

# NASTAD MONOGRAPH

---

*a publication of the National Alliance of State and Territorial AIDS Directors*

## *Linking HIV/AIDS Services with Substance Abuse and Mental Health Programs*

**January 2000**

National Alliance of State and Territorial AIDS Directors  
444 North Capitol Street, NW, Suite 339  
Washington, DC 20001  
(202) 434-8090 – Phone  
(202) 434-8092 – Fax  
nastad@nastad.org – Email  
www.nastad.org

Julie M. Scofield, Executive Director  
Wendy Craytor, Chair

# Table of Contents

Executive Summary	
Introduction.....	1
Treatment and Service Issues Associated with the Linkage of HIV Services with Mental Health and Substance Abuse Programs.....	3
Issues of Multiple Diagnoses: A Layered Challenge.....	3
Challenges to Linking Services .....	4
Activities to Link HIV Services with Substance Abuse and Mental Health Programs.....	7
State Level Coordination of Programs.....	7
Challenges of Program Linkages.....	8
State Highlight: Indiana .....	11
State Highlight: Maryland.....	16
Conclusion.....	20
References.....	22
Acknowledgements.....	25

# *National Alliance of State and Territorial AIDS Directors*

## **NASTAD Monograph Executive Summary**

### *Linking HIV/AIDS Services with Substance Abuse and Mental Health Programs*

Substance abuse and mental illness often are confounding factors in the health of people living with HIV/AIDS. The interaction of substance abuse behaviors, mental illness, and an HIV/AIDS diagnosis is complicated and dynamic. A combination of these diagnoses has been found to complicate the clinical and social/behavioral needs of clients with HIV/AIDS.

Generally, public and private health care systems have not been structured to manage these disorders simultaneously. Public systems of care, in particular, have been structured to function in isolation from other systems. Parallel systems of health care emerge as a result of enacted federal and state health policies and categorical funding streams, often evolving in divergent directions. Public health policies and the structure of related programs must change to be more responsive to the complicated needs of persons living with HIV/AIDS.

As part of a cooperative agreement with the HIV/AIDS Bureau (HAB), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, the National Alliance of State and Territorial AIDS Directors (NASTAD) developed this monograph on *Linking HIV Services with Substance Abuse and Mental Health Programs*. Based on a survey of state AIDS directors in March 1999, an extensive literature review, and interviews with state AIDS directors, this monograph describes the challenges to improving program linkages between HIV/AIDS, substance abuse, and mental health services for persons with a combination of these diagnoses. It also describes the strategies that Indiana and Maryland have implemented to more effectively integrate services for persons living with HIV/AIDS.

States have been confronted with various challenges in linking HIV/AIDS, substance abuse, and mental health services including:

- the lack of awareness about the interactive complications of the combined diagnoses,
- the lack of available and appropriately trained providers,
- social stigma for the patient and the provider who may be reluctant to extend appropriate services, and
- the need to coordinate public financing more effectively.

In contrast, states like Indiana and Maryland have used a range of strategies to improve the integration of HIV health care services with substance abuse and mental health services. This monograph highlights two Indiana programs, the “Indiana Integration of Care Project (IICP)” and the “AIDS Substance Abuse Program (ASAP)” and the “Women in Methadone Program” in Maryland.

Indiana launched a partnership among the state Division of HIV/STD, the state Division of Mental Health, and Indiana University. The “Integration of Care Project” was designed to improve the capacity of community mental health centers to manage an expanding HIV-infected population by training mental health practitioners about HIV disease and the HIV primary care system.

Although the “Integration of Care Project” was terminated, a firm relationship had been established among the participating agencies. In response to receiving an HIV Set-Aside from the state Substance Abuse Prevention and Treatment Block Grant, the Indiana Division of HIV/STD was able to continue to coordinate relationships among HIV and substance abuse providers. They also were able to involve “free standing” substance abuse treatment facilities as well as those located within the community mental health care system.

The Maryland AIDS Administration worked with the state Substance Abuse and Mental Health Administration to achieve more flexible program rules for patient participation. The implementation of training for mental health and substance abuse treatment practitioners and innovative payment systems allowed for more efficient and appropriate client services.

As the federal government continues to devolve responsibility for the administration of programs and requires accountability for the achievement of measurable health outcomes from jurisdictions, states are being challenged to streamline and integrate service delivery. This monograph highlights the activities and strategies of two states to accomplish these goals.

# Introduction

Substance abuse and mental illness are often confounding factors in the health of people living with HIV disease. The interaction of substance abuse, mental illness, and an HIV diagnosis is complicated and dynamic. These diagnoses have been found to interact at clinical as well as social or behavioral levels. Coping with an HIV diagnosis impacts substance abuse behaviors and the diagnosis itself may clinically advance psychopathology. Severe mental illness involves behaviors that put persons at great risk for HIV acquisition, and substance use is endemic in populations with severe mental illness (Sullivan et al., 1999). Substance abuse increases a person's risk for HIV acquisition and also reduces inhibitions associated with transmitting HIV to others (Reback and Grella, 1999).

Generally, public and private health care systems in the United States are not positioned to handle multiple diagnoses. Parallel systems of health care emerge as a result of enacted health policies. These systems seldom interact and are structured to function in isolation. Such systems develop specific infrastructures and frequently evolve in divergent directions, thus sealing system inflexibility and reducing system responsiveness to the needs of people with complex diagnoses such as HIV, substance abuse, and mental illness.

Collaboration at federal, state, and local levels to assure local prevention and treatment services for persons with multiple diagnoses remains a challenge for policy makers, service providers, activists, and the individuals themselves. State level collaboration among HIV, substance abuse, and mental health agencies has been one of the vehicles for achieving needed integration of prevention and care services. Such efforts at the state level are necessary to create a climate for local coordination of services, yet are often insufficient to assure a collaborative service delivery system. Public health policies, as well as the structure of health care delivery, must change so that services can be responsive to complicated client needs.

In this monograph, the National Alliance of State and Territorial AIDS Directors (NASTAD) describes recent efforts to link HIV services with substance abuse and mental health programs. *Linking HIV/AIDS Services with Substance Abuse and Mental Health Programs* is a compilation of findings from the literature and a 1999 study among state and territorial AIDS directors and key informant interviews with the AIDS directors in Indiana and Maryland about each state's efforts to coordinate HIV, substance abuse and mental health programs. This monograph is the first of a series that is produced by NASTAD and supported by the HIV/AIDS Bureau (HAB), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.

There are major challenges to the creation of a linked system of HIV, substance abuse and mental health programs. These challenges include:

- A lack of awareness about the interactive complications of multiple diagnoses within an integrated health system;
- The challenge of serving persons with substance abuse behaviors and/or mental health illness independent of the interactive nature of multiple diagnoses; and

- The need for more responsive program paradigms, practices, and public policies, as expressed through public financing as well as regulatory policies.

