HIV and Mental Health

By: Wade T. Lijewski, Ph.D.

Learning objectives

This workshop is designed to help you:

• Explain how the risk groups for HIV/AIDS today are different than they were 20 years ago.
• Illustrate some complementary treatments that may benefit the individual with HIV.
• Explain the role of outreach in client care and the types of barriers that prevent clients from keeping appointments or continuing to receive services.
• Discuss the clinical assessment for clients triply diagnosed with HIV, a mental disorder, and a substance abuse disorder.
• Apply questions that may be helpful in assessing the client’s social supports, coping skills, medical care, and quality of life.
• Evaluate the role of standardized measures in clinical assessment of the HIV client.
• Analyze examples of common medical complications of HIV infection.
• Severe Mental Illness (SMI).
• Sleep Disorders and HIV.
• Pain.

We will take a closer look at each of these aspects in further detail later in the course.

Overview

Mental health problems are very common among all Americans, not just those living with HIV. In fact, in 2012, about:

A. One in five American adults experienced a diagnosable mental illness.
B. Nearly one in 10 young people experienced a period of major depression.
• Four percent of American adults lived with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression.

A number of studies from across the globe suggest that mental health issues are on the rise in people who have HIV and AIDS. In fact, an analysis of these findings suggests that twice as many people with HIV have mental health issues than that of people without the disease.

AIDS (Acquired Immunodeficiency Syndrome) is a disease that compromises the body’s immune system, causing it to break down and rendering it unable to fight off infection. AIDS is caused by HIV (the human immunodeficiency virus). The HIV virus weakens the immune system, leaving the body vulnerable to infections and other illnesses, ranging from pneumonia to cancer.

Since the advent of the AIDS epidemic, people living with HIV who also have mental and/or substance use disorders have been forced to navigate complex, fragmented, and uncoordinated health care systems in order to access the services they need. Over time, health and human service providers have begun to recognize that these problems are interwoven and present a broad range of challenges for the service provider on practical, economic, and treatment levels.

Mental health problems can strike anybody, but people with HIV are more likely to experience a range of mental health issues. Most common are feelings of acute emotional distress, depression, and anxiety, which can often accompany adverse life-events. HIV also can directly infect the brain, causing impairment to memory and thinking. In addition, some anti-HIV drugs can have mental health side effects.

According to the American Psychiatric Association (2014), some of the more common psychiatric aspects of HIV and AIDS include:
• Clinical Depression.
• Anxiety.
• Cognitive Disorders.
• Delirium.
• Substance Use.

Research

This section reviews data collected from a project devised to address some of these concerns. The Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), and National Institutes of Health (NIH) developed and implemented an HIV/AIDS Mental Health Services Demonstration Project (referred to as the demonstration) designed to focus on the mental health needs of people living with or affected by HIV.

The demonstration was designed to:
• Increase access to integrated mental health, primary care, and support services.
• Develop effective mental health care models that can be replicated elsewhere.
• Improve quality of life for those living with or affected by HIV.
• Prevent further transmission by reducing high-risk behaviors.
• Promote cultural competence in service delivery.

This initiative was unique at the time it was conceived because it was intended to accomplish far more than the mere provision of mental health services to people living with or affected by HIV. It also was created to generate new knowledge about the role of mental health services in primary medical treatment for people living with or affected by HIV and to identify characteristics of the clients served, the types of services they used, and other lessons learned in implementing integrated care.

The 11 service delivery projects were located in eight states and Puerto Rico. In addition to implementing programs tailored to the unique needs of their target population, the projects tested a variety of mental health service interventions, including:
• Mental health services co-located with HIV primary care centers.
• Integrated outreach, case management, and mental health programs.
• Psychosocial rehabilitation programs.
• HIV mental health services integrated into residential drug treatment.

More than 5,000 clients received mental health services from the demonstration projects. Although there was demographic and
socioeconomic diversity among clients, three characteristics were common across all service sites:

- Clients served were financially disadvantaged, with poverty and reliance on public sector service systems as the norm. Forty percent of the clients were covered by Medicaid, while another 40 percent had no health insurance coverage at all.
- The racial and gender composition of the clients resembled the changing face of the AIDS epidemic, with racial/ethnic minorities constituting the majority of the clients and substantial proportions of women, heterosexuals, and injecting drug users included. The projects also served a large number of men who have sex with men and a few transgendered individuals.
- Clients presented with high rates of serious mental and substance use disorders. Three out of four clients met criteria for major depression, one in four met criteria for alcohol dependence, and half met criteria for drug dependence. Co-morbidity of mental and substance use disorders was common, complicating treatment of both disorders.

From the beginning, demonstration project participants expressed a desire to share their cumulative wisdom and experience with individuals and organizations that provide HIV, mental health, and substance abuse services. It is hoped that this knowledge also will be useful to others who are responsible for the organization and delivery of HIV and mental health treatment systems and who are positioned to improve the availability and accessibility of HIV, mental health, and substance abuse treatment. With the rapid development of more effective treatments, it is essential that this new knowledge be applied in the clinical setting so that, as people with HIV live longer, service providers are equipped with the know-how and skills they need to assist clients in living happier and healthier lives.

The information in this course was developed from a collaborative effort of the 11 projects that participated in the demonstration project and is based on experience gained in the clinical setting over a four-year period. It is designed to assist service providers and others in developing comprehensive and coordinated systems of care for people living with or affected by HIV. The course also provides information on a number of important clinical and service delivery concerns.

It is recognized that no single agency or service organization can realistically put all of these ideas or principles into clinical practice. The reader is encouraged to consider the ideas and principles contained in this publication, to compare his/her own personal and clinical experience with those of the authors, to consider the needs of the target population, and to incorporate these ideas and approaches based on the resources available.

Ultimately, it is hoped that this information will inspire a new generation of providers and professionals who are committed to ensuring that all individuals living with or affected by HIV have full and immediate access to a broad range of mental health and support services that will improve both their well-being and their quality of life. Your mental health is just as important as your physical health. When you have positive mental health, you generally are able to:

- Function better at work, at school, and in relationships.
- Cope more effectively with life's difficulties, such as the death of a loved one, ending a relationship, job stress, health issues, and family or financial problems.
- Take better care of yourself physically.
- Provide better care for your children or other family members.

Mental health problems can affect the way you think, feel, and behave, and can change how well you function at work and at home. If you are living with HIV, mental health problems can affect your physical health by:

- Making it harder for you to take all your HIV medicines on time.
- Making it harder for you to keep your health appointments or take advantage of your support network.
- Interfering with your healthy behaviors, such as getting enough sleep and exercise and avoiding risk behaviors such as having unprotected sex.
- Impairing your ability to cope with the stresses of daily life.

Principles of care

The following principles reflect the experience of the 11 demonstration projects in delivering primary medical, mental health, substance abuse, and related support services to people living with or affected by HIV. These principles are based on the knowledge gained by the projects during the demonstration project and are designed to provide guidance to administrators, program planners, and service providers as they establish and implement HIV-specific mental health care service programs. While not empirically based, these principles represent the ideals of the 11 projects.

**Principle 1**
Clients need access to comprehensive primary medical, mental health, substance use, and related support services. Some clients will need access to free or affordable transportation to attend appointments. Others will need assistance obtaining affordable housing, food, child care, permanency planning, HIV risk-reduction education services, medications, and supportive residential services.

**Principle 2**
Services should be flexible and client-centered. Clients will present with a broad range of medical, mental health, substance use, and psychosocial needs. While some clients will benefit from psychotherapy, others may need only support groups or case management. Service plans need to be adapted to meet changing client needs.

**Principle 3**
HIV, mental health, and substance use treatment services should be adequately coordinated and integrated. Often, service providers from different systems of care do not communicate with one another, even though they may be responsible for delivering care to the same individuals. Service systems should establish formal linkages and networks to enhance service coordination and integration. Likewise, service providers representing multiple disciplines should take a “team” approach to meeting each client’s needs.

**Principle 4**
Services should be delivered in a way that is consistent with each client’s cultural needs and expectations. This may require that service systems employ multilingual and multicultural staff. Multicultural sensitivity is essential for those staff who are not culturally matched with their clients.

**Principle 5**
Services should promote individual self-respect and personal dignity. Services can only be delivered effectively when an individual’s self-worth and contributions to society are recognized. In addition, people with HIV who also have mental and/or substance use disorders typically have been stigmatized by both society and the traditional health care delivery system. To meet their needs, service systems must take steps to ensure that the system itself does not stigmatize its clients further.

**Principle 6**
Services should promote healthier behaviors. Providers can work together to promote safe sexual behaviors by clients and to strengthen family relationships. Promoting healthier behaviors involves being comfortable with discussing issues such as risk and harm reduction.

**Principle 7**
Service delivery programs should work to reduce barriers to care for “hard-to-reach” populations. Some service systems have failed to reach populations that desperately need access to HIV primary medical treatment and mental health services, including people in jails and
prisons, people who are homeless, substance abusers, and individuals with severe mental illness.

**Principle 8**

Programs should develop and deliver services that are clinically informed and research-based. Many programs have developed and conducted evaluations of their clinical services. The knowledge gained from these undertakings, as well as the latest research on HIV-related mental health services, can be used to enhance service delivery and program policy.

**Principle 9**

Persons living with HIV need to be empowered to make decisions in collaboration with the service provider. In addition, all segments of the community, including consumer and family advocacy groups, should be actively involved in the establishment, delivery, and quality improvement of services.

**Principle 10**

Programs should work to create an “HIV community.” Service systems can play a major role in creating a community of individuals, agencies, and organizations that work in partnership to increase access to the broadest, most comprehensive range of services possible and to foster the development of an HIV community that offers a sophisticated network of support for clients.

As HIV invades the body, it creates rippling and profound biological and social consequences for those persons infected. In addition to attacking the body’s immune system and causing a broad spectrum of health complications, HIV may present a host of mental and emotional problems by disrupting the infected person’s emotional equilibrium, sense of self, relations with others, and purpose in life. HIV also has socioeconomic consequences that affect one’s most basic human needs, such as housing, food, financial security, and employment. Substance abuse confounds these issues, leading to deteriorating physical and mental health, and the poor judgment that may result in risk-taking behaviors of both a sexual and criminal nature. When addictions become severe and refractory, every aspect of life is affected.

The very complexity of these biological, psychological, and social needs springing from HIV infection argues in favor of an integrated and coordinated approach to care. Failure to address the needs in any one sphere can lead to a breakdown in the effectiveness of treatment in the others. As HIV ends its third decade of widespread existence, the changing demographics of HIV infection reinforce the need for service integration and coordination.

**Epidemiological trends**

In the early days of the epidemic, HIV primarily affected gay white males from a broad range of socioeconomic strata. Since 1994, when the HIV/AIDS Mental Health Services Demonstration project was launched, HIV rates have increased rapidly among disenfranchised ethnic minorities and women. Today, those infected are more often from communities of poverty (i.e., intravenous drug users and their partners, persons who are incarcerated, individuals with serious mental illness, people who are homeless, and the foreign-born) and those engaged in the sex trade. According to the Centers for Disease Control and Prevention’s data from 25 states with integrated HIV and AIDS reporting systems, 63 percent of young persons between the ages of 13 and 24 diagnosed between January 1994 and June 1997 were African American (CDC Update, April 23, 1998).

Recent estimates indicate that 25 percent of those living with HIV in the U.S. were infected through unsafe injection drug use, while 15 percent became infected through unsafe heterosexual sex (CDC, 1997). New and effective medical treatments for HIV, including protease inhibitors, have had a profound effect on those living with HIV. The hope that HIV, for some, has become a chronic, treatable condition instead of a fatal one brings with it an energizing optimism—and a host of additional psychosocial complications. At the same time, there are widespread treatment implications for the future. While the death rate from HIV-related complications decreased 47 percent between 1996 and 1999, the rate of HIV infection has remained steady for some populations and is increasing in others. With those who are infected living longer, caseloads will increase, and the demand for services supporting adherence to a complex array of medical treatments will climb.

These epidemiological changes, coupled with the complex biological and social needs of a growing number of people living with or affected by HIV, call for a comprehensive, coordinated, and integrated approach to care— one that recognizes the importance of mental health issues in providing services to people living with HIV. A specialized approach to HIV mental health service delivery carries many advantages for the client. Sharing the struggle with others who are living with HIV can provide a sense of mutual support, alleviate the stigma encountered in society, and promote a sense of safety. Issues of confidentiality, risk reduction, advocacy, and medication adherence may be emphasized and effectively addressed with appropriately trained staff. Efforts to reach this alienated and heavily stigmatized population require specialized and targeted approaches that involve close collaboration among a broad range of disciplines and service providers.

As this course was initially being developed, three themes repeatedly emerged that bear special significance for the provision of mental health services to people affected by HIV: stigma, multicultural sensitivity, and a bio-psychosocial approach to care. Although these themes are woven throughout the course, their critical impact upon service delivery warrants highlighting them in this introduction.

**Stigma**

Central to an understanding of the person with HIV who seeks mental health services is an understanding of the concept of stigma and its corrosive and debilitating effects. The archaic definition of stigma is “a mark burned into the skin of a criminal or slave (Webster’s New Riverside University Dictionary, 1139).” The HIV-infected client often finds himself/herself stigmatized in many ways—for having a fatal, transmittable disease; for being “crazy;” for being gay; for being sexual; for being a substance user; for being African American; for being poor; for being Hispanic; for being an illegal immigrant; for being unemployed; for being homeless; or for being an ex-offender.

HIV-related stigmatization constitutes an epidemic in itself—an epidemic of fear, prejudice, and discrimination.

The fear of being stigmatized keeps many from seeking services. It also can prevent many clients from remaining in treatment or adhering to a treatment regimen. The feelings resulting from stigmatization may include fear, shame, distrust, rejection, exile, guilt, isolation, hopelessness, helplessness, alienation, lack of self-worth, powerlessness, and aloneness. Empathy for those facing the painful reality of this multiple stigmatization is what propels many to work in the HIV field.
Multicultural sensitivity

An effective HIV treatment team includes clinical providers who are dedicated to the work and possess a depth of knowledge of HIV, mental health, substance abuse, and community resources. The successful worker possesses a sensitivity to, and understanding of, individual differences, different cultures, and subcultures, as well as a broad understanding of the bio-psychosocial effects of HIV infection on the client’s everyday life.

The culturally competent provider must be able to interact in a way that demonstrates an openness, understanding, and respect for the experiences, value systems, and beliefs of others. The culturally sensitive provider will convey to the client an appreciation of the varied cultural perceptions of power and control over one’s life and an understanding of why and how clients may have learned adaptational skills that seem to promote dependency and social marginalization.

Prejudgments—of how persons should have lived their lives, avoided HIV infection, or adjusted to a majority culture that all too often discriminates, stigmatizes, and oppresses—lead to a breakdown of trust.

A specialized bio-psychosocial approach to care

In 1990, AIDS was described as a paradigm of an illness requiring a bio-psychosocial approach. With the advent of new and effective medications, such a designation is increasingly apt. HIV infection is a medical illness caused by a virus often transmitted through socially stigmatized behaviors—unprotected sex and injection drug use—that biologically affects the brain and the immune system. At the same time, a diagnosis of HIV creates a series of immense psychological burdens that occur within a larger, more complex psychosocial arena.

As the importance of adhering to complex antiretroviral medication regimens gains acceptance, the spotlight focuses increasingly on the whole person and his/her capacity for medication adherence. To increase the likelihood of treatment adherence and to promote wellness, the provider must address client-specific concerns on many levels:

- **Social and environmental circumstances.** These include poverty, access to care, family relationships, housing, financial needs, food, child care, transportation, and legal status. Such concerns may be further complicated by homelessness, incarceration, and prostitution.
- **Psychological factors.** These include stress; depression; anxiety; cognitive impairments due to HIV-associated dementia; psychosis; mania; preexisting serious mental illness, including schizophrenia and bipolar disorder; and poor judgment and impulsivity associated with personality disorders. Defense mechanisms, such as avoidance and denial, also may interfere with seeking and accepting treatment.
  - **Biological aspects.** The health issues associated with HIV include the client’s medical condition; health of the immune system; symptoms and common opportunistic infections (e.g., of the brain); medications prescribed both prophylactically and for symptom relief; and co-existing chronic illnesses, such as diabetes, renal and liver disease, and high blood pressure.

