

2010

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Rosalie Simichak

University of Connecticut Health Center

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**Sexual Risk and High Risk Behavior Among Substance Abusing Adolescents in Hartford,
Connecticut: Implications for Effective Treatment Delivery**

Rosalie Simichak

**B.A., St. Joseph College, 1995
M.A., University of Hartford, 1997**

A Thesis

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Public Health

at the

University of Connecticut

2010

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Abstract. Substance use and high risk sexual behavior have significant health consequences for adolescents who engage in these behaviors, including HIV, STD transmission, teen pregnancy, and an array of other associated health problems. The Hartford Youth Project (HYP) established by the Connecticut Department of Children and Families, offers a system of substance abuse treatment which has proven to be effective in reducing adolescent engagement in such high risk behavior. In this study, the data generated by the HYP are examined in conjunction with data derived from a qualitative review of existing services in order to identify a sexual risk profile for substance abusing adolescents in Hartford. The majority of both HYP boys and girls (75% of boys and 56% of girls) reported sexual activity in the last three months. Among both boys and girls, more than a third of both reported that they had sex without a barrier. The large number of substance abusing youth having unprotected sexual activity places them at significant risk of HIV/STDs and pregnancy. Nearly a third of both boys and girls also reported having sex while either they or their partner were high on alcohol or drugs. Although available services have proven to be effective in addressing the issue of substance use and abuse among this population, there is clearly a gap in this service system in the area of HIV, STD and pregnancy prevention. The findings of this study highlight the importance of making services available to youth to address their population's need for such appropriate HIV, STD and pregnancy prevention services.

INTRODUCTION

Substance use and high risk sexual behavior have far reaching implications in terms of the potential harmful health consequences facing adolescents who engage in these behaviors. According to the 2008 Alcohol and Drug Policy Council report, 29,000 Connecticut adolescents aged 12 to 17 met criteria for alcohol or illicit drug dependence or abuse. Among this same population, 16,000 youth aged 12-17 in Connecticut were estimated to be in need of treatment for drug use and 18,000 youth aged 12-17 in Connecticut were estimated to be in need of treatment for alcohol use but do not receive it (Connecticut Alcohol and Drug Policy Council, 2008). Specifically, adolescents who engage in substance use and high risk sexual behaviors are at increased risk for HIV, STD transmission, teen pregnancy and an array of other associated health problems. Human Immunodeficiency Virus (HIV) infections continue to occur at a high rate in the United States and worldwide, with nearly half of these infections in the United States occurring among people between the ages of 13 and 24 years (Johnson, Carey, Marsh, Levin, & Scott-Sheldon, 2003). Research consistently supports the existence of a relationship between sexual risk and substance abuse. Leigh and Stall (1993) found that adolescents are more likely to engage in unprotected sex when they are under the influence of drugs or alcohol. In 2003, of sexually active high school students nationwide, 37% reported that neither they nor their partner had used a condom during their last sexual intercourse, and 25.4% had used alcohol or drugs during their last sexual encounter (Center for Disease Control & Prevention, 2004). The tendency of this population to engage in high risk sexual behavior places them at increased risk for transmission of STDs including HIV. In the United States AIDS was the leading cause of

death for adults between the ages of 25 and 44 in 2002 (Center for Disease Control & Prevention, 2002). Because there is a long incubation period associated with HIV, it is likely that these adults were infected with the disease during adolescence (Center for Disease Control & Prevention, 2001). The data outlined in the MMWR Surveillance Summaries (July, 2009) show that in 2004, there were approximately 745,000 pregnancies among US females under 20 years of age. It is further noteworthy that these same pregnancy rates were increasingly higher among Hispanic and Black adolescent females than that of their White counterparts. These findings highlight the necessity of identifying effective interventions in addressing the high risk sexual behavior associated with substance abuse early for adolescents.

There are currently many models of treatment which have proven to be effective in reducing substance abuse and other high risk behavior among adolescents. The need for such treatment is supported by the National Surveys on Drug Use and Health (NSDUH, 2007) which highlighted that 5.2% of youth aged 12-17 years old in Connecticut were in need of treatment for illicit drug use and were not receiving it. The NSDUH (2007) found that 5.6% of this same group was in need of treatment for alcohol use and was not receiving it. Multisystemic therapy (MST) is one such treatment modality which has proven to be effective in reducing substance abuse and other high risk behaviors (Henggeler, Melton, & Smith, 1992; Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993). MST is an intensive family and community based treatment that addresses the factors which contribute to serious antisocial behaviors in juvenile offenders. The treatment modality targets chronic, violent, or substance abusing juvenile offenders at high risk of out-of-home placement and their families. Broduin, Mann, Cone, Henggeler,

Fucci, Blaske, & Williams (1995) found that MST produced a 63% reduction in rearrests for violent and other serious crimes at 4-year follow-up. Henggeler, Pickrel, & Brondino (1999) found in randomized trials that MST is a promising approach to the treatment of serious antisocial behavior in adolescents. Another effective treatment modality utilized to address substance abuse and other high risk behaviors among adolescents is Multidimensional Family Therapy (MDFT) (Liddle, 2002). This treatment modality is a comprehensive and multisystemic family based program designed to address substance abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency (Liddle, 2002). Research conducted by Liddle (2006) has shown that MDFT was more effective than services as usual in decreasing substance use and improving abstinence rates.

The present study assesses the sexual risk behaviors among adolescents with substance abuse problems to explore their potential needs for HIV and pregnancy prevention services. In particular, the sexual risk profile of substance abusing youth in Hartford, Connecticut is identified in conjunction with services available to address the needs of this population. This study utilizes Center for Substance Abuse Treatment (CSAT) funded Hartford Youth Project (HYP) data in conjunction with interviews with providers who serve this population to assess the sexual risks of this population and the availability of services to address these needs. HYP's target population were Hartford residents aged 10 to 17 who were identified as either having a substance use disorder or were at significant risk of developing one (Simmons, Ungemack, Sussman, Anderson, Adorno, Aguayo, Black, Hodge, & Tirnady, 2008). Hartford was selected as the

identified site of the SCY project because of the "high perceived need for age appropriate need for age appropriate substance abuse treatment services for the city's youth" (Simmons et al., 2008, p.43). The majority of residents in Hartford were persons of color and included 41% who identified themselves as Hispanic and 38% who were African American in 2000 (US Census Bureau, 2000). One of the goals of HYP was to address the needs of the youth in this community before they became involved with the criminal justice system and before they became more deeply involved with substance abuse (Simmons et al., 2008).

The provider agencies included those that had participated in the HYP study and had implemented evidence-based treatment services to address the substance abuse treatment needs of adolescents residing in Hartford. In addition, a search was conducted of Connecticut Infoline's 211 data base to identify available resources for adolescents at risk of HIV, AIDS, other STDs, and pregnancy. These providers included those who offer HIV testing, counseling, and/or substance abuse treatment services. The availability of these services is assessed in the context of the identified needs of this population, and the implications of any identified unmet needs are discussed.

LITERATURE REVIEW

The prevalence of substance abuse among adolescents has remained significant over time both in Connecticut and nationwide. In 2009, 72.5% of high school students nationwide participating in the Youth Risk Behavior Survey (YRBS) had at least one drink of alcohol in their lifetime (Center for Disease Control and Prevention, 2010). Among this same population 36.8% had ever used marijuana; 6.4% had ever used cocaine; 11.7% had sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high; 2.5% had used heroin; 2.1% had used a needle to inject any illegal drug; 4.1% had used methamphetamines; and 6.7% had used ecstasy in their lifetime (Center for Disease Control and Prevention, 2010). The rates of use for students in Connecticut were comparatively higher for marijuana and heroin than in the United States (Center for Disease Control and Prevention, 2010). The lifetime rates of use in Connecticut as reported by the CDC (2008) indicate 38.6% of students had used marijuana; 8.3% had used cocaine; 2.7% had injected illegal drugs and used inhalants; 4.1% had used heroin and methamphetamines; and 6.6% had used ecstasy in their lifetime. A 2008 Alcohol and Drug Policy Council report (2008) estimated that 29,000 Connecticut adolescents aged 12 to 17 met criteria for alcohol or illicit drug dependence or abuse, including 16,000 youth who were estimated to be in need of treatment for drug use and 18,000 youth in need of treatment for alcohol use but do not receive it (Connecticut Alcohol and Drug Policy Council, 2008). Based on a 1995 statewide school survey, it was estimated that 9% of the state's senior high school students and 4% of junior high school students gave sufficient evidence of substance related problems which

warranted the need for evaluation for a substance disorder (Ungemack, Hartwell & Babor, 1997).

Cultural background and gender also impact the prevalence of substance abuse and high risk behavior, as well as subsequent need and engagement in treatment services. Need for substance abuse treatment was associated with increased age, as well as gender and ethnicity. A Connecticut needs assessment study conducted in 1995 found that Hispanics evidenced higher rates of treatment need than either White or Black students (Hartwell, Ungemack, Babor, Stevens, & Delboca, 1996). According to the 2007 YRBS, the prevalence of lifetime alcohol use was higher among female than male students and higher among white and Hispanic than black students, while the prevalence of lifetime marijuana, cocaine, and heroin was higher among male than female students across all racial backgrounds (Center for Disease Control & Prevention, 2008). The prevalence of lifetime marijuana use was higher among white male (41.8%), black male (44.5%), and Hispanic male (42.0%) students than white, black, and Hispanic female students. The prevalence of lifetime cocaine use was higher among black male than black female students and was highest among Hispanic students followed by white than black students. The prevalence of lifetime illegal injection drug use was higher among black male students than white male and female students. The prevalence of lifetime inhalant use was higher among female (14.3%) than male (12.4%) students and higher among white female than white male students. Lifetime inhalant use higher among white and Hispanic than black students. The prevalence of lifetime heroin use was higher among Hispanic than white and black students. The prevalence of having drunk alcohol before age 13 years was higher among male (27.4%) than female (20.0%) students; higher among

white, Hispanic, and black males than white, Hispanic and black females. The prevalence of having tried Marijuana before age 13 years was higher among males (11.2%) than female (5.2%) students; higher among white male (10.0%), black male (14.2%) and Hispanic male (12.4%) than white female (4.4%), black female (4.9%) and Hispanic students respectively (Center for Disease Control & Prevention, 2008).

