

National HIV Prevention Conference 2009
Tuesday August 25th, 2009 Afternoon Plenary Session

Lord, hallelujah

You've been so good to me

Thank you

Lord, hallelujah

I'm grateful
for my blessings

I'm grateful

For my struggles

Trials and tribulations
I've been through

I realize no one

Can love like you do

Thank you

Lord, hallelujah

I feel your presence near

Thank you

Lord, hallelujah

I won't hold back my tears

I gave you my trust

And you took me
out of the dark rain

My Lord, I survived it

I'll give you the praise

Lord, you've been so good

You've been so good to me

I'm so grateful for
my blessings

Giving you all the praise

Lord, you've been so good

You've been so good to me

I'm grateful for
all of my blessings

Giving you all the praise

Jesus loves me

Oh, yes, he does

Jesus loves me

Oh, yes, he does

Jesus loves me

Oh, yes, he does

For the Bible

Tells me

So

So

So

Whoa

So

My Jesus loves me

I know he does

Amen

Amen

Amen

Amen

Amen

Amen, amen

Amen

Amen

Amen

[Applause]

[Music playing]

Mm

Mm, mm

They called me in

And I sat down

They began to explain

About these three
little letters

And how my life
they'd surely claim

In an instant,
fear, shame, and doubt

All ran through my mind

There were so many things
I hadn't done

'Cause I thought
I'd have more time

One mistake
made all the difference

A few moments of pleasure,
oh, it changed my existence

My spirit is torn

How can I survive?

But a small voice inside

Mm

Says, I choose life!

I'm going to live it
to the fullest

Till my heart's full
of contentment

No more tears

No more questions why

I'm still here

And I know it's
for a reason

This is just
a rainy season

Come what may

Joy or strife

I've got to choose life

I've always done

Everything I should

I've never wronged
any man

So I can't believe
I'm standing here

With this burden
on my hands

This can't be true

Lord, take this back

This can't happen
to me

How can I live
a limited life?

What about
all of my dreams?

Oh

Given this burden
by someone I trusted

I'm angry with him

With myself I'm disgusted

Just as I reach the end
of the line

A ray of hope shines
in my eyes

And I choose life

And I'm going to live it
to the fullest

Until my heart's full
of contentment

No more tears

No more questions why

I'm still here

And I know it's
for a reason

This is just
a rainy season

But come what may

Joy or strife

I've got
to choose life

This will not break me

Oh, no, no

I think of my future
and I see

All my dreams

Things I want to do

And I know by faith

They will come true

Whatever it takes

I'll be what I should be

I'm prepared to face

What lies ahead of me

A positive change

Is headed my way

I'm preparing myself

Starting today

Yeah

I'm going to live it
to the fullest

Till my heart's
full of contentment

No more tears

No more questions

Why I'm still here

And I know it's for
a reason, yeah, yeah

This is just
a rainy season

Come what may

Joy or strife

I choose life

Life

Yeah, yeah

Oh, oh

I choose life

[Cheers and applause]

My name is
Prairie Crows Looks Twice.

I'm 24.

I've been living with HIV
for four years,

and I'm a member
of the Oglala Sioux Tribe.

I live on the Pine Ridge
Indian Reservation,

which really isn't very big.

[Laughing]

I have another brother

who we raised,
who my mom raised.

His mom and dad divorced.

He just moved in.

We didn't care, you know.

They would...he would come home

and he'd ask me more and more about how I was doing,

and what HIV
is doing to my body,

and how it's affecting me.

So he said -- and my brother -- I never thought he'd ever
come up to me and ask me questions about sex

and, you know,
all this other stuff,

and I said...I told him,
I said,

the first thing you need to do
is ask the girl

that you're going to be with, because you don't know

if they've been --
if they've already

lost their virginity or not --

if they have a disease or not.

And that's one thing that I told my brother, you know,

you need to go out
and tell your friends --

I know the majority
of your friends ain't virgins,

and you can't tell me
that they are --

you need to tell them that they need to get tested for HIV,

and they need to get tested
for all the STDs,

because there's no way
that one person

can tell if they have STDs
or not.

You know, and they'll just go and sleep here and there,
and they just won't care.

So I have my brother
helping me out there,

telling people to get tested
for HIV.

My name is Nova Lei Gonzales,
and my Hawaiian name

is Ka Leo O Ka Aina,
which is,

translated means,
"The Voice of the Land."

And in a few weeks,
I'll be 62 years old.

And I was diagnosed
in 1989.

What I'll say to someone who is thinking about getting tested --

because I was there --
and of course I knew

I needed to get tested,
but I didn't want to,

because I didn't want to know.

I think a lot of people
don't really want to know,

because then they
have to deal with it.

And as long as they don't know,

that they don't
have to deal with it.

But what they don't realize is that early intervention,
early detection, is what's --

is saving
a lot of people's lives.

Because if you can get into --

if you can get tested now,

even if you think
you have it or not,

I think everybody should get tested, because you don't know.

You know?

Then there is help.

Then you can start
the intervention,

you know, the prevention,
intervention, prevention.

I would say that I think

it's crucial that everyone

gets tested,
just so that they know

where they are, they know.

If you're not positive,
then fine.

Then you take precautions
to not get that way.

If you are positive,
then you take the steps

to get the help that you need,
the assistance that you need.

And there are so many places,
so many things.

In Hawaii -- and I'm sure everywhere --

but in Hawaii, especially, because of the cultural thing,

we have what we call
the No Shame Campaign.

You know, a lot of young people are dying,

a lot of people who have --
who don't get tested

because they don't want to know,
because they don't want

to have to disclose that

to their families.

And so -- but lots of times,
what happens is that

when they do finally get too ill to deal with it,

and they're that far along,
they have to tell them anyway.

So my thing is,
is that you get tested,

and if you have to deal with it,
deal with it at that point.

And people are so surprised --
you know,

I was a hospice worker
for Ward 5B in San Francisco.

And I remember this young man
who was 21 years old,

came to San Francisco
when he was 18

because he wanted
to experience his lifestyle,

which he couldn't do
in his hometown.

And he was positive
and was dying.

And I remember asking him,
"Well, you need to call someone.

We need you to let somebody know that this is happening."

He says, "You can't,
because my mother

doesn't even know I'm gay."

And I said, "Yes, but, you know, she needs to know.

I mean, think of yourself --
you know, she needs to know."

I kept trying to do this.

Well, he says, but, "Yeah,
but she won't understand."

And finally I convinced him
to do it.

And when she came into the room, she looked at him,

and she said,
"Why didn't you tell me before?"

"Why did you tell me now
that you're dying?"

"Why wasn't I here
to take care of you?"

"Why wasn't I here to
learn about this

"so I could,
you know, help you?"

"Why didn't you call me?"

And he says, "Because I didn't think I could."

[No audio]

Watts Davis:
Well, good afternoon

to everyone.

Oh, no, we gotta do
better than that.

Good afternoon!

Attendees: Good afternoon!

Watts Davis: I am so excited
about the next panel

that you're going to
hear from today,

because this is truly
my extended family.

You have your regular family,
you have your work family,

and these are truly
my work family.

But before we start,
as you have in your schedule,

you're going to hear from

our leaders at

the Substance Abuse and Mental Health Services Administration.

But before we do that,
I want to be able to bring

someone else back to the stage that you heard a little bit from
on Sunday night.

This was the night of Magic.

And Magic did
such a wonderful job,

spending time with us,
being amongst you,

that when this gentleman
came up to speak,

there -- he has such good data,
and I've heard from so many

of you throughout the conference that he had such good data,

but you didn't really
get a chance to hear it.

So who I'm
going to bring back

to the stage
is Doctor Jonathan Mermin.

