

Inequality and HIV: The Role of Housing

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The other articles in this edition of the *Psychology & AIDS Exchange* direct our attention to the relationship between poverty and HIV/AIDS and some of the broader structural factors that engender poverty and economic marginalization. This article focuses on the specific issue of housing—or lack of housing—as a crucial structural factor that directly and indirectly affects an individual’s ability to avoid exposure to HIV, or for HIV positive individuals, avoid exposing others to infection. Environments and resources (lack of) associated with homelessness make HIV prevention and control as well as HIV treatment and service delivery especially difficult. The same “fundamental causes” put persons at risk for both homelessness and HIV infection: economic and political contexts, inequality of opportunities and conditions, social processes of discrimination and exclusion. Housing can be seen as a “vector” or “vehicle”—an intermediary by which the pathogenic inequality that inheres in broader economic and political structures is carried to susceptible hosts: those born to poverty, race/ethnic minorities, persons who struggle with mental illness or drug addiction, those victimized by persons or circumstance, people with insufficient social support or community resources to carry them through periods of prolonged or repeated periods of crisis.

The co-occurrence of homelessness and HIV infection has long been recognized. The prevalence of HIV/AIDS is three to nine times higher among persons who are homeless or unstably housed compared with persons with stable and adequate housing, depending upon the population and geographic area studied (Allen et al., 1994; Culhane et al., 2001; Fournier et al., 1996; Paris et al., 1996; Shlay et al., 1996; Torres et al., 1990; Zolopa et al., 1994). However, evidence is beginning to accumulate that suggests that housing status is not simply a correlate, but housing is implicated in multiple causal levels of risk for infection.

Several longitudinal studies have shown that among persons at the highest risk for HIV due to injecting drug use or high-risk sex, those without a stable home are significantly more likely than others to become infected (Joseph & Roman-Nay, 1990; Popkin et al., 1993; Smereck & Hockman, 1998; Song et al., 2000; Susser et al., 1996). Among persons living with HIV, unstable housing and homelessness are recurring issues (Aidala, 1997; Aidala et al., 2000; HUD, 2001; Song 1999). Lack of stable housing is associated with high rates of drug and sex-risk behaviors; and change in housing status is associated with risk behavior change (Aidala, 2003; Aidala et al., in press; Sethi et al., 2004).

Researchers at Columbia Center for Applied Public Health and the Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention undertook a study to examine the relationship between housing and HIV risk behaviors. We used pooled data from over 3,000 clients presenting for services at 24 medical and social services agencies who were participating in a national, multisite, evaluation study (Messeri et al., 2003). Housing status was coded as “homeless” for persons who described themselves as sleeping in the street, a park, abandoned building, or automobile; sleeping in a public place (e.g., bus station) or other place not intended for sleeping; in a shelter for homeless persons; or in a limited stay, single room occupancy (SRO) or welfare hotel or motel. Individuals were categorized as “unstably housed” if they were in a temporary or transitional housing program; in jail, drug treatment, or halfway house with no other address; or temporarily doubled-up with family or friends, in someone else’s home. Thus the analytical focus included not only clients who were literally homeless but also those who were precariously housed, who lacked a stable, secure, permanent living situation they could maintain. Homelessness is but the most extreme position along a continuum of housing difficulties likely to affect the lives of persons infected with HIV/AIDS (Song, 1999). Individuals were defined as “stably



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GUEST EDITOR COMMENTS

The Interrelationship Between Poverty and HIV/AIDS

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The American Psychological Association (APA) has officially acknowledged that poverty and a variety of risk factors, including lack of health care, are interrelated. The Resolution on Poverty and Socioeconomic Status, adopted by the Council of Representatives in August 2000 (see www.apa.org/pi/urban/povres.html), outlines how poverty is detrimental to the psychological well-being of individuals, including women, children, and their families. Although this policy does not make a specific connection between poverty and HIV/AIDS, there is a substantial body of research that shows how poverty adversely affects both those at risk for HIV and those living with HIV/AIDS. Additionally, research shows that HIV/AIDS exacerbates poverty.

This edition of *Psychology & AIDS Exchange* is devoted to a description of the cyclical relationship between poverty and HIV/AIDS. It is well-known that individuals living in poverty have fewer opportunities to access health care, and when they do access health care, they tend to access it infrequently and/or sporadically. For most individuals living in poverty, survival is the main concern, and health care issues, unless they are immediately life threatening, are seen as secondary. The following articles provide numerous examples of the ways in which HIV/AIDS and poverty are entwined.

The first article, written by Angela Aidala, is entitled "Inequality and HIV: The Role of Housing." In this article, Aidala discusses the co-occurrence of homelessness and HIV infection. She states that the prevalence of HIV/AIDS is three to nine times higher among individuals who are homeless or unstably housed than among individuals with stable and adequate housing. Aidala makes the argument that housing is a strategic target for intervention. Finally, she states that the lack of housing represents a more proximal consequence of a broader economic, social, and political set of issues that affect HIV prevention and HIV care.

The second article, written by Rhonda Rosenberg and Robert Malow, is entitled "The Hardness of Risk: Poverty, Women, and New Targets for HIV/AIDS Prevention." This article describes various contextual factors that account for the acceleration of HIV risk among women, particularly minority women. More specifically, the article shows how individual efforts to reduce HIV risk are often trumped by problems related to finances, housing, child care, transportation, looking for or holding down multiple low-skilled jobs, medical care, maintaining intimate relationships, and personal/neighborhood substance abuse and crime.

The final article was written by Elise Arruda and Elsa Vasquez. It is entitled "Living with HIV/AIDS: Interviews From the Frontlines." In this article, the authors describe the role that poverty plays in the lives of two individuals living with HIV/AIDS.

These three articles provide a framework in which psychologists and other providers can begin to look at poverty as a health care issue. 

The Hardness of Risk: Poverty, Women, and New Targets for HIV/AIDS Prevention

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It is fundamental to public health that the possibility of a “cure” has more to do with the hardness of life than with the saving grace of biomedical intervention. Even when it is a matter of a vaccine or a drug, the hardness of people’s lives may prevent access to the intervention or interfere with making use of it. The history of tuberculosis should have made this clear. Yet it was the advent of AIDS that crystallized this public health principle as no other infectious disease had in human history.

Adequate nutrition, clean water, a sense of individual agency, and freedom from violence and social disarray are some of the touchstones of historical declines in infectious disease incidence and mortality. This history has been translated into social determinants research by epidemiologists and into development studies by economists. However, it has taken astronomical disease rates, principally in sub-Saharan Africa, along with drastic shifts in disease burden among different groups in the U.S. population, to clarify HIV/AIDS as something more than a problem of individual risk.