Research consistently shows that there is a relationship between substance abuse and high risk sexual behavior. Leigh & Stall (1993) discovered that adolescents are more likely to engage in unprotected sex while they are under the influence of drugs or alcohol. In the 2003 YRBS, 37% reported that neither they nor their partner had used a condom during last sexual intercourse and just over one quarter 25.4% had used alcohol or drugs during their last sexual encounter (Center for Disease Control & Prevention, 2004). Mott & Haurin (1988) found that substance use increases the probability that an adolescent will initiate sexual activity, and conversely, sexually experienced adolescents are more likely to initiate substance use. Nationwide, the 2009 YRBS survey found that 5.9% of students had had sexual intercourse for the first time before the age of 13 years (Center for Disease Control & Prevention, 2010). Among Connecticut youth surveyed, 4.6% had had sexual intercourse before the age of 13 years (Center for Disease Control & Prevention, 2010). It is estimated that by the end of 9th grade more than a third of adolescents have had sexual intercourse and that by 12th grade two thirds have become sexually active (Center for Disease Control & Prevention, 2008). Nationally, the prevalence of having had sexual intercourse before age 13 years was higher among male (6.1%) than female (2.8%) students. The percentage of students initiating sex before age 13 varied by race and Hispanic ethnicity: white male (4.4%), black male (24.9) and

Hispanic male (9.8%) than white female (2.2%), black female (5.6%) and Hispanic female (3.7%) students (Center for Disease Control & Prevention, 2008).

It is also pertinent that sexually active adolescents tend to have multiple sex partners (sequential and/or concurrent) and to be inconsistent in their practice of safer sex (Center for Disease Control & Prevention, 2008). In the 2003 YRBS, 37% reported that neither they nor their partner had used a condom during last sexual intercourse. There are serious and significant health implications associated with the high risk sexual behavior which appears to be normative of adolescents. Each year, there are approximately 19 million new STD infections and almost half of them are among youth aged 15 to 24 (Weinstock, Berman, & Cates, 2004). Data reported by the CDC in the context of YRBS (2008) indicate that there are an estimated 9.1 million cases of sexually transmitted diseases (STDs) among persons aged 15-24 years. Unsafe sex practices also give rise to a significant number of unintended pregnancies among adolescents. In 2006, a total of 435,427 infants nationwide were born to mothers aged 15-19 years, a birth rate of 41.9 live births per 1,000 women in this age group among which 80% were unintended (Hamilton, Martin, & Ventura, 2007). Although pregnancy and birth rates among girls aged 15-19 years had declined 34% since 1991, birth rates began rising again from 40.5 per 1,000 women in this age group in 2005 (Hamilton, Martin, & Ventura, 2007). The frequency of such unwanted pregnancy among adolescent females has long term social implications and leaves these children vulnerable to involvement with the child protection system (Hoffman, 2006). Teen mothers aged 17 and younger at the time of birth were 2.2 times more likely to have a child placed in foster care than mothers who

delayed childbearing until age 20 or 21 and they were twice as likely to have a case of abuse or neglect regarding their children (Hoffman, 2006).

The tendency of this population to engage in high risk sexual behavior places them at increased risk for transmission of STDs including HIV. In the United States, AIDS was the leading cause of death for adults between the ages of 25 and 44 in 2002 (Center for Disease Control and Prevention, 2002). Given the incubation period associated with HIV, it is likely that these adults were infected with the disease during adolescence (Center for Disease Control & Prevention, 2001).

African Americans represent more than half of all new HIV infections (Center for Disease Control & Prevention, 2000). This finding is echoed by Feist et al. (2004) who noted that minority females are at greatest risk for contracting HIV and AIDS, particularly African American adolescent females. Despite the clear need for treatment and education for this population, there appears to be a clear deficit in addressing this issue in the context of available treatment. Feist et al. (2004) acknowledged this deficit and indicated that theory based, culturally competent substance abuse and HIV interventions are needed to reduce sexual-risk taking behavior. Knowledge about risk is not sufficient to prevent HIV risk behavior. This is illustrated by the fact that there is widespread education about HIV and AIDS provided to students of all racial and ethnic backgrounds. The 2009 YRBS found that 87.8% of female students and 86.3% of male students nationwide had been taught in school about acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection (Center for Disease Control & Prevention, 2010). The percentage of students reporting that they had been taught in school about AIDS or HIV infection varied somewhat by ethnicity. The

percentage of students having been taught in school about AIDS or HIV infection was higher among white (88.6%) than Hispanic (83.2%) students; higher among white female (89.6%) than Hispanic female (83.2%) students; and higher among white male (87.8%) than Hispanic male (83.2%) students (Center for Disease Control & Prevention, 2010). 86.9% of black female students and 85.2% of black male students had been taught in school about acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection (Center for Disease Control & Prevention, 2010). Despite such education, the prevalence of substance abuse and high risk sexual behavior remains significant and concerning.

Differences in the use of alcohol and other drugs and sexual risk behavior by race and Hispanic ethnicity highlight the importance of taking racial background into account when identifying appropriate treatment interventions. Research has shown that treatment that is not culturally sensitive is futile in addressing substance use and reducing the corresponding high risk behaviors associated with such use (Bui & Takeuchi, 1992). Some research has shown that the community mental health system is particularly unresponsive to the needs of ethnic minority youth (Gibbs & Huang, 1989). Some of the factors which have been identified as affecting minorities' use of mental health services are lack of access, biased assessment techniques, cultural and language barriers, and the limited number of minority mental health providers (Bui & Takeuchi, 1992; Cross, Bazron, Dennis & Isaacs, 1989). Most adolescent treatment programs in standard community based programs are plagued by high dropout rates, service fragmentation, and failure to address youths' multiple problems (Liddle et al., 2006). Many individuals in communities of color "express preferences for nontraditional interventions more in keeping with their cultural values and institutions" (Simmons et al., 2008).

METHODOLOGY

There were two components of this descriptive study. First, a secondary analysis was conducted of data collected during the Hartford Youth Project (HYP), a demonstration project targeting substance abusing adolescents in Hartford. The data generated by the HYP to identify a sexual risk profile for substance abusing adolescents in Hartford. Second, interviews were conducted with representatives of agencies which provide substance abuse treatment services in and around Hartford. Additionally, a search was conducted to determine the availability of HIV/AIDS/ STD counseling and screening services, as well as substance abuse treatment services. In 2002, the Connecticut Department of Children and Families (CT DCF) implemented HYP with funding from the Center for Substance Abuse Treatment (CSAT) under the Strengthening Communities for Youth (SCY) Initiative. The CT DCF is the state agency with legislated responsibilities for child welfare, mental health, and substance abuse services. DCF designed HYP as a pilot study for the State's adolescent substance abuse treatment system using a system of care approach to identify substance abusing adolescents and bring them into appropriate community based treatment, especially as an alternative to residential care or incarceration in the juvenile justice system (Simmons et al., 2008). HYP's target population was Hartford residents aged 10 to 17 who were identified as either having a substance abuse disorder or at substantial risk for developing one. One of the goals of HYP was to reach the community before the adolescent became involved with the criminal justice system, historically the primary source of referrals for adolescents entering behavioral health treatment. By targeting community youth, DCF hoped to intervene early before youth became more deeply involved with substance

abuse. A secondary analysis of these data provided important information regarding the service needs of this population and assisted in identifying the elements of treatment which are most effective in meeting this population's needs.

The second component of this research involved an examination of available substance abuse treatment services in and around Hartford. In 2007, there were seven separate agencies which provided substance abuse treatment for adolescents in Hartford, Connecticut. A semi-structured questionnaire was developed to interview program directors from these agencies about the populations their agencies serve, as well as the needs of this population. These agencies all provide substance abuse treatment services for youth who reside in and around Hartford, Connecticut. These agencies included those which participated in HYP. The interviews were conducted by this investigator by telephone with staff from agencies based upon their willingness and availability to participate in this assessment. These staff varied in their cultural background, as well as their position within the agency they each represented at the time of interview. The participants ranged from Case Manager to Vice President. Each of these participants was familiar with their agency's programs and available services and reported that they possessed sufficient knowledge to answer questions contained in the questionnaire. These interviews were conducted in March 2008 through November 2009. In addition, eight additional agencies were identified and reviewed to determine availability of HIV/AIDS testing and counseling services in Hartford. These providers were identified through the use of an Internet search utilizing the Connecticut Infoline 211 data base. These providers were followed up via telephone to determine the availability to HIV testing and counseling services, as well as substance abuse services for urban youth

residing in Hartford, Connecticut. Each screening participant was familiar with their agency's available services and reported sufficient knowledge and willingness to participate in the interview.

RESULTS

The following is an integration of the secondary analysis of data derived from HYP for the purpose of identifying a profile of sexual risk of substance abusing youth in treatment and qualitative interviews to assess the availability of services to address their sexual risk needs.

Secondary Analysis of Hartford Youth Project Data

HYP utilized the Global Assessment of Individual Needs Interview (GAIN-I) in order to conduct a baseline assessment of these youth (Dennis et al., 2001). This GAIN instrument was designed to provide a comprehensive, structured assessment of an adolescent's risks for substance abuse and other problems in association with substance abuse including sexual risk behavior. Table 1 reflects the characteristics of the HYP youth.

With regard to sexual risk behavior, during the past year, almost all HYP males (90.7%) had had sexual experience of some type (Table 2). During the past 90 days, HYP boys reported that they had sex an average of 4.3 times, while girls reported they had sex an average of 7.1 times. 4.7% had sex 13 or more months ago. Most reported recent sexual activity; 10.3% reported that they had sex four to 12 months ago. 23.4% reported that they had sex one to three months ago; 15.9% reported they had sex one to four weeks ago; 19.6% reported that they had sex three to seven days ago; and 16.8% reported having sex during the two previous days. Among HYP girls, 84.4% had been sexually active. Again, most of these adolescent girls reported current sexual activity; 31.3% reported having sex one to three months ago, 6.3% of HYP girls reported having sex one to four weeks ago, and 25% reported having sex within the past seven days.

With regard to frequency, Table 3 shows that HYP girls reported higher frequency of having sex than their male HYP counterparts in the last 90 days. One-third of HYP boys (32.7%) compared to one in eight (12.5%) girls reported having two or more sex partners during the past year.

