

# Presidential Advisory Council on HIV/AIDS

## SAMHSA Update

March 25, 2008

Washington, D.C.

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM.

Director.

Center for Substance Abuse Treatment.

Substance Abuse Mental Health Services Administration.

U.S. Department of Health & Human Services.

President George W. Bush

“A hopeful society acts boldly to fight disease like HIV/AIDS, which can be prevented, and treated, and defeated.... We will also lead a nationwide effort...and come closer to the day when there are no new infections in America.”

January 31, 2006.

## SAMHSA's Organization

Administrator (OA), Terry L. Cline, PhD.

Office of Policy, Planning, & Budget (OPP).

Office of Program Services (OPS).

Office of Communications (OC).

Office of Applied Studies (OAS).

Center for Mental Health Services (CMHS).

Center for Substance Abuse Prevention (CSAP).

Center for Substance Abuse Treatment (CSAT).

SAMHSA Matrix of Priorities. A Life in the community for everyone. Building resilience and facilitating recovery.

Programs/Issues.

Co-occurring disorders.

substance abuse treatment capacity.

Seclusion and restraint.

Strategic Prevention framework.

Children and families.

Mental health system transformation.

Suicide prevention.

Homelessness.

Older adults.  
HIV/Aids and hepatitis.  
Criminal and juvenile justice.  
Workforce development.

Cross-cutting principles.  
Science to services/evidence-based practices.  
Data for performance measurement and management.  
Collaboration with public, private, and international partners.  
Reducing stigma and discrimination, and other barriers to service.  
Cultural competency/eliminating disparities.  
Community and faith-based approaches.  
Trauma and violence (e.g. physical and sexual abuse).  
Financing strategies and cost-effectiveness.  
Rural and other specific settings.  
Disaster readiness and response.

## SAMHSA's Goals.

Accountability.

Measure and report program performance.

- Track national trends
- Establish measurements & reporting systems
- Develop and promote standards to monitor service systems
- Achieve excellence in management practices

Capacity.

Increase service availability.

- Support service expansion
- Improve services organization and financing
- Recruit, educate, and retain workforce
- Create interlocking systems of care
- Promote appropriate assessment
- Assess resources and needs referral

Effectiveness.

Improve service quality.

- Assess service delivery practices
- Identify and promote evidence-based approaches
- Implement & evaluate innovative services
- Provide workforce training & education

## The Challenge.

Past Year Perceived Need for and Effort Made to Receive Treatment among Persons Aged 12+ Needing But Not Receiving Specialty Treatment for Illicit Drug or Alcohol Use: 2006

Did Not Feel They Needed Treatment.

(20,114,000).

95.5%.

Felt They Needed Treatment and Did Not Make an Effort.

(625,000).

3.0%.

Felt They Needed Treatment and Did Make an Effort.

(314,000).

1.5%.

21.1 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use.

## Past Month Use of Specific Illicit Drugs among Persons Aged 12 or Older: 2006

Illicit Drugs. 20.4 million.

Marijuana. 14.8 million.

Psychotherapeutics. 7 million.

Cocaine. 2.4 million.

Hallucinogens. 1.0 million.

Inhalants. .8 million.

Heroin. .3 million

## Past Month Nonmedical Use of Prescription Drugs (Psychotherapeutics) among Persons 12+:2002-2006.

Percent Using in Past Month.

	Pain Relievers	Stimulants	Sedatives	Tranquilizers
2002	1.9	0.5	0.2	0.8
2003	2.0	0.5	0.1	0.8
2004	1.8	0.5	0.1	0.7
2005	1.9	0.4	0.1	0.7
2006	2.1	0.5	0.2	0.7

+ Difference between this estimate and the 2006 estimate is statistically significant at the .05 level.

Past Year Methamphetamine Use among Persons Aged 12+, by Age:  
2002-2006.