The program approaches described in this monograph have established links among substance abuse, mental health, HIV services programs, some more successful than others. Linkage of services through primary care, substance abuse treatment, and case management settings are most often reported. Strategies enhancing program coordination necessarily include:

- Intensive and ongoing staff training;
- Shared data and communication activities, such as patient rounds or common charting; and
- Direct attention to the resolution of structural differences between and among programs.

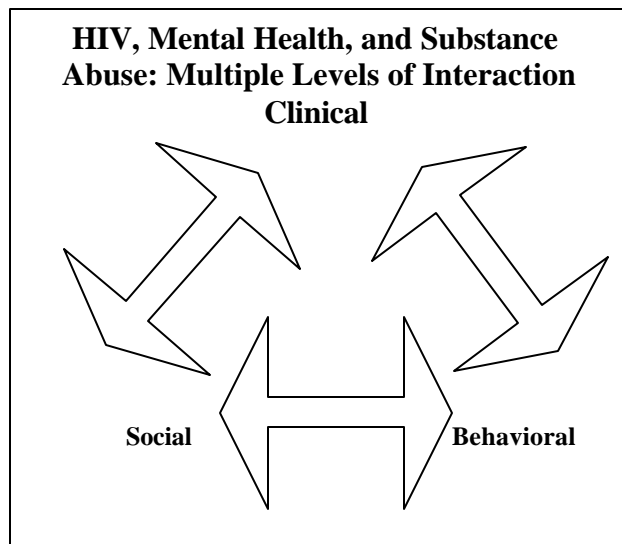
# Treatment and Service Issues Associated with Linking HIV Services with Substance Abuse and Mental Health Programs

## Issues of Multiple Disorders: A Layered Challenge

Federal, state, and local health officials increasingly are collaborating to improve the coordination of services for persons with these multiple diagnoses. Recognition of these multiple diagnoses and their relationship to poverty, racism, and gender inequality are paramount to the development of comprehensive health policy and service delivery. One clinical diagnosis may predispose the probability of another. Moreover, there are behavioral aspects of substance abuse and mental illness that increase the risk for acquiring HIV. All three conditions disproportionately impact persons with limited income and who often have no or limited access to medical care.

The interaction of substance abuse and HIV involves more than HIV infection among persons who inject drugs. There is a documented association between drug use and high-risk sexual behavior (Reback and Grella, 1999; Barrett et al., 1995; and Mulry et al., 1994). Moreover, the use of chemical substances has been noted as a coping mechanism following an HIV diagnosis. Substance abusing behaviors in persons with HIV have an impact upon mental illness as the continued abuse increases the probability of psychopathology (Hymel and Greenberg, 1998). Persons with HIV are more likely than the general population to suffer from a psychiatric disorder. These disorders tend to increase in severity with each stage of HIV infection (Wolcott et al., 1986 and Wright and Shuff, 1995). Though mental illness increases with the advancement of HIV disease, an HIV diagnosis is often preceded by severe mental illness (SMI) and not the converse (Sullivan et al., 1999). Rates of HIV infection among the severely mentally ill are between 4 and 25% (Satriano, 1999 and Sullivan et al., 1999). Moreover, the use of drugs and alcohol in populations with severe mental illness is endemic (Sullivan et al., 1999).

Poverty has a tremendous impact on the ability of persons to obtain adequate primary and ancillary health care services and is a shared issue for HIV, substance abuse, and mental health programs. Even prior to the HIV epidemic, approximately 50% of serious physical disorders among seriously mentally ill persons who were receiving psychiatric treatment were undetected (Sullivan et al., 1999; McCarrick et al., 1986; and Barnes et al., 1983). On a behavioral level,



accessing primary health care for substance abuse may be a challenge due to the disorganizing behavioral effects of addiction. In addition, providers in the medical community may be uncomfortable treating these patients (Herman and Gourevitch, 1997).

## **Challenges to Linking Services**

**Table 1: Challenges to Linking HIV Services with Substance Abuse and Mental Health Programs**

- Lack of problem recognition
- Stigma (patient and provider)
- Program paradigm and practice
- Relationships between and among programs
- Public financing
- Regulatory policy

Jurisdictions working to link HIV services with substance abuse and mental health programs have identified many challenges to effective program linkages. These factors are listed in Table 1 and were gathered from journal reviews, unpublished program reports, and findings from a NASTAD survey of state and territorial AIDS directors (NASTAD,

1999). The survey focused on collaborative state agency activities among HIV, substance abuse, and mental health programs.

## **Problem Recognition**

It is unclear why HIV, substance abuse treatment, and mental health providers tend not to recognize the shared health issues of persons with all three diagnoses. Possible explanations include, but are not limited to:

- Lack of program data describing populations,
- Program isolation,
- The absence of professional training to recognize the complex of diagnoses, or
- Program practices requiring the prioritization of one diagnosis to the exclusion of all others.

In addition, the construction of multiple and separate health systems based on public financing may reinforce the disregard of other health issues.

## **Stigma**

Stigma, as a challenge to program linkage, affects the client, providers, and the community. Stigma may undermine a client's motivation to access appropriate services from particular providers due to perceptions about the provider or service in the community. Examples might include stigmas associated with HIV, sexuality, drug use, or mental illness; and may be exacerbated by urban or rural location, cultural perception, or age (Huba and Brown, 1998; Kwasnik et al., 1997; Sullivan et al., 1999; and Levin, 1993).

Providers may express reluctance to address complex, multiple diagnoses such as HIV, substance abuse and mental illness. Stigma affecting the availability or quality of services also may be expressed through public and professional attitudes (Wright and Shuff, 1995 and Levin, 1993).

### **Program Paradigm and Practice**

Perhaps one of the most significant challenges to linking substance abuse, mental health, and HIV service programs is the difference among program paradigms and practices. The inflexibility of programs and the inability of providers to see beyond a particular service approach, practice, or paradigm to accommodate additional social or physiological challenges in their treatment population are frequently cited in the literature. A related challenge is the reality that professional attitudes can become narrowly focused over time, reinforcing the segregation of health care professionals (Kwasnik et al., 1997; Wright and Shuff, 1995; and Levin, 1993). Such system “tunnel vision” means that providers are less aware of other services for their clients and may feel unequipped to manage their multiple and specialized needs. Examples of program paradigm and practice issues include views about the patient-provider relationship, principles of continuity of care, and patient responsibility.