Doctor Mermin is the Director
of the Division of HIV/AIDS

for Prevention at CDC.

Now, prior to this, he served
as the Director of CDC Kenya,

and the HHS Public Health Attache for the U.S. Embassy,

overseeing programs of research and infectious disease programs

to include HIV/AIDS, malaria,
and tuberculosis.

He has authored
more than 100 publications,

and he still, I'm just looking at that hand

to see if it can still write.

But he's authored more than 100 scientific publications.

He is a graduate
of Harvard College,

of Stanford University
School of Medicine,

and received his
Master's of Public Health

from Emory University.

Now, truly, as partnerships go,
when I saw that he really

had such good data --
and the data really is

data that you all can use
back home to continue

to make the case why this must be on the radar screen

of your policymakers
and your leaders

and your collaborators
and community partners --

I just felt it was really important, as good partners do,

is to share some of our time with him so that he

can again present
the information

that so many of you talked about was so critical.

So I would like to bring to
the stage Mr. Jonathan Mermin.

[Applause]

Well, thank you,
Doctor Watts Davis.

And, you know, good afternoon.

It's good to be back.

I wanted to thank the speakers
for letting me in

as an interloper for 10 minutes.

And I'll start off by saying, I've greatly shortened
this talk, but in the spirit
of marketing

and the fact that you now get less for your time,
I'm calling it
"new and improved."

And I've also expanded
the section on substance use.

Okay, so first, there are
1.1 million people
living with HIV in the country.

It's estimated that in 2006,
there were 56,000 new infections
and 16,000 deaths.

The number of people with HIV
grew by 40,000 that year.

From one perspective,
this is good news,
since it reflects improved care,
and people who start ART now
are expected to live at least
an additional 35 years.

However, without intensified prevention efforts,
we will continue to have
an ever-increasing number
of people with HIV.

And this is a national tragedy.

So some areas of the country
are more affected than others.

This map shows the distribution of AIDS prevalence by state.

66% of persons living with AIDS are in only 10 states.

And a recent report
from NASTAD indicates

that the amount of DHAP funding for prevention
per person living with AIDS

varied by state
from \$240 to \$4,800.

And, as many of you know,
states have experienced

tremendous budget cuts,

such as California,
which lost its entire

state-funded prevention budget of \$31 million.

So, viewing the epidemic
through the lens of risk,

we see striking differences.

57% of new infections occur
in men who have sex with men --

the orange and yellow slices combined --

who make up about 4%
of the adult male population.

16% among people who use injection drugs --

the green and yellow slices,
combined.

And 31% among people
with heterosexual risk.

Examining the epidemic
by race and ethnicity

also shows dramatic differences.

45% of new infections
occur among African Americans,

who make up only 12%
of the population,

and 17% among Hispanics,
who represent only 13%.

Even among risk groups,
there are disparities.

In a five-city study,
25% of MSM have HIV.

And it's estimated
that 30,000 MSM

are newly infected with HIV
each year.

The rate of HIV among MSM
is over 50 times that

of heterosexual men and women.

Overall, the highest percentage of HIV infections
are among white MSM.

However, African Americans
make up 35% of MSM with HIV
and Hispanics, 19%.

In addition,
African American MSM

bear a disproportionate burden.

46% of African American MSM
have HIV.

And among African Americans,
nearly half of new infections occur in MSM.

However, we have seen some prevention success.

When we look at the incidence
of new HIV infections

in different transmission groups over time, we see a decrease
among most groups
by the late 1980s and '90s,

compared with
the '70s and early '80s.

We also see a continued decline
among injection drug users,
shown in black,

and congratulations
to all of you for this.

However, since the mid-1990s,

the incidence
of new HIV infections

among MSM, shown in green,

has been increasing,
indicating a need to reinvigorate prevention efforts.

We've recently reduced
health disparities.

The ratio of black to white
in HIV/AIDS diagnoses,
shown in blue,
and Hispanic to white,
shown in orange,
decreased between 2001 and 2007.

Another example of success
is the history
of perinatal transmission.

We dramatically reduced infants born with HIV by 95%,
to less than 100 cases per year.

[Applause]

And part of the reason was,
there was an understanding

early on that routinely screening pregnant women for HIV

and offering interventions
was operationally

the most effective way
to proceed.

CDC and others have supported

a new emphasis on HIV testing
and a new initiative.

We selected areas representing

95% of the AIDS cases
among African Americans,

and over 1.1 million people
have been tested,

greater than 262,000
in the last three months.

And over 7,000 new people
were diagnosed with HIV.

And there are numerous effective behavioral interventions available, as well.

We compile a Compendium of evidence-based

behavioral interventions, which have increased to 69 in 2009.

And these include a varied selection, including those specifically focused on drug users.

Another critical tool is prevention with positives -- working with HIV-infected adults to decrease transmission.

The premise is that at one point,

every adult with sexually transmitted HIV

was in an HIV-discordant couple,

whether for one night or a decade, and it is efficient

to work with people with HIV and their partners

to decrease transmission.

For example, among adults with HIV, knowing one's status

is associated with a reduction in risky sexual behavior,

and condom use in HIV-discordant couples is associated

with an 80% to 90% reduction in HIV transmission.

And among MSM, it is estimated

that 68% of HIV transmission is from main sex partners,

emphasizing the importance of partner testing.

And we should not underestimate the possibilities

for people with HIV and their partners

to care about prevention.

Between the early 1980s
and 2006,

there was an 89% reduction in the estimated transmission rate
from people with HIV.

Between 2001 and 2006,
prevention resulted

in 350,000 cases of HIV averted,
resulting in \$125 billion
of savings in medical costs.

And this is due to the hard work
of many of you.

Now I want to discuss
the entangled relationship

between HIV and substance use.

Drug injection is a major risk
for HIV.

Substance use is associated
with sexual behavior,

especially methamphetamine use
among MSM.

Substance use is a predictor
of HIV acquisition among MSM,

and substance use is higher

in HIV-positive MSM
than HIV-negative.

However, we have prevention tools for drug users --

needle and syringe exchange programs, which often provide

clean needles, condoms,
HIV prevention counseling,

and referral for drug treatment for participants.

In 103 cities worldwide,
HIV infection declined

by 19% in cities
with syringe exchange programs,

versus an 8% increase in others.

An NIH Consensus Conference
in '97,

the HHS Secretary in '98,
and the Surgeon General in 2000

concluded syringe exchange programs reduced transmission
and did not increase
illegal drug use.

It has been estimated to be
cost-saving

to the health care system,
and many states and communities

support syringe exchange programs,

but due to congressional restrictions,

no federal funds can currently be used for this purpose.

And our division looks forward

to working with SAMHSA
and all of you

to plan for the future
and address this critical issue.

To better address
substance use issues,

SAMHSA and CDC have been collaborating since 2005.

We have had meetings to build cross-agency activities,

including the National Methamphetamine Summit in 2008,

where 20 states developed prevention plans.

And we've also worked together on developing

a Web-based implementation guide

for routine HIV testing
in treatment settings.

In addition, the Center at CDC in which I work

also has established
a drug use work group,

which is updating CDC's
web site,

focusing on injection issues
and developing an MMWR

related to integrated prevention
services for drug users.

CDC has other activities, including five interventions
that are in development
for methamphetamine-using MSM.

We recently completed two trials for injection drug users
and a multi-site trial
for substance-using MSM,

one of which, Do It, was added to the 2008 Compendium.

And two new interventions for men and women in treatment
were added
to the 2009 Compendium.

We also ensure that the expanded testing initiative
includes substance abuse treatment centers.

So all of these data call for us
to optimize and expand
our response.