Among this population of substance abusing youth in treatment, similar percentages of boys (28.2%) and girls (29.0%) reported having sex while either they or their partner were high on alcohol or drugs. With regard to the use of a barrier during sex, a similar percentage of HYP girls (34.6%) and boys (34.4%) indicated that they had not used such a barrier during sex. With regard to the use of any kind of barrier, 4.5% of HYP males and 8.3% of HYP females reported using any kind of barrier during sex.

Neither HYP girls or boys reported having sex with injection drug users. Similarly, respondents in both groups denied trading sex for drugs, gifts, or money and also denied using drugs, gifts or money to purchase sex. Less than one percent of HYP boys reported having sex with another man, while 6.3% of HYP girls reported having sex with another woman. None of the HYP boys reported having sex with a man who has had sex with other men. However, 14.0% of HYP boys reported having sex that involved having anal intercourse, and 9.4% of HYP girls reported having sex involving anal intercourse. Among HYP boys, less than one percent reported having pain during or after sex, while 9.4% of HYP females reported pain during or after sex in the past year. None of the HYP girls reported using alcohol or drugs to make sex last longer or hurt less, although 5.6% of HYP boys so reported.

The data represented in Table 1 reflect that rate at which HYP youth engage in substance use and abuse behaviors. 22.9% of African American HYP youth engaged in substance abuse behavior while 17.0% of Hispanic HYP youth engaged in substance abuse behavior. Rates of weekly marijuana use were similar with 80.6% of African American HYP youth and 81.0% of Hispanic HYP youth reporting such behavior. A total of 62.2% reported use and 19.6% reported dependence. Rates of mental health problems reflected that 7.4% of HYP youth experienced internalizing problems only while 37.4% reported externalizing problems only and 32.1% reported both internalizing and externalizing problems. Rates of illegal activity reflected that 56.8% of HYP youth had engaged in illegal activity in the past year. Rates of lifetime juvenile justice involvement were equally alarming with 89.5% of HYP youth having been involved in the juvenile justice system in their lifetime (Simmons et al., 2008)

Provider Interviews

A series of 17 interviews were conducted with personnel who serve at risk children and adolescents. An interview was done with nine of these agencies using a semi structured questionnaire (see attached). Two of these agencies (CCMC and AIDS Project Hartford/Connections Wellness Center) offer HIV testing and counseling services and do not provide substance abuse treatment services. The remaining agencies were screened during informal telephone interviews to determine availability of HIV testing and counseling services in Hartford, Connecticut. These agencies were selected from a list of resources identified by an Internet search using the CT Infoline 211 database. The purpose of all of these interviews was to identify a profile of available resources for substance abusing children and adolescents who are at risk of HIV, AIDS, and STDS.

These agencies included: NAFI, Village for Families and Children, Hartford Behavioral Health, Connecticut Children's Medical Center, Community Solutions, ADRC, AIDS Project Hartford/Connections Wellness Center, Hispanic Health Council, Urban League, Wheeler Clinic, Community Health Services, Hartford Human Services Department, Family Medicine Center, Charter Oak Health Center, Hartford Gay and Lesbian Health Collective, Loaves & Fishes Ministries, and Planned Parenthood. These providers were identified as belonging to one of two groups. The first group was defined by their status as programs offering substance abuse treatment services or connecting families to such services to adolescents in Hartford, Connecticut (attached). These providers included: Wheeler Clinic, Community Solutions, Village for Families and Children, NAFI, Hartford Behavioral Health, and ADRC. The Hispanic Health Counsel and Urban League also connect families with MST and MDFT services, yet do not officially act as providers. These treatment providers, as well as the Hispanic Health Counsel and Urban League, all have histories of involvement in the HYP, and some remain involved with the continuing outreach and aftercare support program. The provider from ADRC reported that this agency has not provided services to youth since 2003 at which time their grant for funding such services was discontinued. Five of these six agencies provide services or facilitate connection to services in order to address children and adolescents identified as having histories of substance abuse or being at risk of substance abuse. The remaining agencies offer HIV testing and counseling services with some also offering substance abuse treatment services to children and adolescents in Hartford, Connecticut (attached). These agencies include: AIDS Project Hartford/Connections Wellness Center, Connecticut Children's Medical Center (CCMC), Community Health Services, Hartford

Health and Human Services Department, Family Medicine Center; Charter Oak Health Center, Hartford Gay and Lesbian Health Collective, Loaves & Fishes Ministry, Urban League, Hispanic Health Counsel, and Planned Parenthood.

Among the adolescent substance abuse treatment providers, four of these providers offer Multisystemic Therapy services (MST), and three of these providers offer Multidimensional Family Therapy (MDFT) services. One of these agencies offers both MST and MDFT services. Multisystemic therapy (MST) is an evidenced-based treatment modality which has proven to be effective in reducing substance abuse and other high risk behaviors (Henggeler, Melton, & Smith, 1992; Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993). MST is an intensive family and community based treatment that addresses the factors which contribute to serious antisocial behaviors in juvenile offenders. The treatment modality targets chronic, violent, or substance abusing juvenile offenders at high risk of out of home placement and their families. Brodwin, Mann, Cone, Henggeler, Fucci, Blaske, & William (1995) found that MST produced a 63% reduction in rearrests for violent and other serious crimes at 4-year follow up. Henggeler, Pickrel, & Brondino (1999) also performed randomized trials which were supportive of the fact that MST is a promising approach to the treatment of serious antisocial behavior in adolescents. Another effective treatment modality utilized to address substance abuse and other high risk behaviors among adolescents is Multidimensional Family Therapy (MDFT). This treatment modality is a comprehensive and multisystemic family based program designed to address substance abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at risk for continued substance abuse and other problem behaviors such as conduct

disorder and delinquency (Liddle, 2002). Research conducted by Liddle (2006) has shown that MDFT was more effective than services as usual in decreasing substance use and improving abstinence rates. The use of these two models of in home treatment services has proven to be effective in addressing the problem behaviors commonly displayed by at risk youth in Hartford, Connecticut.

In the context of this survey, one of the themes that emerged was that of funding source and referral source. DCF is a significant contributor to funding for available behavioral health services for children and adolescents in Connecticut and often serves as a primary referral source. Many of these adolescent substance abuse treatment providers are funded by DCF. NAFI and Wheeler Clinic are additionally funded by the State of Connecticut Court Support Services Division (CSSD) which is the agency responsible for oversight of adolescents involved with the criminal justice system. Services offered by the Village for Families and Children are funded by Connecticut Children's Medical Center (CCMC) which are supported by funding provided by the State of Connecticut Department of Public Health. The services offered through the Pediatric and Youth HIV program at the Connecticut Children's Medical Center are provided through Ryan White funding. AIDS Project Hartford/Connections Wellness Center offers the Street Smart Program which is funded by the Center for Disease Control and Prevention. The provider from the Urban League reported that his agency recently lost funding for a social worker position recently which has been a disadvantage in meeting clients' needs.

All adolescent substance abuse treatment providers are utilizing evidenced based models of treatment. NAFI, Wheeler Clinic, and Community Solutions all provide MST services which is an evidenced based in-home treatment intervention. Three of the five,

Hartford Behavioral Health, Village for Families and Children, & Wheeler Clinic, also offer MDFT. The Hispanic Health Counsel and Urban League connect families with both MST and MDFT services. CCMC reported that they have selected an evidenced based curriculum for HIV prevention which they will be implementing in the near future. The Street Smart Curriculum offered by AIDS Project Hartford/Connections Wellness Center is an evidenced based prevention program designed to prevent HIV/AIDS and other sexually transmitted diseases among homeless and runaway youth 11 to 18 years of age whose behaviors place them at high risk of becoming infected (Rotheram-Borus, Koopman, Haignere, & Davies, 1991).

The majority of these service providers reported a disproportionate number of boys versus girls being referred for and receiving services. Only Hartford Behavioral Health and the Village for Families and Children indicated that the number of boys and girls receiving services is similar. Despite the fact that the majority of providers interviewed indicated that they served a greater number of boys, few of the interviewed providers reported any implementation of any gender-specific approaches to address the population served. The provider interviewed from Hartford Behavioral Health did report that efforts are made to match children and therapists by gender when possible and activities are geared to the preferences of the two separate genders. The provider from Wheeler Clinic reported that gender-specific approaches were utilized by staff providing services, yet there was no specific mention of what these approaches might include in the context of service delivery. The provider from Community Solutions indicated that “staff are trained in gender specifics” and went on to state that “each intervention is geared to the specific child or adolescent’s needs.” The provider from CCMC said that the “same

approaches are used for boys and girls,” and indicated that they employ Adolescent Specialists to work with children in this stage of development.

The majority of clients served by these providers reside in Hartford. Wheeler Clinic, however, also provides services to youth and families who reside in New Britain and Hartford. Behavioral Health indicates that they additionally provide services to families who reside in Manchester, Connecticut. The Hispanic Health Council reports that they service Hartford, West Hartford, and Bloomfield, yet indicate that the majority of clients served reside in Hartford. Consistent with Hartford’s racial and ethnic population characteristics, primarily African American and Hispanic, the majority of clients who are provided services are of a minority background. The provider from Hartford Behavioral Health indicated that “11 families are Hispanic, four families are white, and three families are African American.” The provider from Community Solutions reported that most of the clients served are Hispanic. The provider from CCMC reported that “51% of clients served are African American, 40% are Latino, and 3% are Caucasian.” The AIDS Project Hartford/Connections Wellness Center respondent indicated that clients who participate in the Street Smart Curriculum are “mostly from minority backgrounds.” The provider from NAFI also said that “most families served are Hispanic and African American.” The provider from the Hispanic Health Counsel indicated that the majority of clients are from a minority background, and the provider from the Urban League indicated that the majority of clients served reside in the North end of Hartford and are African American. Almost all providers interviewed professed to providing culturally competent services to clients they served. The youth in Hartford are the identified population served by all of the providers. Some of the

