Part 3:

Substance Abuse Consumer Survey

I. Introduction

HIV/AIDS surveillance data and annual needs assessments of the Newark EMA HIV Health Services Planning Council have continually underscored that substance use and abuse are major factors in the spread of HIV disease in the EMA. After considerable deliberation, the Substance Abuse Committee of the Council designed a survey to ask consumers who were homeless and/or living in at risk situation, who might be HIV+, about their HIV medical care and substance use treatment patterns. These individuals are the most vulnerable and at risk for HIV disease, and most at risk for dropping out of HIV medical care or not accessing medical care at all due to their transient lifestyles.

Purpose: The purpose of the survey is to obtain information about substance abuse among HIV+ individuals and those at risk of HIV who have not heretofore provided input to the Planning Council. The methodology includes surveying individuals in homeless shelters throughout the five-county Newark EMA and those who might be reached by innovative and nontraditional outreach methods.

Research Questions: This is a survey of homeless individuals and those in highly at risk living situations. Members of the target population may or may not be HIV+ but are at high risk for HIV disease due to transient lifestyles and ongoing exposure to individuals who are using drugs, either through their own drug use or through sexual encounters with those using drugs. Because the target population is so transient, the Council cannot select out those who are HIV+. The approach is to “blanket’ survey as many individuals as possible to obtain information about medical care behaviors of those who are HIV+ and about substance abuse treatment patterns of those who are not HIV+.

The research questions to be answered are

(1) What are the medical care characteristics of HIV+ individuals who are homeless and/or living in high risk situations, and

(2) What are the substance abuse treatment patterns of individuals who are homeless and at high risk of HIV infection in the Newark EMA?

Outcomes: The results are expected to provide information about populations “at risk” for HIV who are not routinely accessed for Newark EMA needs assessments. Specifically, the survey will reach those who are homeless and living in shelters (homeless is one of the EMA’s eight “special needs populations”), those who frequent places targeted by night outreach, and those agencies who provide Title I substance abuse treatment.

The results may show that more efforts are needed to target unserved PLWHA living in homeless shelters, and may hone the research to be conducted among these "special needs" populations in 2006.

II. Methodology

The Substance Abuse Committee decided to administer a written survey to three target populations: (1) homeless individuals regardless of HIV disease, (2) HIV positive (HIV+) individuals receiving substance abuse treatment in Title I funded agencies, and (3) individuals with HIV (diagnosed or undiagnosed) or at risk of HIV who frequented locations known for illegal drug activity. The Committee also wanted to capture the Hispanic/Latino individuals in these target populations.

The initial Substance Abuse Consumer Survey was prepared in December 2004, and was revised several times in 2004 and early 2005 to reflect ongoing input of members of the Substance Abuse Committee. It was presented to the Planning Council for review on its regularly scheduled meeting of March 16, 2005 before implementation. Council members provided suggestions, which were incorporated into the revised survey instrument. The final instrument was reviewed and approved by the Substance Abuse Committee. Once finalized, the survey instrument was translated into Spanish by the Council's Latino Caucus. The English language version of the survey is in Appendix D.

The survey was designed to be completed by consumers residing in homeless shelters throughout the EMA, those receiving Title I funded substance abuse treatment services, and those who participated in outreach efforts of HIV providers in the Newark EMA. Thus, the instrument had to be easily understood by these populations. The surveys were color coded for easier identification and tabulation: (1) purple = homeless shelter, (2) blue = Title I substance abuse provider, (3) orange = night of outreach, and (4) green = Spanish.

Council staff identified the agencies to administer the surveys and mailed out supplies with instructions. The surveys were to be completed on-site at the shelters and treatment sites, with assistance of agency staff as needed. Similarly, outreach workers were to assist individuals in completing surveys during "night of outreach" events. The agencies receiving the surveys and dates of the outreach events are listed in Appendix E.

As of June 30, 2005, 223 surveys were received. The results of these surveys were tabulated and are the subject of this Report. An additional ten surveys were received in mid-July 2005. No respondents were HIV+ nor were they current substance users. These results are not included in the tabulations. a
The interim findings were presented to the Council's Substance Abuse Committee on July 13, 2005 for review and development of recommendations. A summary of highlights was also presented to the Planning Council at its meeting of July 20, 2005.

These findings are based on 223 responses. In its review of the interim report, a Planning Council member suggested that the responses be cross-tabulated by site – homeless shelter,

Title I substance abuse provider agencies, and outreach sites. These cross tabulations are set forth in Appendix H. No narrative is provided, but the tables are self-explanatory.

III. Results

Note: In some of the tables, percentage totalsmay not add to 100% due to rounding. Also, a number of respondents did not answer all questions, and could not be contacted to fill in missing data due to anonymity of the surveys. This accounts for a small number of missing responses.

III.A. Identifying Information

The survey was administered at three types of sites – homeless shelters, Title I substance abuse providers, and via outreach. Surveys were prepared in Spanish language as well. Of the 223 surveys received, more than half – 116 or 52% - were received from homeless shelters. Of the remaining respondents, 92 (41%) were from Title I substance abuse providers and 15 (7%) were from outreach efforts. None were identified specifically as Spanish speaking respondents. See Figure 6-A.

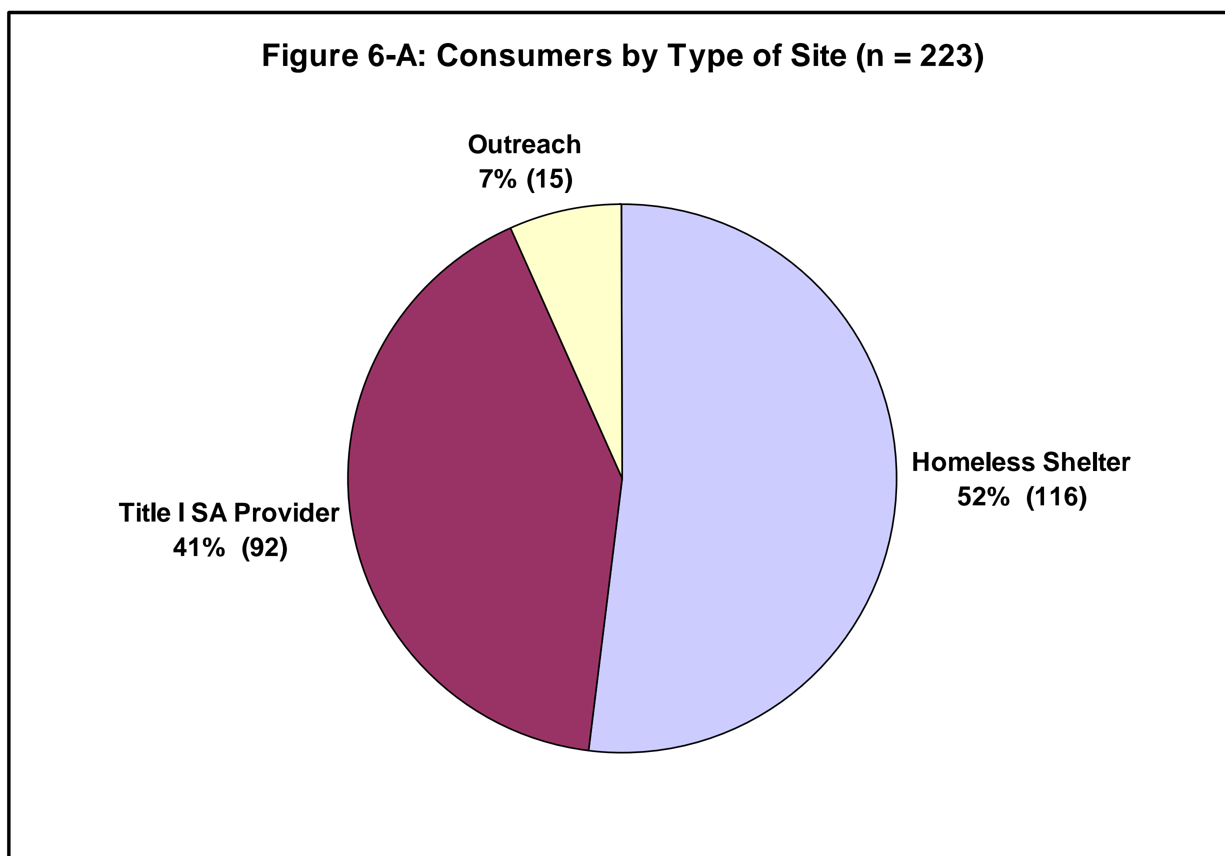


Table 6-1: Type of Site Surveyed and County of Residence (n=223)

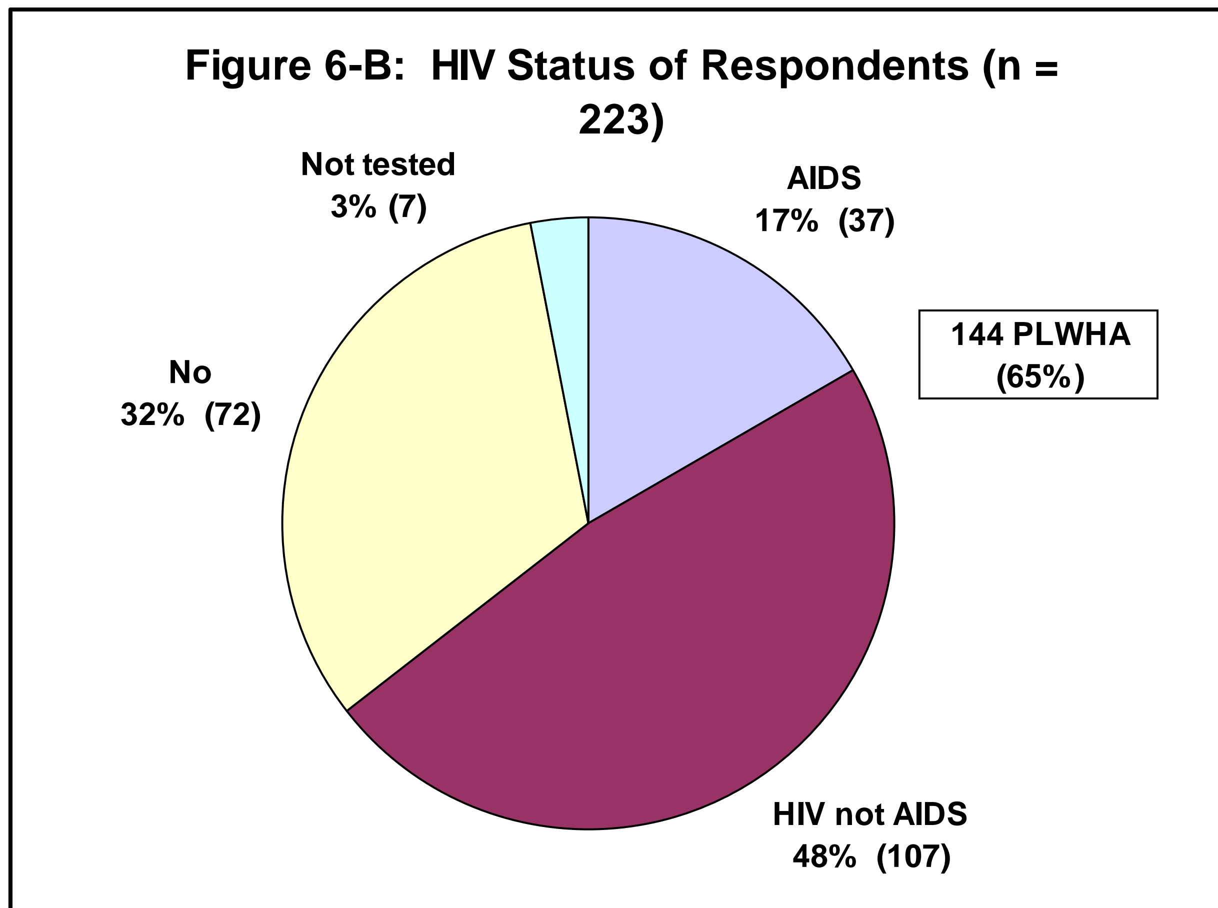
	County of Residence					
Site Type	Essex	Union	Morris	Out of EMA*	Total	**%**
Homeless Shelter	83	12	17	4	116	52%
Title I SA Provider	78	8	0	6	92	41%
Outreach	15	0	0	0	15	7%
Total	**176**	**20**	**17**	**10**	**223**	**100%**
	79%	9%	8%	4%	100%	

*Out of EMA includes: Passaic (3), Camden (3), Mercer (2), Cape May (1), Hudson (1)

To ensure client confidentiality, the Council provided agencies with stamped envelopes which identified only the Council's address, and not the addresses of the providers. As a result, we could not determine which providers had completed the surveys. However, a few agencies did identify themselves with cover letters, etc. This information was utilized by Council staff to cross check data tabulations, but is not being released in this report.

