

**HIV/AIDS and
People with Disabilities in Massachusetts:
A Needs and Resource Assessment**

**Final Report to the
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INTRODUCTION

During the winter and spring of 2002 The HIV/AIDS Bureau at the Massachusetts Department of Public Health engaged the Health and Disability Working Group (HDWG) at the Boston University School of Public Health to conduct a review of HIV-related services available to individuals with disabilities in the Commonwealth. The purpose of this review was to identify existing HIV-related services and resources, to identify gaps in policies and services, and to develop recommendations to strengthen the continuum of care for people with disabilities. The specific areas of inquiry included HIV education and prevention services, HIV counseling and testing, HIV care and treatment, and the availability of disability-specific HIV educational materials. The disability populations included in this review included adults with serious mental illness, developmental disabilities or mental retardation, physical disabilities, blindness, visual impairments, and deafness or hearing impairments.

STUDY DESIGN

In February of 2002, a letter of introduction was mailed to 100 state agency staff, key informants and community-based service organizations across the Commonwealth requesting their participation in an interview. The primary goal was to identify individuals who were knowledgeable about existing policies, practices, and services related to HIV in the disability community. A secondary goal was to identify gaps in knowledge and practice in order to make recommendations for future direction. The third goal was to interview a state agency representative who had policy responsibilities for each disability population who could address how the state agency approached HIV prevention education, counseling and testing, and care.

In order to achieve these goals, we interviewed a purposive sample of individuals who were most likely to have knowledge of these issues as well as the current state of policy and practice. In addition, we made a concerted effort to interview individuals in different parts of the state as well as individuals knowledgeable about different types of disability. Finally, we were interested in learning about the continuum of services from education and prevention, to counseling and testing, to health care and support services.

Between February and May 2002, researchers at the HDWG interviewed a total of 65 individuals to identify available resources, current policies, and gaps in care. Attempts were made to interview 15 additional individuals who did not respond to our requests for an interview. We began by interviewing individuals with disabilities who are currently employed by the Massachusetts Department of Public Health, and branched out to interview other key informants in the community who were identified as being knowledgeable about both HIV and disability. From these initial efforts, we contacted other state agency staff, community providers, and disability advocacy organizations who were reported to have knowledge about the populations and the issues.

In total, 14 key informants, nine state agency staff, and 42 community service providers were interviewed. The community service providers included disability advocacy organizations such as Independent Living Centers, Deaf, Inc., and ARCs.

Most of the key informants were familiar with cross-disability issues, but five were particularly knowledgeable about mental retardation and developmental disabilities; two had a special expertise in physical disability, and one each was particularly knowledgeable about mental illness, visual impairment, and hearing impairment.

State agency staff interviewed included representatives from:

- The Massachusetts Commission for the Blind (1);
- The Massachusetts Rehabilitation Commission (1);
- The Department of Mental Health (1);
- The Department of Mental Retardation (2);
- The Massachusetts Developmental Disabilities Council (2);
- The Massachusetts Department of Medical Assistance (1);
- The EOHHS Office on Disability (1) and
- The Department of Public Health (1).¹

The community agencies and consumer advocacy organizations interviewed were a diverse group. They included agencies that serve:

- A general population including people with disabilities (14);
- Individuals with developmental disabilities and mental retardation (16);
- Individuals with mental illness (8);
- People with physical disabilities (6);
- Individuals with visual impairments (3); and
- Individuals with hearing impairments (2).²

FINDINGS

Overview

For most state policy-makers or service providers in the disability community HIV/AIDS is not a “high profile” issue. One of the key findings of this study is that it was very difficult to find individuals, at any level, who had knowledge of both disability and HIV. Few individuals were able to offer specific information about policies, educational materials, counseling and testing guidelines, or consumer or staff training programs. This was even true among key informants who were selected based on their historic knowledge of and involvement in HIV issues.

¹ The representative from the Commission on the Deaf and Hard of Hearing did not respond to our requests for an interview.

² The totals are larger than the 42 community providers interviewed because several organizations served more than one population group.

Key informants provided information about state policy and provider activities that were initiated to problem-solve and generate policies and practices around HIV prevention and education activities from the mid-1980's and to early 1990's, at the onset of the HIV epidemic. However, some of this energy dissipated as activists moved on to new arenas and the actual incidence of HIV among persons with disabilities as a whole has remained small³. Although the actual incidence of HIV appears to be small, key informants reported that the risk of contracting HIV still remains high for many sub-populations of individuals with disabilities.