It's important that we recognize
that all of these interventions

must be thought of
within the social context

in which people at risk for
or with HIV live.

Poverty, homophobia,
race and ethnic bias,

drug use, gender inequality,
lack of housing, and stigma

make prevention
much more difficult.

HIV often brings out
the best of us,

but it also highlights disparities within our society

and sometimes exacerbates them.

We should support the social change that will enable us

to implement HIV prevention
most effectively.

And there is a strong economic argument for HIV prevention.

Successful prevention
is necessary,

saves lives,
and saves money.

It is estimated that each case of HIV

costs the health care system

\$355,000
in medical care costs alone.

There are an estimated 56,000 new infections per year,

which would equate to
\$21 billion

in lifetime medical costs.

If we include the cost
of lost productivity,

preventing 240,000 infections
by 2020

could save over \$200 billion.

Thus, HIV prevention provides us
with an extraordinary opportunity.

So we're fortunate that

the Office of National AIDS Policy will be organizing

a National HIV Strategy
over the next year,

and they'll be having
a town hall meeting

here at this conference,
and that DHAP will be engaged

in a strategic planning process that's part of this effort.

This will allow us to ensure resources are in line with
where HIV infections are occurring, who is most at risk,
knowing what are the most effective interventions,
and how we can best
monitor and improve
the quality of our HIV prevention programs.

However, to truly maximize HIV prevention in this country,
we need to increase resources
in order to bring programs
to scale.

HIV prevention should be
an essential part
of our nation's health plan,
so that we're not forced
to choose between treatment
and prevention.

And we need to monitor
and continually improve
our programs
while we ensure health equity.

So, as a nation, it's time
we determine the direction
we'll take in fighting this serious yet preventable disease.

One direction leads
to complacency and the injustice
of an HIV epidemic that affects
the most vulnerable of Americans.

And the other turns towards
a re-energized,
science-driven effort
to reduce the spread of HIV.

Public health
and our national conscience
require we make
the right choice.

I wanted to thank the many people at DHAP

for providing
information and comments,

especially Gordon Mansergh
and David Purcell,

who helped me last night.

Thank you.

[Applause]

So we've heard about the nexus,

and I'm really excited
about the next leaders

you're going to hear from.

The first leader you're going to hear from is Doctor Westley Clark.

He truly is a leader
among leaders.

The next three speakers you will hear about will talk about

that \$112.6 million I spoke
to you all about yesterday.

They will describe
a lot of what SAMHSA,

the Substance and Mental Health Services Administration,

is doing, and again,
help provide great direction.

Doctor Clark is the Director

of our Center for
Substance Abuse Treatment.

He leads the agency's effort

to provide effective
and accessible treatment

to all Americans
with addictive disorders.

He was formerly the Chief

of the Associated
Substance Abuse Programs

at the Department of
Veterans Affairs Medical Center

in San Francisco

and an Associate Clinical Professor of Psychiatry

at the Department of Psychiatry

at the University of California in San Francisco.

He has served
as a senior consultant

to the Robert Wood Johnson Foundation

Substance Abuse Policy Program

and was a co-investigator
on various NIDA --

National Institute
of Drug Abuse --

research grants.

He received
his Bachelor's degree

at Wayne State University,

a medical degree
and a Master's in Public Health

at the University of Michigan,

and a juris doctorate
from Harvard University

and a Substance Abuse Fellowship

at the Department
of Veterans Affairs

Medical Center
in San Francisco.

Now, that's kind of what you can read about Doctor Clark,

but what you don't know
about him is,

he truly is
a phenomenal mentor,

and he really is
a leader among leaders.

He is one who guided me
when I first got

to the federal government,
and even before I got

to the federal government,
we were celebrating --

I remember, all across
the country, we were

calling each other when he got appointed, we were so excited

that he was going to be
going to, at that time,

the Office
of Treatment Improvement.

But I do want to tell you all something very unique about him,

because I think he is the only person in the entire country

that has this
very unique feature.

As you know, he is a doctor,
a lawyer,

and he has
his Master's in Public Health.

So he is the only person I know who can read about himself

and who can write about himself,
he can treat himself,

and if he doesn't
like the results,

he can sue himself.

The only person
in the entire country

who is truly --
this is a bad brother.

Doctor Westley Clark.

[Cheers and applause]

[Clears throat]

Thank you, Beverly.

That's why we need
tort reform.

[Laughter]

I want to thank all of you
for being here, and thank you

for the opportunity to talk about CSAT activities,

and thank Jonathan
for his presentation.

I always like to start off
my comments

with a quote
from the chief executive,

President Barack Obama,
who says,

"Despite advances in treatment, HIV remains a major threat
to the health of our nation."

Yesterday, you heard
from Secretary Sebelius.

It is clear that
the administration is committed
to addressing the issue of HIV.

The mission of the Center
for Substance Abuse Treatment

as an integral part of

the Substance Abuse and Mental Health Services Administration

is to improve the health
of the nation by bringing

effective alcohol and drug treatment to every community.

And that becomes an important theme in our discussion.

I'd like to start discussing substances

by pointing out some data that
the Substance Abuse

and Mental Health Services Administration collects.

It is important for us to know that 127 million people

used alcohol in the past month, we estimate.

Of that 127 million,
58 million are binge drinkers --

that's five or more drinks
on a single occasion

in the past 30 days.

Of that 58 million, 17 million are heavy drinkers --

that's five or more drinks
on a single occasion

five or more times
in the past 30 days.

Now, some people think, "Five drinks on a single occasion?"

Gee, Doctor Clark,
that's not that much."

And, in fact, from a social marketing point of view,
the alcohol industry often markets six-packs.

If you have a six-pack
in an evening, guess what --

you're a binge drinker,
by definition.

These are issues that we need
to keep in mind.

We also know that people who use illicit drugs also use alcohol,
and this particular chart
points that out.

Among past-month alcohol users, those who binged on alcohol
during their last occasion
of use

were more likely
than those who did not binge
to have concurrently used illicit drugs.

So these things go hand in hand, and that's something that we
need to keep in mind
when we're talking

about prevention and treatment strategies.

Overall, roughly 8% of those
12 and older

in the United States
admit to using illicit drugs.

Marijuana is the most commonly used illicit drug, at 5.8%.

Increasingly, we're seeing
that prescription drugs

are rivaling any other drug,
at 2.8%,

with pain relievers, at 2.1%,

being the next
most prevalent drug.

And prescription drugs,
of course,

have been in the media lately.

Some of you who saw the news
saw another incident

where prescription drugs
was associated

with the untimely demise
of a fairly famous person.

And as a result, people are addressing that.

But the key issue is that our society uses prescription drugs

both therapeutically
and non-therapeutically.

And we have to keep that
in mind.

The major challenge that we see

at the Center for Substance Abuse Treatment -- and I'm sure

Fran Harding will speak to
some of this when she talks --

and that is that people
who meet criteria

for abuse and dependence
of alcohol and drugs

often perceive no need
for treatment.

20 million people
meet criteria, and...

they perceive no need
for treatment.

So, even though they
endorse having

psychosocial detriment
of function, problems associated

with alcohol and drugs, they
perceive no need for treatment.

The waiting list for treatment is roughly 380,000 people,

and these are individuals
who say,

"Gee, I need treatment,
but I can't get it."

We have already heard
from Jonathan the connection

between substance abuse
and risk behavior.

It can't be minimized.

Drugs like crack, methamphetamine, heroin,

they result in shared needles, sexual practices,

that increase the likelihood
of HIV transmission.

Treating substance use disorders

without addressing
risk behaviors

leaves patients
at risk for HIV,

just as Jonathan
was pointing out.

The key issue for us

in the substance abuse
treatment community

should be KYS (kiss) --
Know Your Status.