	12 or Older	12 to 17	18 to 25	26 or Older
2002	0.7	1.0	2.0	0.5
2003	0.7	0.7	1.9	0.5
2004	0.8	0.7	1.9	0.6
2005	0.7	0.7	1.8	0.5
2006	0.8	0.7	1.7	0.6

+ Difference between this estimate and the 2006 estimate is statistically significant at the .05 level.

Injection Drug Use & HIV/AIDS.

According to CDC data on U.S. adolescents and adults

– in 2005:

- Approximately 20% of the reported new AIDS cases were related to injection drug use.
- 20% of males and 33% of females living with AIDS were exposed through injection drug use.
- Almost one-third (28.2%) of AIDS deaths were adolescents and adults infected through injection drugs.

Source: Centers for Disease control and Prevention, HIV/AIDS Surveillance Report, Vol. 17, Revised Edition, June 2007, retrieved 2/15/08.

HIV Diagnoses by Race/Ethnicity.

In 2005, about half (49%) of the people diagnosed with HIV/AIDS were black (according to information from 33 states). Children are included in these data.

Asian/Pacific Islander	American Indian/Alaska Native	Black	White	Hispanic
1%	1%	49%	31%	18%

Source: CDC HIV/AIDS Surveillance Report: HIV Infection and AIDS in the United States and Dependent Areas, 2005.

## Blacks & HIV/AIDS.

Of the 956,019 AIDS cases reported to CDC through 2005, blacks accounted for:

- 40% of total
- 60% of women
- 59% of heterosexual persons at high risk\*
- 59% of children aged <13 years

Of AIDS cases reported during 2005, 48% were black adults and adolescents.

\*High-risk heterosexual contact with a person known to have, or to be at high risk for, HIV infection.  
Source: CDC HIV/AIDS Surveillance Report: HIV Infection and AIDS in the United States and Dependent Areas, 2005.

## Hispanics & HIV/AIDS.

- Hispanics account for a disproportionate share of AIDS cases.
- Hispanics make up 14% of the population -- yet, from 1981 through 2005, they accounted for:
  - 19% of total number of AIDS cases reported to CDC
  - 19% of women reported having AIDS
  - 22% of heterosexual persons at high risk\*
  - 23% of children aged <13 years

\*High-risk heterosexual contact with a person known to have, or to be at high risk for, HIV infection.  
Source: CDC HIV/AIDS Surveillance Report: HIV Infection and AIDS in the United States and Dependent Areas, 2005.

## Women & HIV/AIDS.

Estimated Number of AIDS Cases and Rates for Female Adults & Adolescents, by Race/Ethnicity.  
2005 – 50 States & DC.

Race/Ethnicity	Cases	Rate (cases per 100,000 population)
White, Not Hispanic	1,747	2.0
Black, Not Hispanic	7,093	45.5
Hispanic	1,714	11.2
Asian/Pacific Islander	92	1.6
American Indian/Alaska Native	45	4.4
Total*	10,774	8.6

\*Includes 83 female adults & adolescents of unknown race or multiple races.  
Source: CDC HIV/AIDS Surveillance Report: HIV Infection and AIDS in the United States and Dependent Areas, 2005.

## American Indians/Alaska Natives (AI/AN) & HIV/AIDS.

- American Indians and Alaska Natives (AI/AN) have the third highest rate of AIDS diagnosis in the United States, despite having the smallest population.
- AI/AN people with AIDS are likely to be younger than non-AI/AN people with AIDS.
- AI/ANs also have the shortest time between AIDS diagnosis and death.

Source: CDC HIV/AIDS Surveillance Report: HIV Infection and AIDS in the United States and Dependent Areas, 2005.

## SAMHSA'S HIV/AIDS & HEPATITIS ACTIVITIES.

### SAMHSA Goals.

#### Minority AIDS Initiative (MAI).

- Increase access of racial and ethnic minority communities to HIV prevention, care & treatment services;
- Implement strategies and activities specifically targeted to the highest risk and hardest-to-serve populations; and
- Establish collaboration, partnership or opportunities for programs and/or activities to be integrated, including
  - Faith & Community-based organizations
  - Research institutions
  - Minority-serving colleges & universities
  - Healthcare organizations
  - State & local health departments
  - Criminal & Juvenile Justice Systems

### SAMHSA MAI Funding.

Dollars in Thousands.

