of crack cocaine, cocaine, opiates and alcohol are linked with high risk sexual behavior for many populations. Thus, exchanging sex for drugs, and impairment of judgment resulting from alcohol and drug use may result in HIV transmission.

Racial and Ethnic Minority Populations

- AIDS continues to affect racial and ethnic minority populations disproportionately. Approximately half of all reported AIDS cases are in racial and ethnic minority populations. While African Americans comprise about 12% of the population, they represent about 30% of AIDS cases (CDC, 1993). Hispanics comprise about 9% of the population, but about 16% of AIDS cases (CDC, 1993b). Other racial and ethnic minority populations, including Asian Americans,

Native Americans and Alaskan Natives include a significant number of AIDS cases.

Women, Adolescents, and Children

- The second decade of the epidemic is characterized by an increasing number of infected women, African Americans, children and adolescents. Heterosexual transmission will be on the rise. CDC projects that the percentage of infected cases who are African-Americans will increase from 30% to 43%; that the percentage who are women will rise from 10% to 17%; and that the percentage who are teens will rise from 1% to 3% The heterosexual transmission of AIDS cases has already increased dramatically -- by 17% in 1992 alone (CDC, 1993b).

Costs

- The economic cost of the HIV epidemic to society is significant and will likely become much greater. The societal cost of HIV/AIDS was estimated to be $66.5 billion in 1991. While that cost is lower than many other diseases (e.g. cancer cost $72.5 billion in 1985; injuries cost $157.6 billion in 1985), it is significant both in magnitude of expenditure and continuing escalation (Farnham, P.G. 1992). Of the $66.5 billion, 83.6% ($55.6 billion) comprise indirect costs and its programs address the needs associated with the indirect costs of HIV/AIDS. Indirect costs are likely to continue to comprise a disproportionate amount of the total HIV/AIDS costs.

Support

- People with AIDS are living longer. Consequently, AIDS is assuming the character of a chronic illness. The need for support for people living with AIDS as a chronic illness, will present an ongoing challenge to the substance abuse and mental health systems. There is a critical need to develop and strengthen infrastructures that will support psychological and social programs for people infected with and affected by HIV/AIDS. Substance abuse and mental health treatment services must be further integrated within the generic health care and public health systems. SAMHSA advocates innovative programs to maximize the continued functioning of individuals living with HIV/AIDS, whether they be children, adolescents, young adults, or older individuals.

A. Gay and Bisexual Populations

SAMHSA programs address the needs of Gay and bisexual men.

Gay and bisexual men have been and continue to be the group most affected by the AIDS crisis. Men who have sex with men constitute about 62% of all AIDS cases reported to date. While studies of Gay men in urban centers indicate that the rate of infection has consistently decreased in recent years, this is not the case for all Gay men. Young Gay men appear to be at considerable risk as they are reported to continue to engage in high risk behavior. The statistics on Gay and bisexual populations include those on people of color. Substance abusing Gay and bisexual men are one of the groups at highest risk for HIV infection. The use of alcohol and other drugs contribute significantly to high risk behaviors among Gay men and bisexuals.

B. Injecting Drug Users

SAMHSA is the primary federal agency supporting services for injecting drug users. It funds a significant number of drug use prevention and HIV prevention programs for drug users.

Approximately 32 percent of all adult/adolescent AIDS cases are related to injecting drug use (National Commission on AIDS, July 1991). As of March 31, 1993 (CDC, 1993b), the number of reported AIDS cases where the mode of transmission was either drug injecting behavior or men having sex with men who inject drugs was 83,819. There are additional cases of transmission related to IV drug use not included in this calculation, e.g. women who become infected through sex with IV drug using men and transmission to infants from HIV positive drug using mothers.

There are about one million IV drug users in the United States. Of these, anywhere from 70% to 90% share injection equipment (NIDA, 1991). Seroprevalence studies of injecting drug users yield significant differences of HIV infection in different geographical areas. The rates of HIV infection are highest (typically 50% or greater) in the New York City area; intermediate (15-35%) in other urban areas such as Baltimore and San Francisco; and low (5% or less) in some western cities (e.g. Los Angeles) (National Research Council, 1989)

There is evidence that in recent years HIV seroprevalence has stabilized in some communities where injecting drug use is widespread, such as New York City and San Francisco, and increased in other areas, such as Louisiana and Maryland (National Research Council 1990). The disproportionate impact of AIDS on minorities remains unabated. Of all males reporting injecting drug use as their only risk factor for HIV transmission, 47.6 % are African American and 32 % are Hispanic

(National Research Council, 1990). As of 1988, African-Americans were 2.8 times as likely to contract AIDS as whites; and Hispanics were 2.7 times as likely to contract AIDS as whites (Friedman et.al., 1992).

In recent years it has become apparent that drugs other than intravenous drugs play a significant role in HIV transmission. In particular, the use of crack cocaine has become a risk factor. People under its influence are more likely to engage in unsafe sexual practices. Crack is reported to have the effect of heightening sexual pleasure for males and is often marketed by promoting this claim. Some females who use crack report exchanging sexual favors for the drug (National Research Council, 1990). Surveys have identified individuals with HIV whose only high risk behavior appeared to be sexual activity associated with crack (National Research Council, 1990). Alcohol use may also lead to diminished self control, which may result in high risk sexual behavior that might not occur otherwise.