So it means,
if you kiss somebody,

you ought to make sure
that they know their status.

That's right.

Inappropriate alcohol use
and risk behaviors --

unprotected sex,
sex with multiple partners,

increased risk for sexual assault, unintended pregnancy,

and sexually transmitted diseases.

These are things
we have to keep in mind.

When we look at alcohol use
and risk behaviors

from our data set, you'll note from this chart that there is

a significant amount
of unprotected sex

in our at-risk population.

At intake and even
at six-month follow-up,

when we look at all
of our discretionary --

we collect data from our
discretionary portfolio --

72.8% of the people
at intake

admit to having unprotected sex,
and six months later,

even though there's progress

with regard
to their substance use,

it only drops down to 66%.

We have a long way to go.

We need to be addressing
that issue.

When you look at the top line,
you see

"Unprotected sex
with somebody who is high,"

it drops from 33.7% at intake
to 17.7%.

And these are individuals
who drink to intoxication.

When you look at individuals who don't drink to intoxication,
the prevalence of unprotected sex is not that much different.

It is different --
it is lower --

but the vectors of value
in the community need to begin

to deal with the issue
of unprotected sex.

That includes everybody --
the faith community,

the fraternities and sororities,
the social organizations,

the gangs and the guilds.

We need to be talking
about unprotected sex.

We don't.
Sex is still verboten.

Even though you have
famous people

like former Senator Bob Dole
and Mike Ditka

on TV talking about ED --

for those of you who are slightly older.

I won't explain ED.

If you haven't seen it on TV,

that means you don't watch TV,

and that's probably
a good thing,

so you don't need to know.

[Laughter]

Crack cocaine -- non-injection drugs like crack cocaine
contribute to the spread of AIDS

when users trade sex
for drugs or money

or when they engage
in risky sex behavior

that they might not engage in when sober.

One CDC study of more than
2,000 young adults

in 300 city neighborhoods found that crack smokers were
three times more likely to be

infected with HIV
than non-smokers.

We heard about methamphetamine.

Methamphetamine reduces inhibitions and judgment,

resulting in the use
of shared needles

and sexual practices
that may increase

the likelihood
of HIV transmission.

Meth users may experience,
as with other stimulant abusers,

mental confusion that impairs the ability to take medications

when they do know
that they are HIV-positive

and are on prescription medications.

Preliminary studies also suggest that meth

may affect the HIV disease progression.

Lessons learned -- substance abuse treatment programs

have demonstrated success in getting patients into recovery.

Decreased substance abuse
does not equate

to decreased risk behavior,
as I've pointed out

and will point out
several times again.

We have to recognize that
the forum for HIV transmission

is broader, and we need to make sure that the treatment system

focuses on changing
risk behaviors.

But, as I've pointed out,

we need the whole community involved in that.

That's our mission.

If we can't get people to change

their risk behaviors,
we have a problem.

Now, Jonathan pointed out,
we have made progress

with regard
to injection drug use.

We have made
substantial progress,

and you deserve credit
for that.

We don't get a whole lot of immediate successes.

We've done a lot
with perinatal transmission,

and we've done a lot
with injection drug use.

We need to acknowledge that,
so when people say,

"Does prevention

and intervention work?"

Yes, it does.

[Applause]

And you need to understand,
yes, it does.

So you're not fighting
a futile effort.

When you look, though,
at transmission categories

for adults and adolescents,
as Jonathan pointed out,

men who have sex with men --
still a major issue.

When we look at females, heterosexual transmission,

CDC data from 34 states --
the CDC is doing something

with the number of states, I've never quite figured out what,

but the fact is, 83% of females

HIV through
heterosexual transmission,

another 16%
through injection drug use.

What are we going to do?

How do we empower women
to say no?

How do we empower women to say if you want to kiss me,

you need to know your status?

[Applause]

There are a lot of women
in the audience.

You need to help.

You need to reach out to your community.

That needs to be the question.

The federal government can't tell you how to have sex.

[Applause]

"I'm from the federal government.

I have a condom."

[Laughter]

Thank you very much.

We also need to be concerned about adolescents.

As Jonathan pointed out,

there's increased sexual activity,

men who have sex with men,

and the prevalence rate
is increasing

among the adolescents.

Sex and drug risk behaviors often cluster together
in adolescent populations.

Alcohol and drug use are linked to early sexual debut
and increased risky
sexual behaviors.

Recent study of perinatally
HIV exposed youth,

12% of the sample, mean age
12.2 were sexually active.

Among those who were
sexually active,

74% engaged in two or more sexual risk behaviors.

42% of the HIV-positive youth compared with

29% of HIV-negative youth reported unprotected sex.

People talk about our future generations

and our obligation to
the future generation.

You hear that with
health care reform.

We are going to saddle our future generations

with a deficit.

But if we don't deal with
the health care needs

of our future generations,

we don't have to worry about them paying the bill.

[Applause]

Look at our adolescents.

When we look at transmission risk factors,

men who have sex with men,
those 13 to 19,

and for women, again, heterosexual transmission.

We at the Center for Substance Abuse Treatment

also started to look at our overall portfolio

of past 90 day HIV
risk behaviors.

We discovered in our
adolescent portfolio

that 64% were sexually active,

33% had sex under the influence of alcohol or drugs.

29% had multiple sex partners.

25% admitted to unprotected sex.

20% were victimized
physically, sexually,

or emotionally,
and 2% used needles.

It is sexual transmission that is waiting in the wings.

We have to deal with this.

Our adolescent portfolio is designed to increase

the provision and effectiveness of alcohol and drug treatment

for adolescents.

Our program includes assertive adolescent and family treatment,

state adolescent treatment coordination.

We're working with states so that we can create a sustainable system of care that breaks the cycle of addiction in families through early identification, intervention, and treatment.

In addition to our adolescents, we have to deal with the issue of co-occurring disorders.

The co-occurrence of serious psychological distress and substance abuse dependence is a major issue.

Fran Harding will talk about specific psychological issues, but the key issue for us in terms of co-occurrence

is we have 5.4 million people who meet criteria for substance dependence or abuse

and serious psychological distress.

We know that a lot of these individuals are not being treated.

Of the 5.4 million with both serious psychological distress and substance abuse disorder,

only 10% receive treatment for both.

53.5% receive no treatment.

These are issues we have to deal with.

And if we don't deal with them, we deal with the consequences.

We know that co-occurring disorder increases vulnerability to relapse and re-hospitalization,

more symptoms,

thought disorders,
inability to manage finances, housing instability
and homelessness, noncompliance with medications and treatment,
increased vulnerability to
HIV infection and hepatitis.

People with co-occurring disorders who are
not HIV infected can successfully combine
substance abuse mental health services with HIV care,
may positively affect
their overall medical care.

We need to make sure
we understand that.

We have an outreach program
at the Center for Substance Abuse Treatment,
and it's the -- we believe --
the only national program

that addresses
the intersection of HIV
and substance abuse treatment aggressively.

The program uses a comprehensive approach to integrate
recovery support services.

All 49 grantees must participate in an evaluation
and as of last year,
fiscal year,

we require a minimum of 80%
of our clients to be tested.

And some people still
want to know,

well, why do we make our grantees test.

And I say "KYS me."

[Laughter]

If we don't know status,
we can't deal with the problems.

When we look at
our demographics --

we look at our demographics,
54% of our TC HIV

and HIV outreach are made up
of African Americans.

27% Hispanics, 20% white,

2.9% Asian, and 3.3% American Indian/Alaskan natives.

56% are male, 43% are female,

1% are transgender.

We can make a difference
with regards to substance use.

Decrease substance use,

increase employment,
increase in housing.

