Professional Expert Key Informant Report on HIV and Substance Abuse

Carol Tobias, MMHS
Mari-Lynn Drainoni, PhD
Jocelyn McCree, MA

Health and Disability Working Group
(formerly Medicaid Working Group)
Boston University School of Public Health

Winter-Spring 2000

This project was funded by a grant from the Human Resources and Services Administration, U.S. Department of Health and Human Services, grant #4H97HA001580201.

Disclaimer: Permission is granted for non-commercial use of documents so long as form of the document is not altered, the copyright is not removed, and a proper citation is made to the document. Non-commercial use of a document is use by a not-for-profit organization in which the document is not sold. If you have questions about appropriate and proper uses, contact the Health and Disability Working Group.

Introduction

The Health and Disability Working Group at the Boston University School of Public Health conducted a series of key informant interviews to obtain information about services delivered to HIV positive substance users and barriers to care. The main purpose of these interviews was to obtain input from experts in the treatment of HIV and substance abuse that could inform other activities of the Evaluation and Program Support Center on HIV and Substance Abuse funded by the Health Research Services Administration (HRSA). These activities include:

- Developing two national surveys of Ryan White CARE Act grantees (one for states funded under Title II and cities funded under Title I, and the other for providers serving HIV positive substance users under all the titles);
- Preparing a literature review on this topic;
- Identifying performance standards that can be used by providers serving HIV positive substance users; and
- Identifying innovative programs and interventions in order to disseminate their success.

Methods

The key informant interviews were conducted between January and April 2000 by researchers at the Health and Disability Working Group. The initial key informants were identified by HRSA. The first group of respondents identified other candidates for interviews. In addition, we held a Key Informant Workshop at the Ryan White All-Titles Meeting in Washington, DC, in January 2000, where interested conference participants had the opportunity to participate in interviews. In order to ensure sufficient representation of people of color, additional key informants were identified by the National Advisory Committee of the Evaluation and Program Support Center on HIV and Substance Abuse in March, 2000.

The key informant interview protocol was a semi-structured tool consisting of 12 open-ended questions that took an average of 30 minutes to complete. Respondents provided information about:

- Their background in substance abuse and HIV/AIDS;
- Interventions that contributed to the success of programs for HIV positive substance users;
- Barriers to care;
- Use of performance standards;
- Evaluations of successful programs; and
- Recommendations they would make to improve service delivery for this population.

A total of 50 interviews were conducted. Fifty-six percent of the respondents were male, and 44 percent were female. The geographic distribution of responses was as follows:

- Northeast – 44%
- Midwest – 22%
- South – 18%
- West – 16%

Respondents reported the following professional backgrounds:

- Substance abuse treatment providers – 38%
- Medical professionals – 12%
- Educators/leaders of community-based organizations – 24%
- Researchers – 20%
- State or federal employees – 6%

The results reported below were analyzed using grounded theory, a standard qualitative research methodology. It is important to note that this is a convenience sample, not a scientifically derived sample. Thus, the findings reported below represent the experiences of this particular group of individuals rather than a full analysis of the state of the art.

The 50 key informants identified a total of 85 programs that they believed were successful in treating HIV positive substance users. They provided more detailed information about 65 of these programs. The largest category of programs (53 percent) was those based in substance abuse treatment settings. The second largest category of programs (22 percent) was those located in HIV medical care settings, primarily community-based or hospital outpatient clinics. Thirteen percent of the programs discussed were case management programs, either standing alone or as part of another organization that was neither an outpatient clinic nor a substance abuse treatment facility. Finally, we obtained information about one or two programs in each of the following categories: referral services, mental health, housing/shelters, and needle exchange.

Successful Program Models and Strategies

Key informants were asked to identify programs they believed were successful in serving HIV positive substance users and the factors that contributed to program success. The three components of program success mentioned most frequently were referral to support services, cultural sensitivity/population-specific services, and integrated service delivery models. Between 40 and 50 percent of the key informants mentioned each of these features in describing the successful attributes of programs serving HIV positive substance users.

Referrals to Support Services

Respondents cited a good system for referring people to support services as the most common reason that programs are generally successful in serving HIV positive substance users (48 percent). Support services included transportation, childcare, employment assistance, legal assistance, food or meals, housing assistance, and a host of other non-medical support services. Many respondents noted that HIV or substance abuse is only one part of a person's life, and it is

very difficult to address these issues if other basic needs are not met. Employment assistance and housing were also mentioned as essential to the recovery process. Specific comments given for the importance of referrals include:

- Case managers act as gatekeepers to all community services, and the clients do not have to make their own referrals.
- The program helps to find the right resources and can get people the individual care they need.
- Clients are provided with a lot of help from the relapse prevention manager. They are linked to job training and continuing education, and transitional services in independent housing.