Disproportionate rates among U.S. minorities have led researchers to look at health disparities and the need for tailored interventions. However, even this redefinition has proven inadequate to the most startling shift in the population patterns of the epidemic: the acceleration of HIV risk among women, particularly minority women (Gerberding, 2004). In this, the U.S. has converged with Africa. Ethnic minority women in the United States seem to be living in a developing country context.

The distinguished public health scientist Tony McMichael (2001) has summed up the dynamic of the AIDS epidemic in the 21st century:

Diseases such as tuberculosis, leprosy, cholera, typhoid and diphtheria are pre-eminently diseases of poverty. As happened historically with tuberculosis, HIV infection seems now to be entrenching itself among the world’s poor and disempowered, especially in sub-Saharan Africa and South Asia. Much of the spread of HIV has been along international “fault lines,” tracking the inequality and vulnerability which accompany migrant labour, educational deprivation and sexual commerce.

The perpetual state of coping observed in the most vulnerable female groups can easily appear amorphous and unsolvable. Individual efforts to reduce HIV risk are often trumped by problems related to finances, housing, child care, transportation, looking for or holding down multiple low-skilled jobs, medical care, maintaining intimate relationships, and personal/neighborhood substance abuse and crime (Barthwell, 1993; Kalichman, Adair, Somlai, & Weir, 1995; Kalichman, Hunter, & Kelly, 1992; Wingood & DiClemente, 1998).

Survival sex is a known risk factor for women in the developing world, but it is also an experience shared by women in the United States who live in a similar context, especially those with substance abuse problems (Logan, Cole, & Leukefeld, 2002).

McGowan et al. (2004) have identified it as a major barrier to HIV prevention with high-risk seropositive women. In their interviews with women receiving antiretroviral therapy, 41% stated that they continued to having unprotected sex, and the significant contributing factor was trading sex for drugs or money.

Let us be very specific about some of the ways in which poverty and its consequences synergize HIV risk. Women who are addicted must often exchange sex for the drugs they need. Women without housing often give sex to men who offer them a safe place to spend a night. Women in violent relationships fear requesting that their partners use condoms because of the threat of partner retaliation for perceived infidelity. Women who cannot pay rent are often forced to give their landlords sex to avoid being expelled from their homes. Women lacking job skills have sex with their superiors to avoid being fired. Women who are incarcerated are subjected to forced sex and the use of unclean needles (for primary resources on these issues, see O’Leary, 2001; O’Leary & Jemmott, 1995; O’Leary & Martins, 2000; and the overview at www.apa.org/monitor/oct03/helping.html).

HIV/AIDS sociobehavioral research, as applied to women, provides several organizing principles to help the policy malaise that often accompanies poverty-related explanations of morbidity and mortality:



Rhonda Rosenberg, PhD



Robert Malow, PhD

Hardness of Risk, continued on page 4

1. The latest survey analyses confirm the applicability of the 'syndemic' model to persistently high-risk groups, such as ethnic minority women. A syndemic is the co-occurrence of epidemics in a population and describes the synergistic phenomenon that links poverty and HIV/AIDS. However, an empirical syndemic model goes the extra step needed in developing an evidence-based science that can be funded to fight such a problem. This is why the recent research by Stall et al. (2003) is so significant. They were able to statistically demonstrate a linked set of four psychosocial health problems, which were each individually excessive in their study population and additively increased the risk of HIV: polydrug use, depression, childhood sexual abuse, and partner violence. Their study population was urban MSM (men who have sex with men) from four major U.S. cities. Similar survey research is needed for high-risk female populations. A tutorial to this approach can be found on the Centers for Disease Control and Prevention (CDC) Web site: www.cdc.gov/syndemics/index.htm.
2. Survey and intervention research has documented the "hardness of risk" for the most vulnerable groups among women. Hardness of risk can be defined as what makes potential exposure to HIV so difficult to avoid and bear or a therapeutic regimen so prohibitive once infected. The importance of this research is that it moves the prevention community beyond the measurement of individual risk and into intervention models that can encompass the context and heterogeneity of women. Foremost, it has had the effect of guiding intervention research toward those studies that can identify factors that mediate and moderate intervention effects. Such research values the incorporation of social and contextual factors. The cumulation of research on the hardness of risk has allowed increasingly precise statements about these influences, as illustrated in the review by McNair and Prather (2004) on the social and contextual risks of African American women. However, as they noted, HIV/AIDS intervention design specifically tied to these factors has lagged behind in prevention with women.
3. Women's experience with HIV/AIDS has sharpened attention on the most basic of facts: Transmission risk is negotiated in couples or dyads and inside of groups. The couple and the group are the new targets of interventions.
4. Although there have been peer-support and family communication interventions, there are none utilizing a social capital approach to the group influence. Holtgrave and Crosby (2003) have identified an AIDS-related social capital effect by replicating the approach used by Harvard's Kawachi, in which state-level surveillance data are used with Putnam's social capital indicators of trust, density of organized groups, and participation (see Holtgrave & Crosby, 2003, for their review of this approach).
5. HIV prevention research has documented that mental health is critical to protective behavior and medication adherence, and, moreover, that therapy matters, even in the most environmentally deprived and disorganized communities. A poignant illustration is a randomized controlled trial

of group psychotherapy for HIV-linked depression conducted in Uganda (Bolton et al., 2003). The research team led by Paul Bolton had already determined the significance of depression in Ugandan areas hardest hit by the epidemic. The intervention trial demonstrated that group psychotherapeutic approaches can be adapted with efficacy in a developing country context. Signs of positive impact on relational health between marital/sexual partners and on the social and financial empowerment of women were identified as areas for further research. This study was reported by Marc Lacey in *The New York Times* on January 15, 2004, and can be found at the JAMA Web site: <http://jama.ama-assn.org/cgi/content/abstract/289/23/3117>.

The major message is that HIV/AIDS prevention research with women has advanced so that even population-based scientists can present case studies of women caught on the fault lines of poverty and the epidemic (O'Leary & Martins, 2000). The case profile is well established by key large-scale studies. The cohort of women in the HERS project—the CDC/National Institute of Allergy and Infectious Disease's HIV Epidemiology Research Study—were mostly Black or Hispanic, lived below the poverty line with inadequate education, and had scores on the Center for Epidemiological Studies–Depression Scale indicating significant symptoms of depression (Moore et al., 1999).