Many drug users are reported to be poly-drug users rather than single drug users. Drugs such as smokable methamphetamine ("ice"), benzodiazepines, amphetamines, alcohol and marijuana are associated with HIV transmission. Injecting anabolic steroids and growth hormones, as is sometimes done by body builders, athletes and adolescents, may involve the sharing of needles, which places users at risk for HIV transmission.

Injecting drug use is the predominant risk factor associated with 70% of pediatric AIDS cases. In these cases the mothers are injecting drug users themselves or they have sex with injecting drug users (National Commission on AIDS, July 1991).

C. Women

Women receive unprecedented emphasis in both treatment and preventive programming through SAMHSA's Residential Program for Women and the Pregnant and Post-partum Women and Their Infants Programs.

The HIV epidemic is spreading faster among women than any other group. While they represented 8% of all AIDS cases in February 1989, women represented 11% of the cases in March 1993 (CDC, 1993b). The increase of women with AIDS between 1991 and 1992 was an extraordinary 17%, compared to 4% for men (CDC, 1993b).

While the primary mode of transmission for women continues to be injecting drug use, (71% of the cases, National Commission on AIDS, July, 1992), sexual contact with an injecting drug user has increasingly become a mode of transmission (21% of cases) (CDC, 1993b). Women are at higher risk than men of having sex with HIV infected heterosexual partners because most IV drug users are

men; almost all hemophiliacs are men and some HIV-infected men are bisexual. In addition, transmission from males to females is more likely than transmission from females to males. One study found that women were 17.5 times more likely to become infected by having sex with an HIV positive male partner than men were by having sex with a HIV positive female partner (Johnson, 1992).

Seventy-three percent of women with AIDS are African-American or Hispanic and live in large metropolitan areas on the Atlantic coast. The average age of diagnosis for AIDS is between 30 and 34 years old. Most are between the ages of 15 and 44, the child-bearing years. Of the one million persons infected with HIV in the United States, it is estimated that about 80,000 are women in the childbearing years. Pediatric AIDS is closely linked to women with AIDS. Approximately 25%-35% of HIV positive women transmit the virus to their children during pregnancy or delivery.

In 1990, AIDS became the sixth leading cause of death for women in the U.S. in the childbearing years. For African-American women, HIV infection was the leading cause of death in five out of thirty states. For young Hispanic women, HIV infection was the leading cause of death in two of 12 states (Selik, R.M., Chu, S.Y, Buehler, J.W., 1993).

In AIDS research, as in other areas of health research, women have been significantly under-represented. As a result, less is known about the progression of HIV infection in women and the manner in which HIV-related drugs affect them. A number of initiatives have been developed by the Public Health Service to ameliorate this situation. The revised CDC definition of AIDS is more sensitive to the presentation of HIV infection and AIDS in women and includes cervical cancer. Increased efforts to include women in clinical trials, and a heightening of general awareness about women's issues through the establishment of several panels, study groups and conferences, has already taken place.

D. Children

SAMHSA, through its support of the CSAP and its High Risk Youth program, offers unique access to many high risk children and youth for HIV prevention initiatives.

As of March 31, 1993, 4,480 children under the age of 13 have been reported as having AIDS (CDC, 1993). As the prevalence of HIV infection rises in women, it will likely rise in infants. In 1990 it was estimated that 80% of pediatric AIDS cases were attributable to maternal transmission. Of infants with AIDS, 60% were born to injecting drug using mothers and 14% were born to mothers who had sex with injecting drug users (U.S. Public Health Service, 1992). It is estimated that between 1,500 and 2,100 HIV infected babies will be born annually.

E. Adolescents

SAMHSA's programs that address the needs of adolescents are broad in scope, ranging from prevention efforts for high risk youth to treatment programs targeted to adolescents including incarcerated and non-incarcerated juvenile offenders.

Adolescents account for less than 1% of reported AIDS cases (a total of 1,167 as of March 31, 1993); however the number of cases is rising rapidly. Between 1991 and 1992, AIDS cases among teens ages 13 to 19 transmitted heterosexually increased by 65% (CDC, 1993a). The number of adolescents infected with the virus is unknown. About 20% of AIDS cases fall into the 20-29 year old age group. With an average 10 year incubation period, the majority of these individuals was likely infected during their teenage years. Thus, it is imperative that teenagers be targeted with aggressive prevention initiatives.

A substantial percentage of cases among adolescent boys and young men are related to homosexual contact. Of male teen cases, 37% were related to homosexual contact. Of the 20-24 year old cases 68% were related to homosexual contact. The highest risk category for male adolescents is exposure to contaminated blood and blood products, accounting for 44% of the cases among 13-19 year olds. This high rate of cases is explained somewhat by hemophilia, which is almost exclusively seen in males (National Research Council, 1990).

Teenagers typically engage in sexual behavior that puts them at risk for HIV infection. Survey data from 1988 indicates that 86% of adolescent males and 77% of adolescent females have had sexual intercourse by the age of 20 (National Center for Health Statistics, 1988). In some communities, the average age may be as low as 12 years old.

Despite increases in condom use among teens, a considerable proportion of sexually active teens still do not use condoms at all, or do not use them consistently. Furthermore, a significant number of sexually active teens have multiple partners (National Research Council, 1990).