To the extent that state agencies and community providers of services to people with disabilities address health care issues, much of the focus is on access to primary care, or management of more highly prevalent chronic illnesses such as diabetes or asthma. Against this backdrop, there are several themes that appear to inhibit a more pro-active approach to HIV education, prevention and care:

- Stigma about HIV still has a strong hold among a subset of policy-makers, providers and families/guardians;
- Some individuals continue to believe that individuals with disabilities are not sexually active and therefore are not at risk for HIV; and
- Policies and practices around confidentiality and informed consent are often confusing or inconsistent, especially for individuals with cognitive disabilities.

However, some of the HIV-related policies and practices initiated ten to twelve years ago still exist today, and there are some agencies and providers that continue to implement them. Several pockets of innovation or excellence were identified; these examples are highlighted. Below we present the summary of our findings from these interviews and description of identified models, grouped by major disability areas.

Serious Mental Illness

Overview

Although the prevalence of HIV among most disability populations is largely anecdotal, there are national prevalence estimates for people with serious mental illness that indicate that this population has a higher incidence of HIV than the general population⁴. Several key informants mentioned that people with serious mental illness were at risk for HIV as a result of sexual assault, injection drug-using practices, and the lack of knowledge or skills to practice safe sex.

The mental health policy and provider communities were well aware that their clients are sexually active and at risk of contracting HIV. However, key informants noted that many mental health professionals assume that their clients have a certain level of knowledge or skill regarding HIV prevention. Thus, while providers may assess clients for their HIV

³ The main exception is among people with serious mental illness. National prevalence estimates indicate that HIV is more common among this population than among the general population.

⁴ The National Institute of Mental Health's 2002 figures show that HIV incidence for people with mental illness NYC is seven times that of the national average. Go to <http://www.nimh.nih.gov/publicat/hivresfact.cfm>.

risk, they do not necessarily assess client skills and knowledge around prevention. Assumptions about consumer knowledge and skill levels can be dangerous, given the wide range of cognitive and functional capacity within this population.

Other important issues for this very high-risk population include the determination of competency to provide informed consent for HIV counseling and testing and the decentralized service delivery system that results in inconsistencies in implementing Department of Mental Health (DMH) guidelines and monitoring subcontractor performance around the guidelines.

State Agency Efforts

The Department of Mental Health began addressing HIV/AIDS issues over fifteen years ago when it established a task force to discuss AIDS-related issues and set policies. In general, DMH assumes that their clients are sexually active and may be at risk for HIV. They also assume that clients are capable of giving informed consent for testing unless they have been deemed legally incompetent.

In June 1999, DMH issued a policy establishing procedures for HIV/AIDS risk assessment, counseling and testing, minimum staff training requirements, and client education. The policy applies to all contracted facilities, programs, and DMH case managers, and states that all clients should be offered an annual risk assessment for HIV and Hepatitis C. This assessment can be administered by anyone involved in the client's care, but must be documented by DMH staff. Clients can refuse this assessment. If the findings of this assessment indicate a high or moderate risk for HIV, counseling and testing options are offered to the client following strict guidelines that address informed consent, record-keeping, and confidentiality.

Adherence to this policy is uneven across the state. At the DMH-run hospitals and community agencies nearly all of the clients receive the assessment. Assessments are administered by DMH clinicians on staff who also document the assessments in client records. However, the majority of DMH clients are served through contracts with private vendors, and the assessment is provided by staff of the private vendors. DMH regional office staff oversee these contracts, but there are no standard procedures for tracking or enforcing the regulations, or documenting the receipt of the assessments. Thus, there is wide variation in adherence.

In addition to the annual risk assessment, DMH requires that all staff receive at least one hour of training annually on issues related to HIV/AIDS in people with serious mental illness. Additional training is required for all non-independently licensed staff who conduct risk assessments and all DMH case managers. This is a strong policy, but it is unclear if implementation is consistent. Some of the interviews suggested that education for staff is not complete because it is limited to universal medical precautions.

The DMH policy also states that each Area Office should ensure that every client in their Area has access to at least one HIV/AIDS education program annually. Again, several of

the interviews suggested that this education does not necessarily address the knowledge and skill-building needs of some consumers.

The DMH policy also addresses HIV counseling and testing, and encourages testing in primary medical care settings that can provide medical care if an individual tests positive for HIV. Clients or their guardians must give consent for counseling and testing.