providers reported that they do not make adaptations to meet the specific needs of youth in Hartford. The provider from Wheeler Clinic indicated that the services “are not adapted, but that cultural background is taken into consideration when providing treatment.” The provider from the Aids Project Hartford/Connections Wellness Center indicated that adaptations cannot be made because the “curriculum cannot be adapted.” In contrast, the provider from NAFI indicated that the staff working with youth in Hartford “encourage involvement in pro-social recreational activities and make use of local vocational resources such as Our Piece of the Pie and the Craft Project.” Hartford Behavioral Health also makes efforts to supplement services in ways which might support youth in achieving success in treatment. Specifically, the provider from this agency indicated that they also refer clients to STAR Mentoring Services and the Hispanic Health Counsel.” The provider from the Urban League reported that they partnered with the Hispanic Health Council in order to better meet the needs of youth in Hartford and divide their services to the separate sections of the city. The provider from the Pediatric and Youth HIV program at CCMC indicated that they utilize children to act as “peer educators in the community.” Such efforts are progressive, yet the primary focus of these services is HIV prevention and the risks created by substance abuse are not directly addressed. The majority of these providers address cultural competency through claims that they employ Spanish speaking staff. NAFI, the Village for Families and Children, AIDS Project Hartford/Connections Wellness Center, Hartford Behavioral Health, CCMC, Community Solutions, Wheeler Clinic, and the Hispanic Health Council all reported that they employ clinicians and case managers who are bilingual. The provider from Hartford Behavioral Health reported that “staff work with families to

develop a treatment plan, and cultural background is incorporated into these treatment plans.” This same provider indicated that they “adapt services to families based on their individual needs including their cultural background and the community they are living in.” The provider for Community Solutions, which offers MST services, reported that they train their staff in cultural competency and have a “bilingual clinician on each of the teams providing services, yet the MST services are not adapted in any way.” The Engagement Specialist from the Urban League reported that they partner with the Hispanic Health Counsel in order to match families with culturally appropriate services. Overall, these providers consistently report their staff are culturally competent yet offer little evidence of this outside of their declaration that they employ bilingual staff.

Providers varied with regard to their utilization of outside resources in the delivery of services. Most did report collaboration with outside partner agencies, yet all reported such collaboration to varying degrees. The provider from NAFI indicated that clinicians work with schools and other providers already involved with families being served and refer to University of Connecticut Health Center (UCHC) for necessary medication management services. The provider from the Village for Families and Children reported that this agency works in collaboration with CCMC to provide services. The provider from AIDS Project Hartford/Connections Wellness Center did report that they “work with treatment centers to connect people with necessary substance abuse treatment services.” The provider from Hartford Behavioral Health indicated that they refer to Hartford Hospital and Planned Parenthood to address any identified need for HIV, AIDS, or STD related services. The provider from Community Solutions reported that “it is a part of MST to include community resources” and as such indicated that their

providers “meet with teachers and other involved providers including schools.” This agency further reported that they reach out to the DCF for support in meeting clients’ needs. The provider from CCMC indicated that they have a substance abuse specialist employed in their program, yet typically refer out for substance abuse treatment services. The provider from Wheeler Clinic indicated that they do not make any referrals to outside agencies, yet indicate that staff “act as advocates for education.” It is noteworthy that Wheeler Clinic was the only provider interviewed who reported no referrals to or collaboration with outside resources to meet client needs. This agency does work in close collaboration with their referral source, DCF, to ensure clients’ needs are being met appropriately. The Hispanic Health Counsel works in close collaboration with the Hartford public school system and offers HIV testing in these settings for youth. This agency also offers a program called High Hill for youth who have tested positive for HIV/AIDS. Both the Urban League and the Hispanic Health Counsel additionally offer a program called the Seven Challenges which is designed to address the needs of adolescents with co-occurring mental health problems in an effort to promote prosocial behavior and adaptive coping skills (Stevens, Schwebel, & Ruiz, 2007). Planned Parenthood, which offers testing and counseling for youth, services the entire state of Connecticut. This agency refers out for substance abuse services when such needs are identified by the youth served.

Most treatment providers interviewed provide services identified to address children and youth who have histories of substance abuse or are at risk of substance abuse. MST and MDFT are the predominant treatment models designed to address this at risk population and both models in Connecticut are in-home treatment

programs. Specifically, NAFI, Wheeler Clinic, Community Solutions, Hispanic Health Council, and the Urban League all provide MST services while Hartford Behavioral Health, the Hispanic Health Council, the Urban League and the Village for Families and Wheeler Clinic offer MDFT services. Wheeler Clinic offers both MST and MDFT services. CCMC offers the Pediatric and Youth HIV program and AIDS Project Hartford/Connections Wellness Center offers the Street Smart Curriculum. The Urban League and Hispanic Health Counsel additionally offer the Seven Challenges Curriculum provided through their continuing HYP outreach and aftercare program. All providers who offer MST services address substance abuse directly through treatment interventions. The providers who utilize this model do not all directly address HIV/AIDS/and STDS or the risks associated with substance abuse and sexual behavior. The provider from Wheeler Clinic indicated that “staff provide education about substance abuse and sexual risk and have ongoing discussions about sexual health and safety.” The Wheeler respondent said that “HIV/AIDS services are provided when parents are affected,” yet no such services are offered for children nor do they “refer children for HIV/AIDS services.” NAFI staff “work with families on education and prevention of STDS and HIV,” yet the provider reported that they do not refer to any outside agencies or utilize any resources to address the issue of sexual risk behavior directly. The Community Solutions provider reported that “therapists work with families around issues of substance abuse and sexualized behavior.” The agency did not formally assess for the need for HIV/STD services, yet did “refer to hospitals and medical providers when there is an identified need for such services.” The Hartford Behavioral provider reported that staff “incorporate education about the

risks of substance abuse and sexual risk into many interventions.” This interviewed provider conceded that they “do not assess the need for HIV/AIDS services,” yet do refer to Hartford Hospital and Planned Parenthood when such a need is identified at the time of intake. The Village for Families worked in collaboration with CCMC and as such provided ongoing education and services which revolve around prevention and education regarding the risks associated with substance abuse.

The Urban League connects youth and their families to both MST and MDFT services which are designed to address substance abuse issues presented by adolescents. The agency facilitates the Seven Challenges curriculum, a psycho-educational group geared at HIV and AIDS prevention one time per month. The Hispanic Health Counsel offered prevention services through the High Hill program, a group for HIV positive youth. This agency facilitates testing for HIV, AIDS, and STDs in local schools in Hartford as well. The Pediatric and Youth HIV Program at CCMC similarly provide case management services and support groups which provide “education about the risk associated with substance abuse and high risk sexual behavior.” The provider from AIDS Project Hartford/Connections Wellness Center indicated that their services are “prevention focused.” This provider also indicated that that they work with treatment centers to “connect people with substance abuse treatment.” The providers who offer in-home services all report that they provide education and make efforts at endorsing prevention. The providers from Hartford Behavioral Health, the Hispanic Health Council, and the Urban League are the only providers who report a consistent incorporation of interventions aimed at promoting such

prevention and education. The Hispanic Health Council appears to be connected to the community they serve and tailors their services to the clearly identified needs of the youth residing in Hartford.

Among the community-based agencies surveyed regarding availability of HIV testing and counseling services, all but one provider reported that they provide both HIV testing and counseling services. The AIDS Project Hartford/Connections Wellness Center indicated that they utilize the Street Smart Curriculum which is prevention based, yet does not include testing or assessment. CCMC, the Health and Human Services Department, Family Medicine Center, and the Hartford Gay and Lesbian Health Collective reported that they do not provide substance abuse services and as such refer clients out for such services when such need is indicated by clients.

DISCUSSION

There are approximately 29,000 adolescents in Connecticut between the ages of 12-17 who meet the criteria for alcohol or illicit drug dependence or abuse (Connecticut Alcohol and Drug Policy Council, 2008). Among these adolescents, approximately 2,000 of these youth statewide receive substance abuse treatment services offered through the Department of Children and Families (DCF) or the Court Support Services Division (CSSD) (Connecticut Alcohol and Drug Policy Council, 2008). The HYP Project served as an inclusive cross section of substance abusing youth who were referred into and received substance abuse treatment services in Hartford. The majority of both HYP boys and girls (75% of boys and 56% of girls) reported sexual activity in the last three months. Among both boys and girls, more than a third of both reported that they had sex without a barrier. The large number of substance abusing youth having unprotected sexual activity places them at significant risk of HIV/STDs and pregnancy. Nearly a third of both boys and girls also reported having sex while either they or their partner were high on alcohol or drugs. Such findings highlight the importance of services to address this population's need for appropriate HIV, STD and pregnancy prevention services. While Connecticut home-based, family focused services have been found to be successful in reducing the prevalence of their use of illegal substances and alcohol, the HYP findings suggest that these services should be expanded to include other related risk behavior. Given the high rates of sexual activity and unprotected sex, programs should be prepared to address prevention in the area of sexual risk behavior in order to prevent the negative health consequences associated with unprotected sex. Research consistently shows that there is a relationship between substance abuse and high risk sexual behavior. Leigh and Stall

(1993) have discovered that adolescents are more likely to engage in unprotected sex while they are under the influence of drugs or alcohol. In 2003, of sexually active high school students nationwide, 37% reported that neither they nor their partner had used a condom during last sexual intercourse, and just over one quarter (25.4%) had used alcohol or drugs during their last sexual encounter (Center for Disease Control & Prevention, 2004). Mott and Haurin (1988) indicate that substance use increases the probability that an adolescent will initiate sexual activity, and relatedly, sexually experienced adolescents are more likely to initiate substance use. The tendency of this population to engage in high risk sexual behavior places them at increased risk for transmission of STDs including HIV. In-home treatment models like MST and MDFT, however, often do not explicitly focus on the issue of AIDS, HIV, STD and pregnancy prevention. Given the frequency of this population's involvement in such activity, it would seem critical that such models incorporate a formal component of this treatment which addresses this issue.

The HYP data indicate that slightly over one third of boys reported having sex with two or more sex partners, while significantly less (12.5%) of girls reported having two or more sex partners. These data reveal boys in substance abuse treatment in Hartford are at greater risk in this area of contracting AIDS, HIV, and STDs. In the United States, AIDS was the leading cause of death for adults between the ages of 25 and 44 in 2002 (Center for Disease Control & Prevention, 2002). Given the incubation period associated with HIV, it is likely that these adults were infected with the disease during adolescence (Center for Disease Control & Prevention, 2001). Prevention efforts implemented with this population should address this issue and further explore the

reasons which contribute to such behavior. Early intervention is key to reducing this population's tendency to engage in high risk behaviors. Prevention programs geared towards both substance abuse and AIDS/HIV/STDs and early pregnancy which begin prior to adolescence will have far greater success in preventing drug use and corresponding contraction of STDs, as well as pregnancy. Community resources, including schools, and community organizations must be utilized to have maximum effectiveness.

