

Professional Counseling (Mental Health)	Pg
Service Category Definition – DSHS State Services	1
DSHS State Services 2011-2012 Standards of Care	3
Mental Health Care Chart Review, The Resource Group 2010	8
HIV & AIDS – American Psychiatric Association	15
Mental Health Matters - HRSA CARE Action, May 2009	17

Local Service Category	Mental Health Services
Amount Available:	To be determined
Unit Cost	
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Cost.
Local Service Category Definition:	<p>Individual Therapy/counseling is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV positive or HIV/AIDS affected individual.</p> <p>Support Groups are defined as professionally led (licensed therapists or counselor) groups that comprise HIV positive individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV positive person.</p>
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected and affected individuals living within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Agencies are encouraged to have available to clients all modes of counseling services, i.e., crisis, individual, family, and group. Sessions may be conducted in-home. Agency must provide professional support group sessions led by a licensed counselor.
Service Unit Definition(s):	<p>Individual and Family Crisis Intervention and Therapy: A unit of service is defined as an individual counseling session lasting a minimum of 45 minutes.</p> <p>Group Therapy: A unit of service is defined as one (1) eligible client attending 90 minutes of group therapy. The minimum time allowable for a single group session is 90 minutes and maximum time allowable for a single group session is 120 minutes. No more than one unit may be billed per session for an individual or group session.</p> <p>A minimum of three (3) clients must attend a group session in order for the group session to eligible for reimbursement.</p> <p>Consultation: <u>One unit of service is defined as 15 minutes of communication with a medical or other appropriate provider to ensure case coordination.</u></p>
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	<p>For individual therapy session, HIV positive or the affected significant other of an HIV positive person, resident of Houston HSDA.</p> <p>HIV positive client must have a DSM-IV Axis I diagnosis eligible for reimbursement under the State Medicaid Plan.</p> <p>Client must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs /providers, until the other programs/providers can take over services.</p> <p>Medicaid/Medicare, Third Party Payer and Private Pay status of clients receiving services under this grant must be verified by the provider prior to requesting reimbursement under this grant. For support group sessions, client must be either an HIV positive person or the significant other of an HIV positive person. Affected significant other is eligible for services only related to the stress of</p>

<p>Agency Requirements:</p>	<p>caring for an HIV positive significant other.</p> <p>Agency must provide assurance that the mental health practitioner shall be supervised by a licensed therapist qualified by the State to provide clinical supervision. This supervision should be documented through supervision notes. Keep attendance records for group sessions.</p> <p>Must provide 24-hour access to a licensed counselor for current clients with emotional emergencies.</p> <p>Clients eligible for Medicaid or 3rd party payer reimbursement may not be billed to grant funds. Medicare Co-payments may be billed to the contract as ½ unit of service.</p> <p>Documentation of at least one therapist certified by Medicaid/Medicare on the staff of the agency must be provided in the proposal. All funded agencies must maintain the capability to serve and seek reimbursement from Medicaid/Medicare throughout the term of their contract. Potential clients who are Medicaid/ Medicare eligible may not be denied services by a funded agency based on their reimbursement status (Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to this grant). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of the provider’s contract.</p> <p>Must comply with the State Services Standards of Care.</p> <p>Must provide a plan for establishing criteria for prioritizing participation in group sessions and for termination from group participation.</p> <p>Providers and system must be Medicaid/Medicare certified to ensure that Ryan White funds are the payer of last resort.</p>
<p>Staff Requirements:</p>	<p>It is required that counselors have the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC PhD, Psychologist, or LMFT).</p> <p>At least two years experience working with HIV disease or two years work experience with chronic care of a catastrophic illness.</p> <p>Counselors providing family sessions must have at least two years experience in family therapy.</p> <p>Counselors must be covered by professional liability insurance with limits of at least \$300,000 per occurrence.</p>
<p>Special Requirements:</p>	<p>Medicare and private insurance co-payments are eligible for reimbursement under this grant (in this situation the agency will be reimbursed the client’s co-payment only, not the cost of the session which must be billed to Medicare and/or the Third party payer). Extensions will be addressed on an individual basis when meeting the criteria of counseling directly related to HIV illness. Under no circumstances will the agency be reimbursed more than two (2) units of individual therapy per client in any single 24-hour period.</p>