Cultural Sensitivity and Population-specific Programs

The second most commonly mentioned component of successful programs (46 percent) was the availability of culturally sensitive services or programs that were specifically targeted to under-served populations. Specific populations included African Americans, Latinos, individuals who are homeless, the recently incarcerated, women, individuals with co-morbid mental health disorders, and the gay/lesbian/bisexual/transgender community. Linked to the availability of population-specific programs is the importance of cultural sensitivity. Many key informants stressed the importance of having program staff who are knowledgeable about, and reflect, the communities they are serving. Specific comments about the importance of cultural sensitivity and population-specific programs were:

- It is important to make sure that program messages are culturally appropriate. Both HIV and substance abuse are really hitting the minority populations.
- Hiring indigenous workers is a big help. Thirty-three percent of the staff is HIV positive, and another 33 percent are recovered addicts. The staff is also primarily minority.
- Providers make a connection with the individuals while they are in jail and follow them from jail into the community.
- Drug treatment providers from community-based organizations that are of the same ethnic/racial background as the client are most effective.
- The staff is appropriate and also culturally competent.
- Staff is trained to believe that mental health problems are chronic, not acute, in nature.
- In many substance abuse treatment programs, people are not comfortable disclosing their sexual orientation. However, being able to disclose sexual orientation is important to full recovery.
- Family-focused services are essential.

Integration or Linked Service Delivery Models

Integration of care was the third most common reason for program success, either within a single program or through very strong referral arrangements. Forty-four percent of the key informants cited the integration of different aspects of care as central to program success. The integration of substance abuse treatment with HIV medical care was the most common form of integration cited as important. One fourth of the programs described as successful provided both services under one roof. It is interesting to note that two thirds of these integrated programs were based

in substance abuse treatment settings, and the remainder were based in outpatient medical settings.

Other linkages were also described as important, including substance abuse and mental health treatment, mental health and medical care, and support services and substance abuse or medical care. The issue of linked and comprehensive care generated the most comments from respondents. Specific comments about successful program components included:

- Providers are very willing to collaborate and communicate with other agencies.
- The program closes the gap between mental health/substance abuse services and primary care by giving the primary care providers more information about the issues that might impact a client's ability to follow through with treatment.
- It is important to offer a number of services under one roof in order to meet individual needs and reduce the barriers caused by services that do not work together or readily coordinate.
- The program realistically looks at the needs of the patient in a way that only a multidisciplinary program can do.
- A physician can consult with a substance abuse counselor immediately.
- Everything is under one roof: methadone maintenance, primary care, and HIV counseling services. If a client needs to talk to a professional, everyone is right there. The client does not have to go through many channels.

Staff Skills and Attitudes

The fourth most commonly cited component of programs' success in serving HIV positive substance users (38 percent of respondents) was staff skills and attitudes, particularly the presence of high quality, sensitive staff. These responses highlight the central role of direct care staff in contributing to program quality and success. Some specific comments included:

- Patients are seen every single day, and as a result the providers can notice the subtle changes. The providers get very involved.
- They are persistent and consistent, and get people to trust them.
- Staff are "user-friendly," non-judgmental about drug use, and seen as being tolerant and accepting.
- Providers exhibit a commitment to issues related to HIV/AIDS.
- Professional staff in the program listen to the needs of the consumers.
- The physicians are very respectful of their patients. They are tolerant of people not keeping appointments. They go the extra mile and will call for follow-up. It's a personal touch approach.
- The homeless staying at this shelter have been rejected everywhere else. They are not rejected here.
- We look at people as whole people, not just as parts or diagnoses.

Treatment Philosophies

The use of a harm reduction philosophy and tolerance for relapse were also considered a common reason for success, as cited by 34 percent of respondents. Specific comments included:

- Staff go to the community and work with clients, even if the clients are actively using.

- Regardless of relapse and other status, clients are not kicked out unless they pose a threat to the program, other clients, clinicians, or themselves.
- People receive services with no mandates, although caseworkers are actively sitting with them talking to them.

Some respondents (14 percent) reported that abstinence-based programs, or programs that were not tolerant of relapse, did not have the strengths of relapse-tolerant and harm reduction models. Conversely, others reported that an abstinence-based approach, with tough, clear boundaries and no tolerance for use, was a key to success. In this discussion respondents noted:

- The program does not tolerate relapse and makes people take responsibility for their own recovery.
- Very tight boundaries are set.
- The court programs have an element of external motivation and monitoring of clients.

Finally, one respondent noted that there is a need for both harm reduction and abstinence models of care, and that one alone is not sufficient in the context of HIV.