### **Public Financing**

Poverty is a confounding factor for persons living with HIV who engage in substance abuse behaviors and/or have mental health disorders. A significant portion of the population living with HIV, substance abuse, and mental illness with low incomes are served by publicly financed health, substance abuse treatment, and mental health systems. A history of inadequate and inconsistent public funding for substance abuse and mental health programs and a more recent systemic shift to managed health care models for public service delivery has provided the impetus to coordinate across programs. However, the ability to coordinate service delivery in a managed care context provides limited cost benefits since the integration of care produces less billable time due to the need for rounds, treatment planning, negotiation of treatment modality, and other activities (Kwasnik et al., 1997). Inadequate insurance coverage for mental health disorders (Wright and Shuff, 1995) and inadequate financing for substance abuse services generally (Levin, 1993) complicates linkage efforts.

Within this context of fiscal austerity, HIV/AIDS programs are financing the majority of programs linking HIV, substance abuse and mental health services. A 1999 survey conducted among state and territorial AIDS directors found that 58% of state HIV programs initiate the collaborative effort among state HIV, substance abuse, and mental health agencies, and 45% of the state HIV programs fund the collaborative efforts (NASTAD, 1999). Programs often were funded from HIV resources for a limited period of time.

Lack of funding may lead programs not to take responsibility for shared patients or clients. This is complicated by the fact that there are no clear indicators as to which program has primary responsibility for coordination (NASTAD, 1999 and Sullivan et al., 1999). Moreover, lack of leadership to link HIV, substance abuse and mental health programs may be a deliberate

decision. In a publicly funded treatment program, there may be little incentive to take responsibility for all of the patient's needs.

### **Regulatory Policy**

Sharing patient information as part of an integrated or linked program system raises issues about patient confidentiality. For example, Herman and Gourevitch (1997) reported that in a primary care structure, the client-doctor relationship was sacred; whereas in an integrated system with substance abuse, the sharing of client information was critical to the overall system of integration.

There may be confusion among providers about the meaning of specific confidentiality regulations. In a recent study among mental health care outpatient programs in New York, providers indicated that confidentiality laws that apply to persons living with HIV frequently may be misunderstood (Satriano et. al., 1999). Findings among state AIDS directors also indicated a lack of clarity about the parameters of confidentiality and their effect on program coordination. It was unclear which among the HIV, substance abuse or mental health regulations posed a problem for program linkage, or whether the coordination issue involved a clash among program practices and norms (NASTAD, 1999).

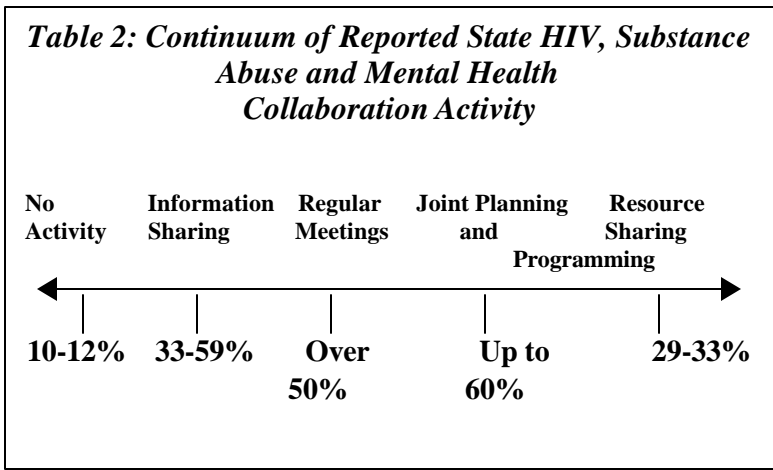
# Activities to Link HIV Services with Substance Abuse and Mental Health Programs

## State Level Coordination of Programs

Since 1981 states have been the recipients of federal block grants for substance abuse and mental health programs (Jacobsen and McGuire, 1996). Under a block grant financing system, states have the responsibility and the opportunity to determine the manner in which substance abuse and mental health programs are funded and managed. Linking state HIV programs with state substance abuse treatment and mental health programs within a block grant funding mechanism can be advantageous to the provision of services for persons with multiple diagnoses.

States also have an important role in the determination of policy and regulation of programs. States have identified “special populations” to facilitate service access. The interpretation of federal regulations and local program regulations can enhance or prevent cross-program linkage. Moreover, state procurement practices affect the ability of state agencies to pool funds for interdisciplinary programs.

State and territorial AIDS directors reported conducting many types of collaborative activities among HIV, substance abuse, and mental health agencies ranging from information sharing to fiscal coordination (NASTAD, 1999). Table 2 describes the range of collaborative activities among state mental health, substance abuse, and HIV agencies as reported. These activities set the context for local efforts to link HIV services with substance abuse and mental health programs.

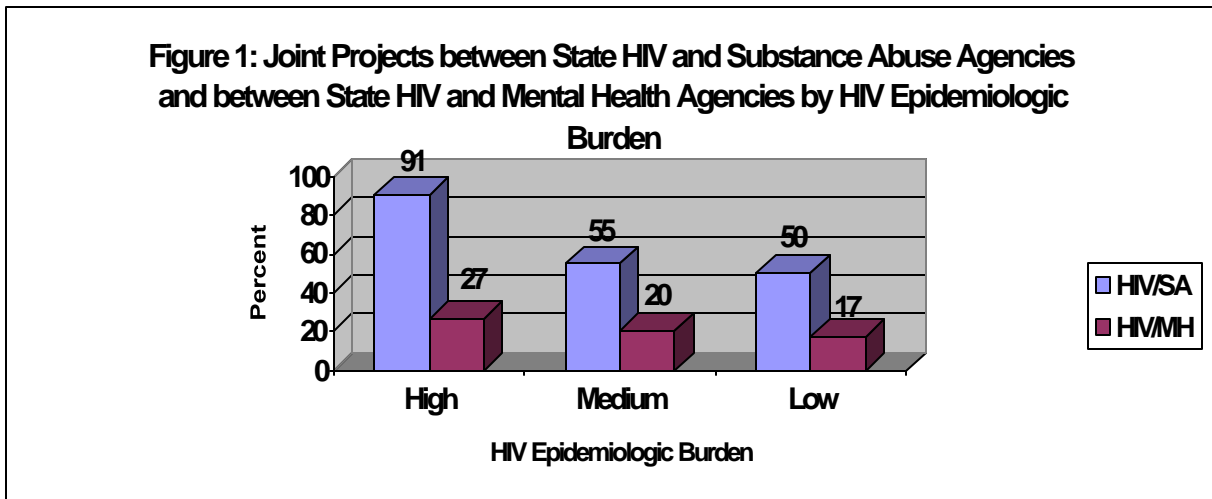


Each point in the range represents a category of reported activities. For example, Resource Sharing includes the transfer of funds, collaboration on grant proposals, and issuance of joint Requests for Proposals and joint contracts.<sup>1</sup> The sum of activities listed will not equal 100%, as responses fell at various points on the

<sup>1</sup> For more information, consult the NASTAD issue brief, *Working Together: Agency Activity to Coordinate HIV, Mental Health, and Substance Abuse Prevention and Treatment Services. Results from a National Survey of State and Territorial AIDS Directors*, 1999.

scale. Sixty one percent of the jurisdictions conduct joint projects between substance abuse and HIV agencies, 20% of jurisdictions conduct joint projects between mental health and HIV agencies, and 27% of jurisdictions conduct joint projects for persons with multiple diagnoses. Examples of coordinated projects among state HIV, mental health, and substance abuse agencies include conferences, coordinated case management, early intervention, education, outreach, pilot projects addressing HIV and substance abuse, services referral, social marketing, and training.