The syndemic approach places a premium on the hybrids of HIV/AIDS prevention research, which simultaneously maintain an accounting of individual factors while aiming for a more explanatory model of what makes it "hard" for a given population. Another example is research from the HIV Cost and Services Utilization Study by Sherbourne, Griffith Forge, Kung, Orlando, and Tucker (2003), which examined individual characteristics of women and obtained clear recommendations for peer-support and other intervention designs that would address the barriers signaled by inadequate income, delays in medical care because of caregiver burdens, high interpersonal conflict, intimate partner violence, and avoidant coping styles. All contributed to the probability of a psychiatric disorder.

Castro and Farmer (2005) have emphasized that tying HIV prevention to poverty and health disparities is not enough and can result in approaches that caricature the target population as hollow victims. Their major point, however, is that populations respond and change their behavior when health care infrastructures and interventions are available that work, and they present evidence from their interventions in Haiti as an illustration. In addition, Menon-Johansson (2005) has shown that HIV prevalence is higher in countries with poor governance. The U.N. Commission on HIV/AIDS and Governance in Africa is indicative of the growing importance of institutional design in fostering sustained outcomes from HIV interventions (see www.uneca.org/CHGA/about.htm).

But it is the World Bank that has been able to spotlight the need for empowering women in HIV prevention efforts. In this instance, an economic model has brought attention to individual and group capacity in adopting protective behavior.

Living With HIV/AIDS: Interviews From the Frontlines

Elise Arruda & Elsa Vasquez

CHOICES Program



Elise Arruda & Elsa Vasquez

The purpose of this article is to provide readers with first-hand accounts about the financial strain created by living with HIV/AIDS. These accounts are derived from interviews conducted with Joseph and Bill, two people living with HIV/AIDS. Both stories are a testament to how HIV/AIDS and economic hardship are cyclically linked to each other.

Joseph

Joseph discovered that he was HIV positive when he was a young adult. Within a few weeks of finding out his status, he started doing research on the disease. Joseph explains that he has a great deal of bitterness toward “the system” because many friends do not qualify for medical assistance, and he believes they are “left for dead.” Joseph stated that “we all want to live in the best health we can and an arbitrary cutting point where one dollar makes a person ineligible is simply ridiculous.”

Joseph is extremely grateful that unlike many HIV/AIDS patients without medical insurance, he was fortunate to have found programs that provide him with the essentials: medication, food, and mental health services. For Joseph, the AIDS Drug Assistance Program (ADAP) is able to fully cover his medication cost, estimated between \$1,200 and \$2,000 per month.

When we asked Joseph what happens to those who do not qualify for medical assistance, he explained that there is a mental burden attached to coping with a lack of financial resources. Apparently, he has witnessed many HIV positive individuals without adequate resources and, as he puts it, “after the health care system gives up on them, they also give up on them-

elves.” Joseph also expressed that an individual’s motivation to fight often dwindles as the surrounding world offers harassment and abandonment. He says “living with HIV/AIDS is a daily fight.”

Joseph certainly stresses the importance of a supportive environment. “There are days where I want to give up, and my friends make up for my lack of willingness to live. If I didn’t have them, I don’t know where I would be.” The insight that Joseph offers is that there are financial hardships for people living with HIV/AIDS, but there is some hope for these individuals as long as society and their friends continue to offer support and do not give up on them.

Joseph, like many others who are living with HIV/AIDS, has accepted his diagnosis as a sign or direction of where to lead his young life. Joseph has become an advocate for HIV/AIDS health services in Los Angeles. He is constantly advocating for the preservation of services for those who are ineligible for medical treatment plans. Joseph sits on various boards, such as ALIANZA, a Los Angeles County Latino Caucus on HIV/AIDS, the Prevention Planning Committee, and the South East Incubation Project. By being on the boards of these committees, Joseph has his voice heard by the individuals who make decisions that affect his life and the lives of his friends. “Being involved and knowing that my voice matters helps motivate me to keep fighting.”

Beyond volunteering on boards, Joseph has chosen an occupation where he can make a direct impact on people’s lives. Joseph is a health educator for a nonprofit health services corporation. It is through this corporation that Joseph has found programs that supplement many of his basic needs, such as food and mental health services.

Bill

Like Joseph, Bill has managed the growing cost of living with HIV/AIDS for several years.

Bill has been living with AIDS for 20 years. When Bill was diagnosed, he had two young children, and today they are both teenagers. Soon after discovering he had AIDS, Bill resigned from his position in law enforcement, not because he wanted to, but because the physical demands of the disease forced him to leave. He recalls that he was constantly missing workdays because he was getting one case of pneumonia after another. Bill talks of a time before his illness, when he and his family would travel to Disneyland and vacation together. Thinking of those trips, Bill becomes saddened that his family will never be able to vacation as they once did. He is well aware that economically he cannot afford to take family outings and that as his health deteriorates, he cannot physically be very far from his home and medical care. Another reality of the financial strain on Bill’s life is that he is now divorced and a single parent. His teenage son lives with him and his teenage daughter lives with her mother. Bill calls these outcomes of the financial strain “the mental burden of AIDS.”

For Bill, the AIDS virus has challenged more than finances; it has also challenged his role as a father. Bill depends greatly on his son, who often has to take the role of caretaker. Bill comments that “My son has had to act like an adult well before he was old enough to be one.” Bill explains that his son often has to help him take a shower and also help in managing the daily routine of his disease.

Currently, Bill and his son live on less than \$1100 a month. Bill’s income has dropped to a third of what it was before

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his diagnosis. He says that this limited income greatly affects his son's social life. Bill says that there are times when he can see that his son would like to have name-brand clothes or be able to go to a school dance. He credits his son for never asking, but he is well aware that his son wishes their lifelong circumstances were different. Bill says that even during periods when he is feeling well and the impact of the disease is less evident, his way of life is compromised by the financial costs.

Bill has also given up driving all together because of the side effects of his medication, and he therefore relies on disability transportation several times a day. This requires planning many days in advance to secure rides to work, school, doctors' appointments, grocery shopping, and other errands. Each day requires substantial structured planning in order for him to adhere to medication protocols and simple normal daily activities.

Despite Bill's medical and financial situation, he has taken on a role as an advocate for AIDS in his community. He is currently an HIV/AIDS commissioner for Los Angeles County, and he


also sits on the Los Angeles Sheriff's Department Advisory Counsel. Beyond his community work, Bill is intent on getting a college degree while also holding down a part-time job at the admissions office of his college.