Other Elements of Success

Other program strengths, though not mentioned as frequently as those cited above, were:

- The availability of case management (28 percent)
- Using outreach to keep people in care (26 percent)
- Family-focused treatment that included children as well as their mothers (10 percent)
- Using ex-addicts as counselors (8 percent)
- Being a client-directed and empowered model of care (8 percent)

Specific statements included:

- Staff work to keep the family together and provide support around sobriety and help for women who need parenting skills or are working to get their children back from DSS custody.
- The program uses a large number of HIV positive outreach workers.
- The program empowers HIV positive drug users to become peer educators, and in this process engages them in their own care and management of HIV infection.
- The client-directed, independent living model empowers people to take control of their own lives with whatever community supports they need.

Barriers to Care for HIV Positive Substance Users

Key informants described many barriers that programs face in serving HIV positive substance users. Some of the barriers related to the experiences of programs that were reported as doing "good work" in this area. Other barriers related to the provider community as a whole.

Funding

The leading barrier reported by key informants was the lack of funding for services. This included lack of funding, lack of insurance coverage, and an inadequate number of treatment slots. Limited funding was reported as a barrier by 62 percent of the key informants in describing the system in general. Interestingly, over half of the HIV medical care programs reported having funding problems, while only one third of the substance abuse treatment programs reported this barrier. Some of the specific comments included:

- For some federal programs, such as Housing Opportunities for People with AIDS (HOPWA), funding levels are determined by Centers for Disease Control (CDC) statistics. These statistics are based on AIDS cases rather than HIV seroprevalence. As a result, the residential program is severely under-funded.
- Insurance practices that limit lengths of stay for drug detoxification are a problem. They make it difficult for people to find aftercare placements because other agencies have such long waiting lists for residential or post-detox care.
- The biggest barrier is the lack of cooperation from the system, such as the state Medicaid program. There are no services available for those clients who have mental illnesses. The hospitals that are left will not take Medicaid patients because there have been so many problems with the state's Medicaid program lately.
- The categorical requirements of different funding sources make it difficult to offer the program to a wider range of clients.
- Many people do not have insurance, which creates another set of obstacles.
- Medicaid does not pay for residential treatment for adults.
- There are not enough drug treatment slots. We need to keep searching and develop relationships with facilities.
- The biggest barrier is definitely financial. We are a for-profit organization and do not get funding. For these reasons it is always a juggling act. We can only carry someone for so long if they cannot pay.

Staffing and Staff Attitudes

The second most commonly identified barrier was staffing concerns, including staff retention, stress, role definition, and training issues. Forty-two percent of the key informants raised this as an impediment to serving HIV positive substance users. Some of the specific comments included:

- The staff turnover rate is very high, and the work environment is very stressful.
- Staff are overburdened and do not have time for follow-up.
- Role definition has been a problem. It often feels like there is a blur between care managers, case managers, and individual therapists.
- Lack of shared in-house education on HIV and substance abuse issues is a barrier.
- Staff need help to understand that addiction is a disease instead of a behavior. This knocks down the argument that if one is strong enough addiction can be controlled.
- We need adequate training in the addictions. The whole HIV epidemic has not given this enough attention (statement of an HIV physician serving a substance using population).

Negative staff attitudes toward HIV positive substance users are closely linked with the staffing and staff training issues. Attitudes were raised as a barrier to substance abuse treatment (16 percent of respondents) as well as to HIV medical care (4 percent of respondents). Specific comments included:

- Providers are reluctant to deal with HIV issues in chemical dependency treatment.
- The language used in the program is negative, for example, "dirty urine," which creates a negative attitude and environment for the clients.
- There is a need to be nonjudgmental and not reject people if they are using due to the shame and secrecy of substance use.
- Traditional medical programs are often insensitive. Medical providers shame drug users for continued use of drugs and becoming HIV positive. Drug users do not want a lecture from their physician.
- The hospital outpatient clinic in one city provides excellent, state-of-the-art medical services through one location, but acceptability (of the program in the eyes of drug users and staff acceptance of drug users) is a problem.

Not surprisingly, key informants expressed different views about where the primary responsibility for problems lies. A few expressed the opinion that the HIV medical community bears the responsibility for not comprehending addiction or appreciating the substance abuse treatment community:

- Medical providers do not understand the number one issue (substance abuse) and are not prepared to cope with it.
- Service providers who work well with drug users are not respected or understood by the traditional medical community.

Others expressed the opinion that the HIV medical community does a better job than substance abuse treatment providers in serving HIV positive substance users:

- Physicians are very accepting of the harm reduction model. Once they are educated, they understand it.
- In one program, our HIV treatment providers are more sensitive to client needs than the substance abuse treatment people. The city is stuck in a very traditional philosophy of substance abuse treatment.