Another high risk behavior commonly found among adolescents is the use of alcohol and other drugs. The 1992 survey of high school seniors indicates that about 41% of all seniors had used illicit drugs at least once; 1.2% had used heroin; and 6.1% had used cocaine (OSAP, 1991). Needle sharing, when injecting drugs, is a high risk behavior for HIV transmission. Use of alcohol and non-injection drugs reduces inhibitions and may lead to unprotected sexual behaviors, which may thereby place adolescents at risk for HIV transmission.

Some research indicates that teens who use drugs are more likely to engage in sexual activity than those who do not. The reverse also appears to be true. One study indicated that teens are more likely to initiate drug or alcohol use prior to sexual behavior rather than sexual behavior prior to drug use (National Research Council, 1990).

Some sub-populations of teens are at particularly high risk for HIV infection. Among these groups are runaway and homeless youth and delinquent and incarcerated youth. Many runaway and homeless youth consider themselves to be Gay or lesbian. Of the one million teenagers that run away from home each year, about 187,500 are involved in illegal behaviors that are related to high risk behaviors for HIV infection. These behaviors include drug use, and prostitution. Anonymous HIV testing at one runaway home in New York City revealed a seroprevalence rate of 7% (OSAP, 1991).

Teenagers involved with the criminal justice system appear more likely than others to be sexually active, involved with drugs and aware of HIV infection. In one study, among 417 incarcerated youth, ages 15 to 17, 90 percent were sexually active -- many with multiple partners and few with condom use. In another study of 113 teenagers in detention, 13% reported drug injection, compared with four percent of high school students (OSAP, 1991).

As with other subgroups of the population, adolescents of color are disproportionately affected by the AIDS epidemic. While African Americans make up only 15.3 percent of the teenage population, they represent 36 percent of AIDS cases. Hispanics represent 10 percent of the teenage population and 18% of the AIDS cases (National Research Council, 1990).

F. The Seriously Mentally Ill

SAMHSA's Center for Mental Health Services is responsible for the funding and guidance of virtually all federal programs addressing the needs of people with serious mental illness.

Research is presently addressing issues related to HIV and serious mental illness. Serious mental illness may increase the risk of HIV infection by contributing to indiscriminate sexual behavior and drug use during times of decompensation (Empfield et.al., 1993). Psychiatric diagnosis and substance abuse are reported to be related (Cournos et.al. 1991). The HIV seroprevalence rate for people with serious mental illness is estimated to be between 5% and 7%, which is significantly higher than the seroprevalence rate for people without mental illness (Meyer et.al. 1992). A survey of 85 state and county mental hospitals from 37 states revealed that most have some in-patients

with HIV infection (Harvey 1989). Seriously mentally ill women and men appear to have about the same rate of infection.

People with mental illness may be particularly hard to reach to provide prevention and treatment services for many reasons. They may be homeless, unaffected from social services and they may have no contact with any medical or health service system. Because of their mental illness, they may have difficulty accessing support systems.

G. Racial and Ethnic Minority Populations

SAMHSA-funded programs are tailored to meet the needs of the racial and ethnic minority populations they serve.

Although African-Americans and Hispanics make up about 21% of the population, they account for about half of all AIDS cases to date (CDC, 1993b). Similarly, a disproportionate representation of minorities is evident among women infected with the virus, children and teenagers. CDC projects that over-representation of minority populations will continue to rise in coming years (Newsweek, June 21, 1993).

H. AIDS as a Chronic Illness

As a services agency, SAMHSA is dedicated to the long term support of individuals with substance abuse and mental illness, including those infected and affected by HIV.

The time from infection to diagnosis with AIDS is quite variable. An average length of time is reported to be 10 years, but for drug abusers an earlier onset due to the existence of co-morbid diseases and a general non-HIV compromise of the immune system is reported. As treatments continue to be available for various opportunistic infections and as prophylaxis, the life expectancy for a person with HIV -- will likely grow. There will be an increasing number of individuals in America living with HIV and AIDS in years to come.

Some commentators have noted that, as we enter the second decade of the epidemic, we enter a decade in which AIDS will be viewed as a chronic condition, rather than as a time-limited epidemic (Fee & Fox 1992). People living with HIV or AIDS will seek to live their lives in as routine a manner as possible with, accommodations to their needs and to the ups and downs of the disease. While the emphasis on scientific research and medical treatment will continue, attention to facilitating the continuation of routine daily life, such as holding a job and continuing a social life, will grow.

The majority of AIDS cases occur among people who are in the midst of their most productive working years -- age 25 to 44. Employees with HIV/AIDS are in the workplace as never before. About two-thirds of large businesses and one in 10 small businesses have employees with HIV/AIDS (National Leadership Coalition on AIDS, 1993). Developing accommodations and supports for people living with HIV and AIDS will be a priority in the second decade of the disease.

III. SAMHSA RESPONDS TO AIDS

A. Office on AIDS

In the fall of 1992, shortly after the Substance Abuse and Mental Health Services Administration was established, the position of Associate Administrator for AIDS and the Office on AIDS were created. This position is located in the Office of the SAMHSA Administrator.