DSHS STATE SERVICES
1112 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	<p><u>Scope of Work</u> Agency will provide the following services: Individual Therapy/counseling is defined as 1-on-1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV positive or HIV/AIDS affected individual. Support Groups are defined as professionally led (licensed therapists or counselor) groups that comprise HIV positive individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV positive person.</p>	<ul style="list-style-type: none"> • Program’s Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.
9.2	<p><u>Licensure</u> Counselors must possess the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC, PhD, Licensed Clinical Psychologist or LMFT as authorized to provide mental health therapy in the relevant practice setting by their licensing authority). Bilingual English/Spanish licensed mental health practitioners must be available to serve monolingual Spanish-speaking clients.</p>	<ul style="list-style-type: none"> • A file will be maintained on each professional counselor. Supportive documentation of credentials is maintained by the agency in each counselor’s personnel file. • Review of Agency Policies and Procedures Manual indicates compliance. • Review of personnel files indicates compliance
9.3	<p><u>Family Counseling Experience</u> Professional counselors must have two years experience in family counseling if providing services to families.</p>	<ul style="list-style-type: none"> • Experience is documented via resume or other method. Exceptions noted in personnel files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.4	<u>Professional Liability Insurance</u> Professional liability coverage of at least \$300,000 for the individual or \$1,000,000 for the agency is required.	<ul style="list-style-type: none"> • Documentation of liability insurance coverage is maintained by the agency.
9.5	<u>Substance Abuse Assessment Training</u> Professional counselors must receive training in assessment of substance abuse with capacity to make appropriate referrals to licensed substance abuse treatment programs as indicated within 60 days of start of contract or hire date.	<ul style="list-style-type: none"> • Documentation of training is maintained by the agency in each counselor's personnel file.
9.6	<u>Crisis Situations and Behavioral Emergencies</u> Agency has Policy and Procedures for handling crisis situations and behavioral emergencies, including but not limited to: <ul style="list-style-type: none"> • verbal intervention • non-violent physical intervention • emergency medical contact information • incident reporting • voluntary and involuntary inpatient admission • follow-up contacts 	<ul style="list-style-type: none"> • Review of Agency Policies and Procedures Manual indicates compliance.
9.7	<u>Other Policies and Procedures</u> The agency must develop and implement Policies and Procedures that include but are not limited to the following: <ul style="list-style-type: none"> • Client neglect, abuse and exploitation including but not limited to definition of terms; reporting to legal authority and funding source; documentation of incident; and follow-up action to be taken • Discharge criteria including but not limited to planned discharge behavior impairment related to substance abuse, danger to self or others (verbal/physical threats, self discharge) • Changing therapists • Referrals for services the agency cannot perform and reason for referral, criteria for appropriate referrals, time line for referrals. 	<ul style="list-style-type: none"> • Review of Agency Policies and Procedures Manual indicates compliance.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.8	<u>In-Home Services</u> Therapy/counseling and/or bereavement counseling may be conducted in the client's home.	<ul style="list-style-type: none"> • Program Policies and Procedures address the provision of home visits.
9.9	<u>Comprehensive Assessment</u> A comprehensive assessment including a psychosocial history will be completed at intake (unless client is in crisis). Item should include, but are not limited to: Presenting Problem, Profile/Personal Data, Appearance, Living Arrangements/Housing, Language, Special Accommodations/Needs, Medical History, Death/Dying Issues, Mental Health Issues, Suicide/Homicide Assessment, Self Assessment/Expectations, Medical History, Education History, Employment/Income, Military History, Parenthood, Alcohol/ Drug History, Family/ Childhood History, Legal History, Abuse History, Sexual/Relationship History, Cultural/Spiritual/Religious History, Social/Leisure/Support Network, Family Involvement, Learning Assessment, Mental Status Evaluation, and 5 Axis Diagnosis.	<ul style="list-style-type: none"> • Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I. • Documentation in client record on the initial and comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the initial assessment will be recorded in the comprehensive client assessment.
9.10	<u>Treatment Plan</u> Treatment plans are developed jointly with the counselor and client and must contain all the elements for mental health including: <ul style="list-style-type: none"> • Statement of the goal(s) of counseling • The plan of approach • Mechanism for review Initial treatment plans must be completed within three sessions. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance abuse as clinically indicated.	<ul style="list-style-type: none"> • Documentation in client record. • Exceptions noted in client file.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.11	<u>Treatment Plan Review</u> The treatment plan shall be reviewed as clinically indicated but at a minimum 12 sessions and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures.	<ul style="list-style-type: none"> • Review of Agency Policies and Procedures Manual indicates compliance. • Client's records • Exceptions noted in client files.
9.12	<u>Progress Notes</u> Progress notes are completed for every professional counseling session and must include: <ul style="list-style-type: none"> • Client name • Session date • Observations • Focus of session • Interventions • Assessment • Duration of session • Counselor authentication. 	<ul style="list-style-type: none"> • Legible, signed and dated documentation in client record.
9.13	<u>Discharge Summary</u> Discharge summary is completed for each client after 30 days without client contact or when treatment goals are met: <ul style="list-style-type: none"> • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, • Date 	<ul style="list-style-type: none"> • Documentation in client record.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.14	<u>Supervisor Qualifications</u> Supervision is provided by a clinical supervisor qualified by the State of Texas. The agency shall ensure that the Supervisor shall, at a minimal, be a State licensed Masters-level professional (e.g. LPC, LCSW, LMSW, LMFT, PhD, Licensed Clinical Psychologist) qualified under applicable State licensing standards to provide supervision to the supervisee.	<ul style="list-style-type: none"> Documentation of supervisor credentials is maintained by the agency.
9.15	<u>Clinical Supervision</u> A minimum of bi-weekly supervision is provided to counselors licensed less than three years. A minimum of monthly supervision is provided to counselors licensed three years or more.	<ul style="list-style-type: none"> Documentation in supervision notes.