Care Coordination

The third most commonly mentioned barrier was the lack of coordination among programs, particularly those providing HIV medical care and those providing substance abuse treatment. Twenty-eight percent of the key informants mentioned the lack of coordination as a system-wide barrier. This barrier was mentioned equally by people familiar with substance abuse treatment programs and those familiar with HIV medical care programs. Some of the specific comments included:

- There needs to be increased communication. Once a person goes through the system he/she will get to know it as a result of experience. Unfortunately, there is no one who sits down and goes through it with you. Likewise, the process of getting care often seems like it is insurmountable, and clients do not deal with the agency anymore.

- The decision to actually go for treatment is a difficult one. The lack of coordination between different programs makes it even harder for the client.
- Better case management is needed. This means the actual collaboration of agencies. It should not depend on who the case manager knows.
- Integrating HIV and substance abuse treatments—truly cross-training and integrating services—is important because they are now separate services.
- Technical assistance in developing collaborations with other care providers, even in traditional substance abuse programs, is also necessary. Having one agency do everything is too much. Building care collaborations helps to provide quality care.
- There is tremendous fractionalization of services in this city, with very little coordination for people with substance abuse and HIV.

Client Behaviors

Client behaviors were cited by 16 percent of the key informants as barriers to care. The behaviors cited included client manipulation of the system, difficulties faced by people in recovery when some members of their peer group return to active drug use, and missed appointments. Interestingly, only case management programs and substance abuse treatment programs cited client behaviors as a barrier. Specific comments included:

- Clients are always trying to con the providers into thinking that they are clean when they are not.
- Many drug users are "services smart." They have been playing with the system for years. Clients have treatment careers. They go in and out of treatment many times before it actually works.
- Clients tend to be pretty erratic, as it is hard to keep a consistent and continuous program.
- Patients who are actively using and those who are not attend the same program. Thus, it is challenging for those who are not using to stick with the treatment.

Treatment Philosophy

Representing a different perspective, 18 percent of the key informants expressed the view that many programs and services do not accept the reality of substance abuse. These individuals stressed the importance of harm reduction treatment models or programs that are relapse tolerant. Specific comments included:

- "The system" is geared toward abstinence-based substance abuse treatment, and this does not always apply to the HIV-positive population. For this population, harm reduction is definitely the preferred goal. These programs must go against the established "system."
- Access to shelters is difficult for those who have difficulty staying off drugs. People must be clean and sober.
- Other treatment facilities have a difficult time dealing with relapse and HIV issues.

In contrast to this view, one key informant expressed the opinion that with the new treatment options available to HIV positive substance users it is time to rethink harm reduction. This individual argued that harm reduction was important when there were few other treatments, both to prevent the spread of infection and to ease pain. However, with the prospects of improved health and longevity it may be time to re-emphasize abstinence as a lifetime strategy.

Stigma, Community Resistance, and Program Siting

The stigma associated with both HIV and substance abuse can be barriers to care for individual consumers who are reluctant to disclose their status to anyone, including providers. This same stigma also contributes to prejudice and barriers created by communities that oppose efforts to serve this population. An important manifestation of community prejudice is the difficulty in siting substance abuse treatment programs, including detoxification units, methadone programs, and residential programs. Fourteen percent of the key informants raised the issues of stigma, community attitudes, and siting problems as barriers to care. Specific comments included:

- People with HIV are forced to stay in the closet for fear of retaliation or judgmental attitudes.
- Facilities cannot have visible "neon signs" that indicate they are a drug or HIV treatment center, because drug users will not go there. If people even suspect that the facility is a drug or HIV center, they will not use it.
- A program encountered community resistance toward drug users: Originally, they tried to be in one city but did not pass the zoning process. They settled seven miles out of town and ended up buying the land where the program is now located.
- Methadone maintenance programs are placed in "holes in the wall" communities and areas that are most likely to be "run down." They are seen as a threat to nice communities in the surrounding areas.

Barriers for Women and Racial/Ethnic Minorities

Twenty-six percent of the key informants mentioned specific barriers to care for women or racial/ethnic minorities. It is interesting to note that no one mentioned barriers for both populations. Ten percent discussed barriers for women, and 16 percent discussed barriers for minority populations. These barriers included the lack of gender or culturally competent programs, barriers to care related to child-rearing responsibilities, and language barriers. Specific comments included:

- There is a lack of support for women, such as daycare and transportation.
- Issues of domestic violence and a person's history of abuse are not dealt with in a meaningful way (in treatment programs).
- Federal housing criteria exclude women who are doubled up or living in unsafe situations. They must be on the street or in a shelter. This gives women who are unsafe a message that they must go to a shelter first before they can qualify for this housing option.
- All the shelters that accept women have a policy that individuals can stay one month in a shelter and then they must pay rent or else go back to the street. However, there are shelters in this city where men can stay with no price attached.
- The ethnicity of counselors is important. There is a scarcity of African Americans working in substance abuse.
- Many people are not comfortable in programs that are not run by peers or people from the same ethnic/racial/language background as they are.
- There are no Spanish-speaking counselors.

