NASTAD HIV PREVENTION FACT SHEET

State Agency Coordination: HIV, Mental Health, and Substance Abuse

HIV, mental illness, and chemical dependency often coexist as diagnoses, particularly in populations that are marginalized from prevention and treatment services. In the United States, separate treatment and prevention systems have been developed to respond to HIV, mental illness, and substance abuse. These systems do not always work well together, and yet their coordination is crucial for the provision of treatment and prevention services to persons with multiple diagnoses. States play a critical role in the management and coordination of HIV, substance abuse, and mental health resources.

Why should states coordinate HIV, mental health, and substance abuse programs?

Mental illness and chemical dependency often affect persons at risk for or living with HIV. Social and health service organizations are now finding ways to include HIV, mental health, and substance abuse-related services into comprehensive prevention and treatment programs. State agencies for health, mental health, and substance abuse play a pivotal role in assuring the coordination of programming, the coordination of resources, and the development of policy to serve persons living with or at risk for the multiple diagnoses of HIV, chemical dependency, and/or mental illness.

Do states coordinate HIV, substance abuse, and mental health programs?

States coordinate among HIV, substance abuse, and mental health agencies in four ways: communication; planning activities; fiscal coordination; and coordinated projects. According to the National Alliance of State and Territorial AIDS Directors, over 70 percent of state HIV programs solicited input from mental health and substance abuse agencies for HIV grants and planning in 1999. Ryan White consortia and HIV prevention community planning groups were frequently cited as providing the means to collaborate, the opportunity for input to grants and plans, and as providing the political pressure to facilitate interagency coordination.

Twenty-seven percent of state AIDS directors reported conducting joint projects for persons with HIV, chemical dependency, and mental illness. HIV programs often take the lead in the development of coordinated programming and overwhelmingly finance such efforts. According to AIDS directors, coordination between HIV and substance abuse programs occurs more frequently than coordination of mental health, HIV, and substance abuse programs. Sixty percent (60 percent) of state AIDS directors reported coordinating HIV and substance abuse programming and 20 percent reported coordinating HIV and mental health programs.

State AIDS directors indicated that it was easier to coordinate with substance abuse agencies because of the targeted nature of funding for HIV-related projects. HIV programs find it difficult to coordinate programs and services with state mental health agencies because mental health programs face significant limitations in funding. These limitations require mental health programs to serve only those who are most severe in their mental illness or mental disorders. Persons living with, or at risk for, HIV who also live with a mental illness may not fall within the program criteria, and yet they rely on public resources for their mental health services due to the sociodemographics of HIV. As such, HIV programs have to supplement financially the mental health programs in order to assure program services for persons at risk for or living with HIV.

What are the barriers to coordination?

Each state and state agency faces unique issues that might prevent coordination among state agencies. State AIDS directors noted that philosophical differences among agencies, funding requirements for programs, budget cuts, the political environment, and the relationship among HIV, substance abuse, and mental health directors served as factors that prevented state agencies from coordinating programs, funding, or information. State agencies might disagree about programmatic approaches to substance abuse prevention, mental health, or HIV. Turf battles could emerge among agencies for limited resources. Program coordination may be a low priority for agencies struggling to address their primary missions of HIV, chemical dependency, or mental health. Moreover, in spite of the increased flexibility afforded to states by the substance abuse and mental health block grants, it has been HIV categorical resources that have financed coordinated efforts.

There is a need for substance abuse treatment, a need for a greater number of treatment providers and stronger local infrastructures for the delivery of substance abuse prevention and treatment programming. Means of documenting the prevalence of substance abuse and mental illness should be improved upon and standardized. Differences in program accountability impact the way in which programs coordinate. HIV programs are called to a higher standard of program accountability, not only by their community planning groups and Ryan White consortia, but by the federal grant makers. For example, state AIDS directors have noted the inability to document how substance abuse block grant or Set Aside resources serve populations who live with or are at risk for HIV and chemical dependency.

State, Territorial, and Local Health Departments Coordinate Services to Meet the Needs of People at Risk for HIV

New Jersey — Offering and Array of Programs: The state of New Jersey, Division of AIDS Prevention and Control and the Division of Addiction Services have jointly financed efforts to provide HIV prevention services to persons with chemical dependency through a special state appropriation for substance abuse services and HIV programs. For example, from 1991 to 1998, dedicated HIV specialists were placed at nine high-volume, urban methadone maintenance programs to perform HIV counseling and testing, and to provide training and case management services.

A second program, the Patient Incentive Program (PIP) is conducted at four drug treatment centers and provides non-financial incentives, free drug treatment, HIV risk reduction counseling and case management services to encourage injection drug users (IDUs) to participate in HIV counseling, testing, to return for test results, and (if infected) to access HIV care and remain in drug treatment. During 1999 the program found an HIV positivity rate of 14.6 percent. As a result of incentives, 74 percent of 113 clients returning for early intervention services kept their appointments. Preliminary program evaluation findings indicate that the PIP program contributed to enrollee employment (23%), a reduction in needle sharing, and an increase in reported safer sex practices.

San Francisco — Providing Services to Those with Multiple Diagnoses: Walden house is a behavioral health provider in San Francisco. Walden House provides services to persons living with HIV, mental illness, and chemical dependency through a variety of programs. They have financed their services through federal grants (SAMHSA [CSAT AND CMHS], medical funding, grants from HRSA, and Ryan White CARE Act funding from the city and county). An example of their services is the Young Adult HIV Project (YAH), which provides services to persons ages 13 to 25 who are chemically addicted, live with mental illness, and are at risk for or living with HIV. Services include variable length residential and outpatient substance abuse treatment programs, a full continuum of support services through a case management program, primary care and dental services, mental health services, HIV education and prevention, and aftercare services.

Maryland — Innovative Payment System: Maryland's activity to coordinate services for persons with multiple diagnoses involves both the provision of direct service and the development of a service infrastructure. Training, health planning, and the establishment of innovative payment systems have allowed for more efficient and appropriate client services.

In Maryland, mental health services remain "carved out" of the Medicaid managed care system for reimbursement on a fee for service basis. The challenge is assuring 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 AIDS Administration, 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.