MENTAL HEALTH SERVICES
2010 CHART REVIEW

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HSDA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts with one Subgrantee to provide hospice services in the Houston HSDA.

INTRODUCTION

Description of Service

Mental Health Services are treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. **Individual Therapy/counseling** is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV positive or HIV/AIDS affected individual. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise HIV positive individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV positive person.

Tool Development

The TRG Mental Health Services Tool is based upon established local standards of care.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

Using the ARIES database the file sample was created from a provider population of 293 who accessed Ryan White Part B primary care funds between 6/1/2009 and 5/31/2010. The records of 20 clients were reviewed, representing (6.9%) of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

Report Structure

A categorical reporting structure was used. The report is as follows:

- Consents
- Eligibility
- Intake
- Mental Health Assessment
- Treatment Plan
- Progress Notes

FINDINGS

Consent for Service

Percentage of clients that have a signed and completed consent for service document in the record

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a documented consent for service in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Consents – Exchange/Release of Information

Percentage of clients that have a signed exchange/release of information document in the record

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a documented Consent for exchange/release of information in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Consents – Proof Of Client Rights and Responsibilities

Percentage of charts reviewed that have evidence that the client received client rights and responsibility information

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a documented Proof of Clients Rights and Responsibilities in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Consents – Proof Of Receipt by Client of Grievance Procedures

Percentage of charts reviewed that have evidence that the client received the agency grievance procedure information