See Figure 1 for a description of differences by epidemiologic burden in the conduct of joint projects.



AIDS directors from southern and northeastern regions reported conducting joint HIV and substance abuse projects more frequently than other regions (91% and 73% respectively). The pattern of more frequent coordination between HIV and substance abuse agencies, as compared with that of HIV and mental health agencies, emerged repeatedly as a significant survey finding (NASTAD, 1999). The differences in frequency of coordination require further investigation, however, currently appear to be due to: 1) the categorical nature of public financing for HIV and the existence of the substance abuse set-aside; 2) the organizational location of HIV, substance abuse, and mental health programs in the state bureaucracy; and 3) the limiting nature of mental health diagnostic criteria for service access.

### **Challenges of Program Linkages**

A review of the literature revealed a variety of state and local practices linking HIV services with substance abuse and/or mental health programs. Table 3 identifies the types of program linkages and the associated jurisdictions as reported.

**Table 3: Programs Linking HIV Services with Substance Abuse and/or Mental Health Programs**

- HIV Prevention and/or Primary Care Services Delivered within the Substance Abuse Treatment Environment (Rothman et al., 1998 and Hymel and Greenberg, 1998)
- HIV Primary Care within the Inpatient Mental Health Treatment Environment (Kwasnik et al. 1997)
- Linking Community Mental Health Centers with HIV Care Coordination (Wright and Shuff, 1995)
- Substance Abuse Treatment and Primary Care in Hospital Settings (Herman and Gourevitch, 1997)
- Coordinated Case Management (Huba and Brown, 1998)

Five jurisdictions linked HIV programming with an existing health care system, either substance abuse (Rothman et al., 1998; Hymel and Greenberg, 1998; Herman and Gourevitch, 1997) or mental health (Kwasnik et al., 1997 and Wright and Shuff, 1995). These programs sought to link HIV with established mental health or substance abuse treatment systems to increase the likelihood of program integration and to increase the delivery of multiple services to populations at high risk for HIV.

Work groups and advisory committees were used by many projects to enhance the development of program coordination and to assure compatibility with organizational culture and structure (Huba and Brown, 1998 and Rothman et al. 1998). Following implementation, interdisciplinary coordinating teams functioned to assure continual coordination (Herman and Gourevitch, 1997 and Kwasnik et al. 1997). These teams used activities such as common charting, patient rounds, and case conferencing for the purposes of communication and information sharing (Huba and Brown, 1998; Kwasnik et al., 1997; and Herman and Gourevitch, 1997). In some cases, the interdisciplinary team coordinated programming and set policy for integrated service delivery.

Programs serving mostly rural areas or those implemented in both urban and rural areas tended to base program linkage on service referral between and among systems (Huba and Brown, 1998 and Wright and Shuff, 1995). In programs in urban areas, serving populations with high HIV epidemiologic burden, referrals were perceived as opportunities for clients to “get lost” due to complications of managing one’s way through multiple systems (Kwasnik et al., 1997).

Case management or care coordination figured prominently in many reported programs (Huba and Brown, 1998; Hymel and Greenberg, 1998; and Wright and Shuff, 1995). Case managers served as the client’s advocate in a system of coordinated care and they provided leadership on the interdisciplinary coordinating teams (Hymel and Greenberg, 1998 and Herman and Gourevitch, 1997).

Flexibility in service delivery was noted as an important component in an integrated program. For example, mental health services were delivered in settings such as hospital rooms, clinic waiting rooms, the pediatric HIV clinic, parole office, and drug treatment centers (Kwasnik et al. 1997). A flexible program model also was reported to be critical, particularly when coordinated programs were implemented in multiple locations in a state. Rural and urban differences, as well as differences in regional needs among cities, were noted as being important factors for consideration in planning coordinated programs (Huba and Brown, 1998 and Wright and Shuff, 1995).

## **Examining Effective State Strategies**

Throughout the United States, states are experimenting with various strategies to improve service delivery linkages. States, being the focal point between federal resources and local services, are best positioned to provide direction for the integration of service delivery across disciplines. There are several key elements that enhance the state's ability to achieve effective service delivery integration, including the following:

- States must have flexibility to manage resources and to develop, implement, and enforce appropriate regulatory policies;
- State leadership and teamwork across state agencies must coalesce around collaborative activities and provide technical assistance to local jurisdictions to extend integrated service delivery to the populations in need; and
- States must identify accessible entry points into a complex system of divergent health care services. Flexibility in the identification of entry points is important to meet the needs of local communities. Entry points into the health care system also should facilitate coordination of services for persons with multiple diagnoses.

NASTAD selected two states, Indiana and Maryland, to highlight in this monograph. Both states have implemented strategies that seem to be working well for their respective residents who are living with HIV/AIDS. The selection of these two states in no way suggest that other states are not conducting exemplary work to assure that their residents are receiving integrated and comprehensive services too. The selection of these states simply presents an opportunity to share information with other jurisdictions and stimulate national discussion among states on how to best meet the needs of persons living with HIV/AIDS in a range of localities.

## STATE HIGHLIGHT: INDIANA

### Indiana Integration of Care Project (IICP) and AIDS Substance Abuse Program (ASAP)

Over the past eight years, Indiana has conducted two programs to integrate HIV services with substance abuse and/or mental health programs. Each project was initiated separately. One program, the Indiana Integration of Care Project (IICP), was discontinued following pilot implementation. The program goals, however, were integrated into the second program, the AIDS Substance Abuse Program (ASAP).