The bio-psychosocial framework is a useful guide in assembling a specialized HIV mental health delivery system. The model helps the treatment provider to remain alert to the interactivity of disorders and stressors, to frame a complete diagnostic picture of the client, and to construct an appropriate and comprehensive treatment plan.

To provide examples of how this bio-psychosocial approach to service delivery may be implemented throughout different stages in the treatment process, the authors will share the experiences of clients served by the Demonstration project. (Case material has been disguised to protect client confidentiality.) Their stories, as told throughout this course, will enable the reader to better understand how the social, psychological, and biological factors described in this introduction interact with one another and define the approach to treatment.

SECTION 1: MENTAL HEALTH SERVICES

People living with or affected by HIV need access to a broad range of mental health services. Some services may be more widely available, particularly traditional mental health services, while others have been developed in response to the unique needs of persons affected by HIV. This section of the course describes the range of mental health services offered by the demonstration sites in response to the ever-changing impact of HIV infection on the biomedical, psychological, social, cultural, and spiritual dimensions of each client’s life and experience.

Clients with HIV infection who enter the mental health service system may have long-standing mental and/or addictive disorders that were present prior to HIV infection. Some may develop symptoms of a mental disorder—such as a mood or adjustment disorder—in response to learning of their HIV status, while others may develop more serious symptoms of psychosis or mania due to the progression of HIV infection itself. Regardless of the severity or duration of mental and/or substance abuse problems, some people living with HIV experience powerful feelings of loss, shame, and guilt related to HIV infection and may cope through deeply held denial or avoidance. Clients can benefit from a broad range of HIV-specific mental health interventions.

However, for some, it may be very difficult to acknowledge a personal need for mental health services. The mental health service system needs to take a flexible approach to engaging clients. For example, a client may not attend one or several scheduled intake appointments. Service providers need to accept this and be willing to reach out to and engage the client. A section discussing approaches to enhance the engagement of clients follows the overview of services described below.

Entering the mental health system

People living with HIV may enter the mental health system through a variety of means:

- Referrals from medical and allied health staff of hospitals, both from general medical units and from inpatient psychiatric units.
- Community-based public health clinics, including sexually transmitted disease/HIV testing programs.
- Non-governmental organizations providing community-based HIV-related services.
Public and private providers of substance abuse treatment.
Various levels of the legal and court system, including prison/jail discharge planners, parole and probation offices, community – based ex-offenders’ groups, and child protective services.
Peer-led HIV service and support organizations.
“Word of mouth” referrals.
Social services staff at local government levels.

Community-based providers of services to people who are homeless.
General mental health service systems, both publicly and privately based, that do not possess the capacity to provide HI-specific mental health care.
People may also find a mental health treatment provider, by using the HIV/AIDS Prevention and Care Services Locator at: http://locator.aids.gov/

Services offered

The following services, either alone or in combination, comprise the foundation of mental health treatment offered by the demonstration projects. Some of these services will be described in more detail later in this chapter. Determining the package of services that will be clinically useful involves an accurate and comprehensive assessment of clients’ functioning so that the link to appropriate treatment and services can be made successfully. For instance, a client recently released from prison who had been receiving psychotropic treatment for bipolar disorder and recently began highly advanced anti-retroviral treatment (HAART) to slow the progression of HIV will need a formal biopsychosocial assessment that may prompt linkages to case management, psychiatric evaluation, medication management, psychotherapy, residential services, or psychosocial rehabilitation, when indicated.

As a component of each service, it is important to incorporate a discussion of risk reduction strategies, specifically ways for clients to promote safer sexual behavior and safer drug use for those clients who use drugs. As more advanced medications become available to prevent the progression of HIV, it is critical that mental health clinicians use their unique perspectives to assist clients in adhering to complex medication regimens. Becoming aware of the psychological and social barriers that may inhibit client adherence to such life-extending medications needs to be addressed in the helping relationship between clinician and client.

Psychotherapy and counseling. Sometimes referred to as “the talking cure,” psychotherapy or counseling with a person with HIV infection can occur at many levels, through diverse modalities, and from different theoretical perspectives. Some clients are only interested in looking at their immediate situation, resolving issues that may cause present pain, ongoing relationship struggles, coping with HIV infection, or sorting out job options. Others may move toward a deeper examination of their past and the early childhood alliances and formative experiences that may have shaped their sense of self, their current relationships, or their functioning.

Clients with a history of sexual abuse often discover that working through aspects of childhood trauma can be both a liberating and necessary step in moving toward a commitment to self-care and risk reduction. Psychotherapy can help clients develop greater self-awareness, stronger coping skills, and greater motivation to engage in meaningful and productive activities. Clients with a history of substance use often discover and begin to heal—through counseling or psychotherapy—the underlying pain against which they have long sought to medicate themselves. (See Section 5 on Psychotherapy and Counseling for a discussion of psychotherapy treatment modalities and theoretical approaches used by the 11 demonstration projects. (See Section 6 for more information on counseling themes.)

Case management. Past experience in serving people with serious and persistent mental illness in community mental health centers led to the development of case management as a supportive approach that provides clients with case managers who link and refer clients to needed services – such as additional mental health treatment, entitlements, housing, clothing, and financial assistance – and advocate on behalf of the client to other agencies and organizations. As trust develops, case managers may be able to introduce more traditional mental health services. Seeking change in a supportive case management relationship in which there are mutually identified service goals may lead to greater empowerment for clients. Ultimately, clients may gain skill and comfort seeking additional services for themselves. (See Section 4 on case management.)

Psychiatric evaluation. Completed as part of a formal and comprehensive biopsychosocial assessment, the psychiatric evaluation involves assessing clients’ presenting mental health symptoms, past psychiatric treatment, current mental health status, and the appropriateness of a psychotropic medication evaluation. Psychiatric evaluations also may be helpful in obtaining a consultation related to diagnoses or further evaluation of neuropsychiatric symptoms. Clients with a history of psychotic mental illness or those with past or current diagnoses of mood disorders (e.g., depression and bipolar disorder) and anxiety disorders may benefit from taking medications that alleviate their symptoms.

Medication management. Once medications have been provided by the prescribing clinician, follow-up is required to ensure that clients understand medication dosing and side effects, to monitor medication effectiveness and adherence, and to watch for possible adverse effects.

There is a heightened need for sensitivity regarding adverse drug effects when working with those with HIV due to possible interactions between psychotropic drugs prescribed simultaneously with HIV/related medications. In addition, close monitoring of organ functioning and blood levels is needed, given the presence of HIV infection and other chronic medical complications.

Inpatient psychiatric hospitalization. Stabilizing a client’s psychiatric symptoms may not always be possible in an outpatient setting. Staff often will recommend inpatient psychiatric hospitalization. Clients may voluntarily agree to such hospitalization, recognizing the need for greater structure and supervision. However, there may be a need for involuntary commitment and detention to an inpatient psychiatric setting for those whose threats of harm to self or others have been assessed as acutely dangerous and whose symptoms or behaviors interfere with accepting help. Psychiatric hospitalization involves a thorough biomedical and psychiatric assessment that may lead to changes or improvements in psychotropic treatments. These efforts are supplemented with group treatment, occupational therapies, and multidisciplinary inpatient care.

Emergency services. Working with persons who have mental disorders requires the availability of emergency and crisis intervention/stabilization services, as well as the programmatic flexibility to accommodate “drop-in” visits when needed. The re-emergence of psychotic symptoms, or decompensation, requires immediate assessment and intervention. Similarly, threats of suicide and/or homicide must be assessed to determine a client’s intent, history, plan, and means to act. The stress of living with HIV may require heightened monitoring of those most at risk for harming themselves or others.

Psychosocial rehabilitation, partial hospitalization, and psychiatric day treatment. For those with serious and persistent mental illness, psychosocial rehabilitation programs offer day support to enhance self-care and social functioning, and to stimulate a sense of self that incorporates and internalizes the ability to manage oneself. Partial hospitalization programs provide more intensive outpatient treatment for those whose mental health symptoms seem too deeply entrenched to be alleviated by outpatient psychotherapy. These approaches include more frequent, often daily, monitoring of medication adherence and greater support, including the use of group work. Partial
hospitalization and psychiatric day treatment may be a short-term intervention during times of intensified symptomatic distress and risk.

**Residential services and treatment.** For those for whom independent living may be too unstructured, residential services may offer placements with varying levels of staff support that seek to maximize medication adherence, social living skills, and self-care, and to introduce tasks of independent living in a consciously stepped fashion so that clients may find success in their efforts toward greater independence. A more structured environment, specifically as it relates to medication adherence, may improve medical and physical outcomes for persons with HIV infection who have lived in more chaotic circumstances, those who have cognitive impairments, and those who have not successfully adhered to their medication regimen. Residential treatment also is often a long-term and intensive intervention that may prove successful in helping clients maintain sobriety.

**Expressive therapies.** Art, music, dance, psychodrama, bibliotherapy, and other expressive therapies can provide a means to access and express emotional experiences that otherwise may not arise in talk-driven psychotherapy. Frequently, for those living with HIV, certain defense mechanisms, like denial and sublimation, serve to protect clients from overwhelming anxiety and fear related to HIV infection and its progression. Expressive therapies seek to uncover such distress in a non-threatening and non-confrontational manner so that the client may gain mastery over it.

### Complementary treatments

Several emerging therapies may be used in combination with traditional mental health services to expand the choices available to clients participating in the development of their own treatment plans. In addition to the sense of empowerment that stems from having choices and assuming greater control in dealing with one’s illness, complementary treatments may offer other means of generating psychological, emotional, and spiritual support. They also may offer relief from pain associated with neuropathy linked to antiretroviral therapies. Service programs may seek partnerships with a diverse range of clinicians who have expertise in these treatments and a clinical understanding of HIV and mental health issues, integrated care.

**Herbal therapies.** There is a growing interest in herbal therapies for the treatment of psychiatric symptoms such as depressed mood, anxiety, insomnia, cognitive slowing, and memory loss. Surveys of research literature have shown that St. John’s wort (hypericum perforatum) seems helpful in the treatment of mild to moderate depression (Linde et al, 1996). Similarly, ginkgo biloba has shown some efficacy and benefit for persons with moderate to severe memory impairment (LeBars et al, 1997). Other herbal therapies have not yet been found to be demonstrably effective for other mental health symptoms.

**Acupuncture.** A component of traditional Chinese medicine that dates back many centuries, acupuncture seeks to enhance energy flow with the use of needles or pressure (commonly called acupressure or shiatsu) at certain points along the body’s network of meridians that conduct chi (energy) through the body. Recently published findings indicate that acupuncture seems helpful for HIV and other medical conditions (Shlay et al, 1998). Though promising, research involving acupuncture’s treatment for psychiatric purposes is not yet definitive.

**Exercise.** The physical benefits of exercise are well known and also may benefit clients with emotional distress. For example, involvement in some form of exercise seems to promote a decrease in symptoms related to mild to moderate depression. Additionally, for persons with HIV, exercise appears to reduce other emotional distress and enhance immune functioning (Perma et al, 1998). It is important to ascertain whether clients have previously been involved in exercise and their willingness to resume physical activity.

**Stress reduction and relaxation techniques.** Relaxation techniques seem to show promise in helping persons cope with anxiety and other distress. Guided imagery, progressive relaxation, meditation, visualization, and hypnotherapy have been shown to reduce emotional distress and promote well-being.

**Other nontraditional therapies.** Approaches such as massage therapy and bodywork have been found to be beneficial in reducing tension and alleviating some physical manifestations associated with HIV infection. Some believe that these approaches are useful as adjunctive measures in treating some mental disorders.

### Engaging clients through outreach

Many of the 11 demonstration projects used outreach as a means to engage and retain clients who may not acknowledge a need for mental health care. In addition, many clients served by the Demonstration project experienced numerous barriers (e.g., lack of transportation or child care, and psychological distress) that prevented them from keeping appointments or continuing to receive services. Service providers can engage individuals in the service delivery process by making repeated telephone calls, finding clients on the street, or making home visits. Outreach contributes to ongoing clinical service delivery by offering supportive telephone counseling and psychotherapy to persons who are unable to travel to the service site. Outreach can be performed by clinicians or paraprofessionals with sensitivity to individuals in alienated subcultures.

### Treatment or services offered outside of the treatment facility.

Clients in detention facilities, hospitals, shelters, long-term care facilities, and those who require home-based services often lack access to treatment and support services. By meeting clients where they are, clinical staff can successfully reach people with disabilities, those with debilitating medical complications, those who cannot afford transportation, and parents whose child care responsibilities interfere with treatment. Off-site service delivery can be negotiated and reassessed periodically between clients and clinicians so that clients do not become unnecessarily dependent on clinicians or other program staff and can begin to receive or resume services at the agency setting when able or feasible.

### Coordination of care

**Conducting joint assessments with primary medical staff.** Offering joint assessments may decrease the need for multiple intakes for clients, reduce the administrative burden for clinicians, and lay the foundation for a team approach to treatment. Involving the client’s primary medical providers in the assessment and delivery of mental health services enables providers and clinicians across disciplines to have a more comprehensive understanding of the client’s primary medical and mental health needs. This step also fosters a treatment approach informed by a bio-psychosocial perspective. Facilitating the development of provider teams also may reduce duplication of services and avoid damaging impediments to the therapeutic process, such as “splitting” or triangulation.

**Offering interdisciplinary “prescription” team meetings with clients.** When a client is receiving many services at the same time, such as medical care, case management, mental health, and substance abuse treatment, coordination of care among providers becomes essential for several reasons. First, duplication or gaps in service can be problematic. Second,
clients with personality disorders sometimes pit one provider against another. And third, a client may present a particular display of symptoms to one provider and quite a different diagnostic picture to another.

By periodically bringing all players, including the client, to the treatment planning table, such obstacles can be addressed and clarified. The Alexandria project makes frequent use of such prescription team meetings throughout the client’s treatment. While, at first glance, coordinating and scheduling such a meeting may seem cumbersome and time-consuming, staff have uniformly found these meetings to be helpful in preventing confusion, misunderstandings, and wasted effort during the course of treatment. The sharing of information from different disciplines also enriches the knowledge, skills, and abilities among providers. Such meetings can be useful at different phases of treatment. Sometimes, one provider through such a meeting can effectively link a reluctant or hesitant client to a historically stigmatized service such as mental health. In working with mothers who are connected to the Child Protective Service system, close coordination usually is essential. During times of crisis, when the client’s situation needs to be stabilized or reassessed, or when an intervention needs to be initiated, the prescription team meeting can be a powerful coordination tool.

Expansion of the traditional mental health role. It was the experience of the demonstration projects that clinicians benefited from being actively involved in case management activities and serving as a consultant to or liaison with the primary medical provider. In addition, clinicians were effective advocates in linking clients to other service providers as they sought access to entitlements and support services, such as legal advice. Once case management needs are identified, clinicians were able to determine the client’s capacity to follow through with potential referrals.

SECTION 2: CLINICAL ASSESSMENT

Working with persons with HIV infection in the mental health arena requires a comprehensive approach to the clinical assessment and treatment planning process that fully incorporates the bio-psychosocial complexity of living with HIV. For many clients triply diagnosed with HIV, a mental disorder, and a substance abuse disorder, the clinical assessment will be a multi-dimensional and dynamic process. Clinicians will meet with clients over several sessions to gather factual and perceptual information, draw hypotheses about what clients are revealing about themselves and their behaviors, and integrate what is learned into a diagnosis. Clinical assessments can then be used to develop client-specific treatment objectives that incorporate the client’s history and current struggles, as well as his/her strengths and resources. This process requires thoroughness and sound clinical thinking, but is a critical step toward ensuring that each client’s unique needs are addressed appropriately—and in a timely fashion. Lessons learned from the demonstration project include the kinds of questions to ask, the value of informal and formal assessment, and issues to consider when conducting a clinical assessment.

Areas to be covered in the clinical assessment

It was the experience of the 11 demonstration sites that clinical assessments need to be tailored to a program’s populations, its settings, and the purpose of its interventions. When clinicians have the opportunity to develop a more comprehensive clinical assessment, it is important to consider the complex biological and social needs of people living with or affected by HIV. This can be accomplished by adding HIV-specific questions to an existing clinical assessment that covers the following areas:

- Demographics.
- Presenting problem.
- Psychiatric history.
- Mental status exam.
- Social history.
- Medical history.
- Alcohol and other drug use history.
- Risk level, including sexual risk-taking and intravenous drug use.
- Social support.
- Coping skills.
- Strengths.
- Financial and other resources.
- Employment history.
- Educational background.
- Religious and spiritual practices.