This is the data
from 115,000 clients.

But, we're still having problems with risk behavior.

When we look at women in terms of heterosexual transmission

or unprotected sex,
notice the decline.

It's not that impressive.

Less than 10% for
unprotected sex.

We made progress in decreasing injection drug use,

progress in unprotected sex
with someone who's HIV positive,

some progress
with unprotected sex

with somebody who's high.

But we're not dealing with unprotected sex.

And these are high-risk individuals

who have substance use
related problems.

When you look at homelessness and the prevalence of HIV among homeless individuals, may be between 3% and 20%

with some subgroups having much higher disease burden.

A 1995 survey of homeless individuals

found that 69% were at risk for HIV infection

from unprotected sex with multiple partners,

injection drug use, sex with injection drug users,

or exchanging unprotected sex for money or drugs.

We link substance use and mental health treatment service

with housing programs and other services

in our Addiction Treatment for the Homeless Initiative.

Increases in the number of homeless persons

placed in stable housing

and who receive treatment services for alcohol,

substance use, and co-occurring disorder.

We expand and strengthen treatment services persons

who are homeless and who also have substance abuse disorder,

mental disorder, and both.

We have 19 grantees listed with HIV as a target population.

So, we encourage people,

despite the fact it's a homeless initiative,

to focus on HIV and AIDS as well as the target population.

But the same recurrent theme now.

How many times have I mentioned this?

In each of our portfolios,
we're asking these questions.

You see the prevalence rate among women
in terms of unprotected sex remains substantial,
both at intake
and at six-month follow-up.

We need your help.

CDC has estimated
a quarter of the people

living with HIV are not aware
of their infection.

People who are infected
but not aware of it

are not able to take advantage of therapies.

We know among people of color that the situation

is more dire because
people present

for treatment much later.

If you don't KYS them,
then you're weeping for them.

It's harder to cure something that can be stabilized
if you don't know you have it.

Cohort studies have demonstrated

that many infected persons decrease behaviors
that help transmit infection to sex or needle-sharing partners
once they know they're aware.

Jonathan pointed that out.

I mention our requirement.

It is important that our grantees test.

Absolutely important.

And we will be collecting
the results of those data.

We first had to get people used to it.

Initially, people said, "Well, gee, Doctor Clark,

why are you requiring this testing?"

I said, "Well, they do HIV work. They need to know the status."

And people were satisfied with that.

We will obtain more detailed data regarding the type and frequency of drug use

and relationship between drug use and HIV, and that includes alcohol.

Many population studies focus on general populations.

We have a high risk population.

We've already got data that suggest that

we are reaching people in need.

We're going to have a multi-site evaluation

in addition to or in lieu of

individual performance assessments

because we want to make sure that the protocols that we're funding are working.

And after all that, as we look at the data,

I always like to remind people

that it's important for us to celebrate recovery.

It is not enough to tell people about the dire consequences of unprotected sex or high-risk behavior.

We also need
to celebrate recovery.

We encourage you to
look at September

as an opportunity
to focus on recovery,

not only from substance abuse,
but mental illness,

and from HIV.

We need to help de-stigmatize
the discrimination

associated with addiction.

We need to understand.

Our message is: help bring hope and healing to others.

So, we need to reach out
to the larger community,

not just to the faith community,
which is present in these halls.

Not just to treatment providers,
not just to community coalitions.

We need to reach
the Kiwanis Clubs

and the Red Hat Women.

We need to reach
the various guilds.

We need to reach
the junior league

and the Jack and Jill clubs.

We need to reach
the fraternities

and the sororities.

We need to reach
the church guilds.

We need to reach the Daughters of the American Revolution.

And since we're in Georgia,

the Daughters
of the Confederacy.

Recovery benefits not just
the individual

who has the alcohol
and drug problem,

not just that
individual's family.

It benefits the whole community.

Knowing your status benefits
not just the individual

who is engaged in
"high-risk behavior."

That individual's family,
and that individual's community.

If we don't marshal together
as a community,

then we will watch brothers
and sisters

fall by the wayside unnecessarily.

So, we will continue to work with CDC and HRSA,

with the department,
with other agencies, with you.

The federal government cannot
do it without the community.

This is not about
the federal government,

even though this is
a federal panel.

This is about our relationship with you.

If we can't work with you to work with the community,

then our ability to bring
a benefit to the community

will be diminished.

So, I thank you again
for being here.

Thank you for listening to me,
and thank Beverly for coordinating this meeting.

[Applause]

Now you know why I love Westley.

He truly is just such
an incredible brilliant,

brilliant, brilliant man.

But I'm equally ecstatic
and excited

to bring to you the next person.

The next person
is Ms. Fran Harding.

And I just want you to know
this is the kind of woman

that I always tell people

I want to be like her
when I grow up.

She's a wonderful woman.

I would follow her into battle at any time, anywhere, any day.

She currently is the Director

at the Center for Substance Abuse Prevention,

and I will tell you when we heard that news,

across the entire field,
we all exhaled

because we were waiting for her and her leadership.

Prior to that, she served as
the Associate Commissioner

of the Division of Prevention and Recovery

at the New York State Office

of Alcoholism
and Substance Abuse.

She also served as a President

of the National
Prevention Network,

an organization that represents all 50 states'

Alcohol and Drug Abuse Prevention Offices.

She's served also
on the board of directors

at the National Association
of State Alcohol

and Drug Abuse Directors.

And in 2004, she became
the first non-researcher

to receive the prestigious Science to Practice Award

from the International Society for Prevention Research.

She is one of the greatest cheerleaders for prevention.

I will tell you, I've heard many of you all in this conference

talk about state relations
and how, you know,

it's hard to work with your states, et cetera.

This is a woman
who really gets it.

She is one of the few truly state directors

that I had the pleasure of working with

that really understood
how to connect

states and communities.

She made sure her states made the community connection.

And I have to tell you something about Fran.

She is methodical and a planner,

but she is truly right there with you in communities.

You know, when there are doors of opportunities

that should be open to us
and they are closed,

Fran is the one who will mobilize

all the folks in the room.

You know, she'll get
the researchers in the room

who will look at the door

and try to tell you how deep
it is and how high it is,

and we ought to study it
and take a look at how

we can get across that door.

Then she will also mobilize,
you know,

the hospitals and clinics.

She will talk about the fact that once you open the door,
they will help you treat them.

Fran will be the one who will go and get the community members

and go take the hinges off
the door

so the door is removed.

And then if that doesn't work,

she goes and gets
activists like me,

and we just kick the door down.

So, truly, I want to bring
to the stage

a woman that I am so, so,
so happy to see in her position.

You all will grow to love her
as we have.

Ms. Fran Harding.

[Applause]

Oh, she's killing me.
She just kills me.

[Laughter]

Well, I got two minutes left.
Thank you, Beverly.

There's like,
the field of prevention
is a sorority of nature.

And whenever you get
an opportunity
to introduce one of your colleagues
from this secret sorority
of prevention,

we tend to be very emotional
and overflowing.

I thank Beverly very much.

Well, good afternoon.

I usually do mornings,
so I almost said "morning."

I wrote "afternoon" very largely on my paper here.

I'm so happy to be here
for the first time

as the Director for the Center of Substance Abuse Prevention.

CSAP is here today
to help you understand

how we support the continuum
of services that are needed

in targeting prevention
of HIV infection,

reducing the use -- the problem of HIV infection --

treating it, and then, hopefully, one day

eliminating the problem altogether.

My speech will be focused on service delivery on programs
and how we all coordinate.

Your efforts are rooted
in the sense

of your purpose and skill
and your determination

to make a difference for everyone in the community
as Doctor Clark has mentioned.