Bill comments that "there are many people who are positive that travel out of this country to get their drugs. They have to; it's so much cheaper."

As our interview comes to a close, Bill looks at his watch and is reminded that his time must be monitored. It is clear that by early afternoon, he has already had a long day and that the stress of his timed schedule is beginning to become frustrating. He comments that one of the hardest things for him personally is finding a way to fit everything into his day when his time is dependent on his medications and transportation schedules. It is visibly evident that this process tires him.

Although Bill's story is not an easy one, he is fortunate to be a veteran of the United States and therefore has most of his treatment and medical costs covered by the Veterans Affairs Hospital. If he were not supported this way, then there would be no way for him to live and certainly no way for his son to live with him.

Although Bill says he is extremely grateful to have this support, he is concerned for those with HIV/AIDS who do not receive the assistance that he does from the government. Bill comments that "there are many people who are positive that travel out of this country to get their drugs. They have to; it's so much cheaper. The trip is dangerous because they could easily become ill. But it is the only way they can survive." Bill is very grateful that he is able to get his care close to home and at a reasonable price. He continues to be involved in community work to advocate for those who are not as fortunate as he, and Bill hopes that some day all individuals with AIDS will be able to get constant and appropriate care.

We thank Joseph and Bill not only for their courage in sharing their stories, but also for taking a stand and educating their community on HIV/AIDS. These two men are a living testament to the reality that living with HIV/AIDS affects the financial capability of infected individuals every day. 

The UN Report

The UN report, entitled "Population, Development, and HIV/AIDS With Particular Emphasis on Poverty," was prepared by the Commission on Population and Development.

The report demonstrates that unless more vigorous actions are undertaken to combat the disease and its effects, the HIV/AIDS epidemic portends a grim future for many countries, especially the poorest countries. The report concludes that the most effective approach to thwarting the HIV/AIDS epidemic is to implement a combination of strategies that reduce risks, diminish vulnerability, and mitigate impact.

The report was prepared by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat. The Population Division acknowledges the contribution of the Joint United Nations Programme on HIV/AIDS (UNAIDS) for the preparation of Section II on the determinants of HIV/AIDS and Section VIII on prevention, treatment, and care.

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See <http://www.un.org/esa/population/publications/concise2005/PopdevHIVAIDS.pdf>

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housed” only if they had their own housing in an apartment, house, or congregate facility with no expectation or requirement to leave in the foreseeable future.

We found that clients who were homeless or unstably housed at baseline were 2-6 times more likely to have recently used hard drugs (heroin, crack/cocaine, methamphetamine), used needles, shared needles, or exchanged sex than persons with stable housing, controlling for demographics, economic resources, health and mental health status, and service utilization variables. Follow-up data collected 6-9 months after baseline were available for clients of a subset of 16 agencies ($n=691$). Longitudinal analysis showed that change in housing status was associated with change in risk behaviors, again controlling a wide range of sociodemographic variables, service utilization currently and in the period between baseline and follow-up, and risk behaviors at baseline. Persons whose housing status improved between baseline and follow-up were half as likely to use hard drugs, use needles, share needles, or have unprotected sex as were individuals whose housing status did not change. Those whose housing status worsened over time were 4 times more likely than others to have recently exchanged sex (Aidala et al., 2003).

Data for a second analysis of overtime patterns of sexual behavior among HIV infected adults was provided by the CHAIN Project, a prospective cohort study of a representative sample of 968 adults living with HIV in New York City interviewed every 6-12 months between 1994 and 2001. Housing status was coded as stable, unstable, or homeless using the above coding scheme. A similar set of control variables were entered into logistic regression models (demographics, economic resources, health status, service utilization, etc.). Persons who recently (past 6 months) experienced homelessness were significantly more likely to report unprotected sex and, for women only, exchanging sex for money or drugs (Aidala et al., 2002; see also Aidala et al., 2003).

These findings are consistent with a causal argument about housing and drug and sex risk behaviors; however, data were not gathered using controlled designs. Thus, findings cannot support causal assertions about the provision of housing and consequent lowering of transmission risk among HIV seropositive individuals. Carefully designed prospective studies are needed that could determine the causal direction and the mechanism linking housing and behaviors that put people at risk for HIV infection or that lead HIV-infected persons to put others at risk.

However, before further research is undertaken, it is instructive to ask, WHY should housing affect HIV risk behaviors? A full discussion of possible mechanisms that may directly or indirectly link housing status to drug and sexual behaviors is beyond the scope of this essay. Several explanations are offered in the attempt to encourage appropriate empirical explorations.

One must begin with the “risky person” model which essentially argues against an independent causal role for housing as it affects risk for HIV infection. One might argue that the above findings

are evidence of the self-selection of “risky persons” into conditions of both homelessness and HIV infection. That is, an individual’s personality dispositions or character “traits” may lead the person to drug use, risky sex, and illegal activities that would have both health (increased risk for HIV infection) and housing (limited economic resources to purchase conventional housing) consequences. Risky person arguments are common in the substance abuse and deviance literature (e.g., Jessor, 1984; Zuckerman, 1994) and echo a range of “trait versus state” arguments in social psychology (Shinn, 1997; Spielberger, 1972).

The risky person model assumes behavior follows the person according to his/her personality dispositions or traits, rather than being influenced by the situation or state of homelessness. In this view, the once-homeless person who receives housing would be expected to continue engaging in risky behaviors that would contribute to a return to homelessness. However, a number of studies reviewed show a contrasting pattern. Formerly homeless individuals who obtain housing are more likely to cease or reduce both drug-related and sexual-risk behaviors (Aidala, 2003; Aidala et al., 2003). Other research has also shown a change in risk behaviors associated with change in housing status over a 6-12 month period (Aidala et al., in press; Valencia et al., 2004). Also relevant are positive evaluations of “housing first” interventions that place homeless persons with substance abuse and/or mental health problems directly into housing without prior demonstration of sobriety, treatment adherence, or other criteria as a condition of receiving housing (Tsemberis et al., 2004; Burt et al., 2002).