One of the themes which emerged as a part of this qualitative assessment with service providers were the issues of funding and referral source for treatment services offered to this population. All of the providers interviewed in this study receive some form of public funding which inevitably guides the course and availability of treatment services. The Department of Children and Families was a significant contributor to funding the services offered by most of these agencies permitting them the freedom to utilize a systems oriented, family-based treatment approach to adolescents in need of services. Such funding allows for the implementation of more unconventional interventions and adaptations to the treatment model being utilized so that the unique needs of the clients served will be met. The Connecticut DCF in the past decade has been supporting the adoption of evidenced-based treatment models including Multisystemic Therapy (MST) or Multi-didactic Family Therapy (MDFT). Both are in-home models of treatment designed to address the treatment needs of children and adolescents presenting with mental health or behavioral issues which often bring them into contact with the juvenile justice and/or child welfare system. These children and adolescents often present themselves while they are near incarceration or displacement from their family of

origin. These approaches, when effective, play a paramount role in positively influencing the long term status and functioning of this population. The use of such an evidenced-based model should be a prerequisite for public funding. This form of funding is both a benefit and a liability in terms of meeting the identified population's needs. The benefit comes from the fact that such in-home family-based services are often facilitated by licensed individuals who receive extensive training in engagement and case management which are often critical in actually affecting any meaningful change in the problematic behaviors presented by urban youth. Traditional treatment modalities which occur independent of the family system are often unsuccessful in affecting any meaningful change for urban youth of minority backgrounds (Liddle et al., 2006). Research consistently indicates that persons from underserved racial and ethnic groups often need supportive services to enhance the effectiveness of treatment interventions (Vera, Buhin, Montgomery, & Shin, 2005). Given the fact that the majority of children and youth identified for services are from minority backgrounds, it would seem that it is both necessary and essential that providers delivering such services be culturally competent. The in-home models utilized by the agencies in this study to try to account for this. The reports offered by all of these agencies indicate that efforts are being made to address the population of youth residing in Hartford with culturally appropriate services. The implementation of the in-home services and the additional efforts to address the issue of AIDS/HIV/STDs indicate that Hartford is a city which is trying to direct its' resources where they are needed. The youth residing in this community have significant service needs which require examination of how resources are allocated and ongoing evaluation of their effectiveness in order to ensure that they have long term public health benefits.

Failure to facilitate positive outcomes through use of appropriate treatment modalities such as these has profound implications on society as a whole. Since these youth frequently engage in risky behavior, the consequence of not addressing their treatment needs may result in an escalation of their risk of STDs/HIV/AIDS, unwanted pregnancies, and other health and social consequences.

All of the service providers interviewed in this study reported that the population served by their agency consisted of more male than female clients and families. This disparity suggests the need for gender specific interventions when addressing this population. On the positive side, all agencies reported staff who facilitate treatment and case management services and who have all been trained in gender- specific treatment. This modern catch phrase of gender specifics is almost a politically correct acronym for knowledge of the fact that boys and girls process information, have different needs, and respond to treatment differently. More research is needed in this area specifically geared towards addressing the needs of minority male and female youth who are more often than not exposed to the criminal justice system as a result of their risk behaviors. Addressing the issue of gender in isolation from the cultural and ethnic background of the youth creates an additional barrier to effective service delivery. Acknowledgement of both of these facts as well as the youth as a whole in the context of their community and family of origin are necessary and essential components of effective service delivery. Most agencies interviewed reported a disproportionately higher number of African American and Hispanic clients than White clients served. Given the fact that the majority of children and youth identified for services are from minority backgrounds, it would seem both necessary and essential that providers delivering such services be culturally

competent. All of the agencies interviewed reported that staff delivering services were culturally competent and as such reported an ability to provide culturally sensitive services. Given the identified needs in the Hartford community, culturally competent service providers are a necessary ingredient of any effective intervention used with this population. The designation of resources for different areas of the city by the Urban League and the Hispanic Health Council is an example of one partnership which takes such cultural factors into account when delivering services. These two agencies provide an example of the increased effectiveness of agencies when they work in collaboration with one another. Such efforts should serve as an example to other providers around the positive impact and subsequent increase of effectiveness such collaboration has to offer. Bilingual capabilities by staff do not in and of themselves address the need for cultural competence nor do they serve as evidence of such competency. All agencies who offer services to adolescents at risk of substance abuse and high risk sexual behavior require sensitivity to cultural considerations in the event they have hope of minimizing the risk presented by this population. It would seem that addressing clients' needs from a cultural context would be a necessary adaptation which would not compromise the integrity of this or any treatment model. The identified needs in the Hartford community which include culturally competent service providers are a necessary ingredient of any effective intervention. The providers interviewed in this study report cultural competency, yet offer little evidence of this outside of their declaration that they employ bilingual staff. One of the limitations of this study consisted of the fact that providers interviewed occupied different positions within their respective agencies. Many of these providers were case managers and several were administrators for their agency. Such distinction

may create a potential source of bias based upon their differential role within their agency. It is noteworthy that the case managers all appeared to be intimately aware of the services provided by their agency and expressed an investment in the potential effectiveness of the services offered. The administrators interviewed were also knowledgeable about services and the demographic profile of clients served, yet lacked the same enthusiasm about the impact services have on the communities they serve. Providers in this study varied with regard to their utilization of outside resources in the delivery of services. Most did report collaboration with outside parties, yet they reported such collaboration to varying degrees. In order to meet the complex needs of mostly socioeconomically impoverished urban youth in Hartford, it is critical that collaboration take place between all stakeholders which impact the life and functioning of the youth and families served. Such collaboration must include schools, courts, DCF, churches, juvenile justice, neighborhood resources, and family members. Treating these youth in isolation from these groups is ineffective and futile.

The in-home services reviewed focus on addressing reduction of substance abuse and/or risk of substance abuse among youth. Substance abuse providers make varying degrees of effort to incorporate interventions which promote prevention of HIV, AIDS, and STDs into their service delivery. This is unfortunate considering that research consistently supports the existence of the relationship between sexual risk and substance use. It is clear that there may be far reaching and lifelong health implications if we fail to identify appropriate services for this high risk population. The providers interviewed for this study show that efforts to address the needs of these at-risk youth in Hartford are being made. However, since substance abuse and HIV, AIDS, and STDS are not

mutually exclusive, interventions designed for this population should address both issues simultaneously and in a seamless and integrated manner.

RECOMMENDATIONS

The data collected as a result of this study provides compelling support for enhancement and expansion of available treatment services for at risk youth residing in Hartford, Connecticut. Recognition of this substance abusing population's specialized needs around risky sexual behavior is a useful tool in developing treatment services which are effective in reducing the frequency at which they engage in high-risk behaviors. The systems that oversee such services must examine the facets of the services which are helpful and maximize these services while incorporating additional creative measures which simultaneously enhance the effectiveness of such services. For example, some of the providers interviewed in this study indicated that they utilize referrals for mentoring services. Incorporation of this kind of supplemental service is a valuable tool in promoting continued pro-social behavior. There are many creative methods of increasing the attractiveness of adaptive and productive activities for youth. Those who oversee these services must recognize the value of such enhancements and afford appropriate subsidy which allows youth opportunities for participation in such activities. Early intervention is also key to reducing this population's tendency to engage in high-risk behaviors. Prevention programs geared towards both substance abuse and AIDS/HIV/STDs and unintended pregnancy which begin early in adolescence will have far greater success in preventing engagement in high risk behavior. Community resources which include not only schools, but also community organizations which are important parts of youth networks must be utilized to have maximum effectiveness. Cultural considerations must be taken into account when assessing these community resources as the minorities most in need of services are best served by organizations they

have trust for and feel connected with. Funding sources have incredible potential to create the continuum of services which may be effective in meeting this population's needs. With improved communication and collaboration, these funding sources have the ability to facilitate long lasting changes in behavior that promote intergenerational health and success. Such success would have a profound impact on the functioning of on an oppressed portion of the population which is often too overburdened to actualize their potential. Development of a model of intervention which addresses all of this population's needs where there is appropriate coordination of available services and appropriate measures of ongoing assessment and evaluation would serve to accomplish this end.

CONCLUSION

The youth in Hartford, Connecticut who enter substance abuse treatment also have significant needs for AIDS/HIV/STDs and pregnancy prevention services. Treatment providers in Hartford recognize the need for such services, yet a comprehensive effort to establish and implement a continuum of services to meet this population's complex needs has not yet been made. Some agencies have made better efforts than others in integrating these services in a meaningful way. The substance abusing youth in Hartford have significant histories of co-occurring mental health problems, trauma, and poverty, and are at high risk of incarceration and/ or involvement in the child welfare system. Such systems have an obligation to these youth and have, to their credit, made some efforts to implement evidenced-based forms of in home family focused treatment which are designed to address their needs. These systems have, however, also created barriers to these youth through their failure to give direct access of these services to all youth in need. "Community outreach and engagement has been identified as an effective strategy to increase the identification and utilization of mental health and substance abuse services by high risk populations with treatment needs" (Simmons et al., 2008). The substance abuse providers interviewed in this study have indicated that most do not incorporate AIDS/HIV/STD and early pregnancy prevention services as a part of their program delivery. Some of these providers do utilize supplemental services and referrals in an effort to address this need. These providers should be applauded for their efforts. Coordination of these services in a standardized way where all youth are provided comprehensive services to meet all of their needs is necessary to avoid long term

consequences which are detrimental to their healthy functioning and a hindrance to their potential for success.