HIV status of respondents. Two thirds (144) of respondents reported having HIV disease – 107 (48%) reported HIV not AIDS and 37 (17%) with AIDS. One third (72) did not have HIV disease and seven respondents (3%) did not know their HIV status because they had never been tested. See Figure 6-B.

Many of the tables and discussion below will present data for both total respondents and those with HIV to assist the Planning Council and its committees.



III.B. Demographics of Respondents

Gender. Over half of survey respondents (56% or 124) were male and 97 (43%) were female. Two individuals (1%) did not list their gender and gender could not be determined from their other responses. This distribution is comparable to the gender breakdown of PLWHA in the EMA.

Rae/ethnicity. The majority (165 or 74%) of respondents were African-American (Black, Not Hispanic) among both men and women. Thirty individuals of Hispanic/Latino ethnicity comprised 14% of respondents (9% of males and 5% of females), and White, Not Hispanic individuals comprised 7% (15) of respondents. (Eight individuals did not report race/ethnicity.) (See Table 6-2.)

Table 6-2: Gender and Race/Ethnicity of Respondents

	Race/Ethnicity				
Gender	White Not Hispanic	Black Not Hispanic	Hispanic	Other	**Total**
Male	8	94	19	0	**121**
Female	6	70	11	5	**92**
Total	**14**	**164**	**30**	**5**	**213**
Male	4%	44%	9%	0%	**57%**
Female	3%	33%	5%	2%	**43%**
Total	**7%**	**77%**	**14%**	**2%**	**100%**
Total (excl gender)	**15**	**165**	**30**	**5**	**215**
	7%	**77%**	**14%**	**2%**	**100%%**

2 respondents did not identify their gender and 8 did not identify their race/ethnicity.

Respondents were proportionately represented by race/ethnicity regardless of type of survey site. With respect to gender, however, women were proportionately represented in homeless shelters and outreach activities, but disproportionately represented (higher rate) as respondents in Title I substance abuse agencies. Table 6-3.

Table 6-3: Gender and Race/Ethnicity of Respondents by Type of Survey Site

	Race/Ethnicity					
	White Not Hispanic	Black Not Hispanic	Hispanic	Other	Total	%
Homeless Shelters						
Male	5	50	8	0	63	56%
Female	3	41	3	2	49	44%
Total	**8**	**91**	**11**	**2**	**112**	
	7%	81%	10%	2%	100%	
Title I Substance Abuse Providers						
Male	3	37	10	0	50	57%
Female	3	26	7	2	38	43%
Total	**6**	**63**	**17**	**2**	**88**	
	7%	72%	19%	2%	100%	
Outreach						
Male		7	1	0	8	62%
Female		3	1	1	5	38%
Total		**10**	**2**	**1**	**13**	
	0%	77%	15%	8%	100%	

2 respondents did not identify their gender and 8 did not identify their race/ethnicity.

Current Age. Half (54% or 118) of the respondents were age 25-44, followed by 41% (88) who are age 45 and older, with 11 (5%) under age 25. All 11 individuals under age 25 resided in homeless shelters. See Table 6-4.

Table 6-4: Gender and Current Age

	Current Age			
	< Age 25	Age 25-44	Age 45+	**Total**
Male	6	53	64	122
Female	5	65	24	94
Total	**11**	**118**	**88**	**217**
Male	3%	24%	30%	56%
Female	2%	30%	11%	44%
Total	**5%**	**54%**	**41%**	**100%**

2 respondents did not report gender and 4 did not report age.

Sexual identification. Most (206) respondents provided sexual identification. The majority (71%) of total respondents, 76% of women and 66% of men, identified themselves as heterosexual. Twenty one percent (21%) of males identified themselves as men who have sex with men (MSM) and 10% of females as women who have sex with women (WSW). Eight percent of males and 13% of females identified themselves as bisexual (10% total). A small number identified themselves as transsexual or transgender. See Table 6-5.

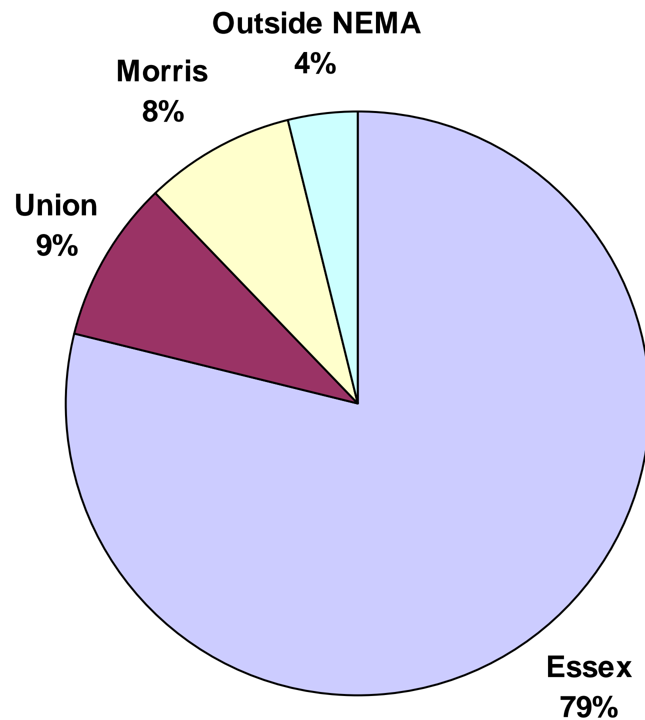
Table 6-5: Sexual Identification by Gender

Sexual	#			%		
Identification	Male	Female	Total	Male	Female	Total
Heterosexual	75	71	146	66%	76%	71%
MSM	23	0	23	21%		11%
WSW	0	9	9		10%	4%
Bisexual	9	12	21	8%	13%	10%
Transsexual	3	0	3	3%	0%	1%
Transgender	2	1	3	2%	1%	1%
Nonsexual	1	0	1	1%	0%	0%
Total	**113**	**93**	**206**	**100%**	**100%**	**100%**

County of residence. Most (175 or 79%) of respondents reported that they resided in Essex County. Only 9% (20) of respondents resided in Union County, and 8% (18) in Morris County. Four percent of respondents reported living outside of the Newark EMA. See Figure 6-C: The counties are listed below.

County Outside NEMA	#	%
Passaic	3	1%
Camden	3	1%
Cape May	1	0.5%
Mercer	2	1%
Hudson	1	0.5%
Total	**10**	**4%**

Figure 6-C: Respondents by County of Residence



Municipality of residence. Respondents were asked to provide their ZIP code of residence. From these ZIP codes, the municipality of residence was coded for nearly all (211 or 95%) of respondents. The remaining 12 (5%) responses were coded as "unknown" municipality. Respondents in Title I substance abuse treatment programs reported their actual ZIP code of residence, not the ZIP code of the treatment facility. See results in Table 6-6 below. The list of respondents by ZIP code area is listed in Appendix H.

More than half of respondents (133 or 60%) reported their residence as Newark. The cities of East Orange, Elizabeth and Morristown followed with 7% of residents each. Five percent of respondents were from Irvington. The remaining cities accounted for lower numbers. However, respondents from outside the EMA lived as far away as Trenton, Camden, and Cape May City.

HIV status by municipality of residence. Table 6-6 also shows the distribution of HIV+ respondents by municipality of residence. Here, 70% of HIV+ respondents live in Newark, followed by East Orange (8%), Irvington (4%) and Elizabeth (4%). These four cities account for 86% of the HIV+ survey respondents.

Table 6-6: Respondents' County and City of Residence and HIV+ Status

County of Residence	City of Residence	#	% Distn	# HIV+	% DIstn
Essex	Newark	133	59.6%	101	70.1%
	East Orange	17	7.6%	12	8.3%
	Irvington	11	4.9%	6	4.2%
	Orange	5	2.2%	3	2.1%
	Montclair	2	0.9%	2	1.4%
	Unknown	7	3.1%	5	3.5%
	Subtotal	**175**	**78.5%**	**129**	**89.6%**
Union	Elizabeth	16	7.2%	6	4.2%
	Plainfield	1	0.4%	0	0.0%
	Unknown	3	1.3%	2	1.4%
	Subtotal	**20**	**9.0%**	**8**	**5.6%**
Morris	Morristown	15	6.7%	1	0.7%
	Boonton	1	0.4%	0	0.0%
	Dover	1	0.4%	0	0.0%
	Parsippany	1	0.4%	0	0.0%
	Subtotal	**18**	**8.1%**	**1**	**0.7%**
Outside EMA	Paterson	3	1.3%	2	1.4%
	Atco (Camden)	1	0.4%	0	0.0%
	Cape May	1	0.4%	0	0.0%
	Trenton	2	0.9%	1	0.7%
	Jersey City	1	0.4%	1	0.7%
	Unknown	2	0.9%	2	1.4%
	Subtotal	**10**	**4.5%**	**6**	**4.2%**
	Total	**223**	**100%**	**144**	**100%**

III.C. HIV Status and Medical Care

As stated above, 144 respondents reported having HIV disease. This section provides information about this subgroup, including demographics and medical care and medications for treatment of their HIV disease.

HIV Status by Gender. Of the 144 individuals who reported that they were HIV positive, 142 identified their gender. Distribution of HIV and AIDS was equal among male and female respondents. Among both males and females, 26% have AIDS and 74% have HIV not AIDS. Within both AIDS and HIV, 54% were males and 46% were females. See Table 6-7.

Table 6-7: HIV Status by Gender

	HIV Status			Distn HIV vs. AIDS		
	AIDS*	HIV not AIDS**	Total	AIDS	HIV not AIDS	Total
Male	19	58	77	25%	75%	100%
Female	17	48	65	26%	74%	100%
Total	36	106	142	26%	74%	100%

* 1 person with AIDS did not list gender. ** 1 person with HIV did not list gender.