These qualities of working
in a community structure

distinguish you as leaders across our country.

You are agents of change.

The many community-based programs

that are represented
in this room

are the prime examples of
the belief that CSAP holds dear,

that local people solve local problems best.

And that people support
what they create,

and what they help to recreate.

As Doctor Clark mentioned,
it is the community

that we reside in and make
a difference

and involve all of the members to create change.

In collaboration with CDC,

we have done
several initiatives in CSAP.

At the national level, our ongoing partnerships with CDC,

our other HHS agencies
and partners --

including, of course,
my colleagues across SAMHSA,

particularly the three Centers we have here.

We have in the past
developed data collections

and implementing guidance
for HIV testing with CDC,

implementing a new CDC HIV testing guidelines,

a report to Congress
on methamphetamine

and the intersection
of HIV and STDs.

We supported and participated in

the National Methamphetamine Summit in November of 2008

and several cross-training events with CDC

of our grantees
at national conferences.

We have common goals.

We serve similar populations,

but they all come in through separate doors.

We embrace that richness.

Each of us has a piece
of the whole

in reaching out to populations affected by HIV,

hepatitis, and substance abuse.

Because the field I love so much, substance abuse,

is complex, chronic, debilitating disease,

those we serve also need
mental health,

substance abuse prevention
and treatment.

We focus on relapse prevention.

And, of course,
recovery services.

And later on, we'll talk about the other health services

we integrate with.

Prevention is at the front line, reaching out to delivering

an array of messages
and targeting evidence-based

prevention practices
to communities, schools,

families, individuals,
places of worship,

and several other locations
in our communities.

SAMHSA has joined forces
with CDC

and other federal partners

in getting the word out to people across the United States

about National HIV Testing Day,

including where to go
in your community

to find out their HIV status.

I can't say it better than
Doctor Clark has said it,

the importance and the focus that our programs have

on knowing your status
and changing the environment

to encourage people to
know your status --

just like we know our cholesterol numbers,

we should all know
the status of health.

Under the leadership of
Beverly Watts Davis,

a person I think most of you have known,

all three Centers collaborate
in planning

the annual World AIDS Day observance events at SAMHSA.

That's important for us.

The emphasis is to educate SAMHSA employees

who may be HIV infected

or one of their loved ones, family or friend,

members of their community,

so that people know where
to get help,

how to improve the lives

of people that are living
with HIV status.

At SAMHSA, we are guided by

CSAP's vision for a life
and a community for everyone.

This vision is the foundation,

and it really is the nucleus of everything that we do at CSAP.

In addition to our longstanding emphasis on youth,

over the last couple of years, we have changed our focus

and added in an increased priority on other age groups

of importance in particular
to this matter.

Young adults in the age of
18 to 25 group

are a fast-growing population
of HIV infection,

alcohol and substance abuse, particularly

prescription drug use.

We are also focusing on our older adult population.

I don't know if we're focusing on our older adult population

because I'm getting older

or because our data is telling us to do that,

but I look at the panel,
with all due respect,

and I wonder why SAMHSA
now is focusing on older adults.

I leave that up to you.

We have also directed our attention to population base

and experience status, such as the returning veterans

and their families.

And also, our workplace.

In each of these cases, HIV/AIDS,

we sharpen our focus to target the problem explicitly

from several angles,
recognizing the danger

of substance abuse in raising the risk of HIV infection,

again, my previous speakers
have spoken about.

About one-third of new
HIV cases each year

are associated with injected drug use.

Other kinds of substance abuse, whether casual or chronic,

can lead to high-risk behavior such as unprotected sex,

which has been mentioned.

At the same time, many young people are informed,

misinformed, or not informed
at all of the dangers

of substance abuse including
the risk of HIV/AIDS.

I'm skipping some data that you've already heard twice.

And any of you who know me,
and I go off script,

it can be difficult --
because you never know.

Our African American population account for 49%

of our new HIV/AIDS diagnosis
in 2005.

An even greater disparity
are among

the African American youth --

account for 70% of all
HIV/AIDS diagnosis.

Followed, of course,
by Hispanic, American Indian,

and our Alaskan Native friends.

The risk profiles of other groups are also concerning.

Young people who represent
one in three

of the HIV infection.

Older adults, who often don't view themselves at high risk

are less likely to adopt
safety behaviors.

Makes sense.

Whether due to susceptibility
or late testing,

older adults are much more likely than younger people

to develop AIDS after being diagnosed with HIV.

We need to change that.

The richness in our prevention programs of our older adults

that come to the programs
and help us will soon be lost.

CSAP's goal is to increase
the capacity of communities

to deliver evidence-based practices

and prevention programming
combined with HIV,

hepatitis prevention services
with a special focus

on minority
and reentry communities.

Their portfolio of grants
which has been added

to the Minority AIDS Initiative,

some of our target
populations are,

we are looking at
the reentry populations,

men having sex with men,

black Latina Hispanic women,

adolescents ages 12 to 17,
young adults ages 18 to 24,

older adults ages 50 or over --
what we mentioned.

Since 1999, CSAP has funded
a total of 424 grants

or cooperative agreements
with 140 projects now operating

through our cohorts 6, 7, and 8.

[Applause]

CSAP continues to place
a high priority

on infusing HIV testing into

all of the Minority AIDS Initiative programs

to make HIV testing a routine prevention service.

HIV testing is an effective
HIV prevention strategy

that is essential --
essential component of our care.

CSAP supports the decision
to initiate testing

for high-risk populations.

CSAP supports the rapid testing as critical

for co-occurring, medically ill,

and substance abusing populations.

As a matter of fact, all of our cohort 7 grantees

are going to be required
to conduct rapid or HIV testing

as part of their prevention program.

In 2008 -- I'm waiting
for the hug.

In 2008, CSAP awarded subcontracts

to 15 faith-based community organizations,

and, of those organizations, they have focused on existing prisoner reentry programs.

As part of the range of a family centered service, hundreds of participants have received HIV/AIDS and substance abuse prevention education, counseling, and HIV testing referrals.

The Minority Education Institution Initiative supports substance abuse, HIV, and hepatitis prevention services on campuses of minority-serving institutions using peer educators to increase student awareness and conduct HIV testing. Since 2005, these institutions have tested over 12,000 minority students using rapid or conventional HIV testing.

That's good work.
Good job.

Partnering with the Tom Joyner Foundation to provide funds for eight historically black colleges and universities to increase minority students' awareness about risk of prevention -- risk of substance abuse, and related HIV transmission.

You might be wondering

why do we focus on the college age.

One in five.

I had the pleasure of meeting with many of our student peer leaders of these programs down in Florida a few months ago.

And I learned that one in five full-time college students
age 18 to 22 use illicit drugs.

Compare that to the overall statistics
that Doctor Clark has given us.

Two in five engage
in high-risk drinking.

400,000 have admitted
to having unprotected sex.

And 100,000 were so intoxicated at the point of the question
they couldn't even remember
if they even had sex.

This is a population
we need to continue to focus on
and to work on.

These are young adults that are residing in our campuses
across our nation
that we must help.

The best way to face our challenge
is to have a planned-out activity
and strategic plan to help us focus on our programming.

The CDC is a leader
in this regard.

Its diffusion of effective behavior interventions --

known commonly by many of
you as the DEBI --

provides -- projects --

has brought
an extensive assortment

of science-based interventions

to the state and local level
for delivery.

CSAP's Minority AIDS Institute grantees

have already taken benefit

of the DEBI and --

with their
intervention training.

Likewise, at SAMHSA,

CSAP's National Registry of Evidence-based Programs

and Practices -- NREPP --

is a tool for choosing evidence-based programs

in addressing HIV/AIDS with
a range of prevention issues.