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- Table 6. Sex Without Any Kind of Barrier among Substance Abusing Boys and Girls in Treatment, HYP
- Table 7. Substance Abusing HYP Boys and Girls who have Sex with Members of the Same Sex
- Table 8. Participation in Sex Involving Anal Intercourse among Substance Abusing Boys and Girls in Treatment, HYP
- Table 9. Pain During or After Sex among Substance Abusing Boys and Girls in Treatment, HYP
- Table 10. Use of AOD to Make Sex Last Longer or Hurt Less among Substance Abusing Boys and Girls, HYP
- Table 11. Times Substance Abusing HYP Boys and Girls had Sex during the Previous 90 Days
- Table 12. Times Substance Abusing HYP Boys and Girls had Sex with Any Kind of Barrier During the Previous 90 Days
- Table 13. Adolescent substance abuse treatment programs in Hartford, Connecticut in Hartford, Connecticut 2008-2009
- Table 14. HIV services offered by community based agencies in Hartford 2008-2009

TABLE 1

Hartford Youth Project Client Characteristics by Racial/Ethnic Background

Client Characteristics	African American (N=117)	Hispanic (N=190)	Total (N=63)
Demographic			
Mean Age (SD)	14.5 years (1.2)	14.7 years (1.2)	14.7 years (1.2)
Male Gender	69.8%	76.7%	74.6%
Single parent	60.3%	72.6%	68.9%
Substance Use			
Past Year Substance Severity			
No Use	4.2%	0.0%	1.4%
Use	64.6%	63.6%	62.2%
Abuse	22.9%	17.0%	19.6%
Dependence	8.3%	19.3%	16.8%
Current Weekly Marijuana Use	80.6%	81.0%	81.4%
Current Weekly Alcohol Use	49.2%	57.3%	55.8%
Comorbidity			
Past Year Mental Health Problems			
Internalizing Problems Only	6.3%	7.7%	7.4%
Externalizing Problems Only	42.9%	35.0%	37.4%
Both Internal and Externalizing	20.6%	24.8%	23.2%
Neither	30.2%	32.5%	32.1%
Ever Victimized	55.6%	43.2%	47.4%
Weekly School Absences in the Past 90 Days	49.2%	53.8%	51.6%
Violent in the Past Year	77.8%	74.4%	76.3%
Illegal Activity in the Past Year	61.9%	54.7%	56.8%
Lifetime Juvenile Justice Involvement	95.2%	86.3%	89.5%
Spent 13+ days in Controlled Environment in Past 90 days	25.8%	34.5%	30.9%

*Includes 10 cases who were not classified as either African American or Hispanic

(Simmons et al., 2008)

TABLE 2
REGENCY OF SEX FOR SUBSTANCE ABUSING BOYS & GIRLS, HYP

LAST TIME HAD SEX	BOYS	GIRLS
NEVER	9.3%	15.6%
13+ Months Ago	4.7%	6.3%
4-12 Months Ago	10.3%	15.6%
1-3 Months Ago	23.4%	31.3%
1-4 Weeks Ago	15.9%	6.3%
3-7 Days Ago	19.6%	15.6%
Past 2 Days	16.8%	9.4%

TABLE 3
FREQUENCY OF SEX FOR SUBSTANCE ABUSING BOYS & GIRLS, HYP

TIMES HAD ANY SEX IN THE LAST 90 DAYS	BOYS	GIRLS
MEAN (SD)	4.4	7.1

TABLE 4
SEX WHILE YOU OR YOUR PARTNER WAS HIGH ON ALCOHOL OR DRUGS
AMONG SUBSTANCE ABUSING BOYS & GIRLS, HYP

HAVE HAD SEX WITH YOU OR YOUR PARTNER HIGH ON AOD	BOYS	GIRLS
YES	28.2%	29.9%
NO	71.8%	71.0%

TABLE 5
2 OR MORE SEX PARTNERS AMONG SUBSTANCE ABUSING BOYS & GIRLS,
HYP

2 OR MORE SEX PARTNERS IN THE PAST YEAR	BOYS	GIRLS
YES	32.7%	12.5%
NO	67.3%	87.5%

TABLE 6
SEX WITHOUT ANY KIND OF BARRIER AMONG SUBSTANCE ABUSING BOYS & GIRLS, HYP

TIMES HAD SEX WITHOUT ANY KIND OF BARRIER	BOYS	GIRLS
YES	34.6%	34.4%
NO	65.4%	65.6%

TABLE 7
SUBSTANCE ABUSING BOYS AND GIRLS WHO HAVE SEX
WITH MEMBERS OF THE SAME SEX, HYP

HAVE SEX WITH THE SAME GENDER	BOYS	GIRLS
YES	0.9%	6.3%
NO	99.1%	93.8%

TABLE 8
PARTICIPATION IN SEX INVOLVING ANAL INTERCOURSE AMONG
SUBSTANCE ABUSING BOYS & GIRLS, HYP

HAVE SEX INVOLVING ANAL INTERCOURSE	BOYS	GIRLS
YES	14.0%	9.4%
NO	86.0%	90.6%

TABLE 9
PAIN DURING OR AFTER SEX AMONG SUBSTANCE ABUSING BOYS
& GIRLS, HYP

PAIN DURING OR AFTER SEX	BOYS	GIRLS
YES	100.0%	9.4%
NO	0.0%	90.6%

TABLE 10
USE OF AOD TO MAKE SEX LONGER OR HURT LESS AMONG SUBSTANCE
ABUSING BOYS & GIRLS, HYP

USE OF AOD TO MAKE SEX LONGER OR HURT LESS	BOYS	GIRLS
YES	5.6%	0.0%
NO	94.4 %	100.0%

TABLE 11
TIMES SUBSTANCE ABUSING BOYS & GIRLS HAD SEX
DURING THE PREVIOUS 90 DAYS, HYP

TIMES HAD ANY SEX	BOYS	GIRLS
MEAN (SD)	4.4	7.1

TABLE 12
 TIMES SUBSTANCE ABUSING BOYS & GIRLS HAD SEX WITH ANY KIND OF
 BARRIER DURING THE PREVIOUS 90 DAYS, HYP

TIMES HAD ANY SEX WITH ANY KIND OF BARRIER	BOYS	GIRLS
MEAN (SD)	4.5	8.3

**PROPOSED QUESTIONS REGARDING AVAILABLE SERVICES TO AT RISK
YOUTH IN HARTFORD, CONNECTICUT**

Steve Hodge, Engagement Specialist for Urban League

What services if any does your agency/organization offer to youth affected by or at risk of HIV/AIDS/STDs? Does your agency provide substance abuse treatment services? Are medical services and/or testing available? Who are your referral sources? How are these services funded?

SH: We offer a HIV/STD psycho-educational group one time per month. Other than this, we refer out for HIV services if needed. We offer MDFT and MST services which are designed to treat adolescents with substance abuse problems. CSSD and DCF fund these services. Both provide us with referrals.

Are these services evidenced based? If so what is this curriculum and how did you come to select it?

SH: The MST and MDFT programs are both evidenced based.

Is the effectiveness of these services or this curriculum measured in any way?

SH: I'm not sure.

Are services delivered by staff employed by your organization or do you also utilize outside resources to deliver these services? Who are these outside resources?

SH: I work with one other Engagement Specialist. We used to have a Social Worker as well but lost funding for this position recently. We, the other Engagement Specialist and myself both provide services in the North end of Hartford. Our partner is the Hispanic Health Counsel. They typically service the South end of Hartford because that area has more Spanish speaking clients.

What ages does your agency/organization serve? Do youth served reside in Hartford?

SH: 10-17 ½ years old. Most youth live in the North end of Hartford.

How many children does your agency serve? What percentage of clients are boys versus girls? What is the ethnic background of these children receiving services?

SH: It seems like there are more boys. Mostly African American.

Do you feel services meet all the presented needs around prevention and management of those who have tested positive?

SH: I think the families in Hartford are unique and don't represent the rest of the country. These families all need education, housing and mental health services and the limitations in funding make it difficult to get their needs met. I think they need to assess the needs in this area before they decide to make budget cuts. They're making cuts to programs where there is the highest need.

Are any services offered which include education about the risks associated with substance use and high risk sexual behavior?

SH: All services are educational and prevention based including a program we use known as the Seven Challenges.

Are available services culturally competent? Are services adapted for kids in Hartford? Do you have Spanish speaking staff? Do you believe there is a need for such consideration when working with this population?

SH: We try which is why we partner with the Hispanic Health Counsel.

Do staff use different approaches with boys and girls? Has it been adapted for adolescents versus adults?

SH: I think it would help to have more male Engagement Specialists. I work mostly with boys.

How does your agency assess the need for HIV/AIDS/STD services? Where would you refer kids who present with a need for such services?

SH: Our focus is really substance abuse services, but we would refer out for these services. We act as a support to our clients in school, court and the community as a whole. Such support would also be provided with kids who have these needs.

**PROPOSED QUESTIONS REGARDING AVAILABLE SERVICES TO AT RISK
YOUTH IN HARTFORD, CONNECTICUT**

**Sandra Odorno, Senior Engagement Specialist for Hartford Youth Project
Hispanic Health Counsel**

What services if any does your agency/organization offer to youth affected by or at risk of HIV/AIDS/STDs? Does your agency provide substance abuse treatment services? Are medical services and/or testing available? Who are your referral sources? How are these services funded?

SO: We offer HIV prevention services through a program called High Hill. This program offers a group for HIV positive youth. We also go to local schools and conduct testing for HIV and STDs. This agency offers a program called the Seven Challenges. This is a psycho-educational group geared towards intervention and prevention.

Are these services evidenced based? If so what is this curriculum and how did you come to select it?

SO: The MST and MDFT programs are both evidenced based.

Is the effectiveness of these services or this curriculum measured in any way?

SO: Effectiveness is tracked through the MST website.

Are services delivered by staff employed by your organization or do you also utilize outside resources to deliver these services? Who are these outside resources?

SO: We screen clients and my boss, Robin Anderson refers the clients to agencies with openings for available services.

What ages does your agency/organization serve? Do youth served reside in Hartford?

SO: Many of the families live in Hartford, but some also reside in West Hartford and Bloomfield.

How many children does your agency serve? What percentage of clients are boys versus girls? What is the ethnic background of these children receiving services?

SO: Most families are Hispanic and African American. Hardly any families are White. There are more boys than girls.

Do you feel services meet all the presented needs around prevention and management of those who have tested positive?

SO: Our services are effective in meeting clients' needs.

Are any services offered which include education about the risks associated with substance use and high risk sexual behavior?

SO: All of the services are educational and focus on helping families understand the risks associated with substance abuse and high risk behavior.

Are available services culturally competent? Are services adapted for kids in Hartford? Do you have Spanish speaking staff? Do you believe there is a need for such consideration when working with this population?

SO: Yes services are culturally appropriate.

Do staff use different approaches with boys and girls? Has it been adapted for adolescents versus adults?

SO: Yes staff are trained in gender specific approaches.