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a documented Proof of Receipt of Grievance Procedures in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Consents Proof of Receipt by Client of Client Eligibility

Percentage of charts reviewed that have evidence that the client received eligibility of service information

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a documented Proof of Receipt by Client of Eligibility Criteria in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Consents Proof of Receipt by Client of Client Confidentiality Policy

Percentage of charts reviewed that have evidence that the client received the agency confidentiality policy

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a documented Proof of Receipt by Client of Confidentiality Policy in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Consents – Proof Of Receipt by Client of Description of Services

Percentage of charts reviewed that have evidence that the client received a description of services of the agency

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a documented Proof of Receipt of Description of Services in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Eligibility – HIV Diagnosis Documentation

Percentage of clients who have evidence of being HIV-positive in the record

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a documented HIV Diagnosis in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Eligibility – Residency In the Houston HSDA

Percentage of clients who have evidence in the record of residing in the Houston HSDA

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a documented Residency in the Houston HSDA in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Eligibility – Income Verification

Percentage of clients who have income verification in the measurement year

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have documented Income in the measurement year.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Eligibility – Proof of Identification

Percentage of clients who have evidence in the record that proves the identity of the client being served.

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a documented Proof of Identification in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Intake

Percentage of client who have a documented intake completed within an acceptable time frame

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a completed Intake with in an acceptable time frame in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Comprehensive Assessment

Percentage of clients who have a completed comprehensive assessment documented in the record.

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a completed comprehensive assessment in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Psychosocial History

Percentage of clients who have a completed psychosocial history documented in the record

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have a comprehensive psychosocial history in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Treatment Plan

Percentage of clients who have documentation of a treatment plan in the client record

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have documentation of a treatment plan in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Progress Notes

Percentage of clients who have progress notes documenting service deliveries in the record.

	Yes	No	Partial	N/A
Number of HIV- positive clients served who have progress notes for service delivery in the record.	20	0	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20	20
Rate	100.0%	-	-	-

Conclusion

Quality of service is excellent. All data elements were 100%.



Healthy Minds. Healthy Lives.

HIV & AIDS

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.

Emotional Distress

Receiving an HIV diagnosis can produce strong emotional reactions. Initial feelings of shock and denial can turn to fear, guilt, anger, sadness, and a sense of hopelessness. Some people even have suicidal thoughts. It is understandable that one might feel helpless and fear illness, disability, and even death.

Support from family and friends can be very helpful at these times, as can professional help. If you are feeling emotionally distressed, it is important that you talk about your feelings. Your physician as well as knowledgeable and supportive friends and loved ones can help. Remember that any strong and lasting emotional reaction to an HIV diagnosis calls for some kind of assistance, and that there is always help through counseling.

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.

Anxiety

Anxiety is a feeling of panic or apprehension, which is often accompanied by the physical symptoms of sweating, shortness of breath, rapid heart beat, 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. 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.

Substance Use

Substance use is very common among those with HIV infection. Unfortunately, substance use can trigger and often complicate mental health

problems. For many, mental health problems predate substance use activity. Substance use can increase levels of distress, interfere with treatment adherence, and lead to impairment in thinking and memory. Diagnosis and treatment by a psychiatrist or other qualified physician is critical because symptoms can mimic psychiatric disorders and other mental health problems.

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.

Signs of any of these problems should be discussed with a physician immediately. New anti-HIV therapies in combination with psychiatric medication can reverse delirium and dementia and markedly improve cognition; however, special care must be taken to ensure that the drugs do not interact with HIV medications. Psychotherapy also can help patients understand their condition and adapt to their diminished level of functioning.

HIV infection and AIDS affect all aspects of a person's life. Those with HIV/AIDS must adapt to a chronic, life-threatening illness and corresponding physical and mental challenges. They often face a myriad of emotional demands such as stress, anger, grief, helplessness, depression, and cognitive disorders. If you have concerns about your or a loved one's reaction to an HIV diagnosis, or if you have questions about the mental problems associated with HIV/AIDS, discuss them with a doctor or counselor. Treatments are available and can greatly improve quality of life.