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate
Center for Mental Health Services	\$9,283	\$9,283	\$9,283
Center for Substance Abuse Prevention	\$39,358	\$39,385	\$39,385
Center for Substance Abuse Treatment	\$62,488	\$63,129	\$63,129
TOTAL SAMHSA	\$111,129	\$111,797	\$111,797

## SAMHSA HIV/AIDS & Hepatitis Targeted Capacity Expansion Grants.

The SAMHSA HIV/AIDS and Hepatitis Targeted Expansion (TCE) grants are administered by each of the 3 Centers:

### CSAT:

- The purpose of the CSAT TCE/HIV grant program (63.1M) is to enhance and expand substance abuse treatment and/or outreach and pretreatment services in conjunction with HIV/AIDS services.
- These grants require that at a minimum, 80% of all clients will be tested for HIV/AIDS.

## SAMHSA HIV/AIDS & Hepatitis Targeted Capacity Expansion Grants.

### CSAP:

- The purpose of the CSAP TCE/HIV grant program (39.3M) is to assist communities in expanding existing HIV/AIDS and substance abuse prevention services.

### CMHS

- The purpose of the CMHS HIV/AIDS Minority Mental Health Services grant program (9.2M) is to increase capacity to provide culturally competent mental health treatment services to individuals living with HIV/AIDS.

## SAMHSA Projects to meet MAI Objectives.

Increase testing of affected populations.

- Rapid Testing Initiative
- Enhancing Substance Abuse Treatment Services to Address Hepatitis Infection Among IDU's

Capacity-building and testing.

- Targeted Capacity Grants
- Minority Education Institution (MEI) Initiative
- SAMHSA/ONDCP Drug-Free Communities Support Program (DFCSP) Faith-based Substance Abuse and HIV Prevention Initiative

Sustainability.

- One-SAMHSA Minority HIV/AIDS Initiative (MAI) Conference

### SAMHSA's Rapid HIV Testing Initiative (RHTI).

- From FY 2005 through FY 2007, 416,895 rapid testing kits were distributed to CSAT and CSAP grantees.
- The RHTI was designed to reduce HIV incidence rates among minority populations who may be at an even greater risk for acquiring or transmitting HIV associated with substance abuse and/or a mental health disorder than other populations.
- SAMHSA secured a federal contract with OraSure Technologies to supply rapid HIV test kits at no cost to eligible service providers.
  - These rapid HIV test kits were approved by the Food and Drug Administration and waived under the Clinical Laboratory Improvement Amendment of 1988 (CLIA) for use in non-clinical settings.

### SAMHSA's Rapid HIV Testing Initiative Goals.

- Incorporate the new rapid HIV testing methodology into SAMHSA's qualified program sites as a strategic intervention:
  - To facilitate early diagnosis of HIV among at-risk minority populations involved in substance abuse (SA) and/or living with a mental health (MH) disorder, and
  - To increase referrals to sustained quality counseling, treatment, and other supportive care services for such persons diagnosed with HIV;
- Provide effective counseling to persons who previously tested negative to decrease their risk of acquiring HIV;
- Identify an increased number of evidence-based prevention and treatment programs and practices in the area of HIV/AIDS associated with SA and/or MH.

### SAMHSA's Rapid HIV Testing Initiative

- SAMHSA provided access to training, including travel, to eligible service providers.
  - The fundamentals of rapid HIV testing, prevention counseling, and related data collection activities was covered during the training.
- Targeted populations included persons with a substance use (e.g., injection drug users) and/or mental health disorder, men who have sex with men, at-risk college students, sex workers, at-risk pregnant women, reentry populations, and transgender populations.