- Effective programs with small budgets, run out of store-front churches with 500 or fewer people in their congregations, do the grassroots work but do not get the funding or training even though they are primary providers for the "underground" population.

In addition to barriers faced by these populations, barriers also exist for the gay and lesbian substance using population. As one key informant reported:

- Funders do not want to pay for a gay treatment program, which is a variable program in terms of quality. However, it is the only place where gays and lesbians want to go.

Housing and Other Support Services

Lack of adequate housing was cited as a barrier to care by 22 percent of the key informants. Lack of other support services, such as transportation and childcare, was sited by another eight percent. Comments included:

- Finding housing that is decent and affordable is a big problem.
- The housing market is very tight in this community, and people have nowhere to go.
- To stop abusing drugs, people need to have an environment to do this, one where everyone around them is not abusing drugs. That's why housing is the key to recovery.
- Housing is the number one issue that needs to be addressed. With secure housing, people can add stability to their lives.

Retention in Care and Lack of Outreach Strategies

The difficulty of retaining people in care was cited as a barrier by six percent of the key informants. Another 10 percent stated that the lack of community-based and street outreach to HIV positive substance users was an important barrier to care. None of these responses overlapped, suggesting that some individuals view retention as a client-centered barrier, while others view it as a failure to employ a successful retention and follow-up strategy. Comments included:

- Getting out in the community and doing hands-on outreach is essential. Providers should not be afraid of going into the community.
- Street outreach is needed using a harm reduction model, such as distributing condoms.
- Service providers are not going to get anywhere with HIV unless they understand what outreach is. Outreach is going on the streets, hitting the bricks, and finding the people. This is the only way they will be found and helped.

Other Barriers to Care

The following barriers to care were reported by eight percent or less of the respondents:

- Cumbersome or restrictive program eligibility rules;
- Difficulties dealing with the criminal justice system;
- Lack of treatment options in rural areas;
- Lack of program standards for substance abuse treatment;
- Government agencies do not work together; and
- Bureaucratic red tape.

Performance Standards

Key informants were asked if they knew of any specific performance standards for programs that serve HIV positive substance users. Respondents had difficulty answering this question. Even when probed to think about types of care or services that HIV positive substance users might receive, more than half of the respondents could not think of any performance standards. Among the 46 percent of respondents who identified performance standards relevant to HIV and/or substance use, there was considerable confusion between performance standards, performance measures, and outcomes. This response indicates that there is a great need to disseminate the concept of performance standards in general, as well as to develop standards specific to HIV positive substance users.

Key informants who were more familiar with programs based in outpatient medical settings were the most likely to identify performance standards (73 percent). This is not surprising, given the existence of numerous standards of HIV medical care developed and published by the United States Public Health Services and the Infectious Disease Society of America. In contrast, only 40 percent of those familiar with case management programs and 33 percent of those familiar with substance abuse treatment programs had knowledge of performance standards that might be relevant to HIV positive substance users.

Among the key informants who could answer the question about performance standards, responses were split between those who identified standards developed by national or local experts, and standards developed and implemented at the program level. Standards developed by national or local experts included:

- Use of the Addiction Severity Index (ASI);
- Use of Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Substance Abuse Treatment (CSAT) measurement tools;
- Use of Shands guidelines;
- Use of Department of Health and Human Services (DHHS) guidelines for medical care;
- Guidelines for prophylaxis and treatment of opportunistic infections;
- Standards for screening for tuberculosis, hepatitis, and sexually transmitted diseases;
- The HIVQual project, which involves specific clinical performance standards and chart reviews; and
- Los Angeles County Standards of Care for HIV.

Some of the key informants reported that specific programs had developed standards of care. Please note that some of these standards may, in fact, be program outcomes:

- Immediate identification of substance users through a screening tool;
- Weekly testing of urine as a prerequisite for receiving services;
- Amount of time a client remains clean and sober;
- National certification for case management;
- Small caseload size;
- Medication compliance; and
- Training of substance abuse treatment staff in HIV (mentioned twice).

Some key informants responded to this question by offering suggestions about areas in which performance standards should be adopted. These included:

- How long a person remains in care;
- Availability of primary care providers knowledgeable about HIV;
- Access to or referral to support services (mentioned twice);
- Connection to medical services for HIV for people in substance abuse treatment programs; and
- Standards for consistency, structure, and guided confrontation in substance abuse treatment.