Because HIV infection and AIDS are associated with a number of physical, psychiatric, and psychological issues, this topic cannot be sufficiently reviewed in a brief summary. Readers are encouraged to consult a physician for further information. This summary is not intended to stand on its own as a comprehensive evaluation of HIV and AIDS.



Diagnosis and Treatment

Case Finding

Adherence Issues

Avenues to Treatment

MENTAL HEALTH MATTERS

We found substantial and consistent evidence that chronic depression, stressful events, and trauma may negatively affect HIV disease progression.¹

—Jane Leserman, University of North Carolina, Chapel Hill

Diagnosis and treatment of mental health issues are essential to the physical health and quality of life of people living with HIV/AIDS (PLWHA). Psychiatric disorders are a barrier to medical care and adherence to medications, and several studies have found that depression, stress, and trauma can lead to disease progression and increased mortality.²⁻⁵ The power of mental health treatment to reduce depression and anxiety, improve adherence and HIV health outcomes and, in turn, reduce the likelihood of death from AIDS-related causes speaks to the vital role of mental health care in the web of HIV care.⁶⁻⁹

The HIV Costs and Services Utilization Study (HCSUS) found that nearly 50 percent of adults being treated for HIV also have symptoms of a psychiatric disorder—prevalence that is 4 to 8 times higher than in the general population. Nineteen percent of patients studied showed signs of substance abuse, and 13 percent had co-occurring mental illness and substance abuse disorders.¹⁰

DID YOU KNOW?

In approximately one-half of people living with HIV/AIDS who have depression, the depression is both undiagnosed and untreated.¹¹

A significant percentage of patients who commit suicide see their primary care clinician in the month before their suicide.¹²



U.S. Department of Health and Human Services
Health Resources and Services Administration

Visit us online at www.hrsa.gov

 **DIRECTOR'S LETTER**

We know that improving health care means more than meeting physical needs. For people living with HIV/AIDS (PLWHA), who have higher rates of depression and substance abuse than the general public, treating mental health disorders is especially critical.

Depression rates for HIV-positive people are as high as 60 percent; yet, one-half of all PLWHA with depression go undiagnosed and untreated. We've got the means to do better. Screening tools like HRSA's *Client Diagnostic Questionnaire* can help detect potential signs of risk, such as social isolation and alcohol dependence. By closely monitoring patients at critical times, such as at the start of antiretroviral treatment, we can aid them at the onset of mental health issues. Because the sooner we see warning signs, the sooner we can act.

Let's remember, too, that treatment regimens only go so far in treating mental illness—relationships matter, too. By providing support groups and strengthening patient-provider bonds, we can boost retention for people at risk, improving patients' bodies and minds in the process.

Deborah Parham Hopson
HRSA Associate Administrator for HIV/AIDS

HRSA CARE Action
Publisher

U.S. Department of Health and Human Services
Health Resources and Services Administration, HIV/AIDS Bureau
5600 Fishers Lane, Room 7-05
Rockville, MD 20857
Telephone: 301.443.1993

Prepared for HRSA/HAB by Impact Marketing + Communications

Photographs

Cover: Clients at the Tarzana Treatment Center, Los Angeles County, CA.
Pp. 3-4: Clients at the Native American Health Center, San Francisco, CA.
Photographs © See Change.

Additional copies are available from the HRSA Information Center, 1.888.ASK.HRSA, and may be downloaded at www.hab.hrsa.gov.

This publication lists non-Federal resources to provide additional information to consumers. The views and content in those resources have not been formally approved by the U.S. Department of Health and Human Services (HHS). Listing of the resources is not an endorsement by HHS or its components.