How does your agency assess the need for HIV/AIDS/STD services? Where would you refer kids who present with a need for such services?

SO: Each family participates in an Intake. We go to schools and do testing and offer the High Hill program.

**PROPOSED QUESTIONS REGARDING AVAILABLE SERVICES TO AT RISK
YOUTH IN HARTFORD, CONNECTICUT**

Donna Ferguson, Director of Community Based Services for NAFI

What services if any does your agency/organization offer to youth affected by or at risk of HIV/AIDS/STDs? Does your agency provide substance abuse treatment services? Are medical services and/or testing available? Who are your referral sources? How are these services funded?

DF: NAFI provides MST services for families with children. These services are designed to address identified substance abuse issues. Approximately 80% of children served have been identified as having a history of substance abuse. Random drug testing is done with all children identified with a history of substance abuse. HIV services are only provided if the individual case identifies the need for it. Services in these cases would consist of education with parents and children. Families are referred by DCF and CSSD. Services are all funded by the Department of Children and Families and the Court Support Services Division (Emily J).

Are these services evidenced based? If so what is this curriculum and how did you come to select it?

DF: Services are based on an evidenced based model of treatment. Staff are all trained in the treatment model.

Is the effectiveness of these services or this curriculum measured in any way?

DF: Effectiveness is tracked through the MST website.

Are services delivered by staff employed by your organization or do you also utilize outside resources to deliver these services? Who are these outside resources?

DF: All services are provided by NAFI staff who have been trained in the MST model with exception of medication management which is done through UCONN Health Center. No other outside resources are used. NAFI staff do work with schools and providers also involved with the families they are working with.

What ages does your agency/organization serve? Do youth served reside in Hartford?

DF: Many of the families served reside in Hartford.

How many children does your agency serve? What percentage of clients are boys versus girls? What is the ethnic background of these children receiving services?

DF: Most families are Hispanic and African American. Approximately 65% are boys and 35% are girls.

Do you feel services meet all the presented needs around prevention and management of those who have tested positive?

DF: Services are effective in addressing needs of identified clients and are family focused.

Are any services offered which include education about the risks associated with substance use and high risk sexual behavior?

DF: Each family is assessed on an individual basis. If the children are identified as having an issue, staff work with parents on dealing with it.

Are available services culturally competent? Are services adapted for kids in Hartford? Do you have Spanish speaking staff? Do you believe there is a need for such consideration when working with this population?

DF: Yes services are culturally appropriate and adapted for children and families in Hartford. NAFI staff encourage involvement in prosocial recreational activities and make use of Vocational resources such as Our Piece of the Pie and the Craft Project. There is definitely a need for consideration of gender, ethnicity and location where clients reside. NAFI does employ Spanish speaking staff for this reason.

Do staff use different approaches with boys and girls? Has it been adapted for adolescents versus adults?

DF: Yes staff are all trained in gender specific approaches. Interventions are different based on these approaches.

How does your agency assess the need for HIV/Aids/STD services? Where would you refer kids who present with a need for such services?

DF: At Intake every family is assessed to determine the need for services. If HIV or STDs are identified as a need, staff work with parents in how to best address this need. We don't refer for services, but would communicate any needs to DCF or CSSD.

**PROPOSED QUESTIONS REGARDING AVAILABLE SERVICES TO AT RISK
YOUTH IN HARTFORD, CONNECTICUT
Denise Stone, Clinician for Village for Families**

What services if any does your agency/organization offer to youth affected by or at risk of HIV/AIDS/STDs? Does your agency provide substance abuse treatment services? Are medical services and/or testing available? Who are your referral sources? How are these services funded?

DS: We provide MDFT and IICAPS services. We work with CCMC to provide any needed medical services.

Are these services evidenced based? If so what is this curriculum and how did you come to select it?

DS: Services are all evidenced based.

Is the effectiveness of these services or this curriculum measured in any way?

DS: Effectiveness of services is measured through tracking on our Web site.

Are services delivered by staff employed by your organization or do you also utilize outside resources to deliver these services? Who are these outside resources?

DS: MDFT and IICAPS services are provided by staff here. CCMC makes referrals to us

What ages does your agency/organization serve? Do youth served reside in Hartford?

DS: We provide services to children aged 4-18 years old. Mostly all clients are from Hartford.

How many children does your agency serve? What percentage of clients are boys versus girls? What is the ethnic background of these children receiving services?

DS: The clients come from diverse backgrounds. Approximately 50% are boys and 50% are girls.

Do you feel services meet all the presented needs around prevention and management of those who have tested positive?

DS: We work in collaboration with CCMC.

Are any services offered which include education about the risks associated with substance use and high risk sexual behavior?

DS: We work with families on a case by case basis. We provide education

Are available services culturally competent? Are services adapted for kids in Hartford? Do you have Spanish speaking staff? Do you believe there is a need for such consideration when working with this population?

DS: Staff are trained in working with children and families from different backgrounds. We employ several Spanish speaking staff.

Do staff use different approaches with boys and girls? Has it been adapted for adolescents versus adults?

DS: Yes staff are all trained in gender specifics and apply these approaches to treatment with identified clients. Services are designed for children and adolescents.

How does your agency assess the need for HIV/Aids/STD services? Where would you refer kids who present with a need for such services?

DS: CCMC assesses the need for these services before referring to us.

**PROPOSED QUESTIONS REGARDING AVAILABLE SERVICES TO AT RISK
YOUTH IN HARTFORD, CONNECTICUT**

Leigh Evans, AIDS Project Hartford

What services if any does your agency/organization offer to youth affected by or at risk of HIV/AIDS/STDs? Does your agency provide substance abuse treatment services? Are medical services and/or testing available? Who are your referral sources? How are these services funded?

LE: We use the Street Smart curriculum for children aged 14-25 years old. We run the clean needle program for Connecticut and we work with treatment centers to connect people with substance abuse treatment services.

Are these services evidenced based? If so what is this curriculum and how did you come to select it?

LE: The Street Smart program is evidenced based. It is funded through the CDC.

Is the effectiveness of these services or this curriculum measured in any way?

LE: No we're working on an evaluation program. Right now we only evaluate the percentage who volunteer for testing. CDC has evaluated the Street Smart program to be effective.

Are services delivered by staff employed by your organization or do you also utilize outside resources to deliver these services? Who are these outside resources?

LE: Services are provided by AIDS Project Hartford.

What ages does your agency/organization serve? Do youth served reside in Hartford?

LE: Clients are 13-20 years old and most are from Hartford. A small number have been from New Britain and East Hartford.

How many children does your agency serve? What percentage of clients are boys versus girls? What is the ethnic background of these children receiving services?

LE: We have served between 200-300 youth this past year. 60% of clients are boys and 40% of clients are girls. Most clients are from a minority background.

Do you feel services meet all the presented needs around prevention and management of those who have tested positive?

LE: Yes services are prevention focused.

Are any services offered which include education about the risks associated with substance use and high risk sexual behavior?

LE: Yes education about risks of substance use and sexual behavior is provided through the Street Smart curriculum.

Are available services culturally competent? Are services adapted for kids in Hartford? Do you have Spanish speaking staff? Do you believe there is a need for such consideration when working with this population?

LE: Yes we have a bilingual facilitator. The intervention is designed for homeless and transient youth. The curriculum can not be adapted.

Do staff use different approaches with boys and girls? Has it been adapted for adolescents versus adults?

LE: The intervention is the same for boys and girls.

How does your agency assess the need for HIV/Aids/STD services? Where would you refer kids who present with a need for such services?

LE: We receive referrals from schools and facilities who have identified youth as at risk.

**PROPOSED QUESTIONS REGARDING AVAILABLE SERVICES TO AT RISK
YOUTH IN HARTFORD, CONNECTICUT**

Melissa Brown, Case Manager for Hartford Behavioral Health

What services if any does your agency/organization offer to youth affected by or at risk of HIV/AIDS/STDs? Does your agency provide substance abuse treatment services? Are medical services and/or testing available? Who are your referral sources? How are these services funded?

MB: We provide MDFT and ICFS services. MDFT is provided for children 11.5-17.5 years old. Services are provided for kids at risk of using or who are actively using Marijuana. 75% of children are actively using Marijuana and 25% are at risk of using Marijuana. We refer to Hartford Hospital and Planned Parenthood for medical services. We are funded by the Department of Children and Families.

Are these services evidenced based? If so what is this curriculum and how did you come to select it?

MB: Services are all evidenced based.

Is the effectiveness of these services or this curriculum measured in any way?

MB: We use the Ohio Scales, GAF scores, and GAIN results at Intake and discharge to measure progress. All results of Intakes and discharges are inputted into a data base we use that we call CMHC.

Are services delivered by staff employed by your organization or do you also utilize outside resources to deliver these services? Who are these outside resources?

MB: Our staff provide the MDFT services but we also utilize STAR mentoring services and the Hispanic Health Counsel to assist in meeting family's needs.

What ages does your agency/organization serve? Do youth served reside in Hartford?

MB: MDFT serves children aged 11.5-17.5 years old. Most clients live in Hartford but some also live in Manchester.

How many children does your agency serve? What percentage of clients are boys versus girls? What is the ethnic background of these children receiving services?

MB: We currently provide MDFT services to 18 families. Approximately 50% are boys and 50% are girls. Eleven of the families are Hispanic; four of the families are White; and three families are African American. The four White families live in Manchester and the rest are from Hartford.

Do you feel services meet all the presented needs around prevention and management of those who have tested positive?

MB: We refer kids to Hartford Hospital and Planned Parenthood if they're at risk, but also do work on educating families about HIV and AIDS.

Are any services offered which include education about the risks associated with substance use and high risk sexual behavior?

MB: We provide education about the risks of substance abuse and sexual activity and incorporate this piece into many interventions.

Are available services culturally competent? Are services adapted for kids in Hartford? Do you have Spanish speaking staff? Do you believe there is a need for such consideration when working with this population?

MB: Yes staff are culturally competent. There are 2 Spanish speaking therapists and 1 Spanish speaking Case Manager. We work with the family to develop their treatment plan and incorporate cultural background into all of these treatment plans. We adapt services to families based on their individual needs including their cultural background and what community they are living in.

Do staff use different approaches with boys and girls? Has it been adapted for adolescents versus adults?

MB: Yes we choose different interventions and activities for boys and girls and also try to match the therapist with the child-Male therapist with male child and Female therapist with female child.