Community Services

Interviews with the eight community providers revealed that most of the providers had experience serving individuals with HIV and serious mental illness, and had implemented some form of staff training, client risk assessment and HIV education services. One provider mentioned using the psychosocial rehabilitation approach of meeting clients where they are at (similar to harm reduction) and working to eliminate barriers across a wide spectrum of cognitive functioning and engagement.

However, several agencies and providers have struggled with the implementation of informed consent and competency assessment for HIV counseling and testing. Neither DMH nor the Centers for Disease Control (CDC) offer specific guidelines for assessing individual competency to consent to counseling and testing for individuals with serious mental illness. The Veteran's Administration (VA), on the other hand, provides more detail about situations in which an individual may not be able to provide informed consent. The VA also has criteria for establishing competency and steps to follow. Other community-based counseling and testing services follow the CDC guidelines for counseling and testing, which do not provide specific guidance in determining competency to consent.

In addition, interviews with two different hospitals revealed different practices for individuals admitted for psychiatric treatment. One hospital does not conduct counseling and testing among people admitted for psychiatric care unless the patient's specific condition suggests that such a test is medically indicated. The other hospital considers HIV counseling and testing on a more routine basis, but always conducts a psychiatric evaluation to determine the individual's competence to consent to testing prior to performing the service.

None of the interviews reported major gaps in medical services for HIV positive individuals with psychiatric disabilities. However, a Boston area focus group was conducted among people with HIV and serious mental illness living in the community as part of a needs assessment process. The individuals in the focus group reported that they received the care they needed if they could manage it on their own. If they needed help, however, access to DMH case managers was limited by long waiting lists. The focus group also reported that some providers were better able to provide care than others based on the amount of time they were able/willing to spend with patients to address their complex needs.

Program Examples

- Vinfen Corporation has developed a comprehensive HIV/STD curriculum for both staff and consumers.
- The Veterans Administration has a full-time HIV/AIDS Coordinator who works with HIV positive individuals who are admitted to the hospital or use their outpatient facilities including the mental health clinic.
- The Zinberg Clinic at Cambridge Hospital estimates that 75% of their patients have a serious mental illness. Their mental health clinicians coordinate care for HIV positive individuals, they have a mobile counseling and testing service, and they provide disability-focused training for staff.
- Vinfen's School Street Residence, a community residential program, has designated slots for DMH "priority" clients with HIV – a partnership model funded jointly by the Departments of Public Health and Mental Health.

Mental Retardation/Developmental Disabilities

Overview

Although most of the key informants and individuals who participated in the mental retardation/developmental disabilities interviews reported that there was a very low incidence of HIV among this population, there are certain individuals who may be at higher risk than others. For example, individuals who live in the community with borderline or mild mental retardation are at higher risk of sexual assault or abuse.

A major barrier to education and prevention for this population is the historical attitude that people with mental retardation are not sexually active, or should not be exposed to this kind of discussion. Several key informants mentioned that family and guardians often block the delivery of information about sexuality and HIV prevention. Finally, providing HIV prevention education to individuals with mental retardation is different than educating other individuals. Cognitive impairments are likely to lead to unsafe sexual practices unless safe sex is repeatedly reinforced. As one key informant noted, "When educating the general public around safe sex, we often use bananas to demonstrate condom use. For people with mental retardation, a banana is a banana – the association may not occur. You need to be very concrete and use anatomically correct models. Education has to be more along the lines of 'hug, kiss, condom', 'hug, kiss, condom' --simple associations that are continuously repeated."

State Agency Efforts

The Department of Mental Retardation (DMR) began working on policy issues related to HIV over 15 years ago. At the time, the emphasis was twofold - defining the messages for direct care staff and nurses to use with their clients, and developing a training curriculum for both staff and consumers. In the 1980's DMR developed a staff training curriculum, including a video and user's guide. DMR requires vendors to provide sexuality education for clients on an individual basis to accommodate differences in cognitive functioning. This policy is communicated in DMR vendor contracts. However, as noted above, the implementation of this policy is often complicated by family and

guardian relationships. DMR staff reported that the Department is doing little in the area of prevention and sexuality education as a result of the influence of parents and guardians. Overall, the Department's main health care focus is on access to primary care and care for some of the more common chronic illnesses, rather than HIV prevention in particular.

Community Services

DMR service providers constituted the largest group of community agencies interviewed for this report, in large part because of the low-profile and particularly controversial nature of this topic for this population. Sixteen community agencies were interviewed in an effort to find individuals or agencies who were actively engaged in HIV-related services. Discussions with community providers revealed some level of knowledge about the DMR policy, but inconsistent levels of activity to conduct individual risk assessments or provide sexuality training. As one key informant stated, "Organizations are very different in their ability to perform skills analysis and conduct skills-building activities. They need to be able to break things down, start at the beginning, and help people with decision-making at many different levels."