Relating the clinical assessment to program issues

The following examples demonstrate how the questions asked in a clinical assessment are related to the program’s populations, setting, and purpose:

- If a client comes into a community mental health center in a highly agitated state and is suicidal, then the assessment should focus on stabilizing the client and making sure appropriate safeguards are in place. More detailed information can be gathered after the client’s crisis has stabilized.
- If a client is assessed for mental health issues as part of his/her medical services, then staff will likely conduct a screening rather than a comprehensive assessment. The outcome of the screening may include recommendations for further assessment, individual or group treatment, follow-up with clients during medical visits, or no treatment at this time.
- If a client comes into a psychosocial rehabilitation program for the first time, staff and other clients probably will want to begin by welcoming the client and introducing him/her to the program gradually. After building rapport, the following areas can be assessed: daily living activities; reading and education level; independent living skills; and leisure skills.
- If an HIV-positive custodial parent is bedridden and very sick, staff will likely conduct an assessment of the client’s most urgent and immediate needs—putting off the assessment of permanency planning issues until the crisis is stabilized.

Whether the program is an HIV-specific stand-alone program or one that offers HIV-specific mental health services within a larger mental health organization, a comprehensive clinical assessment needs to incorporate information from all these areas. This will allow an accurate understanding of the issues that are contributing to the client’s presenting symptoms and/or complaints, as well as how a client’s symptoms and/or complaints contribute to other areas of functioning (e.g., how depression may affect a client’s success in getting social support). Examples of how to incorporate HIV-specific issues into a clinical assessment are provided below. For each area, sample questions are included to keep in mind when gathering information during the clinical assessment. The areas are not presented in any specific order, and the sample questions are not intended to be asked in the manner presented.

Social support. In addition to informing staff about the quality of interpersonal relationships and the client’s reliance upon others, social support questions can be used to ascertain to whom the client has disclosed his/her HIV status. Information about a client’s social support may be gained using established clinical tools—like genograms, which graphically depict a person’s social support network—or by asking direct questions.

www.EliteCME.com
Types of questions that may be helpful in assessing the client’s social supports:
- Have you disclosed your HIV status to anyone?
- Is there anyone who knows about your status and helps you with day-to-day needs?
- How often do you have contact with that person?
- Is your contact with that person limited, or is it ongoing?
- How is this person similar to you in age, gender, ethnicity, HIV status, and risk factors?

Coping skills. These questions can help staff get a sense of how the client has historically and recently approached problems in their life, as well as how the client is coping with being HIV-positive. Staff will want to better understand the client’s strengths (e.g., strong will to live), adaptive skills (e.g., problem-solving, information-gathering, talking to and getting support from others), and maladaptive behaviors (e.g., self-isolation, taking part in potentially self-destructive activities, avoidance, denial, or poor self-care).

Types of questions that may be helpful in assessing the client’s coping skills:
- In the past, when you’ve had to face challenges, how did you respond? How did you cope? What personal strengths did you bring to the situation?
- How did you react when you first found out you were HIV positive? How do you deal with it differently today than when you first found out?
- What do you do to make yourself feel better?
- What would make things more manageable for you? What has worked in the past? What hasn’t worked as well?

Medical care. There are many reasons for including questions about a client’s past and current medical experiences. For example, many people living with HIV have multiple health problems, so gaining a picture of their HIV medical care and a complete medical history of other acute and chronic illnesses is crucial. In addition, adherence to medical treatment and recommendations is so vitally important that a clinician can benefit from knowing how clients interact with their medical providers. As medical care serves as a vital service to those with HIV infection, it is critical to understand how it affects their psychological well-being. The following sample questions are provided as a guideline to get a better understanding of the client’s perspective and can be woven into the clinical assessment.

Types of questions that may be helpful in assessing the client’s medical care:
- When you feel sick, do you go to the emergency room, call your medical provider, or call someone else?
- Have you recently received medical care? What was that experience like?
- Are you currently receiving HIV-specific medical care? What has that been like?
- Has treatment helped, or has it not proved helpful?
- How comfortable do you feel talking to your medical providers?
- How well do your medical providers explain your treatment options?
- Do you think your medical providers are sensitive to your pain (e.g., mental, emotional, physical, and spiritual pain)?
- What is your CD4 count? Has this changed in the past 3 months? What is your current viral load? Has this changed in the past 3 months?
- Do you have any other chronic medical conditions, such as diabetes, asthma, high blood pressure, liver problems, or kidney problems?
- Are you taking any medications for these conditions? What are you taking? How much are you supposed to take? Do you take these medications as prescribed? What are the circumstances when you do not take them as prescribed?
- Are there any side effects with these medications? How do you cope with these side effects?
- How often do you see your medical provider for your other medical conditions? How often do you keep these appointments?

Current service utilization. To gain a better understanding of a client’s service needs and to help a client maneuver through the service system effectively, it may be important for clinicians to inquire about all the other systems (e.g., community-based agencies that offer HIV support services, AIDS service organizations, and community-based agencies that offer relevant services) to which he/she is already connected.

Types of questions that may be helpful in assessing the client’s current use of services:
- Can you tell me about other services you use?
- What has it been like to use these services, now and in the past?
- How have these services benefited you?
- Do you have a case manager? How has he/she helped you?

Quality of life. Given that HIV has become a chronic illness for many individuals, quality of life issues have become more salient for assessment and treatment. In addition to conducting a clinical assessment of specific symptoms and diagnoses, quality of life issues should be assessed because many clients respond more quickly to treatment when these issues are more readily understood and dealt with. One of the benefits of asking quality of life questions is that the clinician is less likely to impose his/her version of quality of life onto the client, and the client’s idea of quality of life is better understood.

Quality of life (QOL) is a term that is popularly used to convey an overall sense of well-being and includes aspects such as happiness and satisfaction with life as a whole. World Health Organization has defined QOL as “individuals’ perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, standards, expectations and concerns.” (World Health Organization, 1998). With the recent advances in clinical tests and treatments for those suffering from human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), the survival of these patients has been increased and their QOL has become an important focus for researchers and healthcare providers. Since the discovery of HIV at in beginning of the 1980s, HIV/AIDS has been one of the greatest health problems in the world. HIV/AIDS places an increasing burden on the health of the population, and causes further socioeconomic problems for individuals, families, communities, and governments in many countries. (Walker, Grassly, Garnett, Stanecki, & Ghys, 2004).

Several factors associated with better QOL among HIV-infected patients have been reported in the international literature, and mainly, the impact of HIV on QOL falls under four major domains. Socio-demographic characteristics such as male gender, younger age, higher socioeconomic status, and employment have been associated with improvement in QOL. Other variables such as lower HIV viral load, greater CD4+ cell count, (Ruiz et. al, 2005) fewer or less bothersome HIV symptoms, and higher levels of hemoglobin (Semba, Martin, Kempen, Thorne, & Wu, 2005). have been shown to be important clinical/immunological indicators of better QOL. In addition, patients with no difficulty in taking medications, those using regimens with a lower number of pills, and those more adherent to antiretroviral therapy (ART) tend to have improved QOL following the start of treatment (Ruiz et. al, 2005).

Many people living with HIV/AIDS find it challenging to attend to daily tasks of living, participate in moderate to vigorous physical activities, or have sufficient energy or vitality to engage in an active social life while managing HIV/AIDS. Fatigue or low energy has been associated with both physical and psychological morbidity and poor QOL in persons with HIV/AIDS. In addition, fatigue and a CD4 T-cell count less than 500 are associated with physical limitations and disability. Among HIV positive patients, disease progression is related to decreasing energy and increasing difficulties with daily activities and pain. (Zinkernagel, Ledergerber, Battegay, Cone, Vernazza, & Hirschel 1999)

Types of questions that may be helpful in assessing the client’s quality of life:
- When did you find out that you are HIV positive?
- How did you spend your time before you became HIV positive? What was your typical day like back then? Who did you spend time with?
- Back then, how satisfied were you with your life?
How do you spend your time now? What is your typical day like?
Who do you spend time with?
How satisfied are you with your life?
How do you see yourself spending time in the future? What do you want a typical day to be like? Who do you want to spend time with? Are there people you would like to get to know better?

How would you like to live your life differently in the following areas: job/career, education/training, social/recreation, spiritual, and volunteer work/advocacy? Would these things give you a greater sense of purpose in life? Would they bring you pleasure?
If you were able to accomplish those goals, how satisfied would you be with your life?

Conducting the clinical assessment

After program planners and clinicians at each of the 11 demonstration sites selected areas to assess, it was then necessary to attend to the administration of the clinical assessment. This section describes the three key elements of a clinical assessment: preparing staff to conduct the assessment; preparing clients to participate in the assessment; and conducting the assessment.

Preparing staff to conduct the assessment. Given the complexity of physical and mental health circumstances for persons seeking HIV-specific mental health services, clinicians should prepare themselves for the following:
- Potentially uncomfortable and sensitive issues that may arise during the initial assessment meetings. These issues include death and dying issues; sexuality and sexual practices; different life experiences (e.g., substance abuse, class differences, sexual orientation); and explicit descriptions of physical symptoms. Through supervision and training, clinicians may learn to be sensitive to and comfortable with these and other issues before they actually conduct assessments with clients.
- Alternative terms and slang. Clients may use alternative terms and/or slang to describe their experiences. To enhance a clinician’s ability to connect with clients, it is important to familiarize themselves with alternative terms and slang by asking clients or other people who are familiar with the culture to explain unfamiliar words.
- Local jurisdictional laws and regulations regarding confidentiality and safety. When working with HIV-infected clients, clinicians need to be aware of state and local liability and disclosure laws—and appropriate ways to respond. This relates to knowing about duty to warn, the emergent risks related to suicidality and homicidality, and the potential risk to children or vulnerable adults. State and local departments of mental health can provide some guidance in these matters.

Preparing clients to participate in the assessment. Many HIV-infected individuals have had negative experiences with human service systems. With that in mind, it is important to make the clinical assessment process as favorable as possible. The collective experience of the 11 demonstration sites has shown that the following practices can increase the likelihood of a successful assessment experience:
- Explain the purpose of the assessment. A client needs to know why clinicians need to understand their story and how this process will benefit them in the long run.

Connecting the clinical assessment with the treatment plan

A comprehensive clinical assessment leads naturally to an effective treatment plan. An accurate and client-focused clinical assessment can ensure that treatment goals reflect client goals and priorities, that the client feels a strong sense of “ownership” over his/her treatment plan, and that clients are motivated to engage and remain in treatment. With those objectives in mind, it might be helpful for clinicians to ask clients the following questions: What are some of the issues you would like to work on in your life? What would you like to improve? And how would you like your life to be different after treatment has successfully been completed? To ensure that the client has ownership of the treatment goals, the following actions also may be helpful:
- Emphasize client-driven goals in the treatment plan.
- Negotiate treatment goals within the framework of which services and interventions are offered by the program and what the client wants.
- Give clients an opportunity to consent to treatment, to review and revise their service and treatment goals, and to sign the plan when it is finalized.

Additional clinical assessment tools

Standardized measures. Many of the demonstration sites used standardized assessment instruments as an adjunct to their clinical assessment. Standardized measures were used for different reasons. Some sites used standardized measures as a means of describing their populations, while other sites used standardized measures to obtain clinical information in a more uniform manner. It is important for program planners and clinicians to agree on the use of standardized measures before introducing them into the clinical assessment. Some standardized measures used by demonstration sites are listed below, as are the advantages and disadvantages to using standardized measures as an adjunct to the clinical assessment.
Pros and cons of using standardized measures

Pros
- May give clinicians information that they cannot get any other way.
- All clinicians use the same procedures to obtain information about specific areas.
- There is a greater probability that the data can be quantified and analyzed.
- The program will have the capacity to compare types of clients served with other programs that are using the same assessment tools.
- May give clinicians another perspective on the client.
- Have established validity.
- May have greater generalizability.
- May provide greater confidence in the findings.

Cons
- The norms may not be pertinent to the program’s target population.
- Can take longer to administer and score than administering non-standardized tools.
- Can require formal training of the interviewers.
- The information may not be meaningful or clinically relevant.
- Getting the information in a timely fashion may not be possible.
- Can be an obstacle for treatment, especially when a program’s “unspoken rule” prioritizes assessment requirements over helping clients with presenting problems.
- Can be an “unfriendly” approach to getting information from clients.
- Can be expensive for purchase, administer, and score standardized measures.

Psychological and neuropsychological testing. Gathering information on thoughts, feelings, motivations, behavior patterns, personality type, relational style, and cognitive capacities fall within the domain of psychological testing. Assessing the presence of specific cognitive impairments, or HIV-associated dementia, and the status of general cognitive functioning is the domain of neuropsychological testing. Performed by clinical psychologists or neuropsychologists, such testing or screening relies on various tests and instruments to assess intellectual functioning; reading and math skills; speed of mental processing or problem-solving; and status of memory and recall.

Because HIV can affect the brain in numerous ways, it is highly desirable for clinicians to use neuropsychological testing as an adjunct to their clinical assessments. While many programs will not have these services available on-site, it is strongly recommended that program planners and clinicians access neuropsychological testing services from other sources because testing can provide a valuable and clinically rich contribution to the assessment and treatment planning process.

Neuropsychological testing can give clinicians a better understanding of the impact of HIV on the brain itself, including functioning associated with tasks related to memory, attention, concentration, planning, and prioritizing. Problems in these areas of functioning may be directly affected by HIV infection—even during its early stages. Clients who complain of forgetfulness, who become lost while traveling, or who have difficulty adhering to scheduled appointments and/or medication dosing may be displaying some signs of the cognitive impairment commonly associated with HIV.

Since these symptoms may not be readily identified by the medical provider, it is important to acknowledge, inquire about, and assess these troubling instances when they occur. Such impairment may not only be related to HIV but may result from other mental or substance abuse disorders, such as depression or substance-induced dementia, as well as from medical diseases, such as poorly controlled diabetes and/or liver disease. Frequently, there are clients who are triply diagnosed, whose symptoms and disorders related to HIV, mental health, and substance use disorders further complicate and contribute to a decline in cognitive functioning.

Once interpreted, both psychological and neuropsychological test findings can prove valuable in determining a diagnosis—even when the clinical symptomatology may be complex. They also may provide an accurate assessment of previous and current capabilities related to memory, attention, problem-solving, and concentration, and identify specifically how a client’s ability to plan, organize, and prioritize life concerns may be impaired. Due to the progressive nature of HIV and its biomedical and psychiatric impact, it is important to monitor cognitive capabilities over time, either informally through observation of a client’s behavior and comments or more formally through repeated psychological or neuropsychological screening or testing. For clients, testing results can help demystify troubling and intrusive symptoms, as well as assist with differential diagnosis; support treatment planning; help educate clients about the implications of cognitive impairment in daily living; lead to strategies clients can use to compensate for cognitive changes; support a client’s disability claims; inform providers about client strengths; and provide information about client support networks.

SECTION 3: PSYCHIATRIC AND NEUROLOGIC CONDITIONS

There are several neuropsychiatric complications associated with HIV infection. These complications have numerous etiologies. Awareness of them will assist clinicians in appropriate client assessment, referral, and treatment. In almost all cases, access to a clinician with skills in neuropsychiatric assessment and treatment is essential.

Neuropsychiatric conditions are rarely isolated occurrences. Instead, they generally occur in conjunction with other medical, mental health, and substance abuse problems. These complications, particularly when
left untreated, are associated with increased morbidity and mortality, impaired quality of life, and numerous psychosocial challenges, such as non-adherence with the treatment regimen. The complexity of these conditions should encourage all mental health clinicians to incorporate multidisciplinary approaches to client-centered care.

Neurological conditions and disorders can range from mild cognitive impairment to severe mental illness. Cognitive impairment may include conditions that simply impact quality of life, such as sleep disorders. Serious mental illnesses, particularly those illnesses which cause persons to experience severely distorted thinking or cognitive impairment, pose unique challenges in HIV treatment. Serious mental illnesses may be conditions that are directly attributed to HIV infection, such as the neurocognitive disorders previously described (e.g., HIV-associated dementia), or conditions that existed before a person becomes HIV-positive, such as schizophrenia, bipolar disorder, and severe personality disorders.