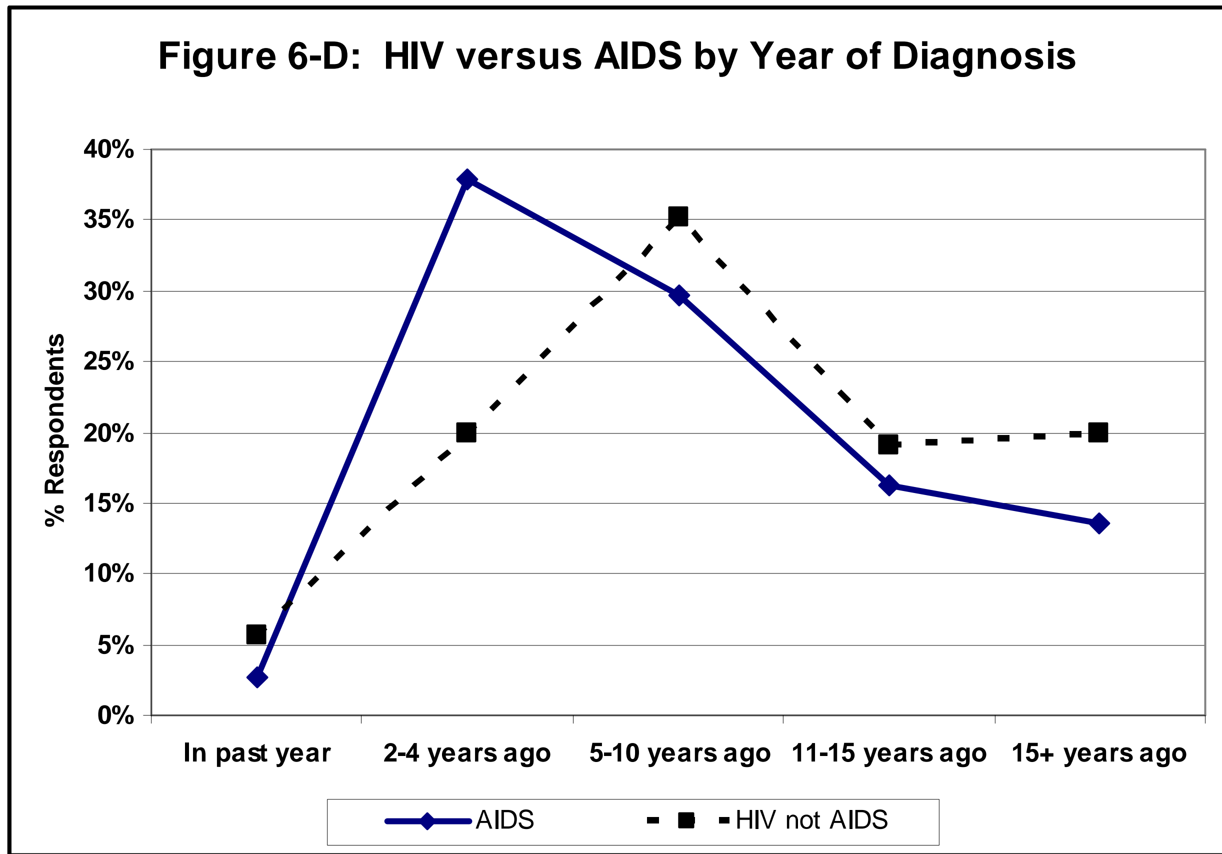
Year of diagnosis. Respondents have been living with HIV disease a long time. Over one third (52) were diagnosed 11 or more years ago – 18% (26) at 11-15 years ago and 18% (26) at more than 15 years ago. Another one third of respondents (48) had been diagnosed 5 to 10 years ago. One quarter were diagnosed within the past 2-4 years and 5% were diagnosed within the past year. See Table 6-8.

Examining the distribution of respondents with AIDS and HIV shows that the highest percentage of those with AIDS were diagnosed 2 to 4 years ago, in contrast to the most respondents with HIV not AIDS, who were diagnosed 5-10 years ago. Figure 6-D.

Table 6-8: HIV Status by Year of Diagnosis

Year of Diagnosis	AIDS	HIV not AIDS	Total	% Distn
Within past year	1	6	7	5%
2-4 years ago	14	21	35	25%
5-10 years ago	11	37	48	34%
11-15 years ago	6	20	26	18%
15+ years ago	5	21	26	18%
Total	**37**	**105**	**142**	**100%**

2 individuals did not provide year of diagnosis.

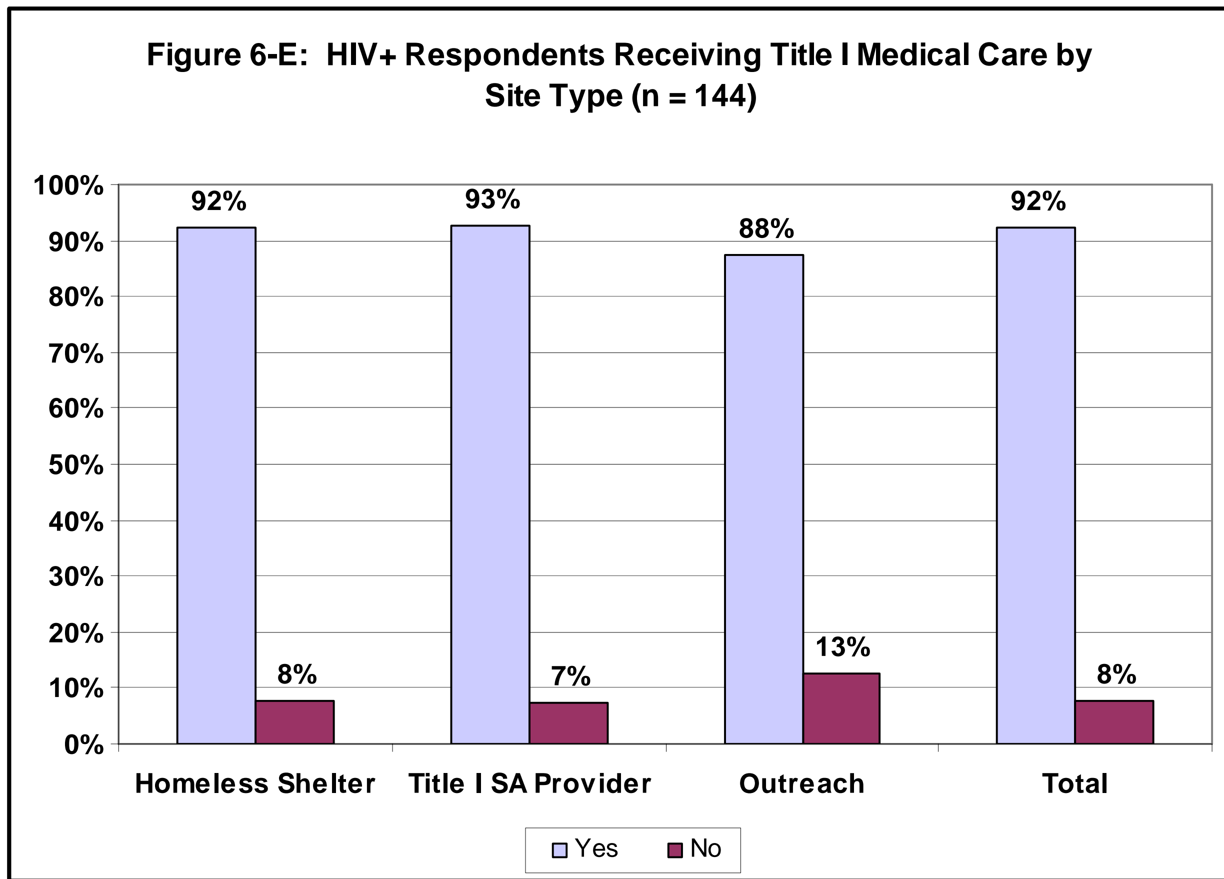


Receipt of HIV Medical Care. Of the 144 HIV+ respondents, 132 (92%) reported receipt of medical care for their HIV. Nearly all (97% or 36) of individuals with AIDS receive medical care, but a lower percent (90% or 107) of respondents with HIV not AIDS receive medical care for HIV. Table 6-9.

Table 6-9: Receipt of HIV Medical Care

	AIDS	HIV not AIDS	Total
Yes	36	96	132
No	1	11	12
Total	**37**	**107**	**144**
% Med Care	**97%**	**90%**	**92%**

With respect to type of survey site, 92% of respondents with HIV disease reported receiving medical care. This was true at homeless shelters (92%), Title I funded Substance Abuse agencies (93%, and those contacted via outreach (88%). See Figure 6-E.



Location of medical care. For purposes of planning for Title I medical services, it is important to know where current patients receive medical care with respect to the county in which they reside. Of the 144 PLWHA, 133 reported the county of medical care. Within the Newark EMA, nearly all PLWHA receive medical care in the county in which they reside. Of the 118 residing in Essex County, 114 (97%) received HIV medical care in Essex County. Similarly, all eight residents of Union County receive HIV medical care in Union County. Table 6-10.

Table 6-10: Location of HIV Medical Care versus County of Residence

County of Residence	County where Receive HIV Medical Care						
	Essex	Union	Warren	Middlesex	Passaic	Hudson	**Total**
Essex	**114**	0	0	2	1	1	**118**
Union	0	**8**	0	0	0	0	**8**
Morris	0	0	0	1	0	0	**1**
Passaic	1	0	0	0	1	0	**2**
Camden	2	0	0	0	0	0	**2**
Mercer	0	0	1	0	0	0	**1**
Hudson	0	0	0	1	0	0	**1**
Total	**117**	**8**	**1**	**4**	**2**	**1**	**133**

11 respondents did not report county of medical care.

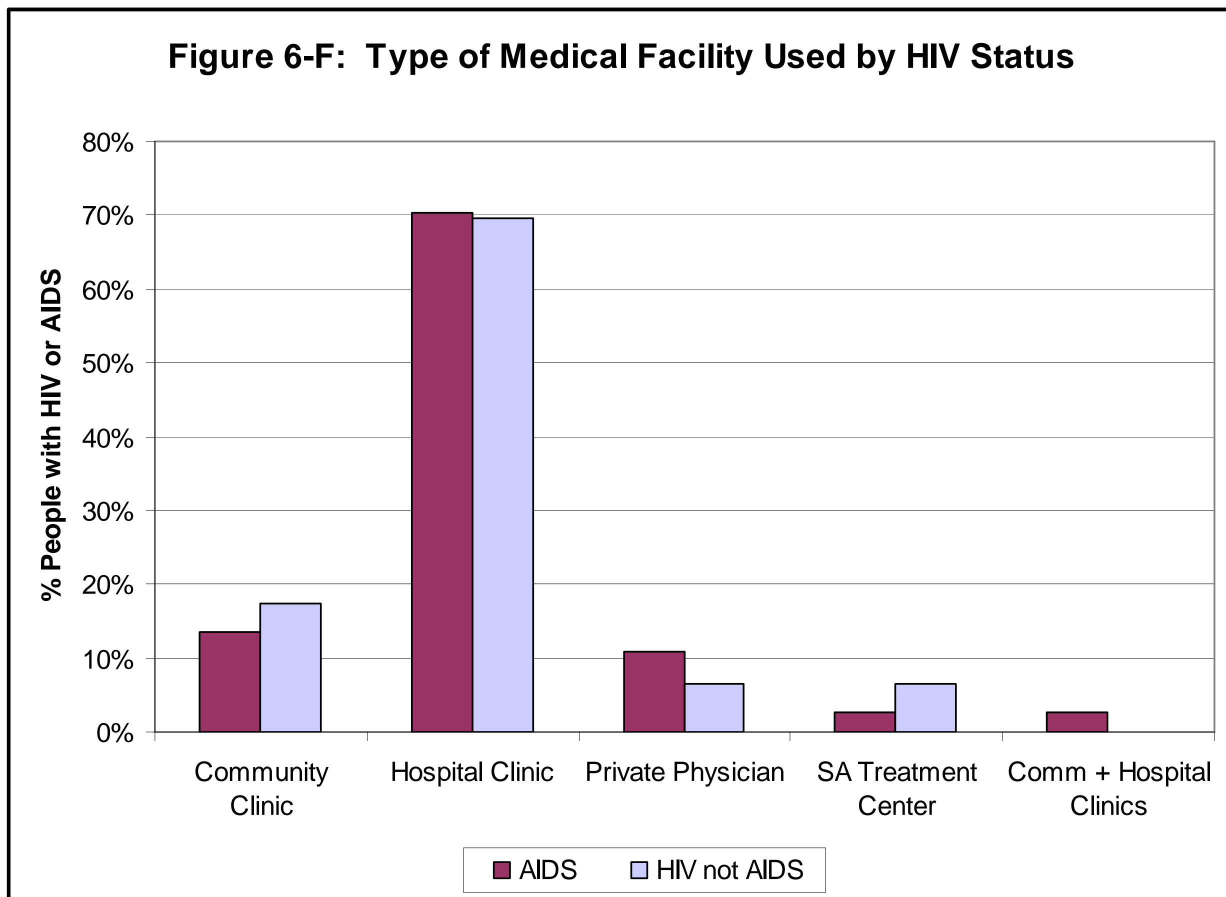
Type of medical facility. The type of medical facility utilized for HIV medical care is also important for Title I medical care planning. Of the 129 PLWHA reporting the type of medical care facility in which they received care, the majority – 70% or 90 - utilized hospital based clinics. Another 16% (21) used community clinics. Fewer than 10% reported using private physicians or substance abuse treatment centers. See Table 6-11.