## Hepatitis A&B Vaccination & Hepatitis C Testing.

### Prevention Strategies:

- Provide an early diagnosis of Hepatitis infection in drug users involved in treatment programs and refer HIV+ clients to care and recovery support services.
- Provide testing for Hepatitis C infection in HIV+ clients of substance abuse treatment programs
- Vaccinate for Hepatitis A and B infections with the Twinrix vaccine, followed by referral to Hepatitis care for those individuals who test positive for Hepatitis C infection to reduce the risk of progressive liver disease.

## Hepatitis A&B Vaccination & Hepatitis C Testing Outcomes.

- CDC-recommended immunizations are occurring as a 'one-stop' patient care service so that patients are effectively immunized against Hepatitis A and B virus that could otherwise result in significant disability or death.
- 40,000 Hepatitis C test kits have been procured and distributed allowing for testing of 800 individuals at each of the 50 testing sites.

## SAMHSA/CSAT & CDC Collaboration.

SAMHSA is actively engaged in collaborating with CDC regarding HIV initiatives and data. Outcomes from a February meeting between SAMHSA and CDC include:

- SAMHSA will identify points of contact for collaboration in data collection and implementation guidance for testing.
- SAMHSA is actively engaged with CDC in implementing the HIV testing guidelines.

## CSAT.

## HIV/AIDS & HEPATITIS ACTIVITIES.

## HHS/SAMHSA CSAT Minority AIDS Initiative.

[Map of the United States highlighting the following states: Alaska, Washington, California, Nevada, Utah, Arizona, New Mexico, Texas, Oklahoma, Michigan, New York, North Carolina, and Florida.]

### CSAT - Minority AIDS Initiative.

- Minority AIDS grants are awarded to community-based organizations with two or more years of experience in the delivery of substance abuse treatment and related HIV/AIDS services.
- Programs target African American, Latino/Hispanic and other racial or ethnic communities highly affected by substance abuse and HIV/AIDS.
- HIV Outreach grants served 22,760 clients
- TCE/HIV grants served 18,158 clients
- As a whole, the HIV Portfolio served a combined 40,918 clients

### HIV/AIDS Outreach – TCE/HIV Evidences of Success.

National Outcome Measures (NOMs)	% at Intake	6-Month Follow-up (%)	Difference
Clients reporting no substance use	31.9%	56.1%	Increased 75.9%
Clients reporting being employed	25.0%	37.6%	Increased 50.7%
Clients reporting being housed	33.5%	39.8%	Increased 18.8%
Clients reporting no arrests	84.9%	87.3%	Increased 2.9%
Clients reporting being socially connected	68.9%	73.0%	Increased 6.0%

### TCE/HIV and HIV Outreach Changes in Risk Behaviors.

Clients reporting injection drug use decreased 62.3% between intake and 6 month follow-up.  
Intake. 11.6%.

6-month follow-up. 4.4%.

Source: SAIS data FY 2004 through 3/21/08.

### TCE/HIV and HIV Outreach Changes in Risk Behaviors.

Clients reporting having unprotected sex decreased 10.4% between intake and 6-month follow-up.

Intake. 68.9%.

6-month follow-up. 61.7%.

Source: SAIS data FY 2004 through 3/21/08.

### TCE/HIV and HIV Outreach Changes in Risk Behaviors.

Clients reporting having unprotected sex with an HIV+ individual decreased 10.1% between intake and 6-month follow-up.

Intake. 5.2%.

6-month follow-up. 4.6%.

Source: SAIS data FY 2004 through 3/21/08.

### TCE/HIV and HIV Outreach Changes in Risk Behaviors.

Clients reporting having unprotected sex with an injection drug user decreased 34.2% between intake and 6 month follow-up.

Intake. 8.9%.

6-month follow-up. 5.8%.

Source: SAIS data FY 2004 through 3/21/08.

### TCE/HIV and HIV Outreach Changes in Risk Behaviors.

Clients reporting having unprotected sex with an individual high on some substance decreased 38.1% between intake and 6 month follow-up.

Intake. 33.6%.

6-month follow-up. 20.8%.