In contrast to an emphasis on the individual personality of risky persons, a more structural “context of risk/pervasive stress” model would seem appropriate, similar to the “nexus of risk” approach described by Dr. O’Leary and colleagues (O’Leary, 2001). Several causal strands to follow would direct our attention to broader processes of inequality and exclusion that lead to the deterioration of housing situations and neighborhood environments for members of excluded groups. In this model, economic marginalization triggers social exclusion and negative psychosocial states. Individuals can find themselves in contexts marked by pervasive risk, competing needs, few personal resources, and few community resources—situations that can, in turn, lead to unstable housing (one lacks financial resources, faces housing discrimination) as well as risky behaviors (e.g., exchanging sex for money or using drugs to self-medicate emotional distress), which both contribute to increased risk for HIV infection. This is not to deny that dispositions and other personal characteristics are involved in drug taking and sexual behaviors. It may be that housing/neighborhood context potentiates personal dispositions. Studies that show independent effects associated with the more directly malleable “state” of housing situation are likely to hold more promise for appropriate intervention than mechanisms far antecedent in psychological development or closer to biological bases of disease.

A more structural argument would be mindful of the fact that

housing effects carry neighborhood effects. Housing includes broader aspects of the surrounding residential setting (Dunn & Hayes, 1999; Fitzpatrick & LaGory, 2003). The homeless and unstably housed are not randomly distributed throughout a city or geographic area, but concentrated in the most devastated neighborhoods, characterized by high rates of crime and violence, limited economic opportunities, and poor service infrastructure. The two factors most consistently associated with differential health outcomes—income and race—are also the factors most associated with access to stable and good quality housing in “good” neighborhoods (Saegert & Evans, 2003). Both housing situation and neighborhood conditions can be sources of comfort and protection or sources of chronic and at times acute stress. A number of studies have shown the extent to which the homeless, especially women, are exposed to trauma and violence (Fisher et al., 1995; Kushel et al., 2003; Wenzel et al., 2004). Neighborhoods of substandard housing, abandoned buildings, and warehouses are not high on “social capital” resources that might mediate the effects of strain and stressful events in the lives of the urban poor. The homeless tend to be socially isolated or involved in social ties and networks that support risky behaviors (substance use, sex exchanges). Substance use as “self-medication” can be a response to stress and/or untreated symptoms of depression or anxiety, increasing risk for HIV infection (Khantzian, 1997; McEwen, 2001). Sexual escape is also an option for some (McKirnan, et al., 2001).

It seems self-evident that lack of housing is one factor that would make it “hard” to “move out of risk or use risk-reducing tools and institutions.” However, unlike other hard risks, housing is a strategic target for intervention.

As Dunn and others (Evans et al., 2003; Hartig et al., 2003) have emphasized, housing has meaning as well as materials dimensions that affect health and well-being. While home and neighborhood are for most people a source of identity and belonging, for those without, being “homeless” is a mark of failure at the most basic level of adult role functioning (Goffman, 1963; Takahashi, 1997). Internalized shame and lack of self-esteem may further contribute to risky behaviors. Another causal dynamic to consider is the role of housing as it structures the private sphere. The lack of housing, transient living conditions, and the communal sleeping arrangements in most homeless shelters pose a formidable barrier to forming stable intimate relationships. Especially in urban settings, the lack of a stable “home” and community ties is associated with multiple sexual partners, casual liaisons, sex exchanges, and low rates of marriage or stable partner relationships (Browning & Olinger-Wilbon, 2003; Castel, 2000; Goode, 1963; Huston, 2000).

It seems self-evident that lack of housing is one factor that would make it “hard” to “move out of risk or use risk-reducing tools and institutions.” However, unlike other hard risks, housing is a strategic target for intervention. Housing (lack of housing) repre-

sents a more proximal consequence of broader economic, social, political, or policy barriers that affect HIV prevention and HIV care. Whereas it is very difficult to address broader societal processes—e.g., to restructure educational and occupational opportunities for the poor or counter the insidious effects of racism—we can do a better job of addressing a more proximal manifestation of these influences by addressing the critical need for housing. Given that research has shown that longitudinal changes in housing status are associated with parallel changes in AIDS risk-taking among HIV seropositive individuals, the provision of housing as a public health intervention holds significant promise.

Acknowledgements: Arguments concerning the mechanisms through which housing might affect HIV outcomes for individuals and communities were developed in conversations with Esther Sumartojo, Ron Stall, and David Harre.

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HIV behavioral interventions have typically neglected issues of human and social capital—that is, the education and training that the individual, his or her family, and social groupings can summon in making use of HIV prevention programs.

One initial step that can be taken in HIV behavioral prevention in this regard, however, is known as “linking.” This involves incorporating linkage mechanisms within or in tandem with proven behavioral interventions that will go beyond information and referral and actually train and direct women to establish linkages with health services and social support. Although not targeted to women, a good example of this approach is ARTAS, the Antiretroviral Treatment Access Study (Gardner et al., 2005; see <http://ssrg.med.miami.edu/x27.xml>).

The latest research from the New York City Health Department may indicate how essential such linkage mechanisms will be in our third decade of the epidemic. Statistics reported in *The New York Times* by Marc Santora (2006) reveal that ethnic minorities, particularly Black women, in Central Harlem are more likely to die of AIDS than are people living in Chelsea, which actually has the highest rate of new cases. Financial obstacles are very minimal in the city. The difference is being attributed to variations in help seeking between ethnic minorities and the large gay White male population in Chelsea. Stigma in ethnic minority communities and heterosexual partnerships is evidently proving harder to negotiate.

The hardest hit are Blacks—male and female—not only in New York City but across the country. The February 10, 2006, *Morbidity and Mortality Weekly Report* (CDC, 2006) is arresting in its portrayal of the pervasive disparity of experience with HIV/AIDS among Blacks in the United States. If preliminary suppositions from New York City are valid, what appears crucial to recognize is the important effect emotional life has on outcomes in this epidemic. Emotional life is at the core of an adequate response to stigma and undermining heterosexual partnerships. Interventions that do not take account of the affective dimensions of the factors that mediate and moderate outcomes—whether they pertain to individual, familial, cultural, or adverse socioeconomic issues—will be unable to sustain women through the inevitable losses and disappointments that accompany attempted adherence to the intervention.

In the end, the outcome to be measured is condom use, no matter how deep the poverty or health disparity. As attention is turned to these macrocontextual issues, it is important to keep in mind, particularly for this forum, that condom use to prevent HIV transmission is also about sexuality, intimacy, and loss. After 25 years of the epidemic, the affective dimensions of both the macro- and the microcontext of condom use are still absent from most measurement methodologies of HIV/AIDS interventions. Even with cognitive-behavioral approaches and targeted psychological outcomes, the psychology of condom use, so to speak, is still waiting to be explored.