Table 6-11: Type of Medical Facility for HIV Care

Type of Medical Care Facility	County of Residence					
	Essex	Union	Morris	Outside NEMA	Total	% DIstn.
Community Clinic	17	3	0	1	21	16%
Hospital Clinic	82	5	1	2	90	70%
Private Physician	9	0	0	1	10	8%
Substance Abuse Treatment Center	5	0	0	2	7	5%
Community Clinic + Hospital Clinic	1	0	0	0	1	1%
Total	**114**	**8**	**1**	**6**	**129**	**100%**

15 respondents did not report type of facility in which they received HIV medical care

Comparing respondents' HIV status, there was little difference in the type of facility used for people with AIDS versus people with HIV not AIDS. A slightly higher percent of people with HIV used community clinics and substance abuse treatment centers for medical care. Figure 6-F.



(129 PLWHA = 37 AIDS and 92 HIV not AIDS.)

Type of Health Insurance. Nearly all respondents (98%) reported whether they had health insurance and the type of insurance. Individual responses are shown in Table 6-12 below. When aggregated, over half (75 or 53%) had Medicaid, 8% (11) had Medicare, 9% (12) were "dual eligibles" with both Medicaid and Medicare, 4% (5) reported having private insurance, and 27% (37) were uninsured (including those reporting Charity Care as a source of health insurance). Figure 6-G.

Table 6-12: Type of Health Insurance Reported by HIV+ Respondents

	#	%
Medicaid	72	51%
Medicare	10	7%
Private Insurance	5	4%
Charity Care	29	21%
None (including Title I)	8	6%
Medicaid + Medicare	12	9%
Medicaid + Charity Care	3	2%
Medicare + Private Ins.	1	1%
Total	**140**	**100%**

4 respondents did not report Health Insurance

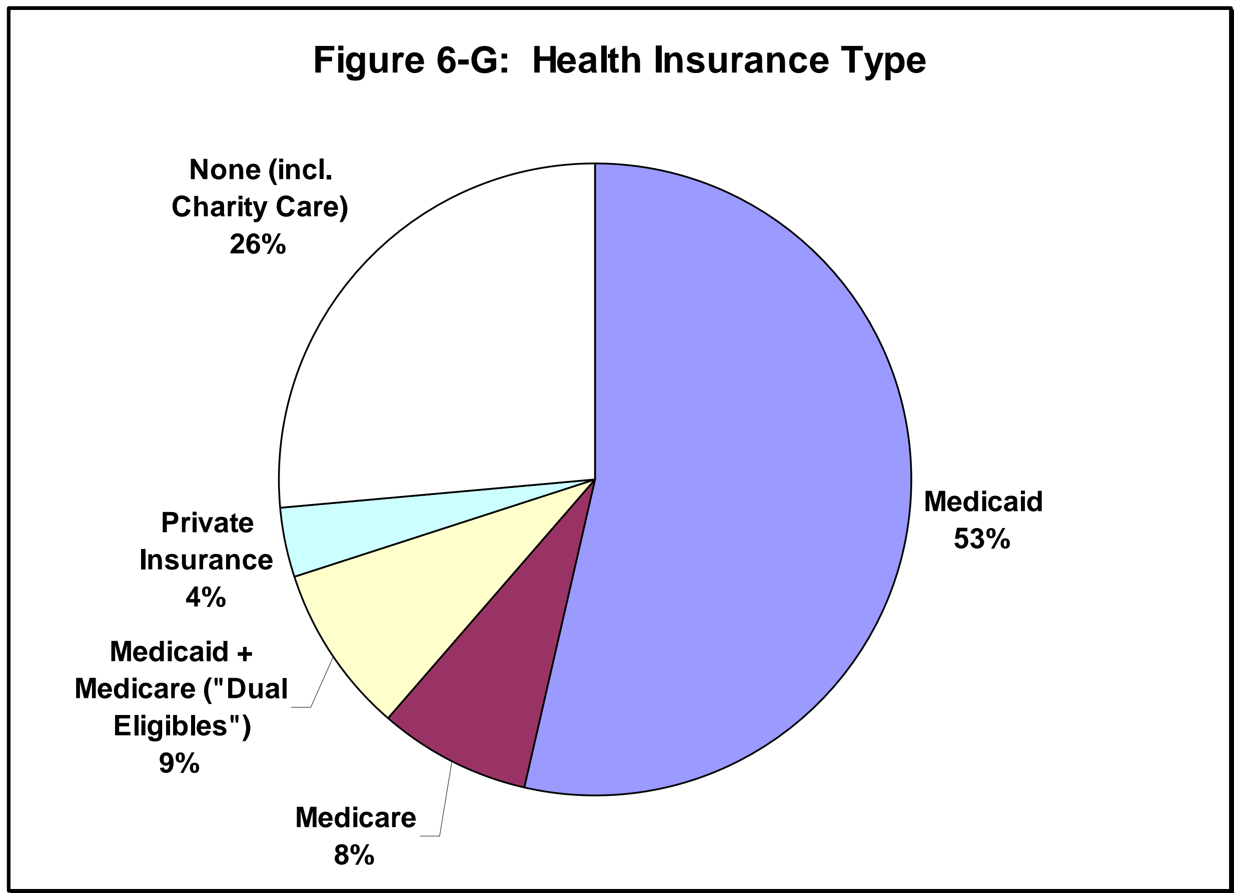
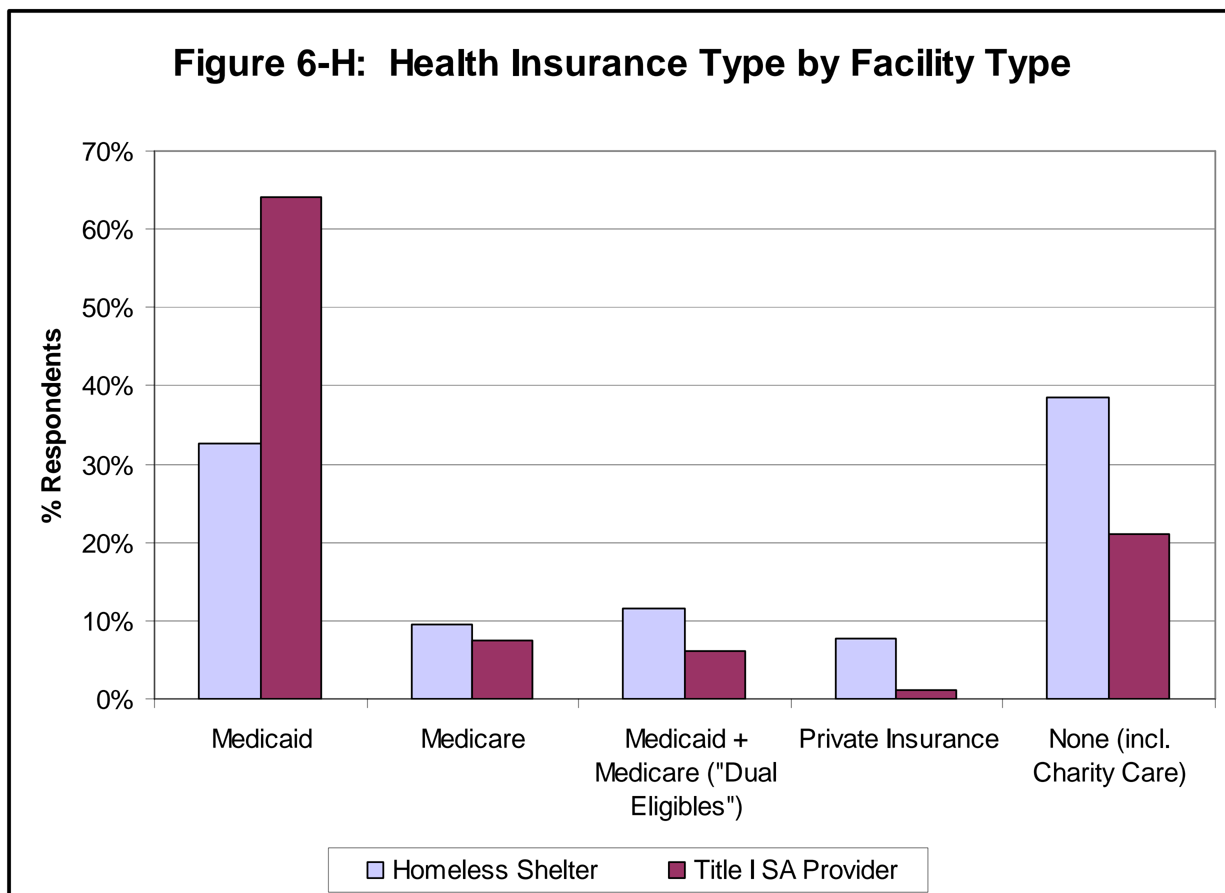


Figure 6-G: Health Insurance Type

Health Insurance Type by Facility Type. The above chart and table may be misleading for all PLWHA, because Title I serves a high number of PLWHA who are uninsured. When tabulated by type of facility in which respondents resided, results were different. Figure 6-H shows the results for PLWHA in homeless shelters (n = 53) and in substance abuse providers who receive Title I funds (n = 83). Outreach respondents were not included due to low numbers (n = 8). (Note: It is not known how many respondents from Title I funded substance abuse providers received treatment funded by Title I. Therefore, readers cannot draw any conclusions regarding Title I payments, with regard to the distribution of self-reported Medicaid versus no insurance.)

With respect to homeless PLWHA, nearly 40% had no health insurance, followed by the 33% with Medicaid, and 12% who were dual eligibles. In substance abuse agencies, nearly two thirds (64%) reported having Medicaid, and 21% had no insurance. See Appendix H for more information by site type.