Source: SAIS data FY 2004 through 3/21/08

### HHS Minority HIV/AIDS Initiative.

#### SAMHSA

- April 2007, received \$3 million to increase or enhance services to American Indians and Alaska Natives at risk for substance use and HIV/AIDS
- Some areas of activity :
  - HIV/AIDS Rapid Testing and training
  - Education
  - Prevention
  - Outreach
  - Capacity building

[M A I. American Indian, Alaska Native. Center for Substance Abuse Treatment.]

### HHS Minority HIV/AIDS Initiative.

- Implementing through partnership with—
  - National Council of Urban Indian Health
  - National Native American AIDS Prevention Center
  - Urban Indian Health Institute
  - National Indian Health Board
  - Northwest Portland Area Indian Health Board
  - Navajo AIDS Network, Inc
  - South Puget Intertribal Planning Agency
  - Ti-chee Native American HIV Prevention
  - Native Health
  - Alaska Native Tribal Health Consortium

### HHS Minority HIV/AIDS Initiative.

- Implementing through collaboration with—
  - Indian Health Service
  - Center for Disease Control

### HIV Rapid Testing.

- Purchase and distribute 50,000 test kits to tribes, tribal organization, urban Indian health clinics that have the capacity to provide HIV Rapid Testing
- Host two CDC Rapid HIV Testing Training
- Host CDC Rapid HIV Testing Train the Trainer

### Challenges

- Stigma in facilities and communities
- Concern for confidentiality
- Jurisdiction in situations at the state level
- Lack of consensus on what / how to educate
- Lack of human resources with local expertise
- Appropriate but competing priorities with funds
- Complacency (#) / perception that HIV is rare
- Gathering data remains complex
- Reactive paradigm

FY 2008

## Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services (TCE/HIV).

### Award Information:

- Application Deadline: March 27
- Funding Mechanism: Grant
- Anticipated Total Available Funding: \$19.8 million
- Anticipated Number of Awards: Up to 50
- Anticipated Award Amount: Up to \$450,000 for treatment services; up to \$350,000 for outreach & pretreatment services
- Length of Project Period: Up to 5 years
- For more information & application: <http://www.grants.gov/>

Proposed budgets cannot exceed \$450,000 (\$350,000 for outreach & treatment) in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals & objectives, timely submission of required data and reports, 7 compliance with all terms and conditions of award.

## SAMHSA/CSAT Rapid HIV Testing Requirements in FY 2008 TCE/HIV RFA.

- CSAT has an HIV testing requirement in the FY 2008 TCE/HIV RFA:
  - All grantees must provide on-site HIV testing in accordance with State and local requirements or provide referral to an HIV testing site certified by the local health department if the client requests off-site HIV testing.
  - CSAT expects that all FY 2008 TCE/HIV grantees test a minimum of 80% of all clients.
    - Grantees must justify an HIV testing rate below 80%
    - CSAT will consider any failure to provide an adequate justification when making annual determinations to continue a grant and the amount of any continuation award.
  - HIV testing may also be made available to the injection and/or sexual partners of the clients.

## CSAT – SAPT Block Grant Set-Aside

- The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act of 1992 amended Title XIX, Part B, Subpart II of the Public Health Service Act
- Requires States with an AIDS case rate of 10 or more per 100,000 individuals (“Designated States”) to set-aside a certain percentage of the SAPT Block Grant to establish 1 or more projects for early intervention services for HIV.
- Currently, all Designated States are required to set aside 5% of their SAPT Block Grant allocations for early intervention HIV services.

## CSAT – FY 2008 SAPT Block Grant Set-Aside

- In FY 2008, 21 States, Puerto Rico, and U.S. Virgin Islands were HIV “Designated States.”
- Total SAPT HIV Set-Aside funding: \$56.77 Million
  - HIV early intervention projects include counseling, HIV testing, and referral services.
  - States are being encouraged to use part of their HIV set-aside to purchase Rapid HIV Test Kits

## Block Grant HIV Set-aside States.

HIV Set-aside State (Reported 10 HIV cases per 100,000 to CDC.