These conditions create numerous challenges for clients and providers alike, including increased likelihood of the client engaging in high-risk behaviors and other maladaptive health behaviors, such as substance abuse and treatment non-adherence. Persons with serious mental illness often experience high rates of unemployment, poverty, and homelessness. For these reasons, these persons with serious mental illness typically lack access to health care, substance abuse treatment, HIV primary medical care, and new antiretroviral therapies. As a result, persons with serious mental illness are likely to have shortened HIV-related survival, severely impaired quality of life, and more complications from HIV and other medical problems that disproportionately affect persons who are marginalized in health care systems.

For the purposes of this course, neuropsychiatric complications are categorized as follows:
- Disorders attributed to HIV.
- Disorders due to medical complications of HIV infection.
- Psychiatric disorders.
- Serious mental illness.

For each of these conditions, comprehensive management strategies require skilled interventions that utilize psychotropic medication management, medical treatment, behavioral management, and psychosocial care.

**Mental Health Disorders and HIV**

**Cognitive Disorders**

Direct or indirect effects of the HIV virus can affect brain functioning. Some medications used to treat HIV infection also can cause similar complications. In people with HIV infection or AIDS, these complications can have a significant impact on daily functioning and greatly diminish quality of life. Among the most common disorders are HIV-associated minor cognitive motor disorder, HIV-1-associated dementia complex, delirium, and psychosis. Signs of trouble may include forgetfulness, confusion, attention deficits, slurred or changed speech, sudden changes in mood or behavior, difficulty walking, muscle weakness, slowed thinking, and difficulty finding words.

The American Academy of Neurology recognizes two clinical neurocognitive disorders diagnosed by use of standard psychological tests: Mild Neurocognitive Disorders (MND) and HIV-Associated Dementia (HAD). An MND diagnosis requires mild neurocognitive impairment in at least two domains of cognitive performance and, at most, a minor functional impairment that isn’t severe enough for a HAD diagnosis. A HAD diagnosis requires cognitive impairment in two or more domains, at least a moderate level of functional impairment due to cognitive symptoms, a lack of delirium, and no evidence of another explanation for the symptoms.

**Asymptomatic Neurocognitive Impairment (ANI)**

ANI occurs without any related decrease in function. High rates of ANI have been found in HIV+ young adults (67 percent) who were infected perinatally, compared with older HIV+ persons (19 percent). Other studies have found as many as 1 in 3 HIV+ persons taking HAART had ANI, but again they were mostly under 40 years old. Because of recent challenges in the diagnosis of ANI a cautious approach for monitoring patients for disease progression is recommended. (APA, 2014)

**Serious mental illness among HIV+ patients**

The prevalence of psychiatric disorders is relatively high among adults receiving care for HIV disease in the United States. “Severe Mental Illness” (SMI) refers to a wide range of psychiatric diagnoses that have common psychiatric symptoms which persist over time and are functionally disabling. They can affect daily living skills, family relations, educational attainment, work productivity, and social role. SMI includes schizophrenia, schizoaffective disorder, bipolar disorder, major depression, autism, and obsessive compulsive disorder. These disorders affect at least 2.8 percent of the U.S. population. No program for people with SMI can be considered comprehensive unless it incorporates services aimed at detecting and preventing HIV, and provides links to medical assessment and treatment for patients who are already infected. (APA, 2014)

**How widespread is SMI among HIV+ patients?**

Epidemiological trends in the HIV epidemic indicate the SMI may be the most vulnerable, disenfranchised subpopulation at risk for HIV infection. Rates of HIV infection and transmission among those with SMI are as much as 76 times higher than in the general population.

Studies of inpatient (residential) psychiatric patients in the Northeast have shown rates of HIV infection ranging from 4 percent among long-stay state hospital patients to 23 percent among those on an acute dual diagnosis unit for people with combined mental illness and alcohol/substance use disorders (APA, 2014). Women were as likely to be infected as men. Unfortunately, the peer-reviewed literature contains little information about outpatients, and is silent on epidemiology in other U.S. regions.

One of the few non-hospital based studies found that 19 percent of men attending a psychiatric program located within a homeless shelter in New York City were HIV+. Advanced HIV disease (AIDS) was the leading cause of death in a sample of 320 patients between 20 and 40 years of age in a longitudinal study of individuals experiencing their first psychiatric hospitalization for a psychotic episode. This study, conducted in suburban and semi-rural Suffolk County, New York, suggested that HIV is a major issue even for psychiatric patients outside of cities known to have high HIV rates. (APA, 2014)

Patients with SMI need to be assessed individually and without preconceived bias regarding their ability to follow an antiretroviral regimen. It is essential first to stabilize their psychiatric condition before starting an antiretroviral regime. Involving significant others and using directly observed therapy (DOT) are useful adherence strategies.

**HIV-associated dementia (HAD).**

Clients who develop HAD generally will experience abnormalities in their cognitive and motor abilities that significantly impair their ability to function effectively. HAD signals progression to AIDS for those HIV-positive persons not yet meeting AIDS-defining criteria. Generally, HAD occurs in later stages of HIV infection, and debilitating symptoms may progress over time. Pharmacological treatments include antiretroviral therapies and psychotropic medications. This condition cannot be diagnosed when a client is simultaneously experiencing delirium (see below). Screening instruments that may be helpful in diagnosing HAD include the Mini – Mental State Examination (Folstein et al, 1975) and the HIV Dementia Scale (Power et al, 1995).

HIV can damage subcortical areas of the brain and produce HIV dementia, resulting in states that are mistaken for clinical depression (APA, 2014). Before HAART (highly advanced anti-retroviral treatment) was available, HIV-associated dementia was a common
AIDS-related complication and cause of death. With HAART the incidence of HAD has fallen, although its prevalence has actually increased because HIV+ people are living longer. Even today, HAD affects 10-20 percent of people living with HIV.

HAD’s exact causes are unclear, although it corresponds most closely to inflammation in the brain rather than with viral load or HIV encephalitis. Neuroinflammation has long been recognized as a common pathological finding in HIV+ individuals and has been linked with CNS dysfunction. Symptoms and signs of HAD include tremor, gait ataxia, loss of fine motor movement, mental slowing, forgetfulness, poor concentration, and behavioral abnormalities.

Risks for HAD include older age, decreased body mass, family history of dementia, and persistent physical symptoms of HIV infection. As many as 15 percent of those with advanced HIV disease (AIDS) are affected by HAD, severely impairing their daily functioning.

According to the recently published ementina is a neurocognitive disorder. In fact, the term “dementia” has been eliminated and replaced with major or minor neurocognitive disorder. It was believed that the word dementia was stigmatizing toward older individuals and not well accepted by younger individuals with HIV dementia. The new term focuses on the decline from a previous level of functioning as opposed to a deficit. (APA, 2013)

- Further, the dementia chapter in DSM-5 is titled “Neurocognitive Disorders,” whereas in DSM-IV it was titled “Delirium, Dementia, Amnestic, and Other Cognitive Disorders.” According to DSM-5, changes for delirium include the following:
  - Disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and orientation to the environment.
  - Disturbance develops over a short period of time (usually hours to a few days) and represents an acute change from baseline that is not solely attributable to another neurocognitive disorder and tends to fluctuate in severity during the course of a day.
  - A change in an additional cognitive domain, such as memory deficit, disorientation, or language disturbance, or perceptual disturbance that is not better accounted for by a preexisting, established, or evolving other neurocognitive disorder.
  - Disturbances in No. 1 and 3 must not occur in the context of a severely reduced level of arousal, such as coma.

The old dementia terminology required the presence of memory impairment for all of the various dementias. It has been recognized that memory impairment is not the first domain to be affected in all of the other diseases that cause a neurocognitive disorder. For instance, in frontal temporal disorder, language could be affected first. This change in terminology will require that all diagnosing healthcare professionals first establish the presence of a neurocognitive disorder and then determine whether the neurocognitive disorder is minor or major.

In DSM-5, a minor neurocognitive disorder is defined by the following:

- There is evidence of modest cognitive decline from a previous level of performance in one or more of the domains outlined above based on the concerns of the individual, a knowledgeable informant, or the clinician; and a decline in neurocognitive performance, typically involving test performance in the range of one and two standard deviations below appropriate norms (i.e., between the third and 16th percentiles) on formal testing or equivalent clinical evaluation.
- The cognitive deficits are insufficient to interfere with independence (e.g., instrumental activities of daily living, like more complex tasks such as paying bills or managing medications, are preserved), but greater effort, compensatory strategies, or accommodation may be required to maintain independence.
- The cognitive deficits do not occur exclusively in the context of a delirium.
- The cognitive deficits are not primarily attributable to another mental disorder (e.g., major depressive disorder, schizophrenia).

**Minor motor-cognitive disorder (MMCD).** Clients who develop MMCD will experience mild and sometimes subtle decrements in their motor or cognitive functioning. Examples include clients who have slight difficulty coordinating finger or hand movements, but not to the extent that use of their fingers or hands is severely limited. Similarly, clients may develop mild impairments in memory, but not to the extent that their impairment is noticeable by others. MMCD does not necessarily progress to HIV-associated dementia.

This is a new diagnostic category in the DSM-5, but subsumes some existing DSM-IV disorders. The APA acknowledges that although the threshold between mild NCD and major NCD is inherently arbitrary, there are important reasons to consider these two levels of impairment separately:

- The major NCD syndrome provides consistency with the rest of medicine and with prior DSM editions and necessarily remains distinct to capture the care needs for this group. Although the mild NCD syndrome is new to DSM-5, its presence is consistent with its use in other fields of medicine, where it is a significant focus of care and research, notably in individuals with Alzheimer’s disease, cerebrovascular disorders, HIV, and traumatic brain injury.

In DSM-5, a major neurocognitive disorder is defined by the following:

- There is evidence of substantial cognitive decline from a previous level of performance in one or more of the domains outlined above based on the concerns of the individual, a knowledgeable informant, or the clinician; and a decline in neurocognitive performance, typically involving test performance in the range of two or more standard deviations below appropriate norms (i.e., below the third percentile) on formal testing or equivalent clinical evaluation.
- The cognitive deficits are sufficient to interfere with independence (i.e., requiring minimal assistance with instrumental activities of daily living).
- The cognitive deficits do not occur exclusively in the context of a delirium.
- The cognitive deficits are not primarily attributable to another mental disorder (e.g., major depressive disorder, schizophrenia).

When diagnosing a minor neurocognitive disorder, one and two standard deviations below appropriate norms is required. In diagnosing a major neurocognitive disorder, two or more standard deviations below appropriate norms are required. This need for cognitive testing will add to patient cost since neither the Mini Mental State Examination nor the Montreal Cognitive Assessment, the common screening tools utilized by many clinicians, yields results in standard deviations. In addition, the requirement that the cognitive deficits are insufficient to interfere with independence is subjective and will cause additional confusion for both clinicians and patients.

Having determined whether a patient has a major or minor neurocognitive disorder, the healthcare professional making the diagnosis must then decide on the etiological subtype of the major or minor neurocognitive disorder. The subtypes that have been listed are neurocognitive disorder due to Alzheimer’s disease; vascular neurocognitive disorder; frontotemporal neurocognitive disorder; neurocognitive disorder due to traumatic brain injury, Lewy body dementia, Parkinson’s disease, or HIV infection; substance-induced neurocognitive disorder; neurocognitive disorder due to Huntington’s disease, Prion disease, or to another medical condition; and neurocognitive disorder not elsewhere classified.

**Delirium.** This neuropsychiatric disorder is characterized by a disturbance of consciousness (i.e., reduced clarity or awareness of one’s environment) with reduced ability to sustain attention. Delirium is accompanied by memory problems and perceptual disturbances, such as illusions (e.g., misinterpreting objects or persons as something else). The condition develops over hours to days and fluctuates throughout the day. Delirium is the most common neuropsychiatric complication in hospitalized persons with HIV who are severely ill. A screening instrument helpful in diagnosing delirium is the Mini-Mental State Examination (Folstein et al, 1975).

Delirium is a generic name for a common mental state with multiple possible causes. As many as 30 percent to 40 percent of hospitalized
HIV+ people with advanced illness (AIDS) are at increased risk for developing delirium. Unlike dementia, delirium usually occurs fairly quickly and an individual is brought to the hospital because of an obvious change in mental status.

A delirious person has a confused relationship to the environment, and the confusion waxes and wanes. S/he may seem to go in and out of a disoriented state, showing confusion about time of day and location (believing s/he is at home rather than in a hospital), misinterpreting the physical environment (seeing certain objects as things they clearly are not), and even experiencing hallucinations and illusions. Behavioral disturbances such as agitation and aggression are common.

Delirium generally develops rapidly over a short period of time (usually hours to days) and fluctuates throughout the day. Delirium, if left untreated, can lead to stupor, coma, and even death. Mortality can be as high as 20 percent. It is considered a medical emergency. Finding the cause(s) of a delirium can be lifesaving.

What are the signs of delirium?
Delirium is characterized by changes in alertness or cognition and an inability to concentrate or process external stimuli. Delirium can cause rapid and unpredictable shifts from one emotional state to another. Someone having problems with the sleep-wake cycle, including daytime sleepiness, nighttime agitation, and disturbances in sleep continuity should be evaluated for delirium. Emotional disturbances, such as anxiety, fear, depression, irritability, anger, euphoria, and apathy should also trigger an assessment.

Delirium in HIV+ people with advanced illness (AIDS) can be caused by any number of factors in combination including metabolic abnormalities, sepsis, hypoxemia, anemia, CNS infections and malignancies, almost all HIV-related drugs, opioids, and illicit substances. Initial HIV infection may also cause delirium. Any time a patient is diagnosed with delirium s/he should be given a full neurodiagnostic workup to exclude various general medical complications associated with HIV infection.

How is delirium diagnosed?
The major challenge in diagnosing delirium is to distinguish delirium from dementia. This is especially true when treating people with advanced HIV disease (AIDS) because HIV-related dementia is so prevalent. Delirium has an abrupt onset, in a matter of hours, while dementia must have memory problems with decreased functioning for at least one month.

Depression
Depression is a serious medical condition that can be paralyzing to sufferers. It is twice as common in people with HIV as in the general population. Depression is characterized by the presence of most or all of the following symptoms: low mood, apathy, fatigue, inability to concentrate, loss of pleasure in activities, changes in appetite and weight, trouble sleeping, low self-worth, and, possibly, thoughts of suicide. There are many different types of treatments for depression, including antidepressants and specific types of psychotherapy, or “talk” therapy. Treatment, however, must be carefully chosen by a physician or a mental health professional based on the patient’s physical and mental condition. (APA, 2014)

Mood disorders, particularly depression, are the most common psychiatric complication associated with HIV disease. Although some studies suggest that depression is no more common among HIV+ people than in those at risk for HIV infection, a large meta-analysis of 10 studies found HIV+ people had twice the risk for depression than those who were at risk for HIV but were not actually infected.

One study estimated the lifetime prevalence of depressive disorders in HIV+ individuals to range as high as 22 percent, compared to lifetime estimates of 5 percent to 17 percent and current major depression diagnoses of only 3 percent to 10 percent in the general population. Delirium is the most common neuropsychiatric diagnosis in hospitalized or critically ill HIV+ patients. The rates of delirium in HIV+ patients are estimated to range from 43 percent to greater than 65 percent in late-stage AIDS. (APA, 2014)

Groups at heightened risk for HIV—African-American men and women, gay and bisexual men of all races—may have higher risk for depression, which may lead to increased risk behavior.

Depression can also be a consequence of HIV-induced brain injury or antiretroviral medication.

HIV+ individuals who have not disclosed their seropositive status, have lost loved ones to HIV, or are themselves in an advancing stage of the illness are at serious risk. Treatment failure, and even treatment success, should also be considered risk factors for depression.

Does HIV cause depression?
Many health care professionals believe that an HIV+ diagnosis will naturally result in depression. Although the diagnosis will certainly trigger anxiety and distress—sometimes so severe it impairs functioning and may even lead to suicide—this kind of situation-specific emotional response is not the same as depression. A person distressed by an HIV diagnosis may indeed need treatment, most likely for an adjustment reaction, but the distress will respond to supportive and other types of psychotherapy rather than medications.