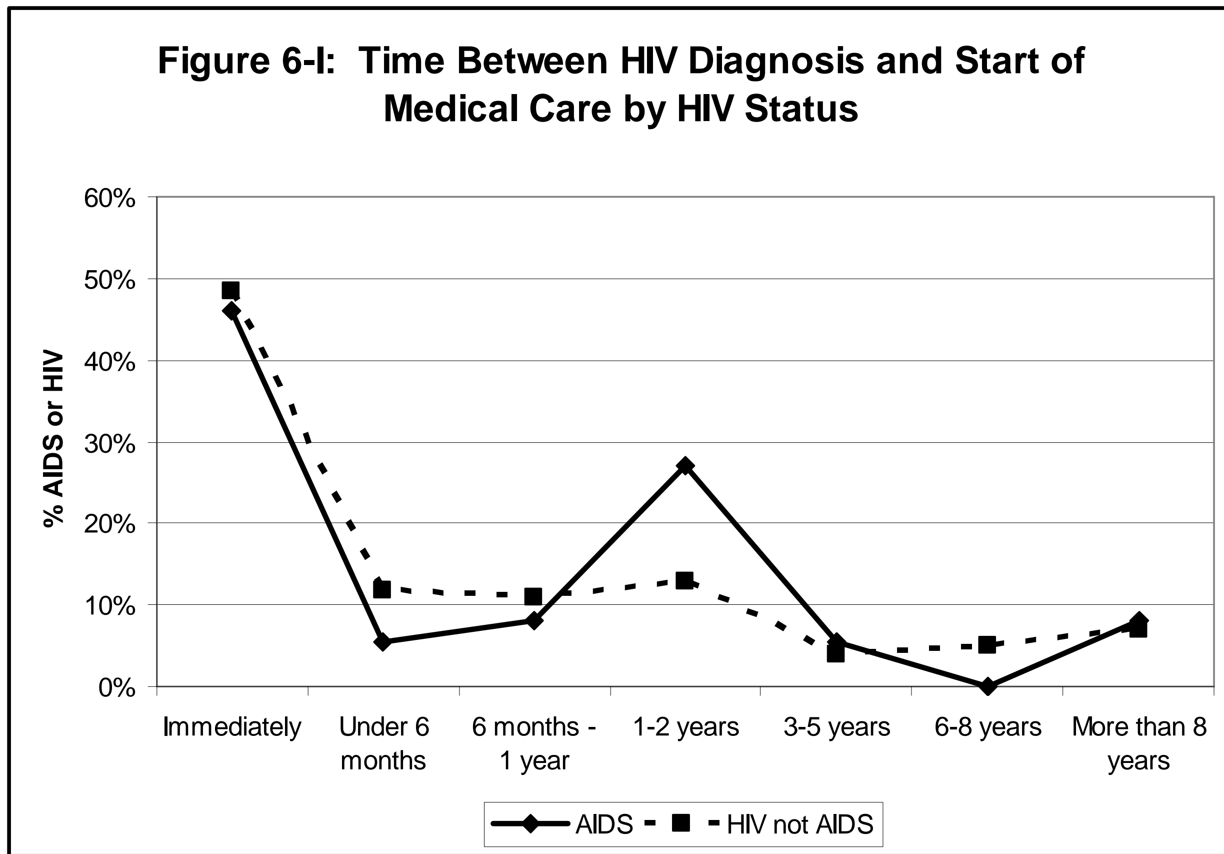


Time between diagnosis and start of medical care. It is important that individuals newly-diagnosed with HIV begin medical care as soon as possible. It is understood, however, that individuals may not want to begin treatment due to factors such as denial, disbelief, or depression. These patterns are evident in this survey. Nearly half (48%) of PLWHA reported that they entered medical care immediately following HIV diagnosis. Nearly one in five (17%) waited for one to two years before entering medical care. Another 15% waited more than three years, sometimes as long as 8 years or longer. Table 6-13. Individuals with AIDS waited longer to get into medical care than those with HIV. Figure 6-I.

Table 6-13: Length of Time Between HIV Diagnosis and Start of Medical Care

	AIDS	HIV not AIDS	Total	% Dist.
Immediately	17	49	66	48%
Under 6 months	2	12	14	10%
6 months - 1 year	3	11	14	10%
1-2 years	10	13	23	17%
3-5 years	2	4	6	4%
6-8 years	0	5	5	4%
More than 8 years	3	7	10	7%
Total	**37**	**101**	**138**	**100%**

6 respondents did not report length of time.



Linkage to HIV medical care. It is important for Title I planning to determine which entities or venues have the most success in linking to medical care PLWHA who are newly-diagnosed or have been out of care or untreated. Of the 144 PLWHA, 134 respondents provided this information. The majority (85%) reported one primary linkage to medical care, while the remaining individuals said that two or three factors got them into medical care. When all factors are counted, the testing site was the linkage that got PLWHA into medical care (18%), followed closely by the HIV physician (17%). Case managers and the individuals themselves each were mentioned 15% of time as being responsible for getting PLWHA into care. A physician other than their HIV physician and friends were each responsible 10% of the time. However, for 10% of individuals, the deciding factor was that they got sick. Table 6-14.

Table 6-14: Types of Linkages to Medical Care

	Individual responses		All linkages mentioned	
	#	**%**	**#**	**%**
1 Linkage				
Testing site	24	18%	28	18%
HIV Physician	20	15%	27	17%
Case manager	19	14%	23	15%
Myself	16	12%	23	15%
Other physician	13	10%	16	10%
I got sick	13	10%	14	9%
Family	5	4%	10	6%
Friends	4	3%	15	10%
Subtotal	**114**	**85%**	**156**	**100%**
2 Linkages	15	11%		
3 linkages	5	4%		
Total	**134**	**100%**		

10 respondents did not answer this question.

A comparison between the types of linkages and time between HIV diagnosis and start of medical care helps to understand which methods might be most effective at linking PLWHA with medical care at varying points in time. Figures 6-J and 6-K below depict this cross-tabulation based on the number of responses.

As shown in Figure 6-J, from time of diagnosis up to 6 months later, the HIV testing site and a physician (HIV specific or other physician) and case manager are equally important in linking the person to medical care. After about one to two years after diagnosis (and later), the physician becomes the most important entity in linking the person to medical care. The case manager may also be important.

Figure 6-K shows the role of the individual and family/friends in linking the person to medical care. It is important to note that the individual himself or herself has a role in getting to medical care. However, after one to two years following diagnosis, the main reason that individuals start medical care is that they became sick and were showing symptoms of HIV disease.

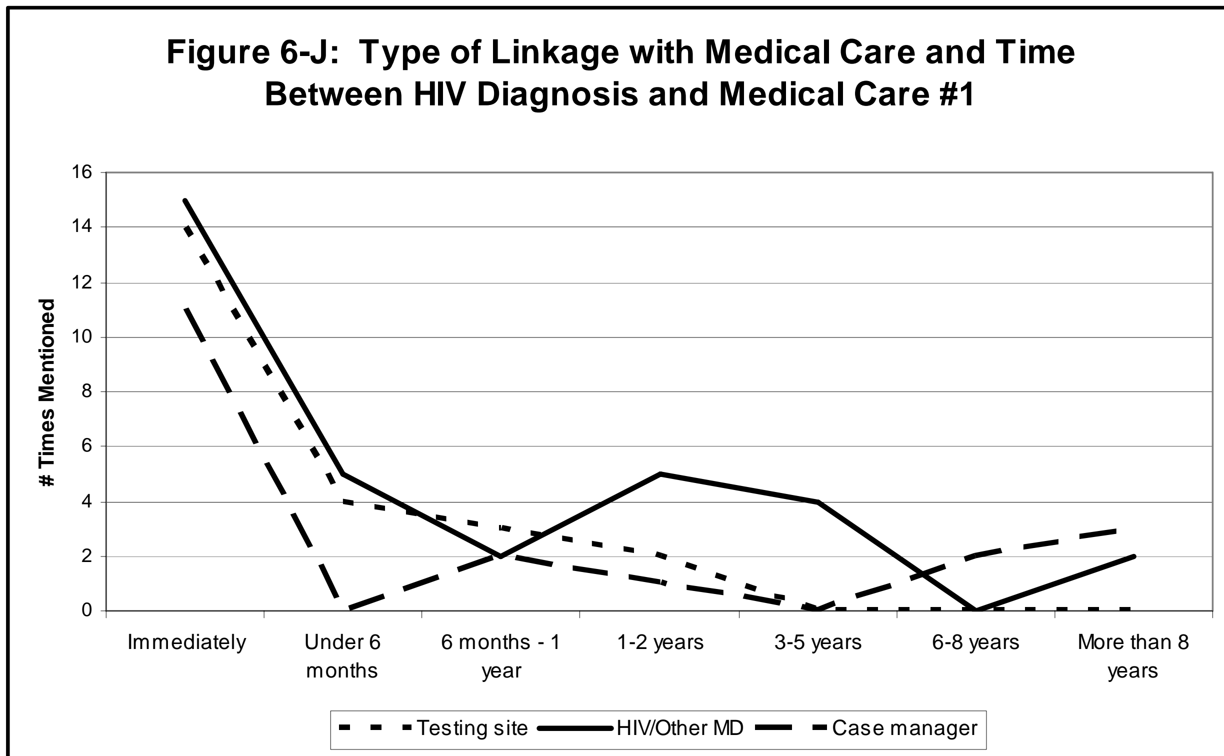


Figure 6-J: Type of Linkage with Medical Care and Time Between HIV Diagnosis and Medical Care #1
Times Mentioned
16
14
12
10
8
6
4
2
0
Immediately
Under 6 months
6 months - 1 year
1-2 years
3-5 years
6-8 years
More than 8 years
Testing site
HIV/Other MD
Case manager

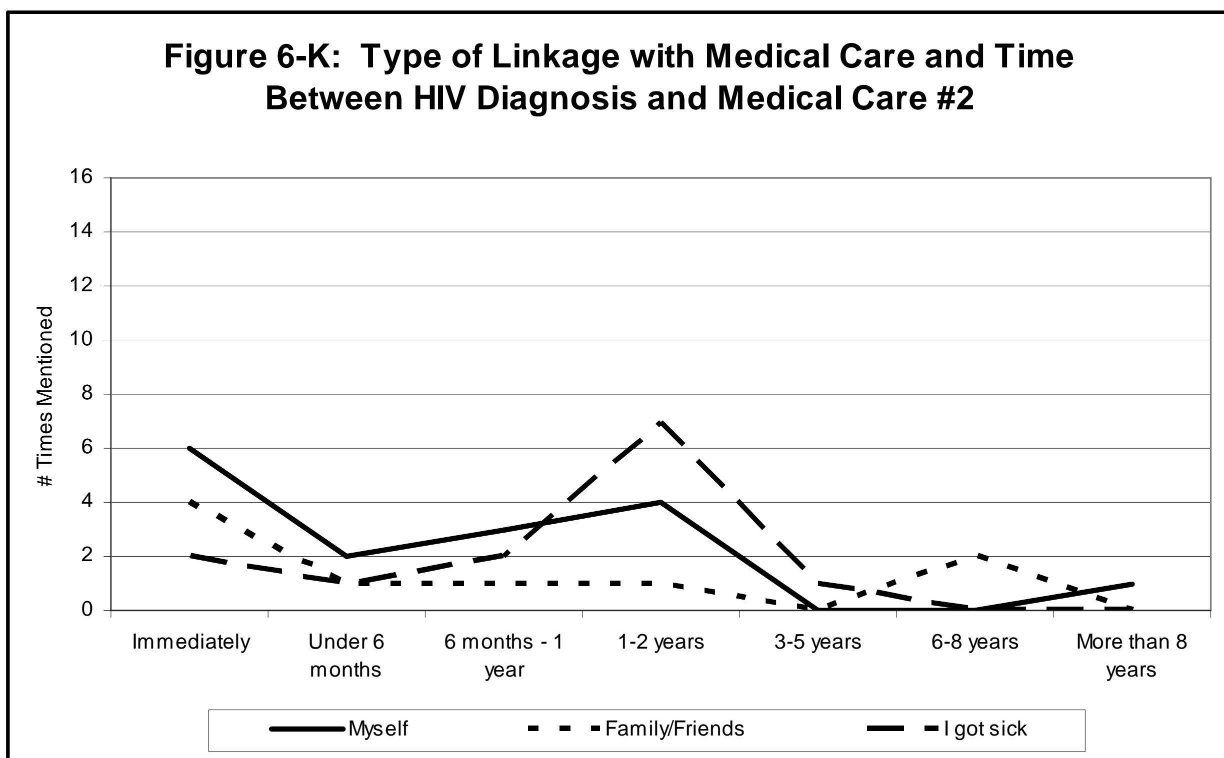


Figure 6-K: Type of Linkage with Medical Care and Time Between HIV Diagnosis and Medical Care #2
Times Mentioned
16
14
12
10
8
6
4
2
0
Immediately
Under 6 months
6 months - 1 year
1-2 years
3-5 years
6-8 years
More than 8 years
Myself
Family/Friends
I got sick

Last time received medical care. It is recommended that PLWHA see their physician every three months for a physical exam. When asked, "when was the last time you saw a physician?" most respondents (117 or 85%) reported that they saw their doctor within the past three months. However, responses varied by whether the individual had AIDS or only HIV not AIDS. Nearly all (35 or 95%) of respondents with AIDS had seen their physician within the past three months, versus only 81% (82) of those with HIV not AIDS. Seven persons with HIV last saw their doctor over one year ago, with one person reporting that they had never seen a physician for their HIV. Table 6-15.