While many of the community providers mentioned that HIV was not an issue for their clients, a few described an entire skill-building curriculum. We interviewed two providers who offer sexuality and HIV training to parents of individuals with mental retardation. One ARC (a family advocacy and service organization) has developed a successful and cost-effective parenting program for people with developmental disabilities, funded by DSS and being replicated at other ARCs. The program includes pregnancy and STD prevention education as part of a broader parenting curriculum.

DMR's policy on HIV counseling and testing is that the test should be administered when it is clinically indicated. None of the counseling and testing sites that we spoke with reported providing HIV counseling and testing to DMR consumers. One individual reported that in fifteen years of providing HIV counseling she had never received any training in assessing individual competency to provide consent, although she was very interested in the subject. One community agency's sexuality educator has developed a 15-page policy manual, currently pending agency approval, that describes the consent process and rights and responsibilities of both staff and consumers.

A study of sixty individuals with mental retardation or developmental disabilities conducted by the Shriver Center about health care access noted that mention of HIV was "conspicuous in its absence." Only two agencies reported that any of their consumers had HIV. One was a community residential program for individuals dually diagnosed with mental illness and mental retardation, in which program case managers helped coordinate their care. The other was a hospital-based clinic that has treated several people with mental retardation living in the community for post-exposure treatment of sexual assault. Community providers and key informants both stressed that those individuals most at risk for HIV – people with mental retardation or developmental disabilities living in the community⁵ – were also those least likely to receive services.

⁵ The vast majority of people with developmental disabilities or mental retardation live in the community.

Program Examples

- DMR contracts with a Sexuality Counselor who has developed a curriculum for both groups and 1:1, using an 8-page individual assessment.
- Till, Inc's Sexuality Trainer has developed a curriculum for client groups, and for staff and parents.
- One ARC's part-time Sexuality Educator has developed an informal curriculum for groups, including staff and parents.
- Planned Parenthood of Massachusetts provides consumer education and a train-the-trainer program.
- Bay Cove Human Services runs a residential program for dually-diagnosed individuals with mental retardation and mental illness or mental retardation and HIV. They provide an individually-adapted consumer education curriculum based on DMH standards and universal precautions, and provide internal case management for treatment.

Blind and Visual Impairments

Overview

The individuals interviewed about services available for this population were neither aware of HIV-related issues nor engaged in the topic. From the state agency perspective, consumers are not particularly affected by HIV and HIV is not of concern for the agency. Rather, the Massachusetts Commission for the Blind views DPH as the agency responsible to ensure that HIV-related information is produced and disseminated in Braille.

Community providers reported no knowledge of education or prevention programs for individuals enrolled in their schools or day programs. In the rare instance where training is provided, the only information offered is universal medical precautions. One provider, in particular, was very reluctant to use the words "HIV" or "AIDS" and reported that her clients "do not function in that way," and that HIV was "the last thing we would deal with."

Deaf/Hard of Hearing

Overview

No state agency contact participated in the interview process; therefore all results provided about services for this population come from interviews conducted with key informants and community agencies. Many of those interviewed spoke about the social isolation and communication issues for individuals who are deaf or hard of hearing, which increases their vulnerability around negotiating sexual behaviors and places them at increased risk for HIV. Several key informants suggested individuals who are deaf often have difficulty accessing medical or mental health services due to communication barriers, which makes prevention, education, and treatment of HIV even more difficult.

The lack of availability and payment for American Sign Language interpreter services creates major gaps in care. These gaps are even more pronounced for Spanish-speaking deaf individuals. Other barriers to care include geographic access to deaf-accessible services and supports.

Community Services

Nearly all of the key informants and many community agencies were familiar with the work of Deaf, Inc. in serving HIV positive individuals who are deaf or hard of hearing. The Hope Program at Deaf, Inc. conducts outreach to raise HIV awareness among this community, provides peer support and case management to individuals with HIV, and offers orientation workshops on the fundamentals of HIV. Although the services provided by Deaf, Inc. are known across the state, their offices are based in Boston. Thus their ability to provide services to consumers in more distant parts of the state is limited by staff capacity and funding.