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BSSV

Behavioral and Social Science Volunteer Program Update



Duane Wilkerson, MPH,
Program Director

The Behavioral and Social Scientist Volunteer (BSSV) Program, funded by the Centers for Disease Control and Prevention (CDC) since 1996, offers technical assistance (TA) for HIV prevention planning and implementation to community-based organizations (CBOs), HIV Prevention Community Planning Groups (CPGs), and state and local health departments (HDs). Technical assistance is accomplished by linking local, volunteer, behavioral and social scientists with the agency requesting TA. Currently, the BSSV Program supports more than 260 volunteer scientists representing a wide range of behavioral and social science disciplines.

It has been a record-breaking year for the BSSV Program on many fronts. Behavioral and social scientist volunteer scientists (BSSVs) participated in 119 TA consultation tasks in various locations, ranging from Alaska to Maine to Florida to Puerto Rico. Recipients of the TA were mostly CBOs, followed by CPGs, and then HDs. During the course of this year, five multiday trainings were conducted to further develop the knowledge and skills of our BSSVs.

The types and intensity of TA provided by BSSVs during this program year varied widely. Some assistance (e.g., reviewing and modifying an existing assessment or evaluation instrument) was completed in 6-8 hours over a period of 2 weeks. Other assistance (e.g., training staff on how to assess clients in an outreach setting using stages of change theory) required 30-40 hours of volunteer time over the course of 3-4 months. Other TA tasks required an ongoing

commitment, such as those involving having a BSSV participate as a voting member of a regional or state CPG. In fact, we have several BSSVs who have been on their local or state CPG for years.


Collaborative efforts, using multiple BSSVs, are not uncommon. One request for TA involved bringing together six BSSVs from Puerto Rico for a 3-day, skills-based training on HIV prevention. The participants of the training were staff from the nine directly funded (by CDC) CBOs. This training was a collaborative effort with the Latino Commission on AIDS in New York City.

An interesting and important collaboration took place this year with the National Association of State and Territorial Directors (NASTAD).

An interesting and important collaboration took place this year with the National Association of State and Territorial Directors (NASTAD). Dr. John Anderson, Director of the American Psychological Association (APA) Office on AIDS, along with NASTAD staff and health department staff from California, Colorado, and Rhode Island, collaborated in developing three products. Each of these products was focused on educating front-line prevention workers about the relationship between mental health and HIV prevention:

- NASTAD's May 2005 HIV Prevention Bulletin focusing on mental health and HIV prevention;
- NASTAD's July 2005 Issue Brief, entitled "HIV and Mental Health: The Challenges of Dual Diagnosis" (see http://www.nastad.org/documents/public/NASTAD_Mental_Health_final.pdf); and
- A 2-hour workshop entitled "Integrating Mental Health with HIV/AIDS Care, HIV Prevention Planning, and HIV Prevention Programs," presented at the 2005 HIV Prevention Leadership Summit (HPLS)

Although it has been a very successful year, the BSSV Program still faces important challenges. Some of these include training and preparing even more BSSVs to be available as coaches for CBOs implementing CDC's Diffusion of Effective Behavioral Interventions (DEBI); expanding the breadth of our BSSVs' TA skills, as some TA requests being sent to us from CDC are different than what we've done in the past (e.g., presentations to CPGs on the CDC Community Planning Guidance); and continuing to provide the level of support to BSSVs while continuing to increase the number of TA consultations being conducted at any one time.

If you are interested in finding out more about the BSSV Program or wish to become a volunteer, please contact Duane Wilkerson by phone, 877-754-1404, or by e-mail: dwickerson10@comcast.net 

HOPE

HIV OFFICE FOR PSYCHOLOGY EDUCATION

**Winter '05/
Spring '06**

HOPE Program Update

*Christopher Rowe,
HOPE Program Training Director*

HOPE Staff and Faculty Host New and Veteran Trainers at the National Training Conference in Memphis

The HIV Office for Psychology Education (HOPE) Program hosted 52 new trainers and 40 veteran trainers at its fifth National Training Conference (NTC), in Memphis, Tennessee, January 26–29, 2006. Though I've said it before and certainly hope to say it again, I really think we offered the best training yet. But before I describe the NTC, why don't I get you caught up on what has been going on here at HOPE since our last *Psychology & AIDS Exchange* update?

At the time of our last update, HOPE was awaiting confirmation of our most recent Center for Mental Health Services (CMHS) contract. We were concluding our fourth 3-year contract at the time. On September 21, 2004, we signed our most recent funding contract—a contract for 5 additional years rather than the usual 3! That's right, gentle reader; HOPE has been continuously funded for more than 14 years and can now guarantee training until at least 2009!

For those of you not familiar with our history, the HOPE Program, funded originally in October 1991 through a 3-year contract with CMHS, created and pilot tested seven 7-hour continuing education curricula on effective mental health service delivery for persons infected with, and affected by, HIV disease. Since that time the HOPE Program, using its train-the-trainer model, has



Christopher Rowe

recruited and trained more than 450 doctoral-level psychologists to be regional trainers, and nearly 250 of our volunteer trainers remain active. HOPE Program trainers have in turn provided HIV/AIDS-related mental health training workshops and seminars to nearly 25,000 psychologists and other mental health professionals around the country.

That brings us to our most recent NTC. Over the years our NTCs, like our training resource materials, have evolved, and each conference is different from the last, especially for our veteran trainers. NTCs are now designed for two tracks—one for new recruits and one for veteran trainers.

Newly recruited trainers are expected to possess a thorough knowledge and understanding of the clinical issues of those infected and affected by HIV, so the training offered them focuses mainly on instructing them in the use of the HOPE Program Training Resource Package to plan and implement high-quality training.

Under the guidance of our faculty, newly recruited trainers take part in a training skills workshop designed to review adult learning theory and styles, and they hone specific training skills like goal and objective setting in order to develop a richer training plan. Once training skills are reviewed, participants are introduced to the HOPE Training Needs Assessment tool used to glean background information related to the requesting organization or group and its specific training request, including the issues underlying the request. The tool is also used to provide the trainer with a fuller understanding of the specific train-

ing needs and to develop an individually tailored HIV/AIDS training for a unique audience. Additionally, new trainers participate in state-of-the-science plenary sessions focused on current and evolving issues related to HIV treatment, adherence, HIV neuropsychology, and women's issues led by nationally recognized experts Monica Rivera Mindt, PhD, Gail Wyatt, PhD, and Richard Elion, MD.

To pull it all together, new recruits hone their training skills by preparing a "teachback." A teachback includes the design of a full training workshop of their own using the contents of the HOPE Training Resource Package, including workshop justification, goal, objectives, agenda, and content based on a faculty-prepared sample training needs assessment. Following their teachback, trainers are offered constructive critiques and feedback about their presentations from HOPE faculty and peers.