Table 6-15: Last Time Received Medical Care

Last time I saw my doctor	Number			Percent		
	AIDS	**HIV**	**Total**	**AIDS**	**HIV**	**Total**
Within the past 3 months	35	82	117	95%	81%	85%
4-6 months ago	2	7	9	5%	7%	7%
7-9 months ago	0	2	2	0%	2%	1%
10-12 months ago	0	2	2	0%	2%	1%
Over 1 year ago	0	7	7	0%	7%	5%
Never saw a physician for my HIV	0	1	1	0%	1%	1%
Total	**37**	**101**	**138**	**100%**	**100%**	**100%**

6 respondents did not answer this question.

Reasons that have prevented PLWHA from accessing medical care. Notwithstanding that many consumers have had a medical visit within the past three months, approximately 54% (78) individuals reported reasons for not accessing medical care at some point in the past. Approximately 60% (47) reported one reason and 40% (31) reported two or more reasons for not accessing medical care. The chief reason for not accessing medical care was the individual's substance use, followed closely by lack of transportation. The next three items mentioned were cannot afford to pay, no available child care and [long] waiting times at the clinic/physician office. Other reasons, such as housing situation, and communications with the physician, were mentioned less often. No one cited religious beliefs as a reason for not accessing medical care. Table 6-16.

Table 6-16: Reasons Preventing PLWHA from Accessing Medical Care

	Individual responses		All reasons mentioned	
	#	**%**	**#**	**%**
My substance use	16	34%	32	24%
Transportation	15	32%	31	23%
Cannot afford to pay	3	6%	17	13%
No available child care	1	2%	13	10%
Waiting times at clinic/doctor office	3	6%	13	10%
My housing situation	2	4%	7	5%
Language barrier	0	0%	4	3%
Do not like doctor's attitude about my condition	1	2%	3	2%
Other	2	4%	3	2%
Difficulty getting referrals	0	0%	2	2%
Don't consistently see same doctor	1	2%	2	2%
Not comfortable around my doctor	0	0%	2	2%
Stress	1	2%	1	1%
Do not feel I need to	1	2%	1	1%
Lack of confidentiality	1	2%	1	1%
Religious beliefs	0	0%	0	0%
Subtotal	47	100%	132	100%
2 reasons	20			
3 reasons	3			
4 reasons	5			
5 reasons	2			
6 reasons	1			
Total	**78**			

66 individuals did not answer this question.

Antiretroviral medications. Most individuals (95% or 137) answered the question whether they took antiretroviral medications (highly active antiretroviral therapy - HAART). Responses varied by HIV status. Of the 37 persons with AIDS, nearly all (35 or 95%) reported taking antiretroviral medications. Only one person did not take medications despite the physician's advice, and another did not take HAART because the physician did not recommend it yet. Compliance was lower among respondents with HIV not AIDS. Only 73% (73 of 100 respondents) reported taking HAART, with 10% (10) not taking medications despite their physician's advice. Fifteen (15%) were not taking HAART because their physician did not feel it was time to start HAART yet. Table 6-17.

Table 6-17: PLWHA Taking Antiretroviral Medications by HIV Status

	AIDS	HIV	Total	AIDS	HIV	Total
Yes	35	73	108	95%	73%	79%
No, despite physician advice to take	1	10	11	3%	10%	8%
Physician does not recommend yet	1	15	16	3%	15%	12%
No	0	2	2	0%	2%	1%
Total	**37**	**100**	**137**	**100%**	**100%**	**100%**

7 individuals did not answer this question.

Reasons for not taking medications. Of the 30 individuals who did not take antiretroviral medications, half reported that the primary reason was that they did not like the side effects. Another five individuals (17%) felt that there were too many pills to take. The remaining individuals reported other reasons, or a combination of the two chief reasons. Table 6-18.

Table 6-18: Reasons for Not Taking Antiretroviral Medications

	Frequency	Percent
Do not like side effects	15	50%
Too many pills	5	17%
Drugs will not help me	1	3%
Other	3	10%
I am in a clinical study	1	3%
I moved to another state	1	3%
I am scared	1	3%
I gave up for some time	1	3%
Too many pills + drugs do not help	1	3%
Do not like side effects + physician is monitoring my viral load	1	3%
Total	**30**	**100%**

Only 30 individuals who reported not taking ARV answered this question.

Adherence to medications. Three quarters (76% or 110) of individuals answered this question. Of those responding, 69% (76) reported that they rarely missed a dose, and 23% (25) reported that they sometimes miss a dose. Fewer than ten (8%) reported that do not regularly take medications. When tabulated by HIV status, persons living with AIDS reported that they "sometimes miss a dose" more often than those with HIV not AIDS. Table 6-19.

Table 6-19: Adherence to Medications by HIV Status

	AIDS	HIV	Total	AIDS	HIV	Total
Rarely miss a dose	21	55	76	58%	74%	69%
Sometimes miss a dose	13	12	25	36%	16%	23%
Do not regularly take meds	2	7	9	6%	9%	8%
Total	**36**	**74**	**110**	**100%**	**100%**	**100%**

34 individuals did not answer this question.

III.D. Substance Use and Abuse

The third part of the questionnaire asked about respondents' substance use (and abuse). The data in this section are presented in total and by respondents' HIV status.

Current substance use. Question 21 asked respondents if they currently used drugs. Of the 216 who responded, over one third (80 or 37%) said "yes" and the remaining two thirds (136) said no. By type of site, 41% in homeless shelters reported current substance use, as did 73% of those contacted by outreach. Most surprising, 26% (23) of respondents at Title I substance abuse provider agencies reported current substance use. See Table 6-20.

Table 6-20: Current Substance Use by Site Type - June 2005

Site Type	Yes	No	Total	Yes	No
Homeless Shelter	46	66	112	41%	59%
Title I SA Provider	23	66	89	26%	74%
Outreach	11	4	15	73%	27%
Total	**80**	**136**	**216**	**37%**	**63%**

9 responses missing.

Current substance use by HIV Exposure Category. A cross tabulation between current substance use and HIV exposure was completed to determine the extent to which PLWHA exposed by IDU were continuing to use or abuse substances. The conclusion is that IDUs, MSM/IDUs and IDUs + Heterosexual/Other exposure did not currently use substances more than any other exposure category. Table 6-21.

Table 6-21: Current Substance Use by HIV Exposure Category

Exposure Category	Yes	No	Total	Yes	No	Total
MSM	10	7	17	20%	8%	12%
IDU	14	27	41	27%	31%	30%
MSM/IDU	1	2	3	2%	2%	2%
Heterosexual	19	38	57	37%	44%	41%
Other/Unknown	5	7	12	10%	8%	9%
IDU+Heterosexual	0	6	6	0%	7%	4%
IDU + Other	1	0	1	2%	0%	1%
Heterosexual + Other	1	0	1	2%	0%	1%
Total	**51**	**87**	**138**	**100%**	**100%**	**100%**
% Distn	37%	63%	100%			

6 PLWHA did not answer the question regarding current substance use.

Types of substances currently used. The questionnaire asked about the types of substances used, and listed three types – alcohol, heroin, cocaine – and "other." Of the 73 individuals who answered this question, half (36) reported use/abuse of a single substance and the remaining 37 reported using more than one substance (poly substance use). See Table 6-22 and Figure 6-L.

How drugs are taken. In response to the question asking how the substances listed above were taken, the overwhelming majority (84%) responded "non-injection" regardless of HIV status. This is surprising since Injection Drug Use remains the leading exposure category for HIV disease. However, the federal Drug Enforcement Agency (DEA), in its *2005 New Jersey Fact Sheet* (www.usdoj.dea.gov) reported on the increasing purity of heroin and other substances as follows:

> "Heroin represents the most significant narcotic problem in New Jersey and accounts for more admissions to state treatment centers than cocaine, marijuana, and all other drugs combined. South American heroin remains readily available throughout New Jersey, continuing to sell at low prices and high purity levels…. Heroin purity in the Newark area continues to be among the highest in the nation.:

Because of the purity of heroin, modes of use have changed from injection to sniffing and non-injection methods. Given these conditions, the survey results may not be so surprising. See Table 6-23 and Figure 6-M.

Prescription medications other than for HIV. A majority of respondents (77%) reported using prescription medications (other than HIV medications) – with 83% of HIV+ respondents using prescription medications. Approximately 55% were using these medications according to their doctor's specifications, and 22% were not. Rates were slightly better for PLWHA. The remaining respondents were not currently using prescription medications. See Table 6-24 .

This use of prescription medications not in accordance with physician instructions indicates another potential source of substance abuse and risk for HIV infection or transmission. The following information from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration (SAMHSA) National Clearinghouse for Alcohol and Drug Information (NCADI) and from the U.S. Department of Justice, DEA, highlights abuse of prescription drugs from the public health and criminal justice perspectives.

Prescription Drugs: Abuse and Addiction Research Report: May 4, 2001

> "Americans are abusing prescription drugs more than ever before, raising a serious public health concern about the nonmedical use of prescription drugs. The new *Prescription Drugs: Abuse and Addiction Research Report* explains that approximately 4 million people ages 12 and older misused prescription drugs in 1999. These people typically used prescription drugs such as sedatives, stimulants, tranquilizers, painkillers, and opioids for nonmedical purposes.
>
> "Abuse of prescription drugs may occur accidentally when a patient doesn't follow the instructions provided by his or her physician and pharmacist. Patients should never

increase their dosage or stop taking prescribed medications without their physician's approval.

"Prescription drug abuse also occurs when a person illegally obtains a legal prescription drug for non-medical use. People are obtaining these drugs in a variety of ways, including "doctor shopping," in which the person continually switches physicians so that they can obtain enough of the drug to feed their addiction. …

"Prescription drug abuse can have very serious consequences, which vary depending on the type of drug abused. Opioids, which include pain relievers such as Morphine, Codeine, Oxycontin, and Demerol, may lead to severe respiratory depression possibly resulting in death. Opioids are extremely addictive, as the user develops a tolerance to the drug they must take higher doses to achieve the same results.

"CNS depressants, often used to treat anxiety and sleep disorders, include Barbiturates and Benzodiazepines such as Valium and Xanax. These drugs slow down brain activity so that when a user stops taking them, the brain activity races out of control, which can cause seizures. Users can also develop a tolerance to CNS depressants after long-term use.

"Stimulants such as Dexedrine and Ritalin encompass the third category of prescription drugs commonly abused. These drugs increase brain activity and are frequently used to treat narcolepsy, attention-deficit hyperactivity disorder (ADHD), and depression. Stimulants increase blood pressure and heart rate and, when abused, may cause cardiovascular failure or seizures.

The DEA reported on the criminal problem that contributes to abuse of prescription drugs which is "Diverted Pharmaceutical Drugs. New Jersey has one of the highest concentrations of both pharmaceutical and chemical firms in the country. Doctor shopping, employee theft, and/or fraudulent phone-in prescriptions remain a source of diversion throughout the state." Substances diverted include "OxyContin®, Percocet®, hydrocodone and Xanax® products via indiscriminate prescribing and/or sale of prescriptions to known drug abusers."