The Office on AIDS is responsible for coordination, advocacy, planning and policy functions within SAMHSA. The Office will formulate policy recommendations concerning HIV/AIDS in the areas of substance abuse and mental health on an ongoing basis. This policy development is done in concert with the Department of Health and Human Services and with the President's AIDS Coordinator. The Associate Administrator works with the three Center Offices on AIDS (see below) to ensure that HIV/AIDS concerns are appropriately addressed in all of SAMHSA's efforts. In addition, the Office serves as a liaison with the SAMHSA Women's Committee and other Federal and non-Federal agencies on programs and issues of mutual concern.

SAMHSA's Office on AIDS, in conjunction with the Center AIDS Offices, is engaged in an ongoing process to further develop HIV-related programs within SAMHSA through:

- A comprehensive and continuing assessment of unmet HIV-related needs of the populations targeted for the Agency's services. These populations include alcohol and other drug abusers, those at risk for alcohol and other drug abuse, those with mental health needs, and the seriously mentally ill.
- Analysis of those unmet needs.
- Recommendations for program development and enhancement of SAMHSA programs.

During the course of developing this strategic plan for HIV/AIDS, SAMHSA's Office on AIDS examined several areas of knowledge and practice related to HIV/AIDS. The Office, with outside consultation, reviewed the literature and the knowledge base in several areas relevant to HIV/AIDS services for SAMHSA programs. One area of examination stood out as being in particular need of continued examination: successful strategies and models for services integration. The literature appears to lag considerably behind practice, and yet this is an area where information dissemination will be critical for effective service delivery in future years.

Services integration is an ongoing challenge in virtually every area of health and human services today. It is particularly challenging for individuals with multiple, complex needs, such as many persons living with HIV/AIDS (e.g., injecting drug users with HIV, people with serious mental illness and HIV). In addition, many people targeted for SAMHSA's services have little ongoing access to any kind of health delivery system. Providing multiple services through one point of entry into the system is of great importance for those with multiple needs who are not part of the system. Interaction with a substance abuse or mental health treatment program may be an individual's only health care related contact. It is important to take advantage of that contact as a way to initiate services to address other needs of the individual.

The linkages initiative of the Center for Substance Abuse Treatment (CSAT) has funded programs to link up a range of health and health related services (e.g. substance abuse treatment, HIV/AIDS counseling and testing, primary health care, mental health services, family counseling and case management.) While many of these programs are reported to be exemplary, little information appears about them in the literature. The SAMHSA Office on AIDS and CSAT will commission a paper on exemplary strategies and models for services integration. This work will be an important contribution to the knowledge base and the field as efforts to integrate services continue.

B. Center Offices on AIDS

Each of the three Centers that comprise SAMHSA has an Office on AIDS and an AIDS Director/Coordinator who meet regularly with the SAMHSA Associate Administrator on AIDS.These Directors/Coordinators and their offices in the respective Centers have the following functions: 1) ensure that HIV/AIDS issues are addressed in all of their funded programs; 2) ensure integration of HIV-related activities among programs within the Center and with those of other Centers, as well as with other Federal and private organizations; and 3) work with SAMHSA's Office on AIDS to share information, coordinate initiatives and make recommendations for improvements to policies and programs.

C. SAMHSA AIDS Work Group

SAMHSA will have an AIDS Work Group that will function under the aegis of the SAMHSA National Advisory Council and will be composed of selected representatives from this Council and from the three Center Councils. It will be the forum for discussion of HIV/AIDS planning and implementation efforts of SAMHSA and its Centers. The SAMHSA Committee for Women's Services will be represented. Representatives will have HIV/AIDS experience in at

least one of the following areas: prevention, training of health care personnel, delivery of treatment services to persons with HIV/AIDS and advocacy for the needs of persons with HIV/AIDS. Consultants to the SAMHSA AIDS Work Group will be chosen on an ad hoc basis by the Work Group members to provide expertise on particular issues as they arise. The Associate Administrator for the SAMHSA Office on AIDS will serve as the Executive Secretary of the Work Group. The AIDS Director/Coordinator from each Center will serve as an ex-officio member of the Work Group.

D. Interagency Collaboration

Through the Office on AIDS, SAMHSA coordinates its efforts with other Federal agencies and with non-Federal agencies. SAMHSA has worked with NIH, NIH OAR, HRSA, NIDA, NIAAA, NIMH, SSA, AHCPR and HUD to share information and coordinate initiatives. SAMHSA works in conjunction with the Public Health Service and the Health and Human Services offices to coordinate agency-wide efforts. SAMHSA will participate with any future mechanisms developed which are intended to coordinate and improve the Federal response to HIV/AIDS.

E. Public/Private Partnerships

SAMHSA is actively developing public/private partnerships in several areas. All SAMHSA grants require the grantees to collaborate and coordinate with public and private entities as a part of the grant program and/or as a condition of grant award.

The Center for Substance Abuse Prevention (CSAP) has a project entitled "Partnerships for Permanent Resources" in which they are facilitating partnerships with private, public and philanthropic agencies at the national, state and local levels. The project is developing a conceptual framework, a resource inventory, a demonstration resource partnership project and expansions of existing communication, education, training and technical assistance networks. A September 1992 meeting was followed by the development of ongoing relationships with the many Foundations that participated. A continuing dialogue is focusing on potential initiatives in the areas of prenatal care, substance abuse treatment for women, and primary, secondary, and tertiary prevention of HIV/AIDS.