#### Indiana Integration of Care Project

##### Program Description

The Indiana Integration of Care Project was initiated to strengthen the nexus between HIV and mental health services through the linkage of community mental health centers and HIV primary care services. Launched in 1991 and concluded in 1996, the IICP was the result of a partnership among the Indiana State Department of Health, Division of HIV/STD, the Indiana Division of Mental Health, and Indiana State University. The program was designed to improve the capacity of the Community Mental Health Centers (CMHCs) to manage an expanding HIV-infected population through provider training about HIV disease and about the HIV primary care system (see Table 4). The HIV primary care system included hospitals, medical centers, independent physicians, nurses, nurse practitioners, HIV care coordinators, community-based and specialty AIDS agencies, AIDS political groups, and other social service agencies providing direct care to people with HIV (Wright and Shuff, 1995). Twenty-two of the 30 Indiana CMHCs agreed to participate in the training program. The training component of IICP involved measured improvement of CMHC staff knowledge and attitudes about HIV and the increase in number of client referrals between and among CMHC and HIV primary care sites.

**Table 4: Intervention Description  
Indiana Integration of Care Project**

- On site (CMHC) service training and education
- Free telephone consultation
- Statewide HIV/AIDS update conference for mental health professionals
- Intensive training for northeast and southwest Indiana CMHCs
- Provision of mental health services for persons with HIV

In the fall of 1993, following the training and education components, Indiana selected a few CMHCs in the northeast and the southwest regions of the state to participate in a more intensive linkage program. There were three phases in this intervention strategy:

- An executive director's summit to develop support among senior organization leaders,
- A regional networking conference comprised of a minimum of two staff persons from the CMHCs and HIV Care Coordinators, and
- The development of local plans to identify and enhance linkages with primary health care agencies.

Evaluations were conducted in 1993 and again at the conclusion of the program. Data from the 1993 evaluation revealed a measurable increase in HIV knowledge and more positive attitudes concerning the treatment of persons with HIV. Evaluators also found that the success of CMHC connections with the AIDS service sector was a joint function of developing stronger ties with other community mental health centers and establishing solid relationships with the care coordination system (Wright and Shuff, 1995).

The CMHC system provided an opportunity for coordinating HIV and mental health services because of the wide geographic distribution of the centers throughout the state. The project was funded by a HRSA Special Project of National Significance (SPNS) grant and a grant from the National Institutes of Mental Health (NIMH). Mental health services provided to persons with HIV were reimbursed by the HIV Early Intervention Program.

### **Challenges to the Achievement of Program Linkage**

When the program was first conceived in 1991, there was no input from clients in the development of the program and issues associated with client use of CMHC services in rural areas. In the course of the project, Indiana found that generally CMHCs did not wish to serve persons with HIV. This prevailing attitude was evidenced by the continued lack of contact between CMHCs and HIV Care Coordination sites that were geographically proximate.

Medical social workers, psychologists, and psychiatrists in the mental health system did not understand how program integration would involve their system and whether such linkage was necessary for their clients. These clinicians, according to state staff, were functioning only within the parameters of mental health services. Evaluators also found that a lack of communication about participation would often serve as a barrier to service access. Some improvement in CMHC staff attitude has been witnessed in recent years. According to the evaluators:

*It was common to have clinical staff trained and serving as clinical contact for IICP yet other service delivery units within the same center would have no knowledge regarding the services they were providing for persons with HIV. This lack of knowledge within the organization typically came to light when a client needed care and the staff contacted by the prospective client denied any knowledge about their center's HIV programming. This situation was replayed repeatedly (Baker, 1997).*

Indiana was a low impact HIV state during this project which presented another challenge to the integration of care. Thus IICP would produce trained providers who would not see a client with

mental illness and HIV. Indiana recommended that the project be replicated in areas with high HIV epidemiologic impact to evaluate the effectiveness of the model.

## **AIDS Substance Abuse Program (ASAP)**

### **Laying the Foundation for the Program**

The Indiana Division of Mental Health currently functions within the Indiana Family and Social Services Administration. Medicaid, Aging and Rehabilitation Services, Division of Family and Children and Social Security also are located within the Family and Social Services Administration. In 1990, Indiana eliminated the Division of Substance Abuse and located the program in the Division of Mental Health. The Administration of Family and Social Services is much larger than the Department of Health; however functionally the Division of Mental Health and the Division of HIV/STD operate at the same administrative level. This type of administrative structure was reported by 22% of state and territorial AIDS directors (NASTAD, 1999).

Indiana initiated the *ASAP* program in response to receiving the HIV Set Aside from the Indiana Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT block grant staff of the Indiana Division of Mental Health served on the HIV Prevention Community Planning Group and was involved with various HIV planning efforts over a number of years. A strong relationship existed between the HIV/STD and the Mental Health Divisions due to the *Indiana Integration of Care Project*. According to Lori Phillips, Indiana's AIDS director:<sup>2</sup>

*When Indiana learned about the requirement to set aside part of the Substance Abuse Block Grant, the Division of Mental Health called us for counsel regarding the use of funding, and to avoid duplication of effort. They felt that it was important to coordinate the planning and management of these dollars with other HIV related programs.*

The ASAP continues to build relationships between HIV services and CMHCs following the conclusion of the Indiana Integration of Care Project. The ASAP coordinates organizational relationships among HIV and substance abuse providers and involves "free standing" substance abuse treatment facilities as well as those located within the CMHC system.

---

<sup>2</sup> Phone interview with Ms. Phillips, August 1999.

## **Program Description**

Since 1995, Indiana has linked substance abuse and HIV services through a care coordination model. The AIDS Substance Abuse Program (ASAP) assures that persons with HIV who also demonstrate substance abuse behaviors receive medical services and certain approved therapies (See Table 5). Under the program, medical, dental, optical and psychosocial services are reimbursed. An extensive formulary includes pharmacological adjuncts to alcohol and other drugs to assist with substance abuse withdrawal, anti-anxiety medications, antidepressants, and mood stabilizers.

**Table 5: Intervention Description  
AIDS Substance Abuse Program**

- Reimbursement for substance abuse treatment
- Counseling
- Case management
- Pharmaceutical services
- Medical services

Eight HIV/substance abuse specialists located at HIV Care Coordination sites in six regions of Indiana coordinate the program. These specialists provide case management for persons with HIV who have a history of substance abuse. Indiana chose to conduct the ASAP program through the HIV Care Coordination sites, because these sites form the foundation for all HIV services in Indiana. Initial locations for ASAP specialists were determined based on a review of HIV incidence and strength of existing programming and whether the Indiana Division of Mental Health funded other substance abuse related HIV prevention programs separate and apart from this funding. Indiana established ASAP sites in locations where there were existing programs funded by the Indiana Division of Mental Health.