[Map of the United States Highlighting the following states that reported 10 HIV cases per 100,000 to CDC: Hawaii, California, Nevada, Texas, Illinois, Louisiana, Mississippi, Alabama, Tennessee, Georgia, North Carolina, South Carolina, Florida, New York, Pennsylvania, Delaware, New Jersey, Rhode Island, Puerto Rico, and the Virgin Islands.]

## Examples of MAI Grantee Activities

- St. Luke’s-Roosevelt Institute for Health Scis - NYC
  - Offers HIV rapid testing, along with pre- and post-test counseling at the hospital’s emergency room. Target population: HIV positive and HIV high-risk minority adolescents with substance abuse problems in school-based and outpatient treatment settings
- Test Positive Aware Network – Chicago, IL
  - Aims to decrease substance abuse and HIV transmission among African American men by providing education, brief interventions, individual and group level counseling, HIV testing, and substance abuse treatment.

## Examples of MAI Grantee Activities (cont’d)

- Latino Community Services Inc. – Connecticut
  - Latino Faith Partnership for Prevention and Treatment, in partnership with a core group of Latino pastors, targets the Latino/Hispanic community in CT with evidence-based practices for community outreach, screening, HIV/STD testing, substance abuse treatment and HIV prevention intervention
- Prototypes – Los Angeles County, CA
  - In collaboration with the Los Angeles County Public Defender’s office, provides HIV/AIDS services, including rapid confidential HIV testing and referrals for medical treatment, to mostly Latina and African American women sex workers in Los Angeles

## CMHS HIV/AIDS & HEPATITIS ACTIVITIES.

### CMHS - HIV/AIDS Initiatives.

#### The Mental Health HIV Services Collaborative (MHHSC) Program

- The MHHSC grant program is designed to support the provision of culturally competent HIV/AIDS-related mental health treatment and case management services to persons in minority communities.
- MHHSC serves to strengthen & expand the capacity of community-based entities to address the treatment needs of under-served individuals.

### CMHS - HIV/AIDS Initiatives.

#### The Mental Health HIV Services Collaborative (MHHSC) Program – Cohort I (2001-2005)

- 20 MHHSC grant sites provided approximately 8,000 individuals with HIV-related mental health services
- 12 of the 20 sites developed or expanded services in traditional (clinical) settings; 8 provided services in both traditional and non-traditional (e.g. home-based or mobile treatment) settings
- The grant sites engaged in collaboration with other HIV & behavioral health services providers in their locations, enhancing a network of care.

### CMHS - HIV/AIDS Initiatives.

#### The Mental Health HIV Services Collaborative (MHHSC) Program – Cohort I (2001-2005) – cont'd

- All 20 grant sites received training on providing culturally-competent care
- All 20 grant sites formed or expanded Consumer Advisory Boards that played a meaningful role in project activities.

### CMHS - HIV/AIDS Initiatives.

#### The Mental Health HIV Services Collaborative (MHHSC) Program – (2006-2010)

- There are currently 16 MHHSC grant sites in Cohort II
- Allocated for Grant Awards: \$8.4 Million annually (approximately \$525 K per grantee per year)
- NOMs data from grant sites is being collected by CMHS' new TRAC system, which went live in 2007.
- Data is expected to be available later in FY 2008.

## CMHS Mental Health HIV Services Collaborative Program

[Map of the United States showing sites funded in fiscal years 2001 through 2005. Twenty sites. And sites funded beginning in fiscal year 2006. Sixteen sites.]

## CMHS - HIV/AIDS Programs.

The Mental Health Care Provider Education in HIV/AIDS Program (MHCPE) III

- Annual allocation of \$450,000 is in the form of 3 contracts for professional training on HIV & mental health:
  - American Psychological Association (\$150,000 annually)
  - American Psychiatric Association (\$150,000 annually)
  - National Association of Social Workers (\$150,000 annually)
- Built on the goals and successes of the original MHCPE program administered by CMHS since 1992, this program has supported training for over 200,000 mental health care providers.