How does your agency assess the need for HIV/Aids/STD services? Where would you refer kids who present with a need for such services?

RL: We don't assess for HIV or Aids services, but would refer to Hartford Hospital or Planned Parenthood if this need was identified at Intake.

**PROPOSED QUESTIONS REGARDING AVAILABLE SERVICES TO AT RISK
YOUTH IN HARTFORD, CONNECTICUT**

Nilda Fernandez, Case Manager for The Pediatric & Youth HIV program

What services if any does your agency/organization offer to youth affected by or at risk of HIV/AIDS/STDs? Does your agency provide substance abuse treatment services? Are medical services and/or testing available? Who are your referral sources? How are these services funded?

NF: We provide comprehensive medical and case management services for children 0-18 years old who living with HIV. We have a substance abuse specialist but usually refer out for substance abuse services. Medical services are available. Referrals come from medical providers. Services are provided through Ryan White funding.

Are these services evidenced based? If so what is this curriculum and how did you come to select it?

NF: We are working towards evidenced based treatment. We will be using a curriculum called Together Learning Choices soon which is an evidenced based model of treatment.

Is the effectiveness of these services or this curriculum measured in any way?

NF:

Are services delivered by staff employed by your organization or do you also utilize outside resources to deliver these services? Who are these outside resources?

NF: Staff here provide services but we also have a program called Peers Against Negligence (PAN). Children are trained here and serve as peer educators in the community. We also have two HIV support groups. One is for children 8-12 years old and the other is for 13-18 year olds. These groups are focused on issues like the challenges of taking medications and how to approach the issue of dating.

What ages does your agency/organization serve? Do youth served reside in Hartford?

NF: Clients are 0-18 years old but we also extend case management services until the age of 24. Kids come from all over the state of Connecticut but most are from Hartford.

How many children does your agency serve? What percentage of clients are boys versus girls? What is the ethnic background of these children receiving services?

NF: We provide medical services for 55 children and youth who are living with the virus. Of these, 50 also receive case management services. 27 of the children are girls and the remaining are boys. 51% are African American, 40% are Latino and 3% are Caucasian.

Do you feel services meet all the presented needs around prevention and management of those who have tested positive?

NF: Yes medical and case management services provide support and education around prevention and management of the disease.

Are any services offered which include education about the risks associated with substance use and high risk sexual behavior?

NF: Yes the HIV support group and all case management services provide education about the risk associated with substance use and high risk sexual behavior.

Are available services culturally competent? Are services adapted for kids in Hartford? Do you have Spanish speaking staff? Do you believe there is a need for such consideration when working with this population?

NF: Yes we have a diverse work force that includes bilingual and bicultural staff.

Do staff use different approaches with boys and girls? Has it been adapted for adolescents versus adults?

NF: Approaches are the same for boys and girls. We do use adolescent specialists with children and adult specialists for adults.

How does your agency assess the need for HIV/Aids/STD services? Where would you refer kids who present with a need for such services?

NF: We receive referrals from medical providers who have identified the need for these services.

**PROPOSED QUESTIONS REGARDING AVAILABLE SERVICES TO AT RISK
YOUTH IN HARTFORD, CONNECTICUT**

Richard Lutz, Vice President of Youth Services for Community Solutions

What services if any does your agency/organization offer to youth affected by or at risk of HIV/AIDS/STDs? Does your agency provide substance abuse treatment services? Are medical services and/or testing available? Who are your referral sources? How are these services funded?

RL: MST services are offered for children aged 13-17 years old. The average age of the children is 15. Treatment services are offered for children with histories of substance abuse. Our referral source is DCF who also funds our services.

Are these services evidenced based? If so what is this curriculum and how did you come to select it?

RL: Services are all evidenced based.

Is the effectiveness of these services or this curriculum measured in any way?

RL: All outcomes are tracked through the MST services web site. Completion rate, reduction of substance abuse, rate of rearrest, and whether they are attending school or working are all tracked.

Are services delivered by staff employed by your organization or do you also utilize outside resources to deliver these services? Who are these outside resources?

RL: Services are delivered by our staff but it is part of MST to incorporate community resources. Staff meet with teachers and other involved providers including the Hartford Public School system. Therapists also reach out to DCF for support.

What ages does your agency/organization serve? Do youth served reside in Hartford?

RL: Youth are 13-17 years old. The average age is 15 years old. All youth live in Hartford.

How many children does your agency serve? What percentage of clients are boys versus girls? What is the ethnic background of these children receiving services?

RL: Almost all clients are Hispanic. Approximately 60% are boys and 40% are girls.

Do you feel services meet all the presented needs around prevention and management of those who have tested positive?

RL: We don't do HIV testing but therapists work with families around issues of substance abuse and sexualized behavior.

Are any services offered which include education about the risks associated with substance use and high risk sexual behavior?

RL: Therapists work with children and parents around issues of sexualized behavior and substance abuse and educate families about both issues.

Are available services culturally competent? Are services adapted for kids in Hartford? Do you have Spanish speaking staff? Do you believe there is a need for such consideration when working with this population?

RL: Yes staff receive training in cultural competency. The MST services provided are not adapted in any way. There is a Spanish speaking Clinician on each of the 4 teams who provide services in Hartford. We look at the needs of the family including their community's needs.

Do staff use different approaches with boys and girls? Has it been adapted for adolescents versus adults?

RL: Yes staff are all trained in gender specifics. Each intervention is geared toward the specific child/adolescent's needs.

How does your agency assess the need for HIV/Aids/STD services? Where would you refer kids who present with a need for such services?

RL: We refer to doctors and psychiatrists in the community. We don't directly assess for HIV, but if the family has identified a need for such services, we would refer to the local hospitals or medical providers.

**PROPOSED QUESTIONS REGARDING AVAILABLE SERVICES TO AT RISK
YOUTH IN HARTFORD, CONNECTICUT**

Reese Palmer, Associate Director of Juvenile Justice Services for Wheeler Clinic

What services if any does your agency/organization offer to youth affected by or at risk of HIV/AIDS/STDs? Does your agency provide substance abuse treatment services? Are medical services and/or testing available? Who are your referral sources? How are these services funded?

RP: Wheeler Clinic provides MST services designed too address children with a history of substance abuse. HIV/Aids services are provided when parents are affected. These services are not provided to children served. Medication management is provided on site. Referral sources are DCF and CSSD. All services are funded by DCF and CSSD.

Are these services evidenced based? If so what is this curriculum and how did you come to select it?

RP: Services are all evidenced based.

Is the effectiveness of these services or this curriculum measured in any way?

RP: Effectiveness of services is measured through tracking on our Web site and MST research outcomes.

Are services delivered by staff employed by your organization or do you also utilize outside resources to deliver these services? Who are these outside resources?

RP: Services are all delivered by Wheeler staff trained in providing MST services. We don't refer to outside agencies but act as advocates for education.

What ages does your agency/organization serve? Do youth served reside in Hartford?

RP: We service clients who live in Hartford and New Britain.

How many children does your agency serve? What percentage of clients are boys versus girls? What is the ethnic background of these children receiving services?

DF: Families are diverse, I'm not sure of proportion of each background. Approximately 70% are boys and 30% are girls.

Do you feel services meet all the presented needs around prevention and management of those who have tested positive?

DF: We don't test for HIV/Aids. Services provide education to families.

Are any services offered which include education about the risks associated with substance use and high risk sexual behavior?

RP: Staff do provide education about substance abuse and sexual risk and have ongoing discussions about sexual health and safety. Risky behaviors are addressed in treatment. Staff work with families to encourage abstinence from the use of drugs. The program is family focused.

Are available services culturally competent? Are services adapted for kids in Hartford? Do you have Spanish speaking staff? Do you believe there is a need for such consideration when working with this population?

RP: Staff are all trained in cultural competency and some staff are Spanish speaking. Services are not adapted but each family's culture is taken into consideration when providing treatment.

Do staff use different approaches with boys and girls? Has it been adapted for adolescents versus adults?

RP: Yes staff are all trained in gender specifics and apply these approaches to treatment with identified clients. Services are designed for children and adolescents.

How does your agency assess the need for HIV/Aids/STD services? Where would you refer kids who present with a need for such services?

RP: We provide services to parents affected by HIV and Aids but not children. We don't refer children for these services.

Planned Parenthood: 1229 Albany Avenue, Ste 3, Hartford, CT
Sarah C., Receptionist

Planned Parenthood offers STD/HIV/AIDS testing and counseling services which are available on an ongoing basis for people of all ages. We service people from the whole state of Connecticut here. We also provide birth control and pregnancy testing and counseling around pregnancy prevention and abortion. We do not provide substance abuse treatment services.

Community Health Services
Nitza Agosto, HIV Program Manager

We offer counseling and testing for STDs, HIV, and AIDS. We have adolescent services where they provide routine testing. We provide some substance abuse counseling services.

Family Medicine Center at Asylum Hill: 99 Woodland Street, Hartford, CT
Anna Martel, Receptionist

If you are an existing patient here, we offer medical testing and counseling for STDs, HIV, and AIDS for youths and adults. We also provide substance abuse treatment, but on a limited basis. We service mostly Hartford clients.

Health and Human Services: Hartford, CT

We offer counseling and testing and education about HIV, STDs, and AIDS for youth over 13 years of age. We go to schools in Hartford and do testing and concentrate on high risk HIV drug use and risks associated with having multiple sex partners. We service mostly individuals in Hartford. We do not provide substance abuse treatment services, but refer to local substance abuse centers for people who require these services.

Charter Oak Health Center: Hartford, CT
Pam Scott-Ashe, HIV Case Manager

About two years ago, we lost funding for our prevention services. We do provide testing and counseling services on a walk in basis. The counseling services are not funded, but providers still offer them on their own because there is such a high need for these services in this area. We service people from all over the state of Connecticut. We also provide substance abuse treatment. We have a substance abuse specialist on staff here.

Hartford Gay and Lesbian Health Collective
Dan Millett, Development Specialist

We offer HIV/AIDS testing and counseling for children and adults. We also have a group, True Colors we offer to youth. We work with True Colors which is a mentor

program for youth. We service people from all over the state and get a lot of response from our internet site. We do not offer substance abuse treatment services.

Loaves & Fishes Ministry

Info Line 211 indicated that HIV testing, counseling and substance abuse treatment services are offered by this agency.