Many foundations have already initiated HIV/AIDS programs. Others utilize the CSAP initiative as a means of forming linkages and filling gaps as well as a way to identify areas for public-private joint sponsorship of specific programs. CSAP is currently designing a program with a private health foundation and another HHS agency to address the needs of children in communities with high seroprevalence of HIV/AIDS.

IV. SAMHSA PROGRAM GOALS

The Substance Abuse and Mental Health Services Administration has a unique responsibility to effectively address the HIV/AIDS epidemic in the most stigmatized and least accessible populations. It recognizes a responsibility to provide a broad range of interventions to those living with HIV/AIDS and those affected by HIV/AIDS who have no other resources to support their mental health and well being. The program goals for SAMHSA are responsive to these mandates.

SAMHSA is seeking to set goals that are measurable and consistent with the standards set for Healthy People 2000. To achieve this end, SAMHSA is committed to working with other Federal agencies in a supportive and complementary fashion. The demonstration and communication programs supported by SAMHSA are a crucial link in knowledge development and transfer of findings from research into practice. In the area of substance abuse and mental health prevention and treatment services SAMHSA accepts the challenge to lead.

SAMHSA HIV/AIDS programming is an integral part of many ongoing programs, as cited in this report. However, only three programs are recognized in SAMHSA's formal budget as identified AIDS related programs. These programs are the CMHS AIDS Training Program, and CSAT's Outreach and Linkage Programs. While many of the goals outlined below can be achieved incrementally in the context of ongoing program activities, significant additional funds will be needed to accelerate the ultimate achievement of the goals that are enumerated.

SAMHSA HIV/AIDS Program Goals are as follows:

1. Increase the effectiveness and responsiveness of the substance abuse and mental health treatment community to HIV/AIDS.

Staff working with people who abuse alcohol and other drugs, people with mental health problems and people with serious mental illness will receive training in HIV/AIDS.

SAMHSA's programs target people who use and are at risk for using alcohol and other drugs as well as those with mental health needs. As a whole, this population is at greater risk for HIV infection than the population at large. Staff that work with these individuals -- substance abuse counselors, social workers, psychologists, physicians including psychiatrists, and nurses -- need training to recognize and address HIV/AIDS. Staff training to understand HIV and AIDS in order to provide prevention and treatment services as well as risk reduction information and support for behavioral changes is an ongoing priority for SAMHSA.

o By 1995 every substance abuse provider should have available state of the art training materials that are culturally appropriate, readily understood, and provide the broad scope of knowledge to allow the effective utilization of the range of resources needed to help injecting and non-injecting drug users with or at risk for HIV/AIDS. These materials will be complemented by technical assistance.

Program Activities:

The Center for Substance Abuse Treatment (CSAT) funds training programs for substance abuse counselors, other health care professionals and primary care providers to meet the demand for knowledgeable, skilled and competent treatment personnel to deliver HIV/AIDS, TB and substance abuse services through entry level training, professional training, and primary care training.

All CSAT Treatment Improvement Protocols (TIPs) stress the importance of screening and treatment for HIV/AIDS, TB, STDs and other infectious diseases. A CSAT TIP that focuses exclusively on screening and treatment of infectious disease among substance abusers is soon to be published.

CSAP's National Training System, which reaches a broad range of providers, trainees and trainers has a track record of effective educational programs. The National Training System now provides for HIV/AIDS prevention training in its network. CSAP's Perinatal Resource Center's Community Team Training has included HIV/AIDS in their initial community assessment, and the Center training programs have addressed how to approach the epidemic in their communities. Technical assistance is provided to help accomplish the plans. Similar training has been provided on a State-wide level.

o By 1995 ensure that there is a core of adequately trained and supported mental health providers to meet the needs of those with HIV/AIDS and those affected by HIV/AIDS.

Program Activities:

The Center for Mental Health Services (CMHS) is supporting 12 grants and 2 contracts for the education of mental health care providers to address the neuropsychiatric and the psychosocial aspects of HIV/AIDS. Two contracts are in the second year and 4 of the 12 grants are in the third year of the three year project periods. The other 8 grants were awarded September 30, 1992 for a 3 year period. Trainees

include the traditional mental health care provider groups, psychiatrists, psychiatric nurses, psychiatric social workers, psychologists, and marriage and family counselors, as well as medical students, primary care providers, and non-traditional mental health care provider groups, such as clergy, police and alternative health care site providers. The CMHS program is the mental health training equivalent of the HRSA Education and Training Centers program for primary care physicians, nurses, dentists, and pharmacists.

2. Increase access to HIV/AIDS treatment for substance abusers.

Alcohol and other drug treatment will include HIV/AIDS services.

Injecting drug users and their sex partners are at high risk for becoming HIV infected. Non-injecting drug users are also at risk due to the sexual behavior that is more likely to occur under the influence of AOD, or as the result of trading sex for drugs. Those who are infected need to be able to access medical treatment and learn how to manage their infection. Those who think they might be infected need to be tested. Those who are not infected need to know how to protect themselves from infection.

o By 1995 the Federally supported treatment capacity for injecting drug users should reach 90% of need and by the Year 2000 drug treatment on demand should be a reality for all.