Table 6-22: Type of Substances Currently Used and HIV Status (n = 73)

	HIV Status			Distribution	
Types of substances	**HIV+**	**Not HIV+**	**Total**	**HIV+**	**Total**
Alcohol	11	3	14		
Heroin	4	2	6		
Cocaine	12	3	15		
Other	0	1	1		
Total - 1 Substance	**27**	**9**	**36**	**59%**	**49%**
Alcohol + heroin	1	0	1		
Alcohol +cocaine	3	3	6		
Heroin + cocaine	7	3	10		
Total - 2 Substances	**11**	**6**	**17**	**24%**	**23%**
Alcohol, heroin + cocaine	7	9	16		
Alcohol + cocaine + marijuana	1	1	2		
Total - 3 Substances	**8**	**10**	**18**	**17%**	**25%**
Alcohol+heroin+cocaine+marijuana	0	2	2		
Total - 4 Substances	**0**	**2**	**2**	**0%**	**3%**
Total – All Respondents	**46**	**27**	**73**	100%	100%
Distribution by HIV Status	**63%**	**37%**	**100%**		

Table 6-23: How Substances Are Taken (n = 69)

	HIV Status		
	HIV+	**Not HIV+**	**Total**
Injection	7	4	11
Non-injection			
Method not specified	28	11	39
Method specified (sniffing, smoking, oral, drinking, combination)	8	11	19
Total non-injection	36	22	58
Total	**43**	**26**	**69**
Injection	16%	15%	16%
Non-injection	84%	85%	84%

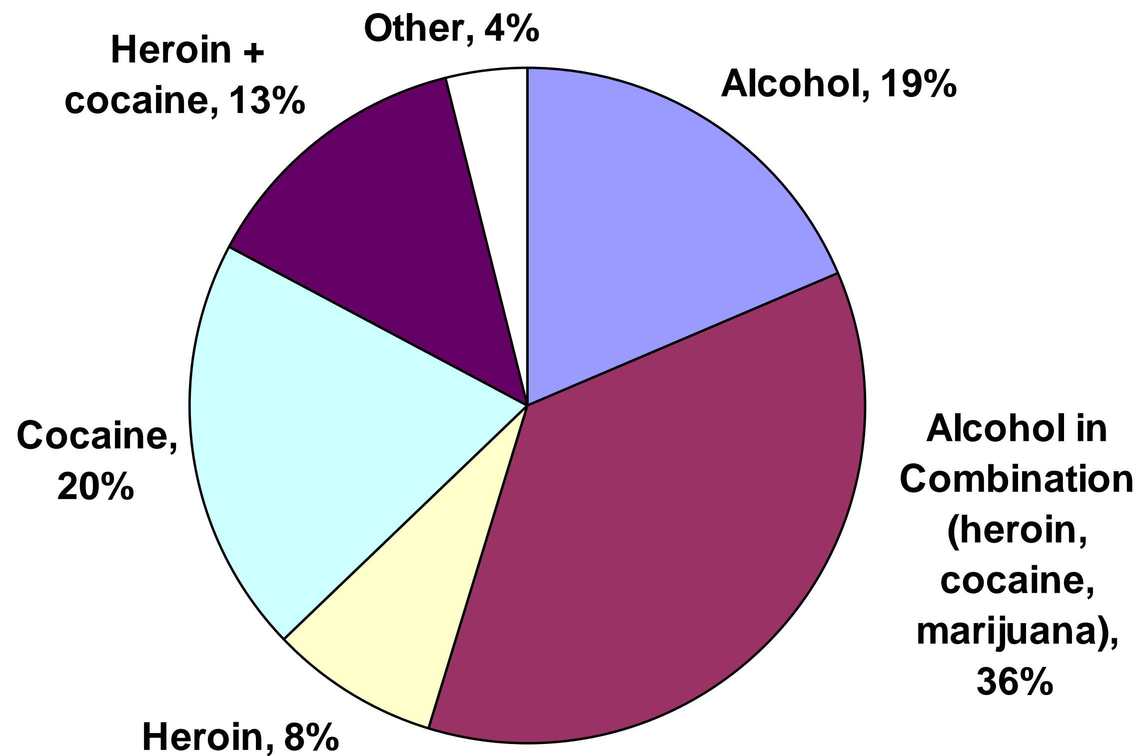
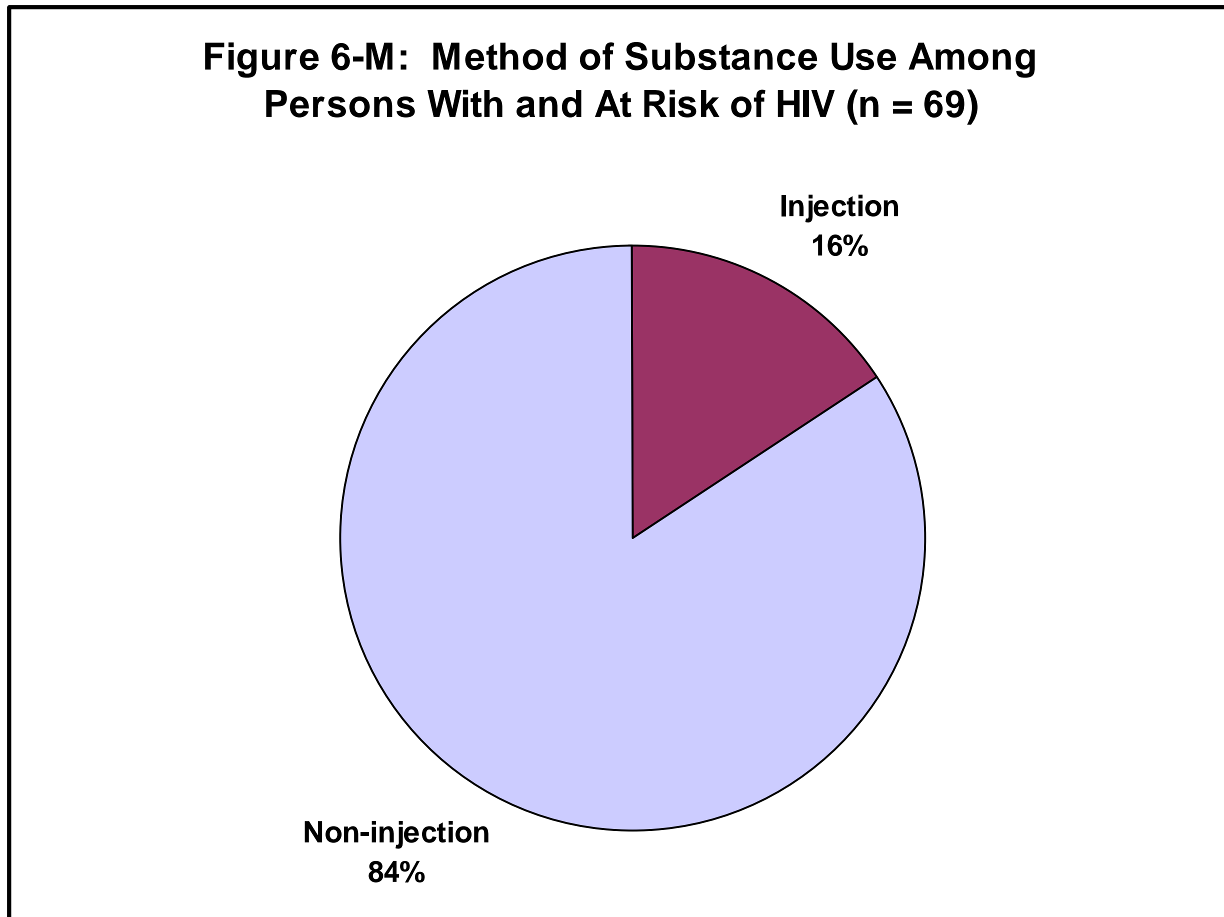


Figure 6-L: Types of Substances Used
Other, 4%
Heroin + cocaine, 13%
Alcohol, 19%
Cocaine, 20%
Alcohol in Combination (heroin, cocaine, marijuana), 36%
Heroin, 8%



Non-injection includes sniffing, smoking, drinking, oral, combination.

Table 6-24: Possible Abuse of Prescription Drugs (not HIV-Related) – Compliance with Physician Instructions (n = 194)

Do you take prescription meds (not HIV) per physician instructions?	# Respondents			%		
	HIV Status			HIV Status		
	HIV+	Not HIV+	Total	HIV+	Not HIV+	Total
Yes	80	27	107	64%	40%	55%
No	24	18	42	19%	26%	22%
I do not take prescription medications now	22	23	45	17%	34%	23%
Total	**126**	**68**	**194**	**100%**	**100%**	**100%**
Responses by HIV Status	65%	35%	100%			

Have you ever received drug or alcohol treatment? There may have been confusion among participants regarding this question. This is because a portion (38%) of respondents who are currently receiving services from Title I funded substance abuse provider agencies reported that they never received treatment for substance abuse. Of the total and HIV+ respondents, over two thirds (68%) received drug or alcohol treatment at some time. See Table 6-25.

Table 6-25: Receipt of Drug or Alcohol Treatment (Ever) by HIV Status and Site Type (n = 205)

Receipt of drug or alcohol treatment?		HIV Status			%	
		HIV+	**Not HIV+**	**Total**	**HIV+**	**Total**
Homeless Shelter	Yes	34	39	73	72%	70%
	No	13	19	32	28%	30%
	Total	**47**	**58**	**105**	**100%**	**100%**
Title I SA Provider	Yes	48	8	56	63%	66%
	No	28	1	29	37%	34%
	Total	**76**	**9**	**85**	**100%**	**100%**
Outreach	Yes	7	4	11	88%	73%
	No	1	3	4	13%	27%
	Total	**8**	**7**	**15**	**100%**	**100%**
Total	Yes	**89**	**51**	**140**	68%	68%
	No	42	23	65	32%	32%
	Total	**131**	**74**	**205**	**100%**	**100%**

18 responses missing.

Types of drug/alcohol treatment received. Individuals indicating receipt of drug or alcohol treatment (at any time) above, they were asked to indicate the types of treatment received. Only 63 of the 140 individuals (45%) answered this question. Short-term inpatient care was received most often (33% or 21 respondents), followed by long-term inpatient treatment (16% or 10) and methadone maintenance (14% or 9). Responses varied slightly for PLWHA. This table can be used as a reference, but no inferences can be drawn due to the relatively low number of responses. See Table 6-26 below.

Table 6-26: Types of Substance Abuse Treatment Received by Respondents in Table 35 (n = 140)

Types of Substance Abuse treatment	HIV Status			% Distn	
	HIV+	Not HIV+	Total	HIV+	Total
Short Term Inpatient	15	6	21	37%	32%
Short Term Outpatient	3	4	7	7%	11%
Long Term Inpatient	5	6	11	12%	17%
Long Term Outpatient	3	0	3	7%	5%
Partial Hosp.	1	0	1	2%	2%
Group Therapy	0	1	1	0%	2%
Detox	2	4	6	5%	9%
12 Step	4	1	5	10%	8%
Methadone	8	1	9	20%	14%
Intensive Outpatient	0	1	1	0%	2%
Other	0	1	1	0%	2%
Total	**41**	**25**	**66**	**100%**	**100%**

74 or 53% of respondents who indicated that they had received drug/alcohol treatment did not answer this question.

Drop out rates from substance abuse treatment. Of the 140 Individuals reporting receipt of drug or alcohol treatment, nearly all (138 or 99%) provided information on whether they dropped out of treatment. Regardless of HIV status, nearly half (48%) of respondents had dropped out of drug or alcohol treatment at some time. See Table 6-27.