Evidence-based programs being implemented by our grantees

has been increasing steadily.

Preliminary data
from nine states show

that 74%
of prevention set-aside funds in

the Substance Abuse Prevention and Treatment Block Grant

are spending on evidence-based practices.

This exceeds the 70% that was seen in 2008,

and we are already seeing signs

that we're going to be increasing that in 2010.

We all know we must use
the science of prevention

to choose the right program
that matches up with our need.

That is the glory
and the advantage

that we now have in our of field of bringing the right program

for both cost effectiveness

and for time,
that we certainly are lacking.

The SAMHSA Strategic Prevention Framework that lays out

a roadmap that teaches us
step-by-step

how to go through to assess
your community

to select, to rank the risks,

and select the right program
has been the cornerstone

of success of your programs
for the last 8 to 10 years.

The HIV prevention activities
that CSAP supports

are providing encouraging results.

Latest data from SAMHSA's National Outcome Measures

show that HIV prevention programs improve

and exceeded targets
on most measures,

including perceived risk
of substance abuse

among young people and adults,

stable non-use of alcohol
and illicit drugs

among youth and adults,

lower rates of alcohol use
among adults who drank on onset,

and exposure to substance abuse

and hepatitis education programs.

I'll close by stating
a couple of facts.

I have had an enormously great first year on the job,
especially in this particular population.

I have seen several
of your programs.

I have learned so much
of the success

that you bring to the table
of combining

the needs of substance abuse with the needs of HIV.

We need to do more.

We are in not a good time.

We are in the best time to do prevention programming.

We have support at the highest level of our country.

It is time that we take advantage of the fact
that we not only have support, we have understanding,
we have experience.

Our President understands community development.

He participated in community development.

Our Secretary in HHS supports

our programming efforts
in community.

The three Centers support education and training
and community work.

You are in the best
field possible for --

during a conversation
of health reform.

We must engage our physical health partners
and help them see during this time of great change,
a focus on prevention initiatives,

that prevention is the first seat at the table
of talking about bringing
good health

to the country
that we live and reside.

SAMHSA is here,
and particularly CSAP,

to continue this learning process so that we can be
engaging in these communities
and these conversations for you.

You have made such great strides

in such a short amount of time
comparatively

to the other chronic diseases that we focus on this country.

I challenge each
and every one of you

every day to think about what can you do personally

to reduce your personal risk

for alcohol, substance abuse,
or HIV?

I also challenge you to think of what can you do

to lower the risk of the loved ones that you hold dear

around alcohol,
substance abuse, HIV/AIDS.

And I do this because
every other chronic disease

that we are focusing on
in this country,

every other person
living in this country

knows the three risks of how they personally

can reduce their risk for
heart disease, diabetes,

obesity, cancer, and the like.

It is time for us to come into the forefront of this discussion

and show people how they can reduce their risks

so that we get the support

and the evidence we need
to continue.

I thank you, and I will see you later in the conference.

[Applause]

Yesterday, we talked about
the fact that

all of the people that you serve truly could benefit

from mental health services.

Our next speaker
is Doctor Frances Randolph,

who is the Director of

the Division of Service
and Systems Improvement

at the Center
for Mental Health Services.

She's the Director of
that division,

and she oversees
the development, planning,

and implementation
and monitoring

of national programs that are designed to improve

the systems and service delivery to children and adults who --

with or are at risk
of mental health problems.

She has the lead responsibility

for behavioral health work force development at SAMHSA,

and that's where
I've had the pleasure

to actually work with her.

Doctor Randolph is working
with developing

a transformation portal,

a mental health transformation web portal

that will provide
a comprehensive source

of information and resources

to support community building for change,

will connect users with evidence-based practices

and emerging best practices,

will facilitate cross-learning and collaboration

and knowledge development,
and will begin to also
be a resource for
job opportunities, for searching multimedia resources,
for finding out about conferences and trainings
and all other resources.

I want you to know that
Doctor Randolph

has received her Master's
and her Doctorate

from the School of Public Health

at the University
of California Berkeley.

And at SAMHSA, she is truly known as the go-to person
for problem-solving.

I bring to you
Doctor Frances Randolph.

[Applause]

Good afternoon.

And thanks, Beverly.

Since I knew I was going to be the last presenter,

I spent Sunday streamlining
my presentation

because it's always the case that we have a little less time.

But still, I have some important things to say to you

about prevention, HIV/AIDS,
and mental health.

Kathryn Power is my boss
and the Director of

the Center
for Mental Health Services.

She couldn't be here today.

However, I spoke to her

earlier today,
and she really asked me to express her appreciation
to CDC for convening this important conference
on HIV and prevention.

You know, when you think
about prevention,
you often don't think about mental health
and mental illness.

You think about preventing substance abuse,
you think about
preventing HIV/AIDS.

But when it comes
to mental illness and HIV,

treatment is prevention --

preventing the consequences of HIV and secondary infections
and in the transmission
of the virus.

And just as treatment is prevention,
so, too, are both resilience building and recovery.

That's because at CMHS,
we look at prevention

as a continuum --

a continuum that ranges
from wellness through illness

and all the way to rehabilitation and recovery.

Our work at CMHS begins from
a public health perspective,

and with the public health
in mind.

Years ago,
Ralph Waldo Emerson said

"Health is the first wealth."

Health is
the first wealth.

He was right.

But at CMHS, we take that statement one step further.

We believe that there
is no health

without mental health.

[Applause]

It's a simple,
yet profound concept

that is necessary to better
the public health.

In fact, the World Health Organization also agrees,

saying "The goals and traditions of public health

"and health promotion
can be applied

"just as usefully in the field of mental health

"as they have been in
the prevention of infectious

or cardiovascular diseases."

For CMHS, the application
of a public health model

in mental health means accepting and acting on several tenets.

First, that health includes
both body and mind.

Illness in one area can result in illness in the other.

Health and illness exist
along a continuum

from wellness through recovery.

Health and illness extend beyond the individual.

In other words, one needs to consider the context

in which an individual lives --

such as poverty,
isolation, trauma --

all of which affect wellness, illness, and recovery.

And, fifth, adopting
a public health approach means

accepting the role
of both health promotion

and illness prevention

along the entire
health/illness continuum.

Through our public health approach, we've learned

that if we intervene early,
we may be able to prevent

the onset
of some mental disorders,

lessen their impact, or preclude comorbid conditions

and long-term disability.

For example, we know from
the Institute of Medicine

that the top three leading causes of disability worldwide
are behavioral disorders.

We know that half of all diagnosable lifetime cases

of mental illness begins
by age 14,

and three-fourths of all lifetime cases

start by age 24.

We know that symptoms occur
two to four years

before the development
of a diagnosable disorder,

which means we have an important window of opportunity

during which to respond.

We know that co-occurring mental and substance abuse problems

are the expectation
rather than the exception.

By identifying and treating
one early,

we may be able to delay
or prevent the other.

We also know that physical disorders such as cancer,
heart disease, and HIV can give rise to mental health problems,
primarily depression, that can interfere with or complicate
treatment compliance, and slow improvements in health status.

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We also know that physical disorders such as cancer,

heart disease, and HIV can give rise to mental health problems,

primarily depression, that can interfere with or complicate

treatment compliance, and slow improvements in health status.

And we know that people
with mental illnesses die,

on average, 25 years --

25 years earlier
than the general population.

Critically, they die from
treatable medical conditions

that are caused by
modifiable risk factors,

including smoking, obesity,

substance abuse,
and lack of exercise.

So where do these facts lead us?

They lead us to the need
for integrated care,

another key force
that drives our work.

Integrated care is more than
just a simply nice concept;

it is a financial
and an ethical imperative.