Program Activities:

CSAT, through the AIDS Outreach for Substance Abusers Program, funds community outreach programs that seek out injecting drug users, other high risk drug abusers and their sexual partners in order to: 1) encourage them to obtain treatment for drug addiction and obtain medical diagnostic services for HIV/AIDS, STDs and tuberculosis; and 2) provide these individuals with information, skills, and other means to avoid those behaviors which increase the risk of acquiring or transmitting HIV/AIDS, STDs and tuberculosis.

The Substance Abuse Prevention and Treatment (SAPT) Block Grant statutorily mandates the provision of HIV/AIDS related services in states where the reported incidence of AIDS is greater than 10/100,000.

All CSAT programs are especially relevant to those with and at risk for HIV infection. These include special populations in identified programs for the Rural and Culturally Distinct, the Residential Treatment of

Pregnant/Postpartum Women, the Residential Treatment of Women and Children Program, and Critical Populations.

All CSAT programs have specific HIV/AIDS components, including the Capacity Expansion Program, Comprehensive Treatment Programs, and technical assistance programs.

3. Limit the spread of HIV/AIDS in vulnerable populations.

Outreach services will be expanded to reduce the risk for HIV infection among people who are substance abusers and people who have mental illness who are not currently in treatment or not seeking treatment for substance abuse or mental illness.

It is unlikely that there will be enough drug treatment slots for those who need them any time in the foreseeable future. Currently, only about 10%-25% of injecting drug users are in drug treatment at any one time. It is not uncommon for drug users who go through treatment to relapse, continuing drug use for a period of time until they go back into treatment again. Thus, for both the injecting drug users who are not in treatment and those who are, outreach to prevent HIV infection is critical. Currently, there are far too few outreach workers to even come close to reaching the estimated 850,000 injecting drug users not in treatment.

The need for outreach services to educate non-injecting and injecting drug users (and their sex partners) about HIV infection and provide training and reinforcement in risk reduction behaviors is ongoing. Outreach services must also be provided to families of injecting drug users.

Through outreach activities not specifically related to entrance into treatment, CSAT, CMHS and CSAP can provide essential clinical services and prevention messages to populations not otherwise reached by current programs. These programs will seek individuals where they are and offer sustained involvement. CSAT will maintain its outreach activities that have entrance to treatment as a goal.

Priority will be given in prevention initiatives to women and adolescents.

Women and adolescents are two high risk groups for HIV infection. In recent years the HIV infection rate has increased notably in women. Women are most at risk of becoming infected with the HIV from heterosexual intercourse. The rate of HIV infection in women is closely related to the rate of HIV infection in newborns.

Adolescence is a period of exploration that often involves sexual activity and drug and alcohol use -- behaviors that may increase

the risk of HIV transmission. Adolescents who are runaways or involved with the juvenile justice system are at an increasingly high risk. Prevention initiatives targeted toward these distinctive groups will be a priority for SAMHSA.

Strategies must be developed to allow at risk populations to help define their own messages and vehicles for dissemination of these messages. Successful prevention interventions for alcohol and drug use need to be appreciated and evaluated for their relevance to HIV/AIDS prevention efforts.

All SAMHSA programs will be culturally and ethnically appropriate and relevant to the intended beneficiaries.

Many SAMHSA programs are targeted to groups of individuals with significant cultural and ethnic minority representation. A demonstrated sensitivity to these populations in designing and implementing programs is critical to their success.

o By 1995 specific educational and communications programs will be available to more effectively reach people with serious mental illness, the homeless, runaway youth and other adolescents, the criminal justice populations, women, and other high risk groups throughout the country.

o By 2000 the full range of prevention and treatment services to meet the special needs of adolescents, and women will be available in communities. The extension of current models of prevention and intervention will need to reach more communities and those who are isolated from the mainstream.

Program Activities:

All new CSAT Program Announcements and Requests for Applications require applicants to provide screening and treatment arrangements for persons with AIDS. The Criminal Justice Grant Program supports projects which provide substance abuse treatment to individuals incarcerated in prisons, jails or community correctional settings and to those who are pre-trial releasees, post-trial releasees, probationers, parolees or those on supervised release.

CSAP's High Risk Youth Program and Pregnant and Postpartum Women and Their Infants Program seek to integrate HIV/AIDS prevention services under their mandates. CSAP is currently developing a number of initiatives to insure the integration of HIV/AIDS prevention services with alcohol and other drug prevention services. These initiatives include (a) requiring all Community Partnership grantees to include active planning and coordination of HIV/AIDS prevention

in their communities; (b) requiring all proposals to include HIV/AIDS outreach and risk reduction demonstration activities; and (c) incorporating an AIDS prevention component into prevention enhancement protocols, state technical assistance plans, and state prevention plans.

The CMHS is a resource on mental health related issues for CSAP, CSAT and other Federal agencies, especially with regards to providing risk reduction counseling and HIV/AIDS related treatment for their target populations.

4. Coordinate primary health care and substance abuse services to facilitate treatment and prevention of HIV/AIDS.

Programs funded by SAMHSA will be encouraged to collaborate in the development or enhancement of a health and/or health-related infrastructure in local communities where they operate.