A more recent study of more than 1,000 PLWHA in North Carolina found even higher rates: 60 percent of study participants reported symptoms of mental illness, 32 percent reported substance use problems, and nearly 25 percent identified both symptoms of mental illness and substance use problems.¹³ High rates of depression and anxiety have been identified in PLWHA regardless of race, gender, or sexual orientation.¹⁴

People with serious mental illness are particularly vulnerable to HIV infection as a result of the higher prevalence among this group of a variety of factors, including poverty, homelessness, high-risk sexual activities, drug abuse, sexual abuse, and social marginalization. Estimates of HIV infection rates among people with mental illness vary widely from 3 percent to 23 percent; the average is about 7 percent. Their health outcomes remain poor.¹⁵

DIAGNOSING and TREATING DEPRESSION

Major depression is the most common mental health disorder among PLWHA; estimates are that about 60 percent of PLWHA will have a depressive episode at some time during their illness.^{16,17} Strong evidence indicates that HIV infection is associated with greater risk of major depressive disorder, although a review of research also found that most PLWHA appear to be psychologically resilient.¹⁸

One challenge in linking patients with depression to care is the attitude of providers. "Too often, we see providers not using medications to treat depression because they are putting themselves in their patients' shoes and the depression makes sense to them," says David Haltiwanger, clinical psychologist at Chase-Brexton Health Services, a Ryan White HIV/AIDS Program grantee in Baltimore. "It is crucial that patients be medicated based on their symptoms for depression, not on the reason for depression."

Recent research reflects the tremendous importance of identifying and treating depression in PLWHA. A retrospective study of more than 3,000 patients found strong evidence that depression without treatment using the

class of antidepressant medications known as selective serotonin reuptake inhibitors (SSRIs) decreased the odds of both achieving adherence to highly active antiretroviral therapy (HAART) and lowering viral load.¹⁹

Conversely, patients with depression who were prescribed and adhered to SSRIs had HAART adherence rates and viral loads similar to those of patients without

depression. In addition, among patients with depression, those taking SSRIs showed significantly greater increases in CD4 T-cell counts than did patients not taking SSRIs. Especially noteworthy, the evidence indicated that the improvements in viral load among patients on SSRIs were not solely attributable to HAART adherence, implying that depression itself may affect viral control.²⁰

➔ DEPRESSION vs. DEMORALIZATION

DEPRESSED*

DEMORALIZED*

Persistent inability to experience pleasure from normally pleasurable life events

Characterized by a “welling up of grief”