At its core,

integrated care provides
a community-based approach

to preventing
and treating illnesses

and to promoting wellbeing.

It addresses treatment
for individuals

across the lifespan

while developing interventions
for the entire population.

Integrated care spans health
sectors, physical and mental;

it spans care settings,
from clinic to emergency room

to private
practitioner's office;

and it spans service systems,
to encompass schools,

correctional facilities,
workplaces,

and social service programs.

In this way,
integrated care helps assure

that every door -- every door --
becomes the right door

to holistic,
person-centered care

that attends
to mental health promotion

and the treatment
of mental illness.

For people with mental illness,
this means focusing

on such issues as poverty,
unemployment, homelessness,

inequitable distribution
of health resources,

and the discrimination, fear,
and bias that keeps people

with mental health problems
at the margins of society.

Without access to housing, healthcare, employment,

and social support,
individuals are excluded

from all that it means to be
healthy in today's society.

Getting there won't be easy.

It involves changing minds
and practices,

tearing down service silos

and building bridges
to collaboration.

And SAMHSA is trying
to help the field get there.

We're going to fund a new
primary and behavioral
healthcare integration program.

The purpose of the program --
and, by the way, don't apply,

because the application
deadlines have already passed.

The purpose of the program is

to improve
the physical health status

of people with serious
mental illnesses

by integrating
primary care services

into publicly funded community
mental health agencies.

We expect the services we fund
will incorporate

a prevention
and wellness approach

and show cooperation
and collaboration

across mental health --

community mental health
and primary care.

But there's one other
critical element

to our public health approach,

and that's the concept
of resilience.

Resilience is a core element
of SAMHSA's mission,

and an underlying precept
in the prevention field,

and a key to promoting recovery
for mental illnesses.

I think I've been
forgetting to --

Former Vice President
Hubert Humphrey has said

"There are incalculable
resources in the human spirit,

once it has been set free,"
and to my mind,

that is the definition
of "resilience."

Resilient individuals bend
rather than break

during stressful conditions.

They are most likely to have
a positive outlook

and a sense of personal mastery,

and to find meaning,
even in difficult circumstances.

Nowhere is the concept
of resilience-building

more important than
in the work of CMHS,

at the intersection
of mental health and HIV/AIDS.

It's challenging work,
to say the least;

getting clients into care
is a challenge.

The stigma that surrounds mental
illness and substance abuse

is challenged by the fear
and misunderstanding

associated with HIV/AIDS.

And, at the same time, meeting care needs is a challenge.

The sheer volume of need,

particularly for culturally competent care,

is impacted by limitations of workforce capacity,

and the need to provide integrated care

is challenged by service and funding silos.

As I said, it's challenging work, and Kathryn likes

to relate a story from the bestselling book

"The Art of Possibility: Transforming Professional

and Personal Life," that has application here.

A shoe factory sends two marketing scouts

to a region of Africa

to study the prospects for expanding business.

One sends back a telegram saying,

"Situation hopeless stop no one wears shoes."

The other writes back triumphantly,

"Glorious business opportunity stop they have no shoes!"

Like the second marketing scout,

when it comes to the challenges of working at the intersection

of mental health and HIV/AIDS, we see opportunity.

CMHS has a long history
of funding HIV/AIDS programs,

beginning with the demonstration
program in '93

and a cost outcome study

that was cofunded with CSAT,
HRSA, and NIH in '98.

And in 2001, we funded
the first cohort

at the Mental Health
HIV Services Collaborative

grant program

and its primary goal is
to expand mental health services

for persons with HIV
in minority communities.

The first cohort of grantees
ended in 2006

and we are currently funding
a second cohort of 16 grantees

that either coordinate
or provide

an array
of very important services,

including mental health,
primary care, substance abuse,

prevention,
and housing supports.

Since its inception,
the program has provided care

for over 9,000 consumers.

Through this program,
CMHS has also helped communities

expand integrated services for
these underserved populations

and has encouraged the creation
of consumer advisory boards.

We're also funding

an independent
cross-site evaluation

that's collecting national
outcome measures and other data,

and although results
are preliminary, guess what --

we know that providing
integrated services

has had a positive impact
on improving care

for persons with HIV,
in mental health.

And also,
we contract with NASW,

the American Psychological
Association,

and the American
Psychiatric Association

to provide training
to over 30,000 providers.

And we also have
a SAMHSA linked web page

that I urge you to go to.

In closing, I want to say that,
while it's important

to collect data,
to identify best practices,

and to create
an integrated care system,

they're all critical

to advancing our knowledge base
about service provision

and the sustainability
of services.

But we're also doing something

that perhaps is
even more important.

Through our grant program,

we offer hope and promise
where there was none before.

The hope for recovery,
resilience, healing,

and the promise for prevention.

At CMHS, we're all about working
to help make everything possible

for people with mental illnesses
and HIV/AIDS.

Thank you.

[Applause]

Just two quick announcements:
for all of the SAMHSA grantees

the One SAMHSA Institute
registration

will open today
from 2:00 to 7:00 P.M.

It will be right at
the Regency 6 and 7 Ballrooms,

so you can register there.

Please don't forget --

you heard those wonderful,
wonderful, wonderful students

right before the session, who
were singing "I Choose Life."

Please join us tonight, right
after the town hall meeting,

for their performance,

to witness truly
"AIDS Has No Color."

It is a part of

R U + THAT U R -? (Are you positive that you are negative?)

So we truly want to thank you
all for this session.

Thank you again.
Bob.

And I want to make
one person in this room

very, very happy, and that
person is Freda Jones.

Your driver's license is
at the registration desk.

The other thing is, since
we've gone over a little bit,

when you get to your sessions,
if you can let

the session moderators know that
they can go over 15 minutes,

and then we'll get right back
on our regular schedule.

So they can go over a little bit
on their 1:30 session,

finishing about
10 to 15 minutes late.

So when you report to those
sessions, let them know that.

And I also want to remind you
that registration

for the One SAMHSA meeting is
at 2:00 on this --

is at 2:00 in the Grand --
actually, one level down,

and that registration tomorrow
starts at 7:00

for the One SAMHSA meeting,

and that will be
by the Regency Ballrooms.

See you at 6:30 tonight.
Thank you all very much.

Funding for the MEI project

was provided by

CSAP, the Substance Abuse

and Mental Health Services Administration's

Center for
Substance Abuse Prevention.

Woman: Miss Beverly Watts Davis
had a vision

to actually want to establish

a specific minority institutional program

that would address

minority students
who could be at risk

for substance use
or for transmission of HIV.

The biggest accomplishment
has been just to open the door

to be able to discuss HIV,

a taboo subject
on the reservation.

That the elders maybe didn't
oppose it at this point.

In the past, they did.

And that was a major
accomplishment because

it opens up the doors to start
talking about other issues.

The Minority Education
Initiative is the grant

that we've received here
at Virginia Union

to help us to raise awareness

and to educate
about HIV and AIDS.

Northeastern is
a federally designated,

Hispanic-serving institution
and we are a part of a cohort

of institutions
from across the country.

And our job, basically, is

to provide
prevention information

to the students,
to the Latino students here

at the University, as an HSI.

Being an MEI grantee,
which stands for

Minority Education Institutions,

is a wonderful opportunity

to get the message out
about HIV/AIDS and other STDs.

Woman: Having this grant
has really enabled the school

to do more in the area
of healthcare,

and especially healthcare
for minority students.

For Savannah State,
it has meant being able

to share this information
about how to prevent,

how it's transmitted,
treatment,

as well as getting everyone
to know their status,

dealing with HIV.

Without this grant,
we would not be able to do this.

Woman: HIV/AIDS
and substance abuse is

a very real issue.