It’s challenging to differentiate clinical depression from the effects of HIV, the side-effects of treatment and even other illnesses, all of which can affect mood. The surest way to finding the difference is in how someone responds to depression treatment. Conditions that are not actually depression will respond poorly to antidepressant treatment.

Anxiety
Anxiety is a feeling of panic or apprehension, which is often accompanied by the physical symptoms of sweating, shortness of breath, rapid heartbeat, agitation, nervousness, headaches, and panic. Anxiety can accompany depression or be seen as a disorder by itself, often caused by circumstances that result in fear, uncertainty, or insecurity (APA, 2014).

Each HIV patient and each experience of anxiety is unique and must be treated as such. Many drugs offer effective treatment, and many alternative remedies have proven useful, either alone or in combination with medication. Among them: muscle relaxation, acupuncture, meditation, cognitive behavioral therapy, aerobic exercise, and supportive group therapy.

Feelings of anxiety are a normal, healthy response to the diagnosis, onset, or progression of HIV infection. But it’s important to recognize the difference between this type of anxiety and the sort that signals a clinical disorder. HIV itself does not cause anxiety disorders, but HIV+ people tend to experience more anxiety than the general population. Certain medications used to treat HIV can also cause anxiety symptoms. Fortunately, anxiety disorders are among the most treatable of psychiatric conditions, and respond well to pharmacological and non-pharmacological treatment.

Anxiety disorders are a serious concern for HIV+ people who don’t have good coping strategies and a strong social support network, such as family, friends, or a faith community. Individuals with a history of abuse—physical, sexual, emotional—are more likely to have an anxiety disorder.

People who have unresolved grief, whatever the source, should be screened for anxiety. Those with a personal or family history of anxiety disorders also are at higher risk for developing them.

A person who has anxiety lasting longer than six months, and who has excessive worries is typically diagnosed with a general anxiety disorder. The disorder has been noted in 15.8 percent of HIV+ persons, compared with only 2.1 percent of the general population.

Some 10.5 percent of HIV+ people, compared to 2.5 percent of the general population, have experienced panic disorder, which can be associated with viral infections, cocaine use disorder, and major depressive disorder. There is also a higher rate of posttraumatic stress disorder (PTSD), which may be related to a history of trauma, physical or sexual abuse. (APA, 2014)
Sleep Disorders
HIV+ people experience insomnia and other sleep difficulties at a greater rate than the general population. But physicians may not always recognize the seriousness of disrupted sleep in a patient’s overall quality of life. Medical providers treating HIV+ patients need to take complaints of sleep difficulties seriously, because they can indicate an increased risk for depression, pain, and substance abuse. (APA, 2014)

Studies have found that 30-40 percent of HIV+ patients have had some difficulty sleeping in the previous year, and as many as 50 percent have experienced insomnia at some time in their life. Between 10-20 percent of patients characterize their sleep problems as constant and severe. Nearly half (45 percent) of the 290 HIV+ patients ages 22-77 years in a 2012 study slept less than six hours per night; 34 percent reported difficulty falling asleep; 56 percent had fragmented sleep; 20 percent had both problems; and only 30 percent were good sleepers. (APA, 2014)

A study of 1,682 women, 69 percent of whom were HIV+, found that HIV+ women were 17 percent more likely to report insomnia symptoms than HIV- women. Women ages 31-40 years experienced even higher levels of insomnia. (APA, 2014)

Sleep disorders in HIV+ people are generally treatable. It is important that physicians monitor patients for sleep disturbances, since early and effective treatment of sleep disorders can greatly lower the potential for complications.

What is insomnia?
Insomnia is the general term for the condition of getting too little, or poor quality, sleep. People with insomnia may have trouble falling or staying asleep, experience “early morning wakening,” or are simply unable to experience restorative sleep. People with insomnia will often in turn experience daytime fatigue, mood disturbance, confusion, or irritability.

There are three categories of insomnia:

- Acute insomnia is temporary and may be caused by pain, fever, or even a stressful event unrelated to HIV. Short-term acute insomnia lasts one to two weeks and is usually associated with a stressor such as job loss.
- Chronic insomnia is diagnosed in patients whose symptoms have lasted three or more nights per week for at least a month. It can be linked to a variety of neuropsychological problems as well as other medical conditions.
- Sleep disturbance, a form of insomnia, is characterized by an increase in stage 1 sleep (when rapid eye movement, or REM, occurs) and a decrease in stage 2, or non-REM sleep.

Chronic insomnia often affects HIV+ people soon after infection, even though there may be no other symptoms. This may be due to anxiety or stress-related factors, or even subtle changes in sleep architecture (the pattern and stages of sleeping) caused by HIV itself.

HIV+ patients just beginning antiretroviral therapy may experience insomnia as a side-effect of the medication itself, though it often resolves as the body adjusts to the drugs. It may be difficult at this point to distinguish the causes of insomnia, as patients also may be experiencing a great deal of anxiety about the medication as well as about HIV, which can interfere with sleep.

Sleep difficulties in HIV+ people who have experienced symptoms of their illness—such as an opportunistic infection if the immune system was seriously compromised before beginning treatment—may be caused by underlying conditions associated with HIV infection, such as fever, pain, dehydration, and poor nutrition. Sleep difficulties are more prevalent for those patients with advance HIV disease (AIDS), and may be due to HIV-related dementia.

Insomnia in HIV+ people, as in HIV- people, can also be caused by stressful life events, substance abuse, and other psychiatric conditions.

Disorders due to medical complications of HIV infection

<table>
<thead>
<tr>
<th>Possible underlying causes of common medical complications associated with HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical complication</td>
</tr>
<tr>
<td>Opportunistic brain infections</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Opportunistic cancers</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Metabolic complications</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Drug-to-drug toxic interactions</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Psychoactive substance use complications – recreational</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Psychoactive substance use complications – prescribed</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

The course of HIV infection may include medical complications that create changes in one’s mental status that mimic more common psychiatric conditions, such as depression, mania, anxiety, and psychosis. The most critical feature of treatment is accurate diagnosis and treatment of the medical causes. Although psychotropic medications often are warranted for symptom relief, at least temporarily, overall management should focus on treating the underlying medical complication(s). When these conditions occur, coordinated care with medical providers is absolutely essential. These complications highlight the need for clinicians to be aware of and knowledgeable about clients’ medications and substance use patterns and to be suspicious of major changes in mental status, particularly among clients with more advanced illness or those on many medications.

Treatment. Primary treatment for these conditions due to complications of HIV infection relies on treatment of the underlying medical etiology.

Mental health treatment of psychiatric disorders should be client-centered, individualized, and comprehensive to encompass the full spectrum of bio-psychosocial needs. In most cases, due to the complexity of these conditions, no single modality of treatment will suffice. Clinicians should consider a full range of treatments, including psychopharmacology; cognitive-behavioral, interpersonal, psychodynamic, and other psychotherapies aimed at individuals, groups, families, and couples; intensive case management; psychosocial rehabilitation; partial hospitalization; day treatment programs; substance abuse counseling; and others.

For persons with serious mental illness, treatment may need to be uniquely tailored to strengthen diminishing social support systems. To promote stability and treatment adherence, consideration must be given to supportive housing, living arrangements, vocational rehabilitation, outreach, and strong linkages with other community resources. Persons with serious mental illness who are not engaged in mental health care are less likely to be engaged in HIV primary medical care (Cournos and McKinnon, 1997). Moreover, they are at higher risk of being lost in the system due to homelessness, incarceration, rehospitalization, and substance abuse relapse. For all of these reasons, diagnosis or identification of mental illness, including HIV-related neuropsychiatric complications, requires aggressive treatment and is a critical component to the overall health care of HIV positive clients.
Psychotropic medications

Psychotropic medications, such as those agents used to treat depression, anxiety, psychosis, and other conditions, are well tolerated and clearly efficacious for persons living with HIV infection. Psychiatric disorders should be treated aggressively with these medications when warranted, especially since untreated disorders can impair one’s quality of life and may be linked to increases in HIV transmission risk behaviors (e.g., unsafe sex and drug use practices). Psychotropic agents should be used judiciously in persons on antiretroviral and other HIV-related medications. In most cases, psychiatrists should manage these medical regimens. The combined use of psychotropic agents and protease inhibitors requires careful attention to routes of metabolism of each of these medications. Because the medications can alter the metabolism of each other, they are best prescribed and monitored by clinicians with an understanding of potential drug-to-drug interactions, side effects, and routes of metabolism. These medications can be used safely and effectively when combined. However, informed treatment and close monitoring is essential.

Caroline’s story

Caroline was an attractive woman in her mid-30s with a pleasant disposition and a ready smile. Diagnosed with schizophrenia and HIV-associated dementia, Caroline’s situation was further complicated by volatile and poorly controlled diabetes. While her schizophrenia was stabilized through regular intramuscular injections of Haldol Decanoate, her short-term memory was impaired by HIV-associated dementia, ruling out the possibility that she could adequately adhere to the range of medical treatments she required on her own. Neuropsychiatric testing revealed that, in addition to short-term memory loss, Caroline had difficulty concentrating, planning, or solving problems. These cognitive deficits prevented her from being able to check her glucose levels (which had soared to as high as 410), determine if she needed insulin, and inject the proper amount. Although her HIV infection was not yet advanced, adherence to needed HIV medications also was problematic.

Her psychological counselor quickly realized that a series of external supports were needed to ensure Caroline’s survival. The counselor enrolled her in a psychosocial support day program and arranged for a Medicaid waiver that provided for a nurse to go into the home twice a day to administer Caroline’s insulin. She was then placed in a group home in which overnight staff could ensure that she didn’t eat middle-of-the-night snacks that would elevate her blood sugar levels or light up cigarettes she might forget to put out. The counselor involved Caroline’s family in treatment planning and educated them about her medical condition and her cognitive limitations. Close coordination with the public health nurses, the residential counselor, and Caroline’s family members has resulted in a safe and supportive environment where Caroline retains some freedom and self-direction, but where her bio-psychosocial needs are met.

SECTION 4: CASE MANAGEMENT

Case management, as an accepted mental health treatment modality, developed largely in response to deinstitutionalization—the release of large numbers of persons with serious mental disorders from state hospitals in the 1980s. Community mental health centers were charged with developing methods for effectively treating and maintaining those who were released back to the community. In order to prevent frequent re-hospitalizations, it was often necessary to put in place a wide range of services to support the client in meeting basic human needs. While the resources—such as food, shelter, medical care, financial assistance—were often already in place in the community, staff with an understanding of serious mental illness and local resources were needed to link clients to services and to monitor treatment adherence and general functioning.

Due to the many concrete service needs of those living with HIV infection, case management has long been a cornerstone of HIV care. The Ryan White CARE Act has recognized the importance of case management and allocates a significant amount of its funding for case management. Today, as HIV increasingly moves into communities of poverty, a disproportionate number of persons who are homeless, have mental and addictive disorders, lack experience in accessing services, or who are in jails and prisons are affected. Given these trends, the need for case management becomes even more profound.

As the HIV/AIDS Mental Health Services Demonstration project progressed, many of the 11 projects found themselves allocating more and more resources for case management, underscoring the growing need and demand for this function in assisting people living with HIV who also have mental and/or addictive disorders. This chapter describes the demonstration sites’ experiences in providing case management services to people living with HIV.

Case management activities

Assessing the client’s needs. With input from the client, the case manager assesses the client’s comprehensive bio-psychosocial needs. The case manager’s assessment will complement the clinical assessment referred to earlier, which needs to be comprehensive and thorough and take the needs of the whole person into account. In cases where the needs are immediate or urgent, the case manager must possess the judgment and skills necessary to make an emergency referral for food, shelter, psychiatric hospitalization, detoxification, or emergency room care.

Developing a service plan. Together, the client and the case manager develop a service plan based on the needs identified in the case manager’s assessment. Encouraging the client to prioritize his/her own needs helps to establish trust between the client and the case manager. It also reinforces the client’s sense of self-determination. The case manager needs to honor what the client sees as the priority. For example, the case manager may believe getting medical care for HIV infection is first on the list, while the client may be more worried about paying next month’s rent. A written service plan—jointly agreed to and signed by the client and the case manager—is a useful instrument in establishing trust and setting service priorities. The agreement can serve as a valuable reference tool for reflecting back upon what has been accomplished and planning for goals not yet met.

Linking the client to services. Clients with HIV often need a broad range of services. These may include primary medical care, mental health and substance abuse treatment, financial assistance, housing, food, financial entitlements, clothing, transportation, child care, dental care, and legal services. Many clients need help in obtaining resources and/or connecting with services. The process of coordinating a broad range of health care and support services requires a case manager with creativity, negotiation skills, political savvy, and a knowledge of community resources. In cases where the client is capable of accessing services, simply giving him/her a phone number may be sufficient help. If, on the other hand, the client has a serious mental illness, HIV-
associated dementia, poor communication skills, or is unfamiliar with the service delivery system, the case manager may need to schedule appointments and accompany the client to the appointment.

The case manager often serves as a “go-between” with the service provider when long and difficult forms must be filled out or when the client becomes tired or frustrated and unable to go through the cumbersome steps required to obtain the needed service. Case managers can make productive use of this time spent transporting or waiting with the client to build a positive therapeutic relationship and to engage him/her in mental health treatment. At the same time, the

response to the person’s mental illness, substance use, HIV status, race, sexual practices, socioeconomic status, cognitive deficits, homelessness, and/or criminal record. When a door is shut, an opportunity is denied, or a right is violated, feelings of helplessness, hopelessness, and rage can take over. While the goal is to empower the client to advocate for himself/ herself, the case manager has a responsibility to intervene when the client is unable to do so.

Examples of discrimination in emergency rooms, housing opportunities, and employment situations abound— as do examples of effective advocacy. While advocacy on an individual level is the immediate task, the dedicated case manager also keeps in mind his/her responsibility to advocate for change on a systems level so that institutionalized prejudice and discrimination against persons with HIV, mental illness, substance abuse, or members of a minority race, minority sexual orientation, or minority religion can be addressed. Effective advocacy on an individual and systemic level can positively affect the whole climate of future service delivery.

Case managers at the Alexandria project identified five phases of treatment in working with persons who are homeless and dually diagnosed with mental and substance abuse disorders (Alexandria Community Services Board, 1994).

- The acute stabilization phase may require detoxification or hospitalization to stabilize acute medical or psychiatric symptoms.
- The engagement phase is the time during which the helping relationship is developed and basic services, such as food and shelter, may be provided.
- The persuasion phase occurs when the case manager encourages the “engaged” client to recognize and accept the need for treatment.
- The active treatment phase is the stage during which the client develops the attitudes, behaviors, skills, and determination to accept treatment and does so.
- The relapse prevention or rehabilitation phase is when the client develops a greater sense of mastery over his/her disorder(s) and exhibits greater competence in functional and social capabilities.

**Advocating on behalf of the client.** Persons with HIV face a broad range of stigmatizing attitudes and actions, stemming from society’s

### Elijah’s story

In recovery from a crack cocaine habit for almost three years and climbing steadily up from a major depression, Elijah faced eviction from the small apartment where he lived with his teenage son. Savings from occasional jobs had supplemented his meager veteran’s disability pension, but now a rent increase forced him to look for subsidized housing. His mental health worker had identified an apartment in a well-kept building in a safe neighborhood where another of her clients lived. She had dealt with the landlord before and set up an appointment to look at the apartment. The moment the white landlady laid eyes on the dark-completed Elijah, she began to make excuses. “Someone in the building has just asked if he could move to a two-bedroom, so I have promised it to him. I’m sorry, but the apartment is no longer available.” Elijah immediately became agitated. A sensitivity born of countless encounters with subtle— and not-so-subtle—race discrimination left no doubt in his mind about the motivation of the woman standing before him. “I’ll never get this

The HIV team immediately took action. A team member called to inquire about the apartment’s availability and was told she could come to see it in the morning, providing sufficient evidence to call the Housing Authority to register a discrimination complaint. “We’ll investigate right away.” The mental health worker, realizing she might need to deal with the landlady in the future, called her and diplomatically expressed her puzzlement and dismay at Elijah’s being turned down and hinting at discrimination. The landlady vehemently denied she had been discriminating, but lo and behold, the upstairs neighbor had changed his mind about moving into a two-bedroom apartment. Elijah and his son got their clean, new apartment. In this true case of discrimination, successful advocacy had a beneficial impact on both the individual and the system.