Cannot be distracted by and enjoy pleasant activities

Can be distracted by and enjoy pleasant activities

Feel worst in the morning; mood improves during the day

Feel best in the morning; mood worsens during the day

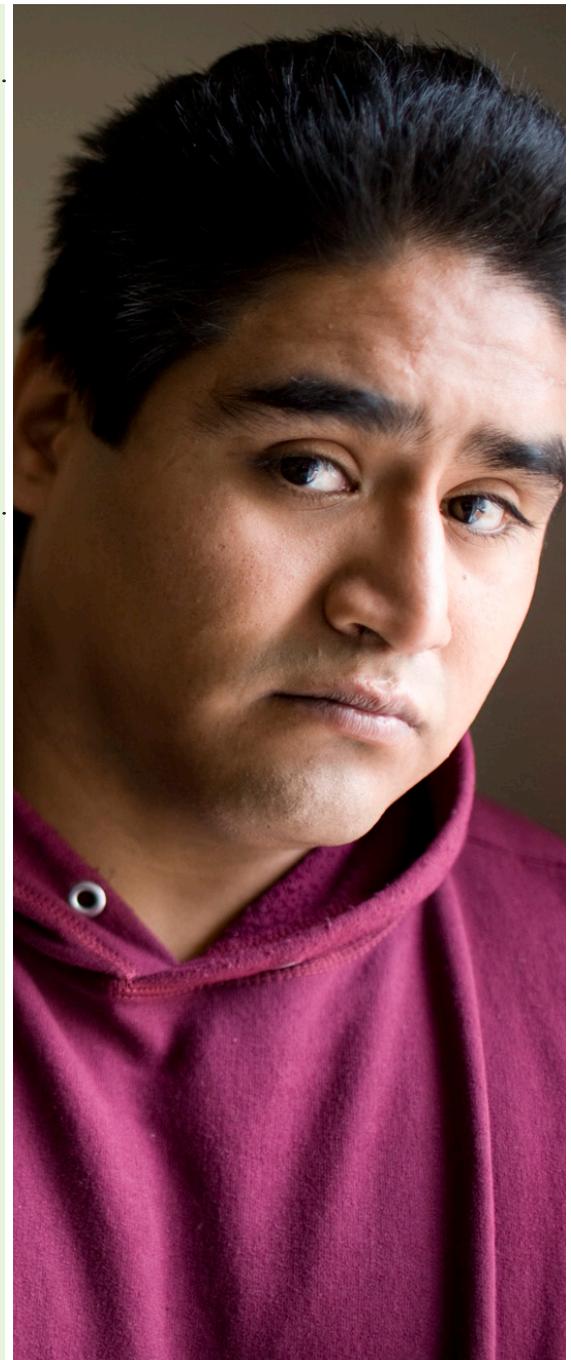
Difficulty staying asleep

Difficulty falling asleep

Although the high prevalence of depression among PLWHA is well documented, clinicians at Johns Hopkins University’s Moore Clinic describe an equally prevalent condition among their patients known as demoralization.²¹ Common among people with physical and mental illness, demoralization is characterized by existential despair, hopelessness, helplessness, and loss of meaning and purpose in life.²²

Although it shares many of the symptoms of depression, demoralization has key differences that affect its symptoms and the course of treatment; correct diagnosis is made trickier because the two disorders can coexist. Unlike depression, demoralization is not a brain disease but an adjustment disorder caused by recent events or ongoing life circumstances.

According to the Hopkins team, clients with major depression respond well to antidepressants, whereas those with demoralization may not. Clients who are demoralized, however, do respond well to psychotherapy, support groups, encouragement, drop-in centers, education, and time.²³



*Note: These are generalized statements; patient symptoms may vary.

Source: Treisman GJ, Angelino AF, Hutton HE. Psychiatric issues in the management of patients with HIV infection. *JAMA*. 2001;286:2857–64.



➔ The drop-in center at the Native American Health Center in San Francisco offers culturally rich activities, caring staff, and holistic approaches to care to address clients' physical as well as mental health needs.

FINDING PEOPLE WHO NEED SUPPORT

Before PLWHA can be linked to the mental health care they need, those who have mental health issues must be identified. Two screening tools developed specifically for PLWHA are aimed at working efficiently in busy clinical or support service settings.

One tool is the HIV/AIDS Bureau's Client Diagnostic Questionnaire (CDQ). The CDQ was developed through the Special Projects of National Significance Program for use in various service sites, including medical clinics, multiservice community organizations, and homeless shelters. The questionnaire, which takes 15 to 20 minutes to complete, can be administered by staff with no mental health training. It screens for depression, anxiety disorder, and psychosis as well as for alcohol and drug abuse or dependence.

The baseline assessment indicates PLWHA who need either further assessment or direct referral to treatment by a clinician. Research on the CDQ's effectiveness found that it identified 90 percent of clients with clinically significant mental health needs.²⁴ Ordering information for the free CDQ and the related training manual is available at <http://hab.hrsa.gov/tools/topics/cdq.htm>.

Another useful tool is a 16-question form known as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS), which has proved its effectiveness as a frontline screening tool.²⁵ The questions take less than 15 minutes to administer, so patients who screen

positive are also advised to undergo a confirmatory psychiatric evaluation.²⁶ English- and Spanish-language versions of the SAMISS, together with the answer keys, can be downloaded at www.dshs.state.tx.us/hivstd/qm/documents.shtm.