## CMHS - mental health AIDS

- mental health AIDS is a free, online, quarterly biopsychosocial research update designed to summarize, organize, and facilitate the practical application of the immense and ever-increasing body of peer-reviewed literature on HIV & mental health for front line clinicians.
- The format reflects a systems-oriented approach to the understanding of health and disease.
  - HIV mental health treatment planning considers not only the psychiatric & psychological aspects of infection, but the biological, social & spiritual aspects as well, so that treatment may be offered from a "biopsychosocial" perspective.
  - A "systemic" model of this type reinforces the use of the provider-client relationship in delivering health and mental health care.
- Web site: <http://mentalhealthAIDS.samhsa.gov>

## Examples of MAI Grantee Activities.

Gay Men's Health Crisis, Inc. – NYC

- Provides culturally competent HIV/AIDS-related mental health and substance use services for African American and Hispanic/Latino New Yorkers living with HIV/AIDS

Haight-Ashbury Free Clinics, Inc. – San Francisco, CA

- Offers targeted mental health care integrated with substance abuse treatment and primary care for medically indigent, dually and triply diagnosed HIV positive African Americans in San Francisco.

## CSAP

## HIV/AIDS & HEPATITIS ACTIVITIES.



Infusion of the Strategic Prevention Framework  
MAI New Approach.

[Chart showing Sustainability and Cultural Competence. Assessment, Capacity, Planning, Implementation, and Evaluation. Arrows lead to State Prevention Infrastructure, Community coalitions action mechanism, and general public awareness and outreach.]

CSAP MAI Active Grants

Cohort #	Fiscal Year	Grants Funded	Number of Years	Average Award Amt.
4	2003 Sept. 2003 to Sept. 2008	22	5	\$336,608
5	2004 Sept. 2004 to Sept. 2008	45	4	\$141,666
6	2005 Sept. 2005 to Sept. 2010	80	5	\$253,828
7	2008 Will be awarded 9/30/08 Sept. 2008-Sept. 2013	46	5	\$400,000 (up to)
Total		193		

CSAP Concentration of Minority HIV/AIDS Grants by States within Region.  
Center for Substance Abuse Prevention. Concentration of Minority HIV/Aids Grants by States Within Region.

Western Region.

Washington. Cohort 5-1.  
California. Cohort 4-5. Cohort 5-8. Cohort 6-13.  
Nevada. Cohort 6-1.  
Utah. Cohort 5-1.  
Arizona. Cohort 4-3. Cohort 6-2.  
Hawaii. Cohort 4-1. Cohort 5-1. Cohort 6-1.

Southwest region.

Colorado. Cohort 5-2. Cohort 6-2.  
Texas. Cohort 4-1. Cohort 5-6. Cohort 6-10.  
Missouri. Cohort 6-2.  
Louisiana. Cohort 4-1.

Central Region.

Minnesota. Cohort 5-2. Cohort 6-2.  
Wisconsin. Cohort 6-1.  
Illinois. Cohort 4-1. Cohort 5-2. Cohort 6-5.  
Michigan. Cohort 5-1. Cohort 6-1.  
Ohio. Cohort 6-2.

Southeast region.

Kentucky. Cohort 6-1.  
Mississippi. Cohort 5-1. Cohort 6-1.  
Alabama. Cohort 5-1. Cohort 6-2.  
Georgia. Cohort 4-1. Cohort 6-3.  
Florida. Cohort 4-1. Cohort 5-5. Cohort 6-7.  
Virginia. Cohort 5-3. Cohort 6-1.  
North Carolina. Cohort 4-1. Cohort 6-1.  
Virgin Islands. Cohort 5-3. Cohort 6-1.

Northeast.