Community providers mentioned several other services or programs for individuals who are deaf or hard of hearing. For example, one of the HIV clinics reported that they had several deaf patients and one staff person who was fluent in ASL. However, it appears that HIV counseling and testing services are somewhat problematic. If an individual does not bring an interpreter to the counseling session, counseling and testing staff reported that they exchange notes with the client.

Program Examples

- Hope Program at Deaf, Inc. provides case management services, information and referral to counseling and testing and health care services, educational materials on HIV/AIDS, and peer support for deaf and hard of hearing people living with HIV.
- The Boston Living Center offers a monthly prevention education session with ASL interpretation.

Mobility Impairments

Overview

The relationship between HIV and physical disability can be viewed from two perspectives. First, people with physical disabilities need prevention education about HIV or may have HIV in addition to their physical disability and require accessible services. Secondly, some people with HIV become physically disabled as a result of complications of HIV. Therefore, the interviews asked about services applicable to both groups of individuals.

People with physical disabilities are often at high risk for HIV but have few opportunities to learn about HIV prevention in the context of their disability. Several clinicians who provide services for individuals with physical disabilities noted that many of their consumers engage in high risk sexual activities. For example, many people with mobility impairments, especially those newly injured, are anxious to have sexual relationships and

may take risks that some non-disabled persons would not take. In addition, some people pay for sex because they do not feel anyone would want to be in a sexual relationship with them. There are no educational programs about how to put on a condom when your arms are paralyzed or you have little motor control, and no programs to help people learn to ask for this assistance. Many spinal cord injuries happen to young men who did not have safe sex skills and practices prior to their injury. This does not necessarily change post-injury. Rather, unsafe practices tend to be exacerbated upon discharge and re-entry to the community.

State Agency Efforts

Massachusetts Rehabilitation Commission (MRC) does not directly support any HIV-related services; their main focus is on rehabilitation and support services for individuals with disabilities. However, Independent Living Centers (ILCs) funded by the MRC respond to requests for services from individuals with HIV, usually for personal assistance services. In MRC's experience, people with HIV do not typically avail themselves of other ILC services such as skills-building, even when they become clients of the personal assistance program.

Community Services

ILCs are an important source of services and support for people with physical disabilities, and have the potential to offer this support for people with HIV as well. However, as one ILC director noted, many people with HIV do not consider their condition to be a disability and therefore do not think to approach the ILCs for services.

Three ILCs participated in the interviews for this project. One of the ILCs offered educational forums on HIV prevention for consumers upon consumer request. However this service has not been requested or provided recently. Another ILC had received requests for personal care attendant services and was interested in knowing more about special health care services for people with HIV. A third ILC had a staff person who tried to form bridges between the ILC and HIV communities for many years, with limited success. Although the ILC and the HIV communities are not well connected at this time, the ILCs are well-versed in barriers to care. In addition, ILCs follow a consumer-driven model that drives them to continuously look for ways to be more responsive to the expressed needs of their consumer clients. All of the ILCs interviewed expressed an interest in incorporating disability-specific printed educational materials and resource directories about HIV into their service system.

Several key informants with physical disabilities noted that many primary care providers do not ask consumers if they are sexually active or have a substance abuse history. Furthermore, many people with disabilities do not use primary care services; they are more likely to visit their specialists who do not have a broader preventive care perspective. Thus, HIV risk assessment and prevention education is often not available to people with physical disabilities as part of their routine medical care.

Several notable exceptions stand out. A sex therapist at the Spinal Cord Injury Center at Boston Medical Center works with newly injured individuals to provide individual

counseling and HIV risk reduction education. Boston Community Medical Group, a primary care group practice for people with disabilities in Boston, provides routine health risk assessments that includes risks for HIV, hepatitis C and sexually transmitted diseases. As part of their primary care model they provide prevention education as well as access to HIV counseling and testing services for people with physical disabilities.

Although we did not interview a full spectrum of health care providers for this study, those providers interviewed reported that they had served individuals with physical disabilities and HIV and were accessible to individuals with mobility limitations.

SUMMARY AND RECOMMENDATIONS

This report is based on information collected from interviews with a sample of individuals who were selected for their policy-making responsibilities, previous involvement in disability and HIV issues; or their potential current involvement in or knowledge of HIV and disability services. Overall, the information garnered from these interviews revealed a lack of focus on HIV services for individuals with disabilities in the Commonwealth. One of main issues identified was the lack of awareness regarding high-risk sub-populations and the need to tailor HIV risk reduction education to the individual circumstances of people with different disabilities. Another central issue was the lack of system-wide capacity to address these issues. However, the innovative program models and unique practices noted above could serve as the foundation for future work.