In the past, veteran trainers, all of whom have experienced the core training-of-trainers at a previous NTC, have simultaneously participated in a different training-of-trainers entitled "HIV and Ethics." (The ethics curriculum, as you may remember from previous HOPE updates, was commissioned by CMHS for use by all of its contractors and grantees.) This time, in addition to the above-mentioned plenary presentations, the NTC provided veteran trainers with a much more "hands on," workshop-centered experience. Nationally known and respected research scientists and practitioners such as Robert Neimeyer, PhD (HIV Grief and Loss), Darrell Wheeler, PhD, MPH (HIV and Men Who Have Sex With Men and Women), and Steven Shoptaw, PhD (HIV, Club Drugs, Gay Men, and Motivational Interviewing), each provided intensive 3 1/2-hour workshops for our experienced trainers. We've never offered anything quite like this before, but our trainers asked—and we answered. I think the workshops went exceptionally well.

Finally, since at its core, HOPE is about a team of trainers, our NTC was peppered

HOPE, continued on page 15

CMS Medicare Prescription Drug Formularies To Cover Nearly All HIV/AIDS-Related Medications

The Center for Medicare and Medicaid Services (CMS) in June issued a new policy requiring Medicare prescription drug plans to cover “all or substantially all” drugs in six categories, including HIV/AIDS-related medications. Medicare beneficiaries without existing prescription drug coverage were able to enroll in the program beginning in November, with coverage beginning Jan. 1, 2006. Enrollment will remain open until May 2006, after which time beneficiaries wishing to enroll will have to pay higher fees. Under the final rules, the average beneficiary enrolling in the prescription drug plan will pay an estimated \$35 in monthly premiums, as well as a \$250 annual deductible. Medicare will cover 75% of the next \$2,000 in prescription drug expenses. After that, beneficiaries will pay full drug expenses until their total annual expenditures reach \$5,100. Medicare will cover 95% of drug costs after that point. Health insurance plans cannot use techniques such as prior authorization or step therapy to

manage drug costs in the HIV/AIDS category, according to the CMS document. However, insurance plans can require physicians to obtain prior authorization before prescribing the injectable antiretroviral drug Fuzeon, CMS said. North Carolina-based biotechnology firm Trimeris and Swiss drug maker Roche jointly developed Fuzeon, which is in a class of drugs called fusion inhibitors and is designed for HIV/AIDS patients who have failed to respond to other medications. The drug has encountered resistance from doctors and patients because of its high cost—about \$20,000 per patient annually—and twice daily injection delivery method. Any drugs in the six categories that are approved for marketing after January 1 will be subject to review by a plan’s “pharmacy and therapeutics committee” to decide whether they will be covered, the agency said. In addition, CMS said it will revisit the drug formularies for the six categories for 2007.

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HIV/AIDS Consumer Web Sites

HIV Testing Site Locator

<http://www.hivtest.org/>

Newly Funded Housing Program From HUD

<http://www.hud.gov/news/release.cfm?content=pr05-163.cfm/>

Mental Health Services Locator

<http://www.mentalhealth.samhsa.gov/databases/>

Substance Abuse Treatment Locator

<http://findtreatment.samhsa.gov/>

AIDS Drugs Assistance Programs

<http://www.atdn.org/access/states/>

Recent Advocacy Activities Related to HIV/AIDS Policy

Karen Y. Chen, PhD

SPSSI James Marshall Public Policy Scholar

During the past year, members of the Committee on Psychology and AIDS (COPA), in collaboration with Office on AIDS and Public Policy Office (PPO) staff, have engaged in a number of advocacy activities related to federal HIV/AIDS programs and legislation. Below, I have highlighted some of our recent work.

Ryan White CARE Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, a legislation focused on the care and treatment of people with HIV/AIDS, including provisions for mental health and substance abuse services, is currently up for reauthorization. This bill is seen as a success and has always garnered bipartisan support since its inception in 1990. Our office has been committed to addressing the mental health and substance abuse needs within the CARE Act during the reauthorization process.

APA presented our recommendations on the CARE Act on April 18, 2005, to the Senate Health, Education, Labor, and Pensions (HELP) Committee. Isabel Fernandez, as a member of COPA, presented on behalf of APA and addressed not only the mental health and substance abuse issues afflicting people living with HIV/AIDS, but also the critical need for mental health and substance use services within the CARE Act. Her presentation was well received by the HELP Committee staff. At the presentation, APA also distributed its briefing sheet, which included background information regarding the mental health and substance abuse issues of individuals with HIV/AIDS, and also APA's proposed Ryan White CARE Act reauthorization recommendations.

PPO, Office on AIDS, and COPA also wrote a letter to Secretary Michael Leavitt in response to HHS's Ryan White CARE Act reauthorization principles, which was introduced in late July. The principles were broad in nature, and there have been mixed reactions from the HIV/AIDS community about the recommendations. The letter addressed concerns about the Administration's intent to establish a set of core medical services, which could potentially exclude mental health and substance abuse services, and to devote 75% of Ryan White CARE Act funding to these "core medical services."

Drs. David Martin, Isabel Fernandez, and Lisa Bowleg participated in an advocacy training/Hill visit on September 29, 2005. The advocacy training was conducted by the Public Policy Office, and the COPA members met with their Senators and Representatives to advocate for needed mental health and substance abuse services within the Ryan White CARE Act. All three of the COPA members had the opportunity to meet per-

sonally with Senator Jack Reed (D-RI). In addition, Dr. David Martin met with the offices of Senator Dianne Feinstein (D-CA), Senator Barbara Boxer (D-CA), and Representative Henry Waxman (D-CA). Dr. Lisa Bowleg met with the offices of Senator Arlen Specter (R-PA) and Senator Lincoln Chafee (R-RI). Dr. Isabel Fernandez met with the offices of Senator Bill Nelson (D-FL) and Representative Jim Davis (D-FL).