Pennsylvania. Cohort 5-3. Cohort 6-3.  
Maryland. Cohort 4-2. Cohort 6-1.  
District of Columbia. Cohort 5-1. Cohort 6-2.  
New Jersey. Cohort 5-1.  
New York. Cohort 4-2. Cohort 5-2. Cohort 6-10.  
Connecticut. Cohort 6-1.  
Massachusetts. Cohort 4-2. Cohort 5-4. Cohort 6-5.]

## HHS Secretariat MAI Emergency Fund.

The HHS Secretariat MAI Emergency Fund includes two programs:

- Minority Education Institution Initiative
- Drug Free and Faith-based Partners Initiative
- Annual Funding:

FY2005	FY2006	FY2007	FY 2008
Actual	Actual	Actual	Actual
\$3M	\$4.5M	\$6.0M	\$6.0M

## CSAP – Minority Education Institution Initiative (MEI).

The MEI focuses on population areas where there are large underserved minority groups at risk for substance abuse and HIV. Project objectives are to:

- Increase the access of racial and ethnic minority communities to HIV prevention and make referrals to care and treatment services.
- Implement innovative strategies and activities specifically targeted to the highest risk and hardest-to-serve subpopulations.
- Establish collaboration and new partnership opportunities for the MEI program or activities to be integrated with.

## MEI Approach.

The MEI Initiative focuses on several priority racial and ethnic groups and subpopulations, including:

- African American/Black,
- Hispanic/Latino, and
- 19 Native American/American Indian students on minority campuses.

## MEI Goals.

- To increase substance abuse prevention education, awareness and HIV/AIDS/Hepatitis health promotion services to reduce health disparities for racial and ethnic minority college communities.
- To improve internal and external collaboration with partners to maximize the impact of MAI funding to minority education institutions.
- To increase HIV testing activities on campuses.

## FY 2008 MEI Initiative Update

- CSAP funds the Minority Education Initiative Program Coordinating Center (MEI-PCC) to administer a total of 18 subcontracts:
  - 11 Historically Black Colleges and Universities (HBCUs)
  - 4 Hispanic Serving Institutions (HSIs),
  - 3 Tribal Colleges and Universities (TCUs).
- MEI project activities include:
  - Training
  - Community outreach
  - Information and referral services
  - HIV testing and referrals
  - Material dissemination
  - Workshops led by trained student peer educators (SPEs)

## MEI Initiative Demographics.

For FY 2006 and FY 2007, students engaged in Substance Abuse Prevention and HIV/AIDS prevention activities ranged in age, and differed by race & gender:

- 77% of students engaged were between the ages of 18 and 21 years of age
- 75% of students engaged were African-American
- 61% of students engaged were female
- 9% of students engaged were Hispanic/Latino
- 6% of students engaged were Native American

## MEI Initiative FY 2007 Outcomes.

- MEI institutions provide a variety of activities:
  - 474 Peer Educator Training sessions conducted
  - 866 HIV Awareness Educational Workshops held on campus and at satellite locations
  - 7,685 HIV Rapid Testing and Standard Testing were conducted
- Across fiscal years 2006 and 2007 the MEI initiative engaged more than 25,000 students in prevention efforts

## Total Served Through All Activities

Student Peer Educators	264
Student Peer Educators Led Participants	8,716
Community Member Participants	74
High School Student Participants	316
Faculty Participants	263
Other Participants	327
Students Reached Through Awareness/Outreach	36,643
Total Reached Through Programming	46,603

## Examples of MAI Grantee Activities.

### Asian American Recovery Services, Inc. San Francisco, CA

- Provides substance abuse prevention and HIV and Hepatitis prevention services to minority populations and minority reentry populations. Targeting Asian Americans and Pacific Islander Americans, the needs of the reentry population, limited English-speaking immigrants and other high risk individuals

### AIDS Service Center of Lower Manhattan

- AIDS Service Center NYC proposes an integrated HIV, Substance Abuse, and Hepatitis Prevention Program to increase the capacity of minority communities in Manhattan to reduce the incidence of HIV, substance abuse (SA), and viral hepatitis among adult black and Latina women at risk (via sexual and/or drug-related behaviors) and among male and female ex-offenders