### Case management providers and settings

Because the need to link persons with HIV to a spectrum of resources and services is readily apparent, a range of disciplines and persons with varying levels of education and skill have felt called upon to provide case management when necessary—from psychiatrists and psychologists to social workers, counselors, case aides, and peers. With the need for case management increasingly being recognized by many health fields, specialized forms of case management have developed in mental health, public health nursing, social services, and substance abuse.

The level of training, education, and skill required to be an effective case manager often is underestimated. To work effectively with clients who are triply diagnosed with HIV, mental illness, and a substance use disorder, a master’s degree in a human services field is highly desirable. An effective case manager brings a broad range and high level of skills and/or natural ability to his/her work, including an ability to establish rapport, to understand the client’s bio-psychosocial needs, and to know the resources that are available in the community. He/she must possess determination, persistence, advocacy skills, empathy, and tact.
In the field of behavioral sciences, increased recognition and credit is being given to case managers and the important work they do. With many case managers working in mental health centers, medical clinics, substance abuse programs, and AIDS service organizations, service duplication and gaps can become problematic. Coordination of services among providers through establishing clear, individual responsibilities is necessary to make the most efficient use of limited resources. Designating a “primary case manager” and holding periodic “prescription team” meetings in which all providers and the client are present is useful in providing quality care. (See Mental health services, earlier) Case management can be provided with varying degrees of intensity. Working with persons who are triply diagnosed and also homeless or recently incarcerated requires a high level of assistance or intensity—and a correspondingly smaller caseload. A high-functioning client may need assistance in accessing HIV or mental health resources from time to time but is generally capable of navigating the system on his/her own with little outside help.

Building a strong helping relationship

At the heart of effective case management is a strong, trusting, and collaborative helping relationship. Working with an HIV-affected population that is increasingly disenfranchised, stigmatized, and alienated from society requires special skills and a special attitude on the part of the case manager. Efforts to engage and retain the client in service often require targeted, strategic approaches. Meeting the client on his/her own turf and hiring culturally sensitive and street-wise outreach workers who establish contact and serve as a bridge between the client and the provider can significantly improve engagement and retention rates. Many clients feel degraded by their present circumstances and have felt rejection from their family, their church, and their peers. Experiences in dealing with “the system,” including the criminal justice system and recovery programs often, have been negative and disempowering.

Barriers to effective case management

Barriers to obtaining needed services, treatment, and interventions exist for both the client and the provider. The effective case manager is presented with the challenge of using ingenuity, creativity, and people and problem-solving skills to overcome these barriers with and on behalf of the client. In the course of their work, the 11 demonstration projects encountered, identified, and overcame many such barriers at both individual and systemic levels. Possible ways to address and minimize these barriers are discussed throughout this course.

Barriers faced by the case manager

- Personality or value conflicts among service providers.
- Ethical issues related to disclosure and “duty-to-warn.”
- Difficulty maintaining professional boundaries with clients.
- Lack of adequate resources to meet client needs.
- Restrictions on the number of days allowed for hospitalization or treatment.
- Bureaucratic red tape preventing quick responses.
- Discrimination against client population.
- Client expectations and demands that are unrealistic or cannot be met.

Barriers faced by the client

- Distance from needed services and providers.
- Unduly cumbersome application and referral processes.
- Lack of transportation to and from appointments.
- Lack of child care while keeping appointments.
- Distrust of the service system.
- Fear of confidentiality violations.
- Social stigma and discrimination.
- Cultural insensitivity and language barriers.

SECTION 5: PSYCHOTHERAPY AND COUNSELING

Therapists make decisions about psychotherapy and counseling approaches based on their education, training, supervision, and personal experience. The 11 sites in the demonstration project found that client need was the most important factor in selecting the approach. Traditional approaches required modification to meet new and complicated problems associated with living with HIV. Psychotherapeutic and counseling approaches used by the demonstration projects included:

- Cognitive/behavioral therapy.
- Supportive psychotherapy.
- Pastoral counseling.
- Crisis intervention/therapy.
- Brief psychotherapy.
- Educational counseling.
- Psychoanalytic psychotherapy.
- Existential psychotherapy.

Professional interventions

Psychotherapy and many types of counseling are primarily provided by trained professionals who are prepared to facilitate behavioral and cognitive change. A mental health professional must consider how the intervention can be shaped to incorporate the many psychosocial complications of HIV infection. It is helpful for service providers to be mindful that “traditional” service patterns often have to be reconsidered in order to provide adequate services. The 11 demonstration projects found the concept of “bending the frame” to be a helpful way of doing this (Winiarski, 1991). For example, through the process of dealing with HIV infection, many service providers have found themselves visiting clients at their homes or at hospitals—something that is not usually considered a common procedure of more traditional mental health service approaches.

Additionally, the crisis of HIV infection brings many individuals into mental health treatment who have no previous experience or familiarity with the process. For example, some traditional psychotherapists elect...
not to call their clients if they miss a psychotherapy appointment. However, the 11 demonstration projects found themselves spending a great deal of time focusing on retention efforts, such as calling clients to remind them of appointments and making follow-up calls. Such calls seemed to help demonstration project clients understand that the therapeutic process was taken seriously by the program staff.

In time, many clients began to take ownership and responsibility for their own treatment, which may have never occurred without the retention efforts put forth early on in the process. Other examples of “bending the frame” included harm reduction approaches to substance abuse treatment, in-home services, telephone sessions, and intensive case management coupled with psychotherapy.

Another important facet of the process was to develop and/or maintain a “community” in which demonstration project clients felt comfortable seeking help. This was accomplished in a variety of ways—from peer interaction to group interventions to a structured community in a psychosocial rehabilitation program.

**Individual interventions.** For persons with HIV who seek mental health services, individual counseling or psychotherapy sessions are generally a first step in the treatment process. Client concerns about confidentiality, substance use, sexual orientation, and sexual practices may initially make one-to-one interventions the most comfortable modality. Counseling generally refers to explorations and problem-solving interventions relating to current concerns and issues, such as adjusting to the HIV diagnosis, managing relationships, and job and workplace issues. Psychotherapy explores feelings, motivations, behavioral patterns, interpersonal relationships, and patterns of thinking over time.

In the experience of the 11 demonstration projects, a significant number of clients with HIV had histories of early sexual abuse and boundary violations. For those clients, working through aspects of the childhood trauma can be both a liberating and necessary step in moving toward a commitment to self-care and a reduction of risk-taking behaviors. Psychotherapy can help clients develop greater self-awareness, stronger coping skills, and greater motivation to engage in meaningful and productive activities. Through counseling or psychotherapy, clients in recovery from substance abuse often discover and begin to heal underlying psychological wounds they attempted to mask through substance use.

**Length of treatment varies by case.** For some demonstration projects, treatment lasted as long as clients kept returning for their appointments. Since most demonstration project clients had complex psychosocial needs, treatment was oftentimes long-term, with mental health professionals constantly re-evaluating their treatment plans to ensure they were realistic and client-centered.

**Group interventions.** All of the demonstration projects used group interventions to some degree. Some used group therapy on an occasional basis, while other demonstration projects were exclusively focused on group interventions. Group interventions can be a very powerful way of facilitating change or managing mental health issues associated with HIV infection. Group interventions can often be modified to better address the specific needs of the group and its members.

Groups can be led by either professionals, peers, or a combination of both. Mental health professionals may be better suited to serve as facilitators in groups designed to deal with mental health issues, such as psychotherapy groups. Peers, on the other hand, may be better suited to lead support groups and group discussions relevant to the experience of living with and adapting to HIV. However, both professionals and peers, depending on their personal experience and training, may be qualified to address either of these concerns.

The 11 demonstration projects found the following issues important when creating a “safe” group:

- Consider issues relating to inclusion/exclusion criteria.
- Have individual selection interviews in which group processes and rules are reviewed and agreed upon.
- Create a “confidentiality agreement” that all clients read, agree to, and sign before ever coming to the group.
- Establish clear rules for the group process, including rules on how to address others, accepted behavior in the group, maintaining a safe environment, outside visitors to the group, schedule and meeting place, and interactions outside the group.

**Group interventions**

Support groups are organized meetings in which participants exchange information on life situations to develop new ways to manage, adapt, or change the situation. Support groups have been the mainstay of psychosocial support within HIV-affected communities since the beginning of the epidemic. Particularly for people living with HIV, support groups offer a venue for sharing information and experiences. For example, disclosure of status with family and friends, reaction to medications and their side effects, disappointments regarding medical setbacks, and issues around re-entering the job market are common themes one may encounter in an HIV support group. A major goal of support groups is to increase the social support networks of its members. One of the benefits is the creation of friendships among participants that may last beyond the group process. Outside interaction is sometimes promoted.

Psychoeducational groups are directed at obtaining and processing new information. They usually have a limited scope and duration. Many use “invited” speakers in addition to the group facilitator. “Teaching” by the facilitator or invited guests can be part of the group process but other interactional processes also can serve as a powerful way of “learning” (Freire, 1993). Examples of psychoeducational group topics from the 11 demonstration projects included recognizing depression, managing cognitive impairment, HIV medication adherence, understanding psychotropic medications, disclosure of status, and returning to work.

**Derrick’s story**

Derrick had been released after serving several years in prison. He had stayed sober while incarcerated and continued to do so in the new community in which he had settled with his family. His HIV course had improved, but he felt lonely and isolated. He became involved in a community support group where he developed several friendships. This proved necessary as he learned that, in addition to his HIV infection, he also had diabetes and advanced liver disease. Months later, a friend from the group was hospitalized with the same diagnoses and died soon after. Derrick became consumed with the idea of his own death and physical status. He focused his energy on weight loss and appetite. He had linked progressive wasting with death. The support group helped Derrick confront this irrational belief and refocus his energies toward self-care.

Couple and family interventions provide the opportunity for the client’s significant other and/or loved ones to join the treatment process. The diagnosis of HIV not only affects the infected person but his/her entire “family.” For example, disclosure of status, safer sex
negotiations with a partner, permanency planning, sero-discordant couples, and unresolved fear and anger are issues that may be encountered by treating a family or couple. Additionally, HIV may bring additional stresses to families already made vulnerable by substance abuse or poverty.

Psychosocial programming groups involve creative expression, skill-building, insight development, and socialization. These groups are very interactive, often involving doing a task rather than verbal discussion alone.

Peer counseling

Peer counseling involves the provision of services by individuals who are members of the treatment population. At some of the demonstration sites, peer counselors shared a number of characteristics, usually including HIV status and/or ethnic and cultural membership. Peer counseling, like professional psychotherapy, can be done in several modalities (individual, couples, families, and groups). While traditional professional psychotherapy may focus on psychological change, peer counseling typically focuses its intervention on support and education. Peer counseling may be a less stigmatizing experience than traditional mental health treatment, increase a sense of trust and empathy between the counselor and the client, allow for a more open discussion of treatment adherence and negotiating the service system, and promote the development of “community” among clients. It also may be a cost-effective way to serve clients.

Training is a crucial component of peer counseling. Peer counselors need specific guidance on when to refer clients to professionals and may need training to improve their listening and assessment skills.

Supervision by a professional mental health clinician is critical to safeguard the quality of services and to help ensure that clients who need professional psychotherapeutic help are getting it. There are also ethical considerations to be addressed to ensure that appropriate counselor/client boundaries are observed. Again, supervision is critical.

How one program used peer counselors

“Our peer counselors have done outreach in medical clinics, provided individual and group support, led educational forums, and directed peer-based substance abuse groups. Those clients whose needs were greater or expressed interest or readiness for professional psychotherapeutic treatment were referred to the mental health team. Many clients have come to mental health treatment through the normalization of the counseling experience by peers. This program is supervised by a licensed mental health clinician in order to ensure appropriate triage.”

– Phil Meyer, LCSW Los Angeles Project

SECTION 6: COUNSELING THEMES AND CLINICAL CONSIDERATIONS

“Will I lose my dignity / Will someone care / Will I wake tomorrow / From this nightmare?” These lines from RENT, the Pulitzer prize-winning musical by Jonathan Larson, evoke the emotional turbulence often accompanying a diagnosis of HIV disease. Counseling and psychotherapy sessions may include poignant, harrowing stories filled with anger, sadness, shame, and rejection. During these same sessions, however, people living with HIV can find hope, survival, acceptance, and redemption. When working with HIV-infected persons, it is essential to be present with such pain and hope, whether it is verbalized or not.

It was the experience of the 11 demonstration projects that certain counseling themes and clinical considerations emerged among all sites. While not an exhaustive list, this chapter highlights the common themes and considerations encountered in the demonstration projects. What arises as the important core issues for clients will vary, depending on their specific life circumstances. For example, clients living with families who are fearful and uninformed about HIV transmission may describe how family members demand that they use only disposable plates and utensils—to “protect” others. Lacking knowledge, the family contributes to a conclusion for the person with HIV that he/she is unclean, thereby promoting isolation and stigma.

The 11 demonstration projects identified the following counseling themes and clinical considerations common in the provision of mental health services to people living with or affected by HIV: sense of self and self-esteem; parenting; fear; disclosure; sexual orientation; loss of loved ones; adherence; Lazarus syndrome; and spirituality.

Sense of self and self-esteem

Empirical studies over the last 15 years indicate that self-esteem is an important psychological factor contributing to health and quality of life (Evans, 1997). Recently, several studies have shown that subjective well-being significantly correlates with high self-esteem, and that self-esteem shares significant variance in both mental well-being and happiness (Zimmerman, 2000). Self-esteem has been found to be the most dominant and powerful predictor of happiness (Furnham and Cheng, 2000). While low self-esteem leads to maladjustment, positive self-esteem, internal standards and aspirations actively seem to contribute to ‘well-
being’ (Garmezy, 1984; Glick and Zigler, 1992). According to Tudor (Tudor, 1996), self-concept, identity and self-esteem are among the key elements of mental health. The outcomes of negative self-esteem can be manifold. Poor self-esteem can result in a cascade of diminishing self-appreciation, creating self-defeating attitudes, psychiatric vulnerability, social problems or risk behaviors. The empirical literature highlights the negative outcomes of low self-esteem.

**Parenting**

Specifically for parents, complex personal struggles will naturally involve guilt over having become infected, having shortened time with their children, and/or leaving orphaned children—all of which may generate a permissive parenting style that impedes setting limits and discipline. As a result, parents may too readily gratify their children’s wants in an effort to assuage their guilt. When HIV-infected parents become ill, it may be more difficult for them to actively parent—to discipline and provide caretaking. In such a situation, children may develop parentified behaviors and assume a caregiver role toward both the parent and younger siblings. When a parent recovers or ultimately dies, a child may find it difficult to relinquish such a role and return to a developmental stage suited to his/her age.

**Maria’s story**

Maria, a 22-year-old Latina, lost custody of her daughter, because of neglect relating to Maria’s addiction to crack cocaine. Maria did not appear to understand the responsibilities of being a parent, but she was intent upon regaining custody of her daughter—even though her worker from Child Protective Services (CPS) thought this highly unlikely. Over the course of three years, Maria, with the help of her therapist, worked diligently on parenting skills, communication with her family, her relationship with CPS, and her substance abuse problem—in both individual and family therapy sessions. Several months ago, Maria was given custody of her daughter, and her CPS case was closed. Maria remains in treatment and currently is working on setting clear and consistent limits with her daughter, as well as issues around returning to school to get her GED.

**Fear**

Fear is a reasonable and expected reaction to HIV. Clients may fear the infection and its progression. They also may fear rejection from friends, family, or co-workers when they disclose their status. As a result, they may choose not to disclose their infection, preferring to keep this a secret. This becomes especially complex for families and their children as noted above. A parent may choose to keep his/her children and the family removed from interacting with others in the extended family or in the community to protect this secret and to delay or avoid disclosing his/her status.

Parents also may decide to disclose HIV-related information selectively— but only after determining criteria about who will be told. Families that fear repercussions related to stigma may develop a boundary around the family and limit contact with extended family or the community. Such insularity may deplete the parent as he/she serves as the sole emotional link for the children and limits other potentially supportive contacts for the children. Older children may sense that a secret exists and may become suspicious regarding the nature and reason for the secret, a suspicion that the parent is unwell and has HIV.