Program Evaluation

Key informants who identified programs they considered to be successful in serving HIV positive substance users were asked if they knew of any formal program evaluations that had been conducted. Some of the respondents were staff members or directors of programs that they described as successful, and thus were able to respond to this question. However, over one third of the respondents (38 percent) could not answer this question because they were not familiar enough with the specific programs to respond.

Among those who were familiar with the evaluation status of programs, 61 percent reported that an evaluation had been conducted, and 39 percent reported that one had not been conducted. Approximately two thirds of the evaluations were conducted by external consultants, and one third were conducted in-house.

Some types of programs were far more likely to be evaluated than others, either formally through an external evaluator or informally, through patient satisfaction surveys, quality monitoring, or utilization reporting. Respondents who were directly associated with programs reported that 88 percent of the case management programs were evaluated. However, only 46 percent of outpatient medical programs and 26 percent of substance abuse treatment programs were evaluated. Many key informants reported that specific programs lacked funds for formal evaluations. This was particularly true for residential programs. However, several respondents reported that, as a result of their Ryan White Title II funds, they can now look at quality improvement measures and program evaluation.

Key informants identified the following obstacles in conducting program evaluations:

- Funding for program evaluation was sought, but we did not receive it.
- There is no money for program evaluation.
- We will never get a clean evaluation because of the high level of need of the clients.
- People are defined in too many ways.
- “Welfare to work” and funding issues have made longitudinal studies difficult.
- Services are being labeled differently over time. Clients receive the same services, but they are being called something different. Also, clients are receiving different diagnoses.

Conclusion

In summary, the key informants provided valuable information about successful program models and strategies for HIV positive substance users, as well as insights into barriers to care. In contrast, approximately half of the key informants could not provide any information about performance standards relevant to services for HIV positive substance users. Those standards that were identified are fairly well known in the literature.

Referrals to support services was the most commonly referenced strategy for successful programs. This drives home the point that many individuals living with HIV and using drugs have multiples issues and needs. In many cases, if these needs are not addressed, the individuals will not be able to access care and treatment. Key informants also stressed the importance of providing culturally sensitive and population-specific programs. This is essential in terms of engaging people in care and building the trust to keep them connected with services that can address addiction, health care issues, and basic needs. Language capacity and cultural sensitivity were seen as contributing to program success, whereas negative or discriminatory attitudes and rigid program policies or treatment philosophies were seen as barriers.

Integrated systems of care are another essential component of successful programs. When systems were not integrated, the fragmentation was seen as a barrier to care. When present, integrated services were considered an important component of success. This integration applied most frequently to co-located substance abuse treatment and primary medical care, but also included other models and forms of integration, such as mental health and support services.

Staff skills and attitudes also figured very prominently in key informant comments about the reasons for program success or barriers to care. This highlights the critical importance of qualified, well-trained, well-supervised staff who work on the front lines of serving HIV positive substance users. Another less frequently mentioned strategy that contributed to successful programs was an outreach approach to client follow-up and retention in care. Although outreach is a more common practice in HIV prevention programs, it was stressed that ongoing outreach was an important factor in keeping people engaged in care once they knew their status.

Finally, it should be noted that the biggest single barrier to successful programs was funding or insurance coverage. Despite the expansion of public benefits over the past few years, there are still major funding barriers. Although the key informant interviews did not provide a lot of depth on the funding issues, it appears that lack of coverage for substance abuse treatment and integrated program models are serious concerns and need to figure prominently in future research.

Successful Programs

1. Action Point Center, San Francisco, CA
2. AIDS Community Research Consortium, San Mateo, CA
3. AIDS Health Care Foundation, Los Angeles, CA
4. AIDS Substance Abuse Program, Indianapolis, IN
5. AIDS Path Force of Southeast Central Indiana, Indianapolis, IN
6. AIDS Serve, Indianapolis, IN
7. AIDS Task Force, Fort Wayne, IN
8. Aliviane, El Paso, TX
9. Andrew House, Quincy, MA
10. A Safe Haven, Chicago, IL
11. Bethel Recovery Center, Bridgeport, CT
12. Bienestar, Los Angeles, CA
13. Bridge Project (SPNS), San Francisco, CA
14. Bureau of Alcohol and Drug Abuse of the State of Nevada, Carson City, NV
15. Catholic Family Service of Bridgeport, Bridgeport, CT
16. Collaborative Care Management Program, East Boston Neighborhood Health Center, East Boston, MA
17. Community Awareness Group, Detroit, MI
18. Community Counseling Center, Las Vegas, NV
19. Community Health Assessment Group, Detroit, MI
20. Connections Day Treatment, East Boston, MA
21. Damien Center, Indianapolis, IN
22. Day by Day, Selma, NC
23. Drug Court, South Boston, MA
24. Ebony House, Phoenix, AZ
25. Erie Family Health Center, Chicago, IL
26. Gay and Lesbian Center, Los Angeles, CA
27. Glide Memorial Church, San Francisco, CA
28. Harvest House, Newton Grove, NC
29. Haymarket Center, Chicago, IL
30. Health Link, Hunter College, Center on AIDS, Drugs, and Community Health, New York, NY
31. Health of Ark Refuge, San Francisco, CA
32. Helping Hands, Bridgeport, CT
33. Hennepin County Methadone Maintenance Project, Minnesota, MN
34. Henry Lee Willis Center, Worcester, MA
35. HIV Cybermall, Panorama City, CA
36. HIV Diagnostic Evaluation Unit, Boston, MA
37. Immaculate Conception Shelter and Housing Corporation, Hartford, CT
38. Immunology Center (HIV Clinic), Miriam Hospital, Providence, RI
39. Immuno Deficiency Clinic at the University of Pennsylvania, PA
40. Infectious Disease Clinic, Presbyterian Hospital, Pennsylvania, PA
41. Latinos Contra Sida, Hartford, CT
42. Lincoln Medical and Mental Health, Lincoln Recovery Center, Bronx, NY