Initially, Indiana found that there were few persons who chose to access the ASAP services. Client service use increased; however medical services remain under-utilized by persons with HIV and substance abuse behaviors. Such medical services include physician visits and diagnostic evaluation. Current patterns of medical service use tend to indicate client access to health care on emergency bases. Indiana's experience with the lack of primary care access by persons with substance abuse is also reflected in the literature as a noted challenge for treatment coordination (Rothman et al., 1998; Kwasnik et al., 1997; and Herman and Gourevitch, 1997).

## **Challenges to Achievement of Program Linkage**

The operation of the ASAP revealed that the challenge to program linkage has more to do with long term system linkage than with individual relationship building. Staff turnover at CMHCs and "free standing" substance abuse treatment centers have a major impact on the linkage system. For this reason, the ASAP specialists often take up to six months to re-establish new organizational contacts. Such activity includes the identification of another staff point-person and the assurance that this person attends the ASAP training. It has been Indiana's experience that the efforts of the ASAP have been unmatched by the CMHCs and the "free standing" substance abuse treatment centers.

Another challenge to service coordination involves the shortage of detoxification and residential treatment beds. According to Ms. Phillips<sup>3</sup>, the population served by ASAP often experiences transitional housing problems due to the economic hardship. These clients would greatly benefit from services in a residential setting.

Frequently programs funded with pilot resources face problems associated with the continuance of the program following the termination of the funding. Although the Indiana *ASAP* was not funded through pilot resource, the program experienced a loss in funding during FY 99. Continued decreases in funding from the state Substance Abuse Block Grant is expected. Diminishing resources may be a function of the fact that Indiana, like other states with fluctuating rates of AIDS cases, was not required to “set aside” a portion of the SAPT block grant for the provision of HIV Intervention Services. The Division of HIV/STD is working closely with the Division of Mental Health to address the challenge.

---

<sup>3</sup> Phone interview with Ms. Phillips, August 1999.

# STATE HIGHLIGHT: MARYLAND

## *Women in Methadone Program*

### **Laying the Foundation for the Program**

Structurally, Maryland's HIV, substance abuse, and mental health programs are separate administrations, the heads of which all report to the Secretary of Public Health. In 1999, 22% of states reported similar administrative structures (NASTAD, 1999).

The *Women in Methadone Program* was a HIV and drug treatment collaboration which was funded by the state AIDS Administration. According to Maryland's AIDS director, the collaborative program occurred as a direct result of outreach by the AIDS Administration and the provision of HIV funding. This one-sided impetus occurred in the development of coordination, despite the existence of strong relationships between and among the AIDS, Substance Abuse, and Mental Health Administrations.

According to Maryland's AIDS Administration, a significant level of negotiation was required to establish the *Women in Methadone Program*. For example, the methadone program staff needed to be encouraged to be more flexible about program rules in an integrated framework. Maryland found that a critical issue associated with program flexibility involved whether and under what conditions clients in the methadone program would be allowed to continue program participation. According to Maryland AIDS director, Dr. Liza Solomon:<sup>4</sup>

*Methadone programs are very strict in enforcing rules against any drug use by clients. The perspective of HIV prevention is really more reflective of a harm reduction approach, even if someone is not drug free, reducing the use of illicit drugs means the client is at least safer. There is clearly a difference in values between these two approaches. Negotiation and flexibility on both parts was necessary in order to create this collaboration.*

### **Program Description**

The *Women in Methadone Program*, formally called *Reducing High Risk Sexual and Drug Behaviors in Methadone Dependent Women and Adolescents in Their Social Networks*, was administered from 1996 to 1999. The program was designed to assist women with a history of drug use and other adolescent females in the social networks of these women. Though the *Women in Methadone Program* was initiated as an HIV prevention intervention, it served a number of HIV-positive women; and, therefore, was considered to be a secondary HIV prevention strategy as well as a program linking women with substance abuse behaviors and living with HIV to other services.

<sup>4</sup> Phone interview with Dr. Solomon, August 1999.

The *Women in Methadone Program* was conducted by the School of Nursing at the University of Maryland at Baltimore (UMAB). Program clients were referred on a volunteer basis either from methadone programs with which UMAB had a relationship or through other women participating in the program. Adolescent girls from the families or social networks of the participating women also were recruited. A description of the program intervention is found in Table 6.

**Table 6: Intervention Description  
Women in Methadone Program**

- Sixteen (16) day training program - 4 days per week for 4 consecutive weeks for participants.
- Meeting duration - 4 hours for women, 2 hours for adolescents.
- Follow-up sessions held once a week for eight weeks.
- Compensation for participation - \$15.00 for women and \$10.00 for adolescent girls.

During the three-year program period, there were 12 groups with a total of 130 adults and 100 adolescents. Surveying the profiles of 91 women revealed that 55% did not graduate from high school, 90% were currently not employed, 40% received public assistance, and 59% supported two or more individuals. Of the 53 adolescents profiled, 34% were 11 or 12 years old, 38% were between 13 and 14 years and 28% were between 15 and 16 years of age (Harris, 1999).

Harris measured differences in attitudes and behaviors that reflected self-esteem and consideration of health-promoting alternatives to risky behaviors, and improved personal growth and development. The evaluation revealed an increase in many of the behavioral and attitudinal indicators. Significant among the participants was an observed decrease in reported total drug use. By the six month post-test, adult women decreased reported drug use by 51%, while adolescents decreased reported drug use by 38% (Harris, 1999).

Evaluators reported that program strengths included strong social support for the sample population as demonstrated through consistent participant attendance and articulation of the enjoyment in the program by group members. The program also provided an opportunity to communicate information about HIV/AIDS. According to the evaluators, the program participants expressed a desire to be in the program, and found that there was a waiting list to participate (Childers, 1998).

The evaluators also reported that adherence to a structured program format was inconsistent due to the plethora of concerns and issues arising in the course of group work. A process evaluation undertaken in 1998 revealed that only 31% of the sessions for adults and 25 % of the sessions for adolescents followed the planned curriculum (Childers, 1998).

## **Additional Efforts to Coordinate HIV, Mental Health and Substance Abuse Programs**

Maryland is engaged in several efforts to coordinate HIV services, substance abuse, and mental health programs in addition to the Women in Methadone Program. Table 7 briefly describes these activities. Maryland's activity to coordinate services for persons with multiple diagnoses involves both the provision of direct service and the development of service infrastructure. Training, health planning, and the establishment of innovative payment systems have allowed for more efficient and appropriate client services. The purchase of substance abuse treatment slots for persons with HIV and the financing of substance abuse case managers has expanded client service capacity.