**Disclosure**

Disclosure can present its own turbulent struggle. Disclosing one’s HIV status may contribute to strong feelings of rejection and isolation, or it may facilitate finding support and lessening one’s burden. The risk and complexity of disclosing one’s status is especially weighty for those in intimate relationships or those attempting to establish such a connection. For many, disclosure becomes a complicated dilemma that may best be handled through discussion in counseling sessions.

Therapists can encourage clients to discuss their own emotional responses to HIV and their beliefs about reactions from others. This will assist clients in determining if disclosure needs to occur at all. For clients whose boundaries in relationships frequently blur and may become enmeshed with others, there may be benefits if they can learn to protect their privacy and limit disclosure to prevent emotional upset.

**Sexual orientation**

Gay, lesbian, or bisexual clients may feel guilt or shame as a result of society’s negative and distorted beliefs about homosexuality. Some may even believe that their infection is a “punishment” for being gay. Many people remember when HIV was initially identified as gay-related immunodeficiency disease (GRID), and for some, disclosure of one’s HIV-positive status is complicated by whether others will automatically assume they are gay. Many heterosexual individuals do not want to risk what they view as a societal stigma, and many gay individuals are not prepared to publicly acknowledge their sexual orientation. Such reactions may damage the client’s sense of self and lead to low self-esteem and isolation. Therapeutic work with issues of sexual orientation requires specific knowledge, sensitivity, an appreciation of the effects of homophobia, and an affirming attitude.

**Loss of loved ones**

In communities where there have been a great number of deaths associated with AIDS, such as in the gay community and now more commonly in impoverished communities of color, there is a toll from the trauma of multiple deaths that complicates grieving. Multiple losses is a common theme for many people living with or affected by HIV. For clients not infected with HIV who belong to communities
Section 7: Substance Abuse Treatment

Substance abuse has been associated with HIV/AIDS since the beginning of the pandemic. It is well known that sharing injection equipment is a leading cause of HIV transmission among those who inject drugs. But drug and alcohol use also put people at higher HIV risk by disinhibiting them and making it more likely they will engage in unprotected sex.

The National Institute on Drug Abuse (NIDA) reports that from 2005 to 2009, 64 percent of HIV+ people in the U.S. had used an illicit drug, but not intravenously; only 19 percent had never used an illicit drug. A 2009 study found one in four of those living with HIV reported alcohol or drug use at a level warranting treatment. Besides injection drugs, other substances associated with HIV risk include cocaine (“coke, crack”), amphetamines (“speed”), alcohol, inhaled nitrites (“poppers”), and “party” or “club” drugs, such as crystal methamphetamine (meth) or MDMA (“ecstasy”).

NIDA further reports that drug abuse and addiction can worsen the progression of HIV and its consequences, especially in the brain.

Adherence

The interplay between adherence to medication and treatment regimes, clients’ psychological and emotional state, and their health is critically linked. The greater use of protease inhibitor treatment, for example, has contributed to renewed health for some with advanced HIV infection and a longer period without disease progression for those with asymptomatic HIV infection. Managing the doses and administration of these drugs requires a significant level of commitment from providers and clients as there are risks when medications are not taken properly. Realistic fears about adverse effects, reluctance to acknowledge one’s need for medications, and avoidance of HIV itself may affect one’s emotional reaction to initiating protease inhibitor treatment. For many to cope, HIV itself needs to be put out of their minds as they continue to live from day-to-day. However, beginning protease inhibitor therapy becomes a frequent reminder of their HIV infection.

Lazarus Syndrome

A central psychological theme that accompanies protease inhibitor therapy is the emergence of the “Lazarus syndrome,” in which persons with advanced HIV infection notice a significant improvement in the medical indicators of immune system function and HIV viral load. With improved health, they may experience varying degrees of increased energy and fewer immobilizing symptoms. For many, this is a relief and becomes a welcome opportunity to reconstruct their lives. For others, there may be a sense of existential angst and the development of symptoms of depression, such as lethargy, isolation, and sadness, because they already had prepared to die.

Spirituality

Attending to the spiritual aspect of clients’ coping may prove helpful in stimulating resources for living, as well as assisting clients to extract and integrate meaning into their experiences of living with HIV. Provider insensitivity to the client’s spiritual background and belief system can erect an insurmountable barrier to treatment. Mental health providers may need to increase their own comfort with religious traditions and spiritual practices as clients may not wish to meet with a separate pastoral counselor. Counselors and therapists may consider integrating spiritual issues into their counseling work by exploring the meaning of faith as it relates to the client and the purpose it serves in the client’s life. Linked to this is the need for providers to remain open to clients’ belief systems—especially when clients’ beliefs are not reflective of their own religious traditions (specifically for individuals among recent immigrant groups and communities of color) and utilize the client as a resource.

By incorporating concepts of faith, strength, and redemption (as determined and described by the client) into the therapeutic process, mental health providers may find that this approach offers comfort and solace to clients, especially those experiencing increasing health complications or those facing death. By being willing to explore the topic of spirituality or faith, mental health providers can begin to discuss ways to help clients integrate their spirituality and HIV status into their lives more effectively.

Edward’s Story

Edward had begun treatment with protease inhibitors in May of the previous year. His response to the medications was excellent, as his viral load became undetectable and his T-cells increased. Edward had survived the deaths of practically everyone else he knew who had been infected with HIV. When he considered his survival, he was consumed with the question, “Why me?” Diagnosed with an AIDS-defining illness in the 1980s, Edward expected a trend of deterioration and death. However, protease inhibitor treatment revised that assumption. Edward was called upon to confront the task of life reconstruction complicated by survivor guilt and the developmental dysynchrony that comes from not progressing to the next stage he was expecting. Edward seemed ashamed that he was not happier and more pleased by his improved health. Treatment, consisting of both an increase in an anti-depressant medication and insight-oriented psychotherapy with a focus on loss, helped Edward to reinvest himself in life and make a trial return to work.

Alan’s Story

Alan had cared for his partner, Jerome, for a year after symptoms of HIV-associated dementia appeared and created drastic changes in Jerome’s personality. Alan speaks of how he tenderly cared for Jerome until his death. When faced only a month later with his father’s death, he describes how he felt numb and disconnected. Further complicating his grieving was the earlier death of a family member and several deaths of friends. Alan’s therapist helped him reflect on his relationship with Jerome and strive for reconciliation. His coping capacity was enhanced after grief work was incorporated into several counseling sessions.

www.EliteCME.com
Animal studies have shown that stimulants can increase HIV viral replication. A human study found HIV caused greater neuronal injury and cognitive impairment in drug users than non-users.

**How does substance abuse complicate HIV treatment?**

Concurrent (or dual) diagnoses of HIV, substance use, and mental health disorders may affect one another, complicating the course of HIV infection. Problematic drug and alcohol use can undermine both prevention and treatment adherence. A substance-using patient is less likely to adhere to antiretroviral medications, increasing the risk for viral resistance. (APA, 2014)

Needle-exchange programs and information about cleaning injection equipment has reduced new HIV infections among injection drug users. But injection drug users, often with limited access to care, don’t tend to seek medical care for HIV until the disease has progressed, complicating treatment.

Drugs such as heroin, cocaine, and alcohol can suppress the immune system. Drugs can also interfere with HIV medications, and vice versa. Amphetamines, ketamine (“Special K”) and heroin can interact with specific antiretrovirals, while Ritonavir can increase the potency of MDMA to a fatal degree. (APA, 2014)

There has been a long-standing relationship between HIV infection and substance use disorders. The correlation between injection drug use and HIV infection is well known and documented. There also exists a relationship between non-injection drug use and HIV infection. Individuals are at greater risk for HIV transmission while under the influence of alcohol or other drugs due to impaired decision-making processes. Continued alcohol or other drug use can further suppress the immune system. It also has potentially damaging psychological effects that may interfere with well-being and functioning. The experience of the 11 demonstration projects confirms the high correlation of HIV infection and substance abuse. Demonstration data show that approximately 25 percent of clients served in the 11 sites had a diagnosis of alcohol dependence, while approximately 50 percent of clients met criteria for drug dependence.

A diagnosis of HIV can be overwhelming, and a common response of the newly diagnosed is to self-medicate with alcohol or other drugs. HIV-specific substance abuse treatment must incorporate treatment approaches that are sensitive and responsive to the presence of multiple diagnoses. In addition, service providers need to be better informed of the broad range of substance use disorders and better equipped to make accurate substance use diagnoses. To make sound and clinically responsible choices about the proper approach to substance abuse treatment and the selection of the appropriate treatment modality, service providers can look to the assessment process as the best place to start the treatment regimen. This is especially true when a client meets criteria for substance abuse and/or dependence. (See Clinical assessment, earlier)

**Treatment approaches**

Increasingly, persons infected with HIV are from indigent, marginalized populations. It is essential that they be linked with some type of substance abuse treatment programming if they are dependent on alcohol or other drugs.

**Abstinence.** The historical approach to substance abuse treatment has been to promote abstinence from non-prescribed substances. This approach has been, and continues to be, supported by involvement in 12-step programs (Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous). Abstinence-based programs are generally appropriate for individuals who are diagnosed as substance dependent, self-identified as addicted, or who want to abstain regardless of diagnosis. Some professionals working within the 12-step framework believe that the prescribed use of psychotropic and/or pain medications is not appropriate. However, adherence to this belief has declined significantly in recent years.

**Harm reduction.** The harm reduction model has become increasingly popular, partially in response to the HIV pandemic. It recognizes that some people will not or do not need to abstain from all substance use. In light of this recognition, the harm reduction model focuses on the need to decrease the potentially damaging effects of alcohol or substance use and on reducing the risk of HIV transmission. Persons with HIV who use alcohol and illicit drugs are vulnerable to engaging in high-risk behavior. Furthermore, these individuals may have failed abstinence-based substance abuse treatment programs in the past. They may, however, benefit from approaches that emphasize health and well-being, rather than total abstinence from substances. Harm reduction is applicable to a range of self-destructive behaviors, including high-risk sexual activities. Types of harm reduction programming include methadone maintenance, needle exchange, and programs that teach persons to use alcohol and other drugs in ways that are less harmful. Frequently, individuals are referred to abstinence-based programs from harm reduction programs.

**Treatment modalities**

A number of substance abuse treatment modalities were used by demonstration projects in working with people with HIV who also had a substance use disorder. In sites where substance abuse treatment services were not provided, existing community resources were critical. These modalities are described below.

Medical detoxification may be required for the individual with a long history of substance use/dependence—particularly those using alcohol or heroin. Medical detoxification includes a brief period of hospitalization (approximately 3 to 7 days) and the administration of medication to alleviate withdrawal symptoms. Medical detoxification also may be considered when beginning substance abuse treatment for those with chronic medical diseases to control the impact of withdrawal on the client’s medical condition. Mental health services offered in conjunction with detoxification services may be effective in encouraging participants to access more structured care following the detoxification experience.

Social detoxification occurs in either a hospital or non-hospital setting and usually does not include medication to treat withdrawal symptoms. The length of stay varies from 7 to 21 days, depending on the client and his/her available financial resources. Social detoxification provides the individual with an opportunity to quit using substances without medication while under constant supervision.

Inpatient treatment programs provide a 24-hour structure for clients in substance abuse treatment. These programs are located within hospitals, psychiatric institutions, or as separate, stand-alone facilities. The length of inpatient treatment varies, depending on program rules, ability to pay for services, and other concerns. Clients may receive more personal attention than in other substance abuse treatment settings, as well as a higher number of service contacts in a shorter period of time. This approach does not work for some clients—largely because they are placed in a setting that is dramatically different and more structured than their usual environment. In addition, they are not exposed to situations that may jeopardize their recovery. One cautionary note is that this may create a false sense of success. Also, inpatient treatment programs often are short-term interventions that may not provide ongoing support services. Fewer insurance companies reimburse for inpatient treatment than in the past, and many others have decreased the number of days that they will cover for such services.

Residential treatment can occur in a setting that provides constant structure and substantial client supervision. Residential treatment programs vary both in the length and the intensity level of treatment. Some programs are as short as 30 days, while others may provide residential treatment for more than a year. These programs may include treatment groups, individual sessions, vocational rehabilitation...
Relapse prevention counseling focuses on identifying high-risk situations and developing plans to decrease any potential for relapse to substance abuse generally begins with internal psychological and emotional issues that may lead the client to placing himself/herself in high-risk situations. 

Relapse prevention acknowledges that addiction is a chronically relapsing condition, but that relapse can be avoided. Relapse prevention planning services are provided at two levels:

- Relapse prevention counseling focuses on identifying high-risk situations and developing plans to decrease any potential for relapse. This is achieved through either individual or group sessions for a specific period of time—usually eight to twelve sessions.
- Relapse prevention therapy helps the client identify core psychological and emotional issues that may lead the client to placing himself/herself in high-risk situations.

Clinical concerns

Comorbidity. Individuals diagnosed with a substance use disorder, a mental disorder, and HIV infection are commonly referred to as triply afflicted with inpatient treatment and are part of the continuum of care offered by such entities. These programs offer group and individual sessions during daytime hours to clients who require some supportive structure in their lives but do not require 24-hour monitoring. The comprehensiveness of such programs depends on the needs of the client and varies from one agency to another. Some clients participating in a day treatment program attend a few hours a day, while others attend one or two days a week, depending on whatever is deemed appropriate and necessary for the client. This option is particularly necessary for addicted single parents with children who are unable to move into a residential treatment program without losing their dependents.

Methadone maintenance is useful for some persons with a long history of heroin use. Methadone is used in place of heroin and is itself addictive. Methadone maintenance requires medical supervision. Clients usually are required to submit urinalysis or blood toxicology screens to determine whether they have used other substances while taking the many medications necessary to manage the progression of the illness. The client may be required to take multiple pills at numerous points during the day. Taking the many medications necessary to manage HIV infection can cause drug interactions, and any one of these medications may cause severe side effects. The service provider can be an important resource for the client by providing information and support that helps the client adhere to his/her medication regimen. If clients are reluctant to take certain prescribed medications, the service provider can discuss various treatment options with the client and help him/her make a clinically appropriate and informed decision. In particular, clients who have a history of drug use—especially those currently in recovery—may be reluctant to take certain psychotropic or pain medications. Conversely, clients accustomed to abusing alcohol and other drugs may manipulate service providers to secure more medication than is necessary.

Medicinal marijuana. Currently, the federal government does not deem the use of medicinal marijuana appropriate or legal. However, some jurisdictions have passed legislation legalizing the use of marijuana for medical purposes. People living with HIV may use marijuana to deal with the side effects of certain medications or to increase their appetite. For example, some clients with persistent nausea or a poor appetite may try tetrahydrocannabinol, an active metabolite of marijuana, in pill form (e.g., Marinol, by prescription). However, delineating use and abuse of marijuana in the setting of HIV infection is important. Program staff must be fully informed of state and local laws related to the medicinal use of marijuana.

Individuals work with professionals to identify those changes necessary to prevent them from putting themselves at risk. This often involves a thorough examination of the individual’s system of core values and beliefs. This process occurs once a client has stabilized, has maintained abstinence for an appropriate period of time, and has demonstrated the necessary behavioral changes. The length of the process varies with the client's history and level of commitment to change.

The realities of relapse. Relapse is often a normal part of the recovery process and should not be considered a treatment failure. Substance abuse is an underlying behavioral symptom of dysfunctional coping skills. Relapse to substance abuse generally begins with internal dysfunction that is either psychological, emotional, or mental in nature. Resuming substance use often is the last in a series of steps that lead to alcohol and other drug use.

www.EliteCME.com
Adherence. Successful substance abuse treatment can play a major role in helping clients adhere to recommended services and prescribed medications. Individuals can become more willing and able to take HIV-related and psychotropic medications as prescribed, thus impeding the progression of HIV infection and improving the client’s mental and emotional well-being. There is a strong correlation between HIV medication adherence and longevity, and it is common for many individuals actively using drugs and/or alcohol to not adhere to their HIV medications.

Programming challenges

Outreach. Since a large number of clients may not access mental health and substance abuse treatment through traditional avenues, it is important for programs to include outreach as a key programmatic activity. Outreach helps agencies reach a greater number of potential clients and establish and maintain important relationships. It also can increase public awareness of the service program and its efforts. Here are examples of activities that make for successful outreach:

- **Going to the places where clients use alcohol and other drugs.** This means traveling into the neighborhoods where drug use is prevalent and meeting clients in a diverse range of areas, such as where the sex trade is prevalent, shooting galleries, crack houses, neighborhood bars, street corners, and parks. Safety training is important for workers going into dangerous areas.