A key problem in many communities with high rates of drug abuse, HIV and mental illness is that there is a lack of a health or health-related infrastructure. Clinics may not be located in the communities. Programs may be run by organizations that depend on funds from outside of the community, so that when those funds expire, the program and the organization itself may cease to exist.

When a structure does exist, it is not always viewed as a part of the community and may not be readily accessed. Community members may feel disenfranchised from its services. Historical distrust of public health officials among racial and ethnic minority populations and experiences of discrimination are likely to play a role. People who need services may feel that they will be judged or reported for an illegal activity, such as drug use, if they seek services. They may feel that additional stigmas will result.

Programs funded by SAMHSA will demonstrate how they can contribute to (or help to create) the health or health-related infrastructure within the community they serve. Such programs will demonstrate strategies for community involvement and collaboration with other Federal and non-Federal resources. They will encourage demonstrations of how to continue services when the federal funding ceases.

Initiatives intended to integrate services will be developed, promoted, and funded.

Linkage programs in SAMHSA are important initiatives in the ongoing efforts to ensure the integration of mental health and

substance abuse services in general, including HIV/AIDS services, in communities. SAMHSA will seek to extend the linkages concept to other programs in order to further promote client-friendly services. SAMHSA will pursue new strategies for integrating prevention and treatment programs with mental health services. Given the fragile status of mental health and substance abuse services and prevention activities, a continued emphasis and visibility for this special class of health-related activities is essential.

o By 1995 SAMHSA supported substance abuse focussed, community-based programs will be fully coordinated with the Ryan-White community coalitions and the health promotion and prevention coalitions sponsored by CDC.

Program Activities:

CSAT funds two linkages programs. One is funded in conjunction with HRSA. This program awards grants to substance abuse programs to develop comprehensive care demonstrations that link AIDS programs to the mental health and the primary health care systems. The goal is to ensure availability, accessibility and affordability of comprehensive high-quality treatment for individuals infected with HIV who are in need of primary health care and ADM services. The array of services includes screening and treatment for infectious disease, HIV/AIDS counseling, primary health care, outpatient addiction counseling, mental health services, family/collateral counseling, case management and program evaluation.

The other CSAT linkage program supports projects that link and integrate the delivery of primary health care, mental health and substance abuse services for individuals with alcohol and drug problems. Projects offer a comprehensive continuum of care including HIV/AIDS counseling and mental health services. CSAT will offer models for substance abuse treatment as the focal point of "one stop shopping" for substance abusing populations.

CSAP has a long and extensive history of supporting AOD prevention grants and cooperative agreements. These programs exist in every State, the District of Columbia and many territories. CSAP uniquely fosters its programs in a family focused community based manner. The more than 250 Community Partnership Grants exemplify this philosophy and support community-wide efforts to raise the visibility of HIV/AIDS prevention efforts.

5. Provide supportive services to those living with or affected by HIV/AIDS.

Serving persons infected and affected by HIV/AIDS will be a priority in the provision of mental health services.

SAMHSA will strive to develop and promote strategies, programs and initiatives that will result in meeting the mental health needs of all persons living with HIV and AIDS and all persons otherwise affected and infected with HIV and AIDS.

People at risk for and people living with HIV or AIDS experience a broad range of psychosocial needs and require assistance in coping with the psychological impact. The possibility of early death, stigmatization, and a variety of losses are some of the difficult issues that they confront. People with HIV wonder how long and to what degree will they be able to continue their daily set of activities. They worry about money -- particularly being able to support themselves should they lose their jobs or become unable to work. A recent survey of people with AIDS (National Association of People with AIDS 1992) noted that 32.5% of the respondents noted a need for financial assistance to obtain services such as mental health services, transportation, employment and housing. Nearly half of the respondents noted that they have problems carrying out everyday activities such as going to work, working in the yard or taking a bus. Many indicated that they had trouble obtaining the help they need.

In addition, research and clinical experience have yielded increasing evidence that HIV may infect the brain, resulting in central nervous system impairment and neuropsychiatric complications, including AIDS Dementia Complex. Adjustment disorders, depression, mood disorders, including organic mood disorder, are other possible complications.

Volunteer and professional health care providers, other caretakers and loved ones for the HIV infected population also experience anxiety, grief, losses and, ultimately, burn-out. The cost, both in human and financial resources, is staggering and often preventable. It is important to provide preventive mental health services not only for families, children and adolescents at risk for HIV/AIDS and substance abuse, but for the legion of providers and caretakers. It is clear that there are considerable mental health needs of people infected and affected by HIV and AIDS. Gay people and racial and ethnic minorities are disproportionately affected by HIV and AIDS and may experience ongoing loss and cathartic grief. Specialized programs to address the needs of these populations require ongoing development.

o By 1995, supportive mental health counselling should be available to all those in need.

Program Activities:

Virtually all CMHS-funded projects come in contact with individuals affected by HIV/AIDS in some manner. The Center AIDS program promotes an awareness of HIV/AIDS among all CMHS grantees and serves as a technical resource to grantees when needs arise. The CMHS program goals for HIV/AIDS include: the development of models of primary prevention to reduce the transmission of HIV, risk reduction programming in people with serious mental illness and children with serious emotional disturbance, the development of increasingly sophisticated and relevant pre and post test and risk reduction counselling strategies, the development of comprehensive systems of mental health services for people at risk for contracting the HIV, people living with HIV/AIDS and the many special populations served by CMHS programs, and the training of a diverse provider network. The implementation of this goal depends on the details of health care reform implementation.