43. Living and Recovering Community (LARC), Jamaica Plain, MA
44. Lower East Side Service Center, Manhattan, NY
45. McKinney Residence, Stanford, CT
46. Medical and Health Research Associates, New York City, NY
47. Memorial Hospital, Pawtucket, RI
48. Meridian Program, East Boston, MA
49. Methadone Clinic, Boston Public Health Commission, Boston, MA
50. Metropolitan Inter-Denominational Church, Nashville, TN
51. Minority Health Coalition, Fort Wayne, IN
52. Narco Freedom, Bronx, NY
53. Nazareth House, Roxbury, MA
54. New Haven Community Healthcare Van, New Haven, CT
55. New York State Department of Health, AIDS Institute, Albany, NY
56. Omega House, Willimantic, CT
57. Outreach, Atlanta, GA
58. Partnerships for the People, Philadelphia, PA
59. Peter's Retreat, Hartford, CT
60. Pride Program, Lake Shore Hospital, Chicago, IL
61. Prevention Point, Philadelphia, PA
62. Project Bridge, Providence, RI
63. Project LifeRoad, Houston, TX
64. Project Return, New York, NY
65. Project Teach, Philadelphia FIGHT, Philadelphia, PA
66. Prototypes, Los Angeles, CA
67. Rhode Island Hospital, Providence, RI
68. Rural Aids Action Network, Minneapolis, MN
69. Safe Start, Low Income Trust Fund I and II, Chicago, IL
70. Sisters Together in Reaching, Baltimore, MD
71. Southern Illinois Healthcare Foundation, Centreville, IL
72. Spectrum, Worcester, MA
73. Spectrum HealthCare, Jersey City, NJ
74. STOP, San Francisco, CA
75. The Measurement Group, Culver City, CA
76. University Medical Center/HIV Wellness Center, Las Vegas, NV
77. Tampa Care Clinic/Pinellas Care Clinic, Tampa Florida
78. Tenderloin Care (TLC) Collaboration (connected to Tenderloin AIDS Resource Center [TARC]), San Francisco, CA
79. The Village Center, Brooklyn, NY
80. Tri-County Community Health Center, Newton Grove, NC
81. University Medical Center/HIV Wellness Center, Las Vegas, NV
82. Walden House, San Francisco, CA
83. Walter B. Jones Alcohol and Drug Abuse Treatment Center, Greenville, NC
84. Well-Being Institute, Detroit, MI
85. Women's Hope Transitional Program, Boston, MA
86. Women's Health Project/Park City Primary Care Center, Bridgeport, CT