Karen Y. Chen, PhD

Federal Funding for HIV/AIDS Programs

Our office has been working toward increasing funding for several federal HIV/AIDS programs. In March, PPO and the Office on AIDS developed briefing sheets around the need for increased funding for the Rapid HIV Testing Initiative within SAMHSA and for the Minority HIV/AIDS Initiative within SAMHSA's CMHS. Denis Nissim-Sabat and Karen Chen from PPO met with both Senate and House staff on the Committee on Appropriations to advocate for increased funding for the Rapid HIV Testing Initiative and for the Minority HIV/AIDS Initiative within CMHS for fiscal year 2006 (FY2006). Language was included in the House FY2006 Labor, Health and Human Services, and Education appropriation report that highlights the role of substance abuse and mental health service providers on rapid HIV testing and prevention counseling and recommends an additional \$1 million toward the Rapid HIV Testing Initiative. The Senate FY2006 LHHS appropriation report included similar language, but without the funding increase.

Drs. David Martin, Jeff Parsons, and Bianca Guzman met with their Senate staff in their home district in late May to advocate for increased HIV/AIDS funding issues within NIH's Office of AIDS Research and SAMHSA's CMHS for FY2006. Drs. David Martin and Bianca Guzman met with the office of Dianne Feinstein, and Dr. Jeff Parsons met with the office of Senators Hillary Clinton (D-NY) and Charles Schumer (D-NY).

HIV/AIDS in the Communities of Color

COPA has also decided to have stronger collaboration with the three ethnic minority caucuses to address the growing HIV/AIDS issues within the communities of color. On October 25, 2005, Dr. Isabel Fernandez, who was in Washington, DC, for a meeting, met with the offices of several Latina congresswomen (two of whom were members of the Congressional Hispanic Caucus) to advocate for needed mental health and substance abuse services within the Ryan White

Recent Advocacy, continued on page 15

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CARE Act. She met with the offices of Representative Hilda Solis (Chair of the Congressional Hispanic Caucus' Health Task Force), Representative Grace Napolitano (Chair of the Congressional Hispanic Caucus and Chair of the Mental Health Caucus), and Representative Ilena Ros-Lehtinen (Congresswoman in Miami, FL).

If you would like more information about our advocacy efforts or have any questions or comments, please feel free to contact me at kchen@apa.org or (202) 336-6097.

with opportunities for team building. Networking sessions based on areas of clinical interest and region allowed veteran and new trainers time to come together around shared interests and to get to know each other in order to promote team and regional training. In fact, our first full evening in Memphis offered a special opportunity for meeting and greeting. Our very own HOPE Administrative Coordinator David DeVito set up a special event at the National Civil Rights Museum. If you ever find yourself in Memphis, I can only say, "Don't miss it!" Memphis really set the tone for the entire conference.

HOPE Training

Well, that brings us to the here and now. Are you interested in having a HOPE trainer provide training for your staff or students? HOPE training workshops are designed to be highly interactive and include didactic presentations, facilitated discussions, and skills-building exercises. To locate a HOPE trainer in your region, please contact me at the telephone number or e-mail address at the end of this article.

We are pleased to note that our first, interactive, online APA continuing professional education course, "HIV Treatment and Adherence: What Psychologists Need to Know About HIV/AIDS Treatment and Helping Clients Deal With Medication Decision-Making and Treatment Adherence," is available to any and all with Internet access. This course contains short multimedia clips, an unmoderated discussion board, and a test. The goal of this continuing education offering is to provide psychologists (and other mental health professionals) with the necessary knowledge base to better address HIV treatment complexities, HIV treatment decisions, and medication adherence issues that HIV-seropositive and AIDS-diagnosed clients commonly face. You may view and participate in the course online at <http://webclients.captus.com/apa/catalog.htm>. Please check it out.

The true focus of what HOPE does is training. Each of our CMHS contracts has stipulated that HOPE must provide training for a minimum of 1,000 mental health professionals per contract year. That's never been a problem; we consistently more than meet our goals. There's simply no stopping our dedicated HOPE trainers.

That's it for now. If you'd like additional information about any aspect of the HOPE Program, please feel free to contact me, Christopher Rowe, at CRowe@apa.org or (202) 216-7603, or contact David DeVito at DDeVito@apa.org or (202) 336-5158. We are looking forward to hearing from you.

Office on AIDS

The American Psychological Association's Office on AIDS provides information, training, and technical assistance on a wide range of HIV/AIDS-related topics associated with coping, mental health services, prevention, technology transfer, community collaboration, public policy, and ethics.

BSSV Program

The BSSV Program is a national HIV prevention technical assistance program directed by the American Psychological Association, Office on AIDS. The BSSV Program, funded by the Centers for Disease Control and Prevention (CDC), through a subcontract with ORC/Macro, has established a national network of behavioral and social science volunteers to assist with HIV prevention efforts in their communities. This national network of psychologists, sociologists, anthropologists, and public health experts is organized to offer free and ongoing technical assistance to community-based organizations (CBOs), health departments, and HIV-prevention community planning groups (CPGs) that want state-of-the-science prevention for their communities. Highlights of activities of the BSSV program can be found on page 10 of this issue of the *Exchange*.

HOPE Program

The HIV Office for Psychology Education (HOPE) Program, funded by the center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMSHA), utilizes a train-the-trainer model to educate mental health providers about working with people living with or affected by HIV/AIDS. The program develops and pilot tests HIV/AIDS training curricula and then recruits and trains trainers to use curricula to educate mental health providers across the country. A comprehensive, Internet-based training program has been developed to expand the HOPE Program's training capability. A report of recent HOPE program activities can be found on page 11.

The APA Ad Hoc Committee on Psychology and AIDS

The Office on AIDS provides administrative support and staff support for the seven-member APA Ad Hoc Committee on Psychology and AIDS (COPA), which reports directly to the APA Board of Directors. In August 1990, the APA Board of Directors and Council of Representatives (COR) approved funding for COPA for three years. COPA was charged with the following responsibilities: provide policy direction and oversight for current APA activities related to AIDS; advise APA staff and establish liaisons with governance groups regarding AIDS issues; and formulate new APA initiatives to meet the continually changing challenges posed by the epidemic.

Providing Guidance on HIV/AIDS Advocacy Issues

The APA Office on AIDS collaborates with the APA Public Policy Office in advocating for the development and implementation of national policies that support behavioral and social science HIV/AIDS research and science-based mental health service delivery and education. Briefing sheets and background information related to emerging HIV/AIDS policy issues are developed and distributed to APA members, members of Congress, and federal agency officials.

Requests for Information

Office on AIDS staff respond to inquiries from APA members, other behavioral and social science researchers and practitioners, community-based organizations, federal agencies, and state and local departments of health. Staff routinely provide information, training, technical assistance, and referrals in the areas of HIV/AIDS-related research, mental health services, ethics, education, and policy. To request information, please e-mail us at officeonAIDS@apa.org, or by calling (202) 336-6052.



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