Interviewees cited several barriers and challenges as underlying the lack of prioritization given to HIV-related services for people with disabilities. These included:

- A continuing belief that persons with disabilities are not sexually functioning beings;
- The low incidence of HIV among most people with disabilities in the context of other competing health concerns;
- Lack of consent and confidentiality protocols adequately adapted to disability-specific needs; and
- Provider reaction to the “Do more with less” phenomenon underlying the unfunded state service mandates.

Vulnerable Populations in Need of HIV Education and Prevention

Persons with disabilities must negotiate multiple and complex barriers when accessing health and social services. The collateral presence of HIV/AIDS compounds these factors. A number of interviewees related grave concern for the most vulnerable of people with disabilities: those who share certain environmental and psychological risk factors above and beyond those faced by the general population. In general, people functioning more independently in the community, often younger individuals with limited oversight or support, were identified as “at risk”. Education and prevention information were inconsistently available or lacking for these individuals. Furthermore, these factors were often compounded by an individual’s personal sense of vulnerability which impacts their view of available options, their judgment, and their behavior choices.

Social isolation makes these sub-populations more susceptible to sexual abuse and victimization, and cognitive impairments can impact decisions about sexual activity and substance use. Those vulnerable sub-populations identified in interviews included:

- Independently living individuals with mental retardation or serious mental illness;
- Persons requiring personal care assistance in activities of daily living from staff and/or other caretakers;
- Recently injured young men with spinal cord injuries;
- Young, gay, deaf men; and
- Women with developmental disabilities who are victims of sexual assault.

Overall, the interview findings indicated that both discrete and wide-ranging gaps exist for persons with disabilities in the Commonwealth across the continuum of HIV services, from education and prevention, to counseling and testing, to health care and support services. The study also identified individuals across the Commonwealth who are knowledgeable about HIV and disability. Many of these leaders and program models have been present since the onset of the epidemic and remain active today. Their dedicated leadership is crucial to bringing into focus, addressing and sustaining involvement in HIV/AIDS services for persons with disabilities.

Recommendations

The following recommendations are presented with acknowledgement of the current fiscal constraints on state agencies and service providers in the Commonwealth. The recommendations span a range from general information dissemination with minimal cost in terms of human and fiscal resources to more resource intensive activities such as the expansion of certain programs or the development of uniform skills-building tools and training.

- Disseminate the study findings and accompanying resource materials as broadly as possible to range of stakeholders and planning groups including:
 - DPH-funded counseling and testing sites
 - DPH-funded prevention/planning groups
 - Statewide consortia
 - DPH statewide advisory committee
 - Other state agencies
 - The Olmstead initiative planning group
 - DPH Office of Health and Disability
 - Websites
- Affirm/provide recognition of ongoing efforts of leaders, including the interviewees who provided critical information for this report
- Post resources on the DPH web-site

- Forge regional relationships/partnerships between the regional AIDS Consortia and the Independent Living Centers
- Work with the Office of Health and Disability and Substance Abuse Bureau to orient all DPH-contracted providers around the issues of disability and HIV
- Expand Deaf, Inc.'s Hope Program statewide
- Develop a risk assessment tool for all human service agency populations to identify priority populations and a point of contact at each agency for HIV
- Contract with disability agencies and advocates to develop disability-specific prevention education curricula and materials
- Work with state agencies to develop consistent monitoring and enforcement of HIV/AIDS contractual provisions with community vendors
- Revive the Executive Office of Health and Human Services inter-agency task force to collaborate and troubleshoot around the needs of people with disabilities in the face of this ever-changing epidemic

Addenda to this Report

HIV/AIDS and People with Disabilities – Needs and Resource Assessment

The HDWG has prepared an overview presentation of the findings of the study, entitled: “HIV/AIDS and People with Disabilities – Needs and Resource Assessment”. This presentation was prepared with the intent of disseminating the findings to key stakeholders.

HIV/AIDS Resource List

A listing of HIV/AIDS resources, derived from web searches, literature searches and materials from local interviewees, has been collected and organized by disability type as a complimentary resource to the Massachusetts specific information gathered from interviews. The Massachusetts specific resources have been incorporated into the listing and are identified as “local” resources. This list was prepared a reference source and general orientation to resources available for further exploration. It is not meant to be comprehensive or exhaustive in nature; rather, we encourage the HIV/AIDS Bureau to build upon this list as new resources come to light.