**Table 7: Maryland Activities to Coordinate HIV Services with Mental Health and Substance Abuse Programs**

- Training mental health practitioners re: HIV
- Consortia participation by the Substance Abuse Administration
- Annual mental health, substance abuse, and behavioral health conference
- Innovative HIV/mental health payment system
- HIV counseling and testing in drug treatment centers
- Funding of two substance abuse case managers
- Purchase of substance abuse treatment slots for persons with HIV

## **Building Capacity for Service**

Maryland convenes an annual statewide mental health, substance abuse and behavioral health conference. According to the AIDS Administration staff, this conference is very successful with over 500 participants. Recent plenary subjects have included methods to negotiate risk reduction behaviors in persons with mental illness and the appropriate diagnosis of depression in persons with HIV as a treatment adherence issue. Maryland highlights either mental health or substance abuse as an organizing theme for the conference.

Maryland offers an innovative public health payment system. Mental health services remain "carved out" of the Medicaid managed care system for reimbursement on a fee for service basis. The challenge is to assure that the Ryan White health care system and participant providers are aware of the sources of payment through the Mental Health Administration, and that these providers coordinate efficiently with these services. According to the state AIDS Administration staff, there is a somewhat greater level of coordination among HIV, mental health, and substance abuse services for people in Medicaid due to the mental health "carve out," and the requirement that managed care organizations provide substance abuse services.

For persons who are not Medicaid eligible, the AIDS Administration finances the purchase of drug treatment slots with Ryan White Title II resources. The *Baltimore Substance Abuse Service System* (BSASS), a coalition of substance abuse treatment centers, offers a way to purchase treatment slots with any participating drug treatment center without the need of multiple contracts. In 1998-1999, the AIDS Administration purchased \$500,000 of treatment for persons with HIV and substance abuse behaviors. Evaluation of this effort is forthcoming.

## **Challenges to Achievement of Program Linkage**

According to Dr. Solomon, the challenge of linking HIV services with mental health and substance abuse programs is that each program functions in isolation. Building relationships among the programs is important, though does not assure flexible policies or program practices. Moreover, there is a danger in emphasizing the development of HIV and substance abuse program linkages. Dr. Solomon says:<sup>5</sup>

*We need to be mindful that although it is important to have linkages between HIV prevention and drug treatment, in fact, the people who are most at risk for HIV are those injection drug users not in treatment. According to a study conducted in Maryland of injection drug users not in treatment, the seroprevalence was 25%, the seroprevalence on the needle exchange van was 30%, and in selected drug treatment facilities about 7%.*

---

<sup>5</sup> Written communication from Dr. Solomon, September 1999.

## **Conclusion: Key Components of Successful Linkage**

The Indiana and Maryland programs provide an opportunity for reflection about activities and program components that facilitate successful linkage of HIV services with substance abuse and mental health programs. Key among the components are staff training, the use of the HIV Care Coordination system, and the development of policies and program paradigms. These activities support the delivery of integrated services (See Table 8).

**Table 8: Factors Enhancing Linkage of Services**

- Policy initiatives
- Use of primary care setting
- Use of established systems of care: substance abuse or mental health
- Training and technical assistance
- Communication and shared information
- Developing relationships through working groups and teams
- Coordinating case management
- Stable funding

### **Policy Initiatives**

Policy initiatives cited as reinforcing the linkage of HIV services with mental health and substance abuse programs included:

- The identification of HIV, substance abuse and/or mental health as targeted for support and reimbursement (Wright and Shuff, 1995);
- Organizational merger within state government; and
- Systematic update of policy guidelines to reflect the changing aspects of HIV, substance abuse, and mental illness (McCarty et al., 1996).

For example, a number of policy directives were enacted by the Indiana State Department of Health to encourage state supported agencies to enhance services through the inclusion of mental health services as part of the array of services reimbursable under the Ryan White funded HIV Early Intervention Services Program. In 1994 the Division of Mental Health officially designated HIV infected persons as a vulnerable “special” population (Wright and Shuff, 1995). In Massachusetts, another state example, the merger of the state’s Alcohol and Drug Rehabilitation Authority under the Department of Public Health in 1986 facilitated organizational and policy readiness to coordinate and expand services, particularly for injection drug users. In this case, the director of the state’s alcohol and drug rehabilitation authority became the new director of the Department of Public Health (McCarty et al., 1996).

## **Settings for Coordination of Services**

In the 1980s there were a number of efforts to link primary care and substance abuse services (Herman and Gourevitch, 1997). Substance abuse treatment providers have access to persons at the highest risk for HIV and who, for a variety of reasons, have historically experienced difficulty accessing adequate primary care (Rothman et al., 1998). There is documented success with the linking of primary care services and methadone treatment (Herman and Gourevitch, 1997). Adherence to medical regimens, use of primary care services, and favorable medical outcomes have been associated with such projects.

The CMHC system is the nation's public mental health system. It was established in the 1960s and 1970s and provided geographic catchment areas through regulation (Wright and Shuff, 1995). These catchment areas enabled a state's population to gain access to local mental health services. For rural communities, the system appeared to increase access to services. Public mental health treatment services were subjected to a number of funding challenges in 1981 and again in 1992 with the various iterations of federally funded block grants for mental health and substance abuse (Jacobsen and McGuire, 1996).

The public mental health systems are positioned to play a critical role in the treatment of persons with severe mental illness and HIV related illnesses, however many public mental health system providers appear reluctant to address issues of HIV. Sullivan et al., (1999) posit that this reluctance is due to concerns about confidentiality, clients' mental competency, and public responsibility associated with treating HIV positive persons with serious mental illness. Moreover, there remains a question about the current viability of the CMHC system.

## **Policy Context for Services**

The regulatory and funding contexts, as well as the environment of support for programs to coordinate across disciplines, was noted throughout the literature and by Indiana and Maryland state personnel. It is notable that HIV resources provided the financing for the majority of projects. From the perspective of state AIDS directors, state AIDS agencies initiated and sustained the collaborative effort. It might be perceived that the interaction of mental illness, substance abuse, and HIV is a problem only for those in the HIV context. Support from mental health and substance abuse programs at state and federal level will be necessary to increase shared responsibility for services to persons with HIV, substance abuse and/or mental illness. Such support also will be required to assure regulatory flexibility in an integrated program framework. Public managers, interest groups, local service providers and clients have been successful in raising the issue of multiple diagnoses to the level of state and federal policy discourse. Continued leadership will be necessary to assure requisite health system changes.