Data from the HCSUS also identified certain characteristics that may predict a greater likelihood of mental health issues. An analysis of a subsample from the HCSUS found that those most likely to screen positive for mental illness

- ▶ Were under age 35,
- ▶ Lived alone or with a nonromantic partner,
- ▶ Were unemployed or disabled,
- ▶ Experienced more HIV-related symptoms, or
- ▶ Used illicit drugs other than marijuana.²⁷

Severity of HIV disease did not play a role in the findings, although women in the study who showed signs of mental illness were more likely to have advanced disease or need income assistance.²⁸

More recent data from the North Carolina study echoed the association between younger age and mental illness and also found that mental illness rates were higher among Whites and patients with higher viral loads.²⁹

People working with or supporting PLWHA should be on the lookout for other signs of mental health

difficulties, such as missed appointments or abruptly changing or stopping medications. Specific triggers that may lead to mental distress include the following:

- ▶ Learning of one's HIV-positive status
- ▶ Disclosure of one's HIV status to family and friends
- ▶ Introduction of medication
- ▶ Occurrence of any physical illness
- ▶ Recognition of new symptoms or progression of disease (e.g., a major drop in CD4 cells, an increase in viral load)
- ▶ Necessity of hospitalization (particularly the first hospitalization)
- ▶ Death of a significant other or anniversaries of loved ones' deaths
- ▶ Holidays
- ▶ Diagnosis of AIDS
- ▶ Changes in major aspects of lifestyle (e.g., job loss, end of relationship, relocation)
- ▶ Need to make end-of-life and permanency planning decisions.^{30,31}

ADDRESSING MENTAL HEALTH ISSUES SUPPORTS ADHERENCE

The experiences of the Medication Support Team (MST) at Chase-Brexton illustrate the impact of mental health issues on the initiation of and adherence to HAART. MST Coordinator Tracey Salaam recounts the experience of a patient who confronted severe anxiety as he prepared to begin therapy. A mental health patient for many years, the patient had been HIV positive for 3 months when his primary care doctors recommended HAART. "Mentally, he could understand why it was so important, but he had so much anxiety about treatment and his concerns that it would throw him off the stability he had attained in his mental health," said Salaam.

Chase-Brexton's multidisciplinary MST works closely with patients to ensure that they are ready and equipped to begin treatment. Salaam met with this patient at least six times over 3 months to address his anxiety, but he was still not ready. In addition to Salaam, the patient's

therapist and psychiatrist were involved, but no one ever pushed the patient to begin HAART.

With a strong support team in place, the patient did eventually begin treatment, although not without anxiety. He spent 15 minutes on the sidewalk in front of the building sweating profusely before his appointments. The prep work paid off, however—the patient has now been on treatment for 18 months and has an undetectable viral load. Salaam attributes the patient's success in part to his ability to sustain a regimented medication routine, a skill that came from years of taking medications to stabilize his mental health.

According to Haltiwanger, the patient's anxiety about medication was not uncommon. "The medication regimen can be very stressful," he says. "Our patients may be asking themselves, 'Am I taking the medications correctly?' and 'What will my results show?' and those issues can cause tremendous anxiety."

One strategy Chase-Brexton uses to provide support is "Club Med"—a biweekly support group led by a health and behavioral psychologist. At group meetings, participants fill their pillboxes, support one another in their efforts to be adherent, and discuss issues they are confronting. "We focus on the benefits of HIV medications and strategies to stay healthy. We also talk about anything and everything they want, and some of the topics that come up are addictions, depression, loneliness, stress management, and suicide," says Salaam.

These kinds of struggles are real. One member with a history of drug addiction was clean when she started on HAART. When it became obvious that she was abusing drugs again, Salaam, her case manager, her primary care provider, and staff at the local methadone clinic talked with her about the importance of maintaining her medication regimen. When