Table 6-27: Drop out rates from substance abuse treatment (n = 190)

HIV Status & Prior Drug Treatment		Yes	No	Total	Drop Out Rate
HIV +					
Prior drug/alcohol treatment?	Yes	42	46	88	**48%**
	No	1	35	36	3%
	Total	43	81	124	35%
Not HIV+					
Prior drug/alcohol treatment?	Yes	24	26	50	**48%**
	No	1	15	16	6%
	Total	25	41	66	38%
Total Responses					
Prior drug/alcohol treatment?	Yes	66	72	138	**48%**
	No	2	50	52	4%
	Total	68	122	190	36%

Number of times dropped out of substance abuse treatment. When asked about the number of times they had dropped out of treatment, all "drop out" individuals in Table 6-27 provided an answer. Over three fourths of individuals dropped out fewer than four times, regardless of HIV status. Several respondents reported dropping out 10 times. See Table 6-28.

Table 6-28: Number of Times Respondents Dropped out of Drug or Alcohol Treatment (n = 63)

# Times dropped out	HIV Status		Total	% Distn	
	HIV+	Not HIV+		HIV+	Total
1	15	6	21	33%	29%
2	10	11	21	22%	29%
3	10	4	14	22%	19%
4	3	3	6	7%	8%
5	2	0	2	4%	3%
6	1	1	2	2%	3%
7	3	1	4	7%	6%
10	1	1	2	2%	3%
Total	**45**	**27**	**72**	**100%**	**100%**
Drop out < 4 times	35	21	56	78%	78%

73 or 52% of respondents who indicated that they had received drug/alcohol treatment did not answer this question.

Types of programs from which respondents dropped out. A smaller number of participants (43 or 64% of 67) specified the types of treatment programs from which they had dropped out. See Table 6-29. The percent distribution among treatment programs roughly corresponds to the types of programs that participants entered in Table 6-27 above.

Table 6-29: Types of Treatment Programs from which Respondents Dropped Out (n = 44)

Types of programs dropped out from	HIV Status		Total	% Distn	
	HIV+	Not HIV+		HIV+	Total
Short Term Inpatient	10	2	12	33%	27%
Short Term Outpatient	3	3	6	10%	14%
Long Term Inpatient	2	2	4	7%	9%
Long Term Outpatient	5	1	6	17%	14%
Detox	0	1	1	0%	2%
12 Step	3	1	4	10%	9%
Methadone	7	3	10	23%	23%
Intensive Outpatient	0	1	1	0%	2%
Total	**30**	**14**	**443**	**100%**	**100%**

Reasons for dropping out of substance abuse treatment. More participants (52 or 72% of 72 dropouts) provided reasons for dropping out of treatment. The principal reason – cited by half– was that they started using drugs again. The second reason was (19%) that they did not like the treatment program, or that the program was not appropriate for them (8%). Respondents additionally reported that they were unwilling to comply with program requirements or that they were not ready to stop using drugs (4% each). Additional reasons included that participants had no time, did not give themselves a chance, did not like program staff, lack of money, need for long term inpatient care, other problems, and being sent to prison. See Table 6-30.

Table 6-30: Reasons for Dropping Out of Substance Abuse Treatment (n = 49)

	HIV Status			
Drop out reasons	**HIV+**	**Not HIV+**	**Total**	**%**
Started using drugs	19	7	26	50%
Did not like program	7	3	10	19%
Program not appropriate	3	1	4	8%
Unwilling to comply	2	0	2	4%
I wasn't ready to stop using the drugs	2	0	2	4%
No time	0	1	1	2%
Did not give self a chance	0	1	1	2%
Did not like program staff	0	1	1	2%
Was sent to prison	1	0	1	2%
Money	1	0	1	2%
I need long-term inpatient	1	0	1	2%
Problems	1	0	1	2%
Other	1	0	1	2%
Total	**38**	**14**	**52**	**100%**

Currently in drug treatment. Most respondents (201 or 90%) answered this question about whether they were currently in drug treatment. It is important to analyze the responses with respect to the prior history of drug treatment, as asked in survey question #23 and set forth in Table 6-25. Of the 140 individuals who had a history of drug treatment, 136 responded, and nearly half (48%) indicated they were currently in treatment. A slightly lower percent (45%) of PLWHA previously in drug treatment were currently in treatment.

Of the 83 who had no history of drug treatment (no acknowledged addiction problem), only 6% were currently in drug treatment. Adding both sets of responses, 34% of total respondents are currently in drug treatment, including 30% of PLWHA. See Table 6-31.

Table 6-31: Respondents Currently in Drug Treatment by HIV Status and Prior Drug Treatment (n = 201)

Prior drug treatment status	**Currently in treatment?**	HIV Status		Total		
		HIV+	Not HIV+		HIV+	Total
Previously in drug treatment (Table 6-24)	Yes	39	26	65	**45%**	**48%**
	No	48	23	71	55%	52%
	Total	**87**	**49**	**136**	**100%**	**100%**
No prior drug treatment	Yes	1	3	4	**2%**	**6%**
	No	45	16	61	98%	94%
	Total	**46**	**19**	**65**	**100%**	**100%**
Total respondents	Yes	40	29	69	**30%**	**34%**
	No	93	39	132	70%	66%
	Total	**133**	**68**	**201**	**100%**	**100%**

22 individuals (10%) did not answer this question.

Additional comments. Twenty-two respondents provided additional comments in the appropriate section of the survey. These are listed in Table 6-32 below, by respondents' HIV status and prior history of substance use/abuse.

Table 6-32: Additional Comments from Survey Respondents - 22 Responses
HIV Status and Drug History
HIV+ and History of Drug Treatment (10 responses)
Being in Broadway House has helped me stay off drugs
Hope to finish with my methadone program.
I attend Relapse prevention support group
I really need help with drug problem
I'm in recovery
Its difficult to get charity care
My social worker helped me
Need help with my feelings about being HIV posit
No available drug treatment
Satisfied with treatment
Someone will help me into a program
The drug and alcohol programs are helpful
I'm now clean but jobless
HIV+ and No reported drug problem (2 responses)
Clinic need to have another entrance other than
Never used drugs
Not HIV+ and History of Drug Treatment (10 responses)
Ask about jail and how long one has used drugs
Has been sober for 120 days
I am currently in Integrity House. This is my f
I am currently in treatment now, and this time I
I like my current program
I need help
Outpatient
Please send me survey results
Spirituality helps me cope
Treatment works only if you are willing to learn

IV. Conclusions

It is clear that substance use and abuse remains a major problem in the Newark EMA among individuals with HIV disease and those at risk for HIV, living in homeless shelters and frequenting high drug use areas. Substance use interferes with HIV medical care and treatment – causing drop outs, relapses, and lack of adherence to medication regimens and medical care.

Of those PLWHA who were surveyed, the following information was important for purposes of planning for HIV-related service delivery. There is significant self-reported compliance with standards of medical care, but there is need to strengthen the linkage between HIV diagnosis and start of medical care.

- Nearly all PLWHA receive medical care in the county in which they reside.
- Most PLWHA receive medical care in hospital based clinics, followed by community based clinics. This is true regardless of HIV status (AIDS versus HIV not AIDS).
- Payment for medical care varies with the type of facility surveyed and by the economic situation of PLWHA. With respect to PLWHA living in homeless shelters, the majority (38%) have no health insurance, and some have Medicaid (33%). With respect to individuals receiving services at Title I funded substance abuse provider agencies, the majority (64%) had Medicaid, and 22% had no health insurance.
- Examining the time between diagnosis and start of medical care, slightly less than half of PLWHA (AIDS and HIV not AIDS) had started medical care immediately. People who currently have HIV began medical care immediately or within one year after diagnosis. In contrast, many people who currently have AIDS did not begin medical care until 1-2 years after diagnosis.
- Linkages to medical care in priority order were: #1 testing site, #2 HIV physician, #3 case manager and PLWHA themselves. Another non-HIV physician was #4, and finally people went into medical care when they got sick (#5).
- The majority of PLWHA reported seeing a physician for medical care within the past three months. However, a small minority reported that they had not seen their physician for HIV for more than one year, and one person had never seen a physician for their HIV.
- The main reason preventing PLWHA from accessing medical care was their substance use. The second reason was lack of transportation, followed by cannot afford to pay. Lack of available child care and long waiting times at clinic/doctor offices were also cited.
- Most PLWHA are taking antiretroviral medications. Some are not taking them because their physician has not yet recommended HAART. A few are not taking HAART despite their physician's recommendation.
- The chief reason for not taking the antiretroviral medications was that they did not like the side effects. Some said there were too many pills, or gave other reasons.
- With respect to adherence to medications, two thirds stated that they regularly take medications, but those with AIDS report a lower percentage.

Patterns of current and past substance use provided by survey respondents raise questions about the efficacy of treatment programs.

Responses regarding current substance use were the most surprising. Over one third (37%) of the 216 respondents reported current substance use, including 26% of respondents in Title I funded substance abuse treatment programs. Apparently, individuals are not being monitored closely for substance use or are being ignored – or relapse is being allowed. (Readers should cross-reference the *2004 Needs Assessment* and recommendation for "wet shelters" or "low threshold" programs which accommodate relapse.) Current substance abuse prevails regardless of HIV exposure category. In other words, PLWHA who were exposed by drug-related activity (IDU, etc.) were no more likely than others (heterosexuals) to use drugs now.

With respect to substances currently used, most reported alcohol in combination with another drug – mostly heroin, and also cocaine and marijuana. Substances are taken mostly by non-injection (84%) including snorting, sniffing and drinking versus injection (16%). Notwithstanding alcohol use, this finding is due to the purity of heroin coming into the Newark EMA and New Jersey, which makes injection unnecessary.

Over one third of respondents take non-HIV prescription medications, which may lead to abuse of these drugs.

Over two-thirds of respondents had received substance abuse treatment at some point in time, including two thirds of PLWHA. Short term inpatient treatment had been used most, followed by long term inpatient and methadone maintenance, and short term outpatient care.

Nearly half (48%) of respondents who had been in substance abuse treatment had dropped out, regardless of HIV status. The chief reason was because participants starting using drugs again.

Of those respondents currently in drug treatment, nearly half (48%) had been in treatment before.

V. Recommendations

All components of the Newark EMA HIV continuum of care must address the issue of substance use among PLWHA, and to assist in removing this barrier to medical care. There needs to be a rigorous review of current treatment programs, particularly those funded by Title I, to determine their effectiveness, the current substance use of participants, and interrelationship between treatment programs and participation in medical care and medical outcomes.

- Screening for all types of substance abuse should be incorporated into routine history taking with questions about what prescriptions and over-the-counter medicines the patient is taking and why. Screening also can be performed if a patient presents with specific symptoms associated with problem use of a substance.

  - The key point of such screening is the Title I medical provider. The Newark EMA Primary Medical Standards of Care require such screening at the initial medical visit and during follow up visits. The Council's Care and Treatment Committee should review current findings with respect to substance use among patients and issues related to treatment referral and follow up, including the impact on treatment adherence.
  - As the second gateway into Title I services, case management agencies should be screening all patients for substance abuse (and mental health issues) and referring them for further testing and/or appropriate treatment. The Council and/or grantee should review with all case management agencies the prevalence of substance use among clients, and standard operating procedures for capturing screening results, referral for treatment and follow up. This is particularly important for clients who are not receiving Title I medical care.

- Title I substance abuse provider agencies should review their HIV clients for current substance use. The Council and/or grantee should review each with respect to policies regarding current substance use among patients and document. Each agency should report policies, practices and outcomes regarding coordination of substance abuse treatment with medical care for HIV disease. This review should encompass referral to clients to medical care and follow up to ensure they remain in care while receiving treatment, as well as the relationship with the client's medical provider.

- The Planning Council may want to review substance abuse treatment programs that are not funded by Title I, their standards, and their interrelationship with Title I medical care for HIV+ clients. This review may involve the grantee, and should cover the same topics as the review with Title I substance abuse providers.

- The Council's Substance Abuse Committee should review this study and determine future directions and items warranting further study. Such study can include consumer input regarding injection versus noninjection substance use, and strategies to improve adherence to treatment programs and compliance with HIV medical care and medication regimens.