Key Informants

1. Hortensia Amaro, Ph.D., Professor of Psychology, Social and Behavioral Sciences Department, Boston University School of Public Health, Boston, MA
2. Chuck Barker, Assistant Executive Director/ASAP Specialist, AIDS Path Force of Southeast Central Indiana, Richmond, IN
3. Linda Brandt, Executive Director, Rural AIDS Action Network, Minneapolis, MN
4. Carl Chambers, Health Program Coordinator, Southern Illinois Healthcare Foundation, Centreville, IL
5. Michael Collins, Registered Nurse/Certified Alcohol and Drug Abuse Counselor, University Medical Center/ HIV Wellness Center, Las Vegas, NV
6. Sue Cu-Uvin, Assistant Professor of Ob/Gyn, Brown University/Director of Immunology Center, Miriam Hospital, Providence, RI
7. Annet Davis-Vogel, Clinical Specialist/Research Coordinator, University of Pennsylvania, Philadelphia, PA
8. Anne Doolen, Director of Development/ Perinatal Substance Abuse Consultant to the State of North Carolina, Tri-County Community Health Center, Newton Grove, NC
9. Michael Doolen, Behavioral Health Specialist, Tri-County Community Health Center, Newton Grove, NC
10. Ricardo Dunner, Associate Medical Director, Freedom Neighborhood Family Community Health, Bronx, NY
11. Ruth Finkelstein, Sc. M., Director, Office of Special Populations, New York Academy of Medicine, New York, NY
12. Dr. Robert Fullilove, Associate Professor of Clinical Public Health and Associate Dean for Community & Minority Affairs, Columbia University, New York, NY
13. Sterling Gildersleeve, Executive Director, A Safe Haven, Chicago, IL
14. Linda Gorman, Program Director, Omega House, Willimantic, CT
15. Marjorie Gutman, Director of Prevention Research, Treatment Research Institute, Philadelphia, PA
16. Kathy Hagearty, Director of Community Services, Catholic Family Service of Bridgeport, Bridgeport, CT
17. David Hale, Public Health Administrator, Centers for Disease Control, Atlanta, GA
18. Kim Hanton, Program Manager, Connexions Day Treatment, North Suffolk Human Services Association, East Boston, MA
19. Delbert Harman, Case Manager, Indiana Urban League AIDS Substance Abuse Program, Indianapolis, IN
20. Pamela Hines, Executive Director, Minority Health Coalition, Fort Wayne, IN
21. Leah Holmes, L.I.C.S.W., Senior Project Director, Miriam Hospital, Providence, RI
22. George Huba, Ph.D., President, The Measurement Group, Culver City, CA
23. Bruce Johnson, Ph.D., Director, Institute of Special Populations Research, NDRI, New York, NY
24. Stephanie Johnson, L.I.C.S.W., Care Manager, East Boston Neighborhood Health Center, East Boston, MA
25. T. Stephen Jones, Associate Director for Science, CDC/DHHS/NCHSSTP/DH, Atlanta, GA
26. Janice Kelly, Founder and Executive Director, Bethel Recovery Center, Bridgeport, CT
27. Vicki Kenyon, R.N., Manager, St. Joseph’s Hospital, Tampa, FL

28. Allen “Skip” Land, Certified Substance Abuse Professional/Behavioral Health Service Coordinator, Erie Family Health Center, Chicago, IL
29. Shawn Lang, Special Project Coordinator, Connecticut AIDS Resources Coalition, Hartford, CT
30. Stephen Manocchio, M.D., Infectious Disease Physician, Hoboken, NJ
31. Dave Martineau, Executive Director, Immaculate Conception Shelter and Housing Corporation, Hartford, CT
32. Michael Massing, Writer, New York, NY
33. Judith Mayo, Ph.D., Project Manager and Evaluator, Northeast Valley Health Corporation, HIV Cybermall, Panorama City, CA
34. Lisa Metsch, Assistant Professor, University of Miami, Miami, FL
35. Dave Metzger, Ph.D., Director, AIDS Research Division, University of Pennsylvania Medical Center for Studies of Addiction, Philadelphia, PA
36. Lydia Myers, Care Program Coordinator, Community Health Awareness Group, Detroit, MI
37. Meg Musselman, Family Nurse Practitioner, Coastal Health District, Department of Public Health, Brunswick, GA
38. Bruce Occena, Independent Consultant, City and County of San Francisco Community Substance Abuse Services and Women and Children’s Family Services, Oakland, CA
39. Bob Olander, Director of Chemical Health Services, Chemical Health Division of Hennepin County, MN
40. Billy Pick, Program Manager, City and County of San Francisco Department of Public Health, HIV Health Services, San Francisco, CA
41. Harold Pollack, Assistant Professor of Health Management and Policy, University of Michigan, School of Public Health, Ann Arbor, MI
42. Eugene Richards, Consultant, Innovative Health Solutions Corporation, Emeryville, CA
43. Felipe Rocha, LICSW, CADAC, Deputy Director, HIV/AIDS Bureau, Boston, MA
44. Nate Rush, Assistant Director of HIV and STD, Indiana Minority Health Coalition (IMHC), Indianapolis, IN
45. Jeffrey Samet, M.D., Co-Director of HIV Diagnostic Evaluation Unit, Boston Medical Center, Boston, MA
46. Deborah Scott, Ph.D., Community Research/Social Marketing, Sage Associates, Houston, TX
47. Pernesa Seele, Founder and Chief Executive Officer, The Balm in Gilead, New York, NY
48. Christopher Smith, Director of AIDS Program, Glide Memorial Church, San Francisco, CA
49. Richard Whitley, HIV/AIDS/STD Director, State of Nevada Health Department, Carson City, NV
50. Reverend Thann Young, Manager of National Anti-Drug and Violence Campaign, Congress of National Black Churches, Washington, D.C.