- **Providing tangible items to potential clients.** These may include “safer sex kits” that include condoms and lubricants or “safer drug use kits” that offer clean needles and/or bleach.

- **Using peers.** Outreach efforts can be enhanced and more effective when peers or clients are part of the outreach effort. These individuals may be able to relate to potential clients more effectively because they know the drug “lingo”; understand the subcultures of drug use, the sex trade, and formerly incarcerated individuals; and are better equipped (because of their personal experience with the program) to establish trust with potential clients. Such individuals may be able to educate clinical staff in such issues.

- **Persistence.** Outreach activities should go beyond an initial contact. Additional outreach efforts and multiple contacts with clients may be necessary to engage and retain them in the service delivery process.

Engagement. This concept involves being able to identify and encourage individuals to accept and receive treatment and support services. Genuine engagement is an ongoing process that only starts by getting a client involved in service delivery. The following elements are key components of a sound approach to engagement:

- **Ability to provide immediate services.** Clients may request substance abuse treatment when in crisis. It is essential that services be available at that time.

- **Provide clinically and socially appropriate services that are based on a thorough assessment.** Assisting the client’s substance use history—including past involvement in treatment, types of treatment attempted, previous periods of recovery, and relapse history—will generate a treatment plan that matches the client’s current needs. Agencies frequently offer limited substance abuse treatment options, such as outpatient group therapy or short-term inpatient treatment. These limited approaches may not be sufficient for some clients.

- **Cultural competence.** This concept encompasses taking a multicultural approach to client engagement. As clients are engaged, service providers and other staff must be sensitive to the client’s race/ethnicity, sexual orientation, personal and professional experience, and other factors. Although staffing patterns do not have to specifically match the client base, program managers should take whatever steps are necessary (e.g., sensitivity or cross-cultural training for staff) to ensure that staff are prepared to take a multicultural approach to client outreach and engagement.

Risk reduction

Risk reduction refers to the impact substance abuse treatment may have on decreasing HIV-related risk behaviors. Due to decreased inhibitions while under the influence of drugs and/or alcohol, clients may participate in unsafe sexual activity or use injection drugs. Individuals participating in substance abuse treatment should be encouraged to reduce or eliminate behaviors that put them or others at risk for HIV transmission. Risk reduction efforts can be further strengthened by relapse prevention planning, mental health services, abstinence or harm-reduction approaches. (See Risk reduction, on this page)

Barriers

The Demonstration projects found that numerous barriers to substance abuse treatment can arise. For example:

- **Potential clients may view substance abuse treatment programs as part of the legal system and therefore want to avoid it.** This perception may be based on an individual’s previous, court-ordered experience in treatment programs.

- **There is high potential for relapse—especially among clients who have not stabilized or made a solid connection with the treatment program.** Extra efforts may be needed to pursue these clients.

- **Language itself can be a barrier to substance abuse treatment.** Clients may use street or drug culture language, and this “lingo” may differ from one geographical location to another. Service providers must be able to work through this barrier by learning the language or at least asking clients to explain terms that are not immediately clear to the provider.

- **Lack of support is another barrier that may prohibit individuals from accessing substance abuse treatment.** Potential clients may not have the encouragement from family, friends, or service providers to enter or re-enter substance abuse treatment.

- **Finally, substance abuse treatment should be offered to anyone requesting such services, including those individuals who remain under the influence of alcohol and/or drugs.** It is essential that treatment remain accessible to HIV-infected populations even if they have not previously benefited from a treatment episode.

These are just a few of the barriers that may occur. Programs need to be aware of these and other barriers to ensure that services are available and accessible to the target population, and appropriate for their needs.

Risk reduction

Risk reduction activities cover a range of educational, cognitive-behavioral, and skills-building interventions. The demonstration project considered risk reduction as an intervention designed to diminish maladaptive behaviors and promote a healthy lifestyle. Risk reduction activities can be delivered via both individual and group modalities at any time during the intervention process. Risk reduction interventions may be implemented in locations where persons with HIV are served.
Factors and behaviors

The 11 demonstration projects identified several factors and behaviors that may negatively affect the health and well-being of people living with HIV. For example:

- **Engaging in unprotected sex.** Re-infection often results in the introduction of new strains of HIV. Persons are especially vulnerable to other sexually transmitted diseases and hepatitis.
- **Use of alcohol and other drugs.** The use of alcohol and drugs reduces inhibitions and increases the likelihood of engaging in unsafe sexual activities. Their use can further impair the immune system and can adversely interact with HIV medications. Sharing of hypodermic needles can reinfect and spread HIV as well.
- **Lack of medication adherence.** HIV medications must be taken as prescribed to have maximum benefit. The lack of strict adherence to antiretroviral medications can lead to ineffective treatment and the potential to produce drug-resistant strains of HIV. Although medication regimens often are difficult to follow, clients need to understand the importance of observing a strict dietary routine and medication schedule—largely because treatment adherence is strongly associated with survival. Other medications, including psychotropic drugs, often are essential in helping persons adhere to HIV medication regimens.
- **Poor nutrition.** It is important that persons with HIV pay close attention to nutritional guidelines. Optimum absorption of HIV medications depends upon following these guidelines. Proper nutrition is necessary to avoid HIV-related wasting syndrome and to enhance one’s ability to cope with a compromised immune system.
- **Untreated medical conditions.** Persons with HIV frequently have co-occurring medical conditions. Chronic illnesses, such as diabetes, liver and renal disease, and cancers must be treated aggressively, and adherence with medical regimens must be monitored.
- **Untreated emotional distress.** A range of psychological or emotional disorders frequently interfere with an individual’s ability to actively manage HIV. It can interfere with medication adherence, client’s ability to keep appointments, their judgment, and their ability to assume responsibility for their behavior.
- **Homelessness.** Without stable housing, all other therapies and treatment interventions can be seriously compromised. Lack of housing can exacerbate co-occurring disorders or other problems with mental health, substance abuse, and HIV infection.
- **Lack of a strong sense of self-worth.** Poor self-image can be one of the greatest barriers to the cultivation of healthier habits.

Implementing risk reduction activities

Clinicians can employ a range of techniques to teach persons with HIV risk reduction practices. The process of immunizing clients against high-risk behaviors can be woven into the treatment process by providing information, teaching skill-building techniques, and offering self-esteem enhancing activities. First and foremost, persons with HIV must be made aware of high-risk activities and how certain behaviors can jeopardize their health. This can be accomplished through didactic seminars, written materials, and individual and group therapy sessions. It is essential that a curriculum be developed that covers behaviors associated with increasing or decreasing risk.

Information by itself, however, is not sufficient. Clients may not have the motivation or self-esteem to engage in preventive activities. Skill enhancement concerning assertive behaviors can be taught effectively. Insisting on condom use, negotiating other safe sex practices, and saying no to drugs and alcohol under peer pressure can all be taught in skill-building or assertiveness training workshops.

Methods of promoting healthier behaviors and improving physical, emotional, and spiritual health include:

- Involvement in support groups focused on HIV-related medical conditions.
- Close monitoring of people with advanced HIV infection.
- Access to prenatal care.
- Tools to enhance medication adherence.
- Taking a more active role in one’s health care.
- Linkage with medical treatment advocates promoting healthier behaviors.

Other considerations

Many service providers may need education and training to increase their knowledge and understanding of risk reduction activities and the potential benefits for the clients they serve. In addition, an awareness of cultural practices is necessary to help negotiate risk reduction behaviors. For example, women of different cultures and socioeconomic groups have varying degrees of power in heterosexual relationships, which may affect their ability to insist upon safer sexual practices. It also helps to know how different cultural groups manage and interpret different social contexts. For example, poor, gay Latino immigrants sometimes use class markers (e.g., how well someone is dressed, what kind of job someone has) as part of their decision-making around sexual risk-taking (Ayala and Diaz, 1997). Knowledge of the specific dynamics of relationships among various cultural groups and the kinds of attributions individuals may make regarding class, race, and power can assist clinicians in their efforts to assist clients in adopting healthier behaviors.

APPENDIX A

Guide to completing the psychosocial assessment

In an attempt to provide greater uniformity in completing psychosocial assessments, here are some general guidelines on completing the various components.

For each section indicate in writing at minimum the following domains:

1. **Appearance:** Please comment on: a) age; b) ethnicity; c) gender; d) build/height; e) dress; f) hygiene; g) sexual orientation and risk factor if patient is forthcoming.
2. **Mental status:** This section aims to provide a brief mental status of the patient at assessment. Please comment on the following areas: a) intelligence; b) judgment; c) memory (STM and LTM); d) thought disorder; e) delusions/hallucinations; and f) mood/emotional state.

For example: “pt. is oriented x3, displays above average intelligence, memory appears intact, judgment intact, no indication of thought disorder or delusions/hallucinations and mood seems to be sad.”

3. **Suicide/homicide:** If patient denies suicidal at present, check “denies” and move on. If patient reports suicide or homicidal potential, elaborate with focus on ideation vs. gestures vs. attempts.
For example: “pt. reports having suicidal ideation w/o plan”; or “pt. has made suicidal gesture (took larger amount of meds than needed) but denies being suicidal at present”; or “pt. reports being suicidal has plan (slit wrists) and means.”

4. **Psychiatric history:** In this section, we would like to get an indication current and past psych. tx. Indication whether pt. is currently in tx by marking yes or no. If yes, indicate type frequency and duration (e.g. “pt. is being seen at ISPO’s output program on a weekly basis x 2yrs.” or “pt. has recently been released from Read where he was hospitalized for 2 weeks for suicide attempt”). If patient is aware of his diagnosis, it may be helpful to indicate.

5. **Substance Use:** This section should provide a snapshot of patient drug use and indicate whether it is a factor in psychological functioning at intake. Specifically, indicate patient’s primary drug of choice and attempt to get as accurate an assessment of onset, frequency, and attempts to stop. The past use section should cover past substance abuse patterns and previous tx. for substance use. Below are a few examples of varying degrees of specificity:

- **Poor:** “Pt. reports using various drugs on an intermittent basis.” Past: “pt. reports having heroin problem in past.”
- **Better:** “Pt. drinks alcohol and smokes marijuana occasionally. He does not identify substance use as a concern.” Past: blank.
- **Best:** “Pt. indicates that he drinks (beer x3day/week, 1 six-pack per day) Pt. uses cocaine (snorts 1gm x 1/months). He reports onset of alcohol use at age 18 and cocaine use at age 27. No other drug use at present. Past: Pt. has entered 3 detox programs (88, 94, and 95) never successfully completed drug tx. program.”

6. **Social support:** This section has provided in the past a great deal of variability. It would be best to indicate social support along two domains (practical/financial and emotional): Practical support, which would include assistance with daily living activities and emotional support which refers to whom the person talks with to receive emotional support for living with HIV. Also, may want to assess level of HIV disclosure (to whom and why and reasons not disclosed to others).

For example: “pt. reports living with family who provide food, and transportation to medical appointments. Family not supported for emotional needs, with family not telling other family member of pt’s health status. Pt. reports not talking to anyone about living with HIV.”

7. **Vocational:** please indicate whether pt. works fulltime, part-time, or unemployed or unable to work at present. Indicate nature of work (e.g., fast food or administration). For past, indicate primary job or job hx. (e.g., pt. worked for gas company for 9 yrs. or pt. held numerous part time jobs). You may want to comment on whether pt. has concerns about HIV impacting work situation.

8. **Initial impressions:** This section is the section where the most variability has existed. It may be best to conceptualize this section in the following way: 1) Consider the audience other health and social service staff: 2) “What would be helpful for them to know about the patient’s psychological functioning?” and “what’s your impression of this client’s psychological management of his HIV diagnosis?” Write very clearly (try to keep psychological jargon to a minimum) and provide concrete examples to substantiate your impressions. Providing an initial diagnosis is optional at present. Below is an example:

- “Pt. is a 35 y/o gay AA male dx. HIV+ in 6/95. Pt. appears to have cognitive impairments particularly in memory superimposed with active substance use, and failing health. Etiology for memory impairment is unclear but may be due to seizures. HIV, underlying psychosis (as evidenced by possible delusion) or a personality disorder. Preliminary diagnosis: Cocaine abuse, R/O psychotic disorder, NOS. Pt. does appear to respond well to structure and this should be factored in to tx. planning.”

9. **Recommendations:** Self-explanatory. Use “other” section for a more detailed discussion of tx. rec.


Case Management


Alexandria Community Services Board, Breaking the cycle: An intensive case management model to engage homeless people with co-occurring mental illness and substance abuse disorders. 1994.


Psychotherapy and Counseling


Risk Reduction


HIV AND MENTAL HEALTH

Final Examination

Select the best answer for each question and then proceed to www.EliteCME.com to complete your final examination.

1. An effective HIV treatment team includes clinical providers who are dedicated to the work and possess a depth of knowledge of HIV, mental health, substance abuse, and ___________.
   a. Community resources.
   b. Medicine.
   c. Alternative treatments.
   d. Investigative interviewing.

2. ______________ can help clients develop greater self-awareness, stronger coping skills, and greater motivation to engage in meaningful and productive activities.
   a. Psychotherapy.
   b. Case management.
   c. Medication management.
   d. Behavioral therapy.

3. If a client comes into a community mental health center in a highly agitated state and is suicidal, then the assessment should focus on:
   a. Medicating the client.
   b. Referring the client to services.
   c. Stabilizing the client.
   d. Conducting an immediate treatment team meeting.

4. During the clinical assessment, it is essential to ______________ with clients prior to conducting the assessment.
   a. Research family history.
   b. Maintain the level of respect and trust initiated.
   c. Assess available local community support systems.
   d. Access all medical history.

5. The category of ______________ includes schizophrenia, schizoaffective disorder, bipolar disorder, major depression, autism, and obsessive compulsive disorder.
   b. Serious mental illness.
   c. Cognitive impairment.
   d. Moderate cognitive illness.

6. HIV can damage subcortical areas of the brain and produce HIV dementia, resulting in states that are mistaken for:
   a. Schizophrenia.
   b. Anxiety disorder.
   c. Bipolar disorder.
   d. Clinical depression.

7. According to the recently published DSM-5, the term “__________” has been eliminated and replaced with “major or minor neurocognitive disorder”.
   a. Anxiety.
   b. Dementia.
   c. Bipolar.
   d. Depression.

8. Mental health treatment of psychiatric disorders should be ______________, individualized, and comprehensive to encompass the full spectrum of bio-psychosocial needs.
   a. Client-centered.
   b. Disorder-centered.
   c. Client-driven.
   d. Disorder-driven.

9. ____________ generally refers to explorations and problem-solving interventions relating to current concerns and issues, such as adjusting to the HIV diagnosis, managing relationships, and job and workplace issues.
   a. Psychotherapy.
   b. Assessment.
   c. Counseling.
   d. Intervention.

10. While traditional professional psychotherapy may focus on ___________, peer counseling typically focuses its intervention on support and education.
    a. Client medical needs.
    b. Psychological change.
    c. Behavioral change.
    d. Dream analysis.

11. Parents also may decide to disclose HIV-related information selectively— but only after determining criteria about who will be told. Families that fear repercussions related to ________ may develop a boundary around the family and limit contact with extended family or the community.
    a. Persona.
    b. Stigma.
    c. Societal norms.
    d. Medical issues.

12. Many people remember when HIV was initially identified as ______________, and for some, disclosure of one’s HIV-positive status is complicated by whether others will automatically assume they are gay.
    a. Attributed gay immune disease.
    b. Gay immune disorder.
    c. Acute immunodeficiency gay syndrome.
    d. Gay-related immunodeficiency disease.

13. “_________________,” is a term used when persons with advanced HIV infection notice a significant improvement in the medical indicators of immune system function and HIV viral load.
    a. Zalarus syndrome.
    b. Lazarus syndrome.
    c. Lazarus factor.
    d. Recovery syndrome.

14. ______________ acknowledges that addiction is a chronically relapsing condition, but that relapse can be avoided.
    a. Addiction control theory.
    b. Relapse prevention.
    c. Relapse intervention theory.
    d. Addition relay response.

15. ______________ refers to the impact substance abuse treatment may have on decreasing HIV-related risk behaviors.
    a. Risk reduction.
    b. Treatment impact.
    c. Relapse reduction.
    d. Relapse analysis.