## References

- Alexander, E. R. (1995). *How Organizations Act Together: Interorganizational Coordination in Theory and Practice*. Amsterdam: Gordon and Breach.
- Baker, T., IICP final report submitted to the Indiana State Department of Health, August 1997.
- Bardach, E. (1998). *Getting Agencies to Work Together: The Practice and Theory of Managerial Craftsmanship*. Washington, DC: Brookings Institution Press.
- Barnes, R.F., Mason J.C., Greer C.Y. et al (1983). Medical Illness in Chronic Psychiatric Outpatients. *General Hospital Psychiatry*, 5, 191-195.
- Barrett, D.C. and Lange W.R. et al. (1995). Coping Strategies, Substance Use, Sexual Activity and HIV Sexual Risks in a Sample of Gay Male STD Patients. *Journal of Applied Social Psychology*, 25, 1058-72.
- Berger, J. M. and Levin, S. M. (1993). Adolescent Substance Abuse and HIV/AIDS: Linking the Systems. *Journal of Adolescent Chemical Dependency*, 2 (3/4).
- Childers, K.V. (1998). *Reducing High Risk Sexual and Drug Behaviors in Methadone Dependent Women and Adolescents in Their Social Networks: Process Evaluation Report*. Annapolis, MD: Maryland AIDS Administration.
- Cigler, A. J. and Loomis, B. A. (1998). *Interest Group Politics* 5<sup>th</sup> ed. Washington, DC: CQ Press.
- Cresswell, J. W. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks, CA: Sage.
- Harris, R. (1999). *Annual Report on Women in Methadone Program*. Annapolis, MD: Maryland AIDS Administration.
- Hassett, S. and Austin, M. J. (1997). Service Integration: Something Old and Something New. *Administration in Social Work*, 21(3/4): 9-29.
- Heckman T.G. and Somlai, A.M. et al. (1998). Barriers to Care Among Persons Living with HIV/AIDS in Urban and Rural Areas. *AIDS Care*, 10, (3), 365-375.
- Herman, M. and Gourevitch, M. N. (1997). Integrating Primary Care and Methadone Maintenance Treatment: Implementation Issues. *Journal of Addictive Diseases*, 16 (1), 91-102.

- Himmelman, A. T. (1994). *Communities Working Collaborative for a Change*. Minneapolis, MN: Himmelman Consulting Group. This monograph is no longer available in its original form, but can be found in Hermann, M. S., ed. *Resolving Conflict: Strategies for Local Government*. Washington, DC: International City/County Management Association.
- Huba, G. J. and Brown, D. V. (1998). Missouri Department of Health: Integrated Care for Individuals with HIV/AIDS, Mental Illness, and or Substance Abuse Problems (*unpublished*).
- Hymel, M. S. and Greenberg, B. L. (1998). The Walden House Young Adult HIV Project: Meeting the Needs of Multidiagnosed Youth. *Journal of Adolescent Health*, 23S, 122-131.
- Jacobsen, K. and McGuire T. G. (1996). *Federal Block Grants and State Spending: The Alcohol, Drug Abuse and Mental Health Block Grant and State Agency Behavior*. *Journal of Health Politics, Policy and Law*, 21 (4).
- Kwasnik, B. C., Moynihan R. T. and Royle, M. H. (1997). HIV Mental Health Services Integrated with Medical Care, in Winiarski, M.G., ed., *HIV Mental Health for the 21<sup>st</sup> Century*, 209-223. New York: New York University Press.
- Levin, S. M. (1993). Public Health Care Perspectives for the 1990s: What Are the Options? *Journal of Adolescent Chemical Dependency*, 2 (3/4).
- McCarrick, A. K, Manderscheid, R. W., et al. (1986). Chronic Medical Problems in the Chronic Mentally Ill. *Hospital and Community Psychiatry*, 37, 289-291.
- McCarty, D., LaPrade, J., and Botticelli, M. (1996). Substance Abuse Treatment and HIV Services: Massachusetts' Policies and Programs. *Journal of Substance Abuse Treatment*, 13 (5), 429-438.
- Mulry, G., Kalichman, S.C., and Kelly, J.A. (1994). Substance Use and Unsafe Sex Among Gay Men: Global Versus Situational Use of Substances. *Journal of Sex Education and Therapy*, 20, 175-84.
- National Alliance of State and Territorial AIDS Directors (NASTAD) (1999). *Working Together: State Agency Activity to Coordinate HIV, Mental Health and Substance Abuse Programs*. Washington, DC: NASTAD.
- Reback, C. J. and Grella, C. E. (1999). HIV Risk Behaviors of Gay and Bi-sexual Male Methamphetamine Users Contacted Through Street Outreach. *Journal of Drug Issues*, 29 (1), 155-166.
- Rogers, D. I., Whetten, D. A. (1992). *Interorganizational Coordination: Theory Research and Implementation*. Ames: Iowa State University Press.

- Rothman, J. R., Birkhead, G. S., Maki, G. et al. (1998). Co-Locating and Integrating Comprehensive HIV Prevention and Primary Care in Methadone and other Drug Treatment Programs in New York. *International Conference on AIDS*, 12, 606 (Abstract No. 32421).
- Satriano, J., Rothschild, R. et al. (1999). HIV Service Provision and Training Needs in Outpatient Mental Health Settings. *Psychiatric Quarterly*, 70 (1).
- Sharp, E. B. (1994). *The Dilemma of Drug Policy in the United States*, New York: Harper Collins.
- Sullivan, G., Koegel, P. et al. (1999). HIV and People with Serious Mental Illness: The Public Sector's Role in Reducing HIV Risk and Improving Care. *Psychiatric Services*, 50 (5).
- Wolcott, D. L., Fawzy, I. et al. (1986). AIDS Patients' Needs for Psychosocial Services and their Use of Community Service Organizations. *Journal of Psychosocial Oncology*, 4(1/2), 135-146.
- Wright, E. R. and Shuff, I. M. (1995). Specifying the Integration of Mental Health and Primary Health care Services for Persons with HIV/AIDS: The Indiana Integration of Care Project. *Social Networks*, 17, 319-340.

## **Acknowledgements**

The National Alliance of State and Territorial AIDS Directors (NASTAD) gratefully acknowledges the state AIDS directors and their staff in Indiana and Maryland for their assistance in the completion of this monograph. NASTAD also acknowledges Beth Meyerson who served as a NASTAD consultant and primary author of this monograph and the NASTAD staff for their editorial and technical support.

This monograph was funded by the HIV/AIDS Bureau (HAB),  
Health Resources and Services Administration (HRSA),  
U.S. Department of Health and Human Services and  
the National Alliance of State and Territorial AIDS Directors (NASTAD).

National Alliance of State and Territorial AIDS Directors  
444 North Capitol Street, NW Suite 339  
Washington, DC 20001  
(202) 434-8090 – Phone  
(202) 434-8092 – Fax  
[nastad@nastad.org](mailto:nastad@nastad.org) – Email  
[www.nastad.org](http://www.nastad.org)

Julie M. Scofield, Executive Director  
Wendy Craytor, Chair