V. CONCLUSIONS

Based on an assessment of the current and future state of the HIV epidemic and an analysis of the overall role that SAMHSA should play in responding to the epidemic, SAMHSA offers the following conclusions.

1. There is no indication that the spread of HIV will slow or end in the foreseeable future.

It is unlikely that a cure will be found in the immediate future. We expect there will be a great need to further expand treatment and prevention services well into the next century. People currently at risk are likely to continue to be at risk.

2. From the perspective of the delivery of health care services, as HIV/AIDS makes a transition from becoming a time-limited plague, like cholera, to becoming a chronic condition, like cancer, new challenges will rise.

While SAMHSA will continue to focus on treatment and prevention, we will increase our efforts directed toward those living with this virus, with this disease. Continued efforts to integrate HIV/AIDS services into existing service delivery systems, such as substance abuse treatment and mental health services will be required. The mental health care needs of those affected and infected with HIV/AIDS is expected to dramatically increase as more people with HIV/AIDS live longer.

3. No matter how much service development there is in primary care, SAMHSA will continue to have crucial access to those outside the primary health care system.

Many of the people SAMHSA serves are not linked into the generic health care system. Even with overhaul of the health care system, it is unlikely that all individuals, especially those with needs related to drug use and mental illness, will be adequately reached by the system. Because of its track record in working with these hard-to-reach populations, SAMHSA will continue to have unique access to certain at risk populations.

4. Addressing the needs of at risk young women, children and adolescents must be done in the context of their vulnerability to substance use and abuse as well as the men who exercise control over their lives.

Programs designed for women with HIV or at risk for HIV must be developed in relation to the environment in which they live.

Understanding the context of women, children, and adolescents in relation to the communities in which they live and the significant men in their lives is critical to the development of effective intervention.

5. No matter how effective and comprehensive our health care system becomes, inadequate attention to the behaviors that lead to HIV transmission will enable continued progression of the epidemic.

HIV is transmitted by behaviors that can be modified. The fact that the epidemic can virtually be halted if people change their behaviors continues to demonstrate the best known way to end the epidemic. Aggressive intervention to reduce the risks of transmission is warranted. No degree of effective health care can substitute for behavior changes that reduce the risks of transmission. SAMHSA's mental health and substance abuse programs embrace this goal. SAMHSA will provide to the vast provider network and the mentally ill and substance abusing populations the critical information necessary to support behavior change, and provide insight and direction to other PHS agencies regarding behavior change.

6. In the face of concern over the delayed development of effective treatments for AIDS and vaccines, we must redouble our efforts to provide effective prevention interventions which will decrease the transmission of HIV.

Prevention continues to be the most effective way to respond to the HIV epidemic. With effective drug therapies and vaccines likely only in the distant future, we must give increased attention to effective prevention initiatives. CSAP and CMHS's prevention efforts are unique in their target audiences and strategies.

7. SAMHSA has a critical role to play in the ongoing development and implementation of services and prevention strategies to curtail the HIV/AIDS epidemic.

Access to populations uniquely affected by the AIDS epidemic, the ability to capitalize on expertise in mental health and substance abuse treatment, and the knowledge of working intimately at the community level on prevention strategies are important ingredients that will enhance SAMHSA's effectiveness. In certain areas, the work of SAMHSA is sufficiently circumscribed and meaningful in and of itself to represent programming deserving of ongoing and increased support. In other areas, it is evident that close collaboration is the only means to accomplish the goal of effective programming. The newly forming SAMHSA AIDS Work

Group, in conjunction with the SAMHSA Office on AIDS, will continue to work to assess the needs of those targeted to receive SAMHSA funded services and develop a plan for addressing those needs.

8. The SAMHSA strategic plan for AIDS is dependent on the initiative of the SAMHSA Centers within the mandate for SAMHSA to take the lead in the provision of services strategies to treat and prevent substance abuse and mental illness.

As evidenced in this report, the Centers are continuing to develop specialized and collaborative initiatives. This is being done with very limited financial resources. The areas of greatest significance are in training, outreach, access to the most isolated and disenfranchised populations outside traditional primary health care systems, and development of specific preventive interventions for high risk groups.

9. Effective working relationships with constituency groups are essential to the implementation of SAMHSA's strategic plan for HIV/AIDS.

A dialogue with constituency groups representing the needs of people with HIV and AIDS began during the development of this strategic plan. With the development of this initial plan, and with the organizational development that has taken place, the groundwork for an enhanced and sustained dialogue with constituency groups has been established. The planning and dialogue will be ongoing processes.

10. SAMHSA has the commitment, expertise and human resources to continue the battle to overcome the effects of the HIV epidemic, to improve the lives of those affected by HIV and AIDS, and to lead in the development of new strategies for treatment and prevention.

As a partner with other federal agencies in leading the nation's response to the HIV epidemic, SAMHSA assumes a critical role as part of its mandate to address addiction and mental illness in our nation. SAMHSA's unique role complements and strengthens the nation's ongoing effort to end the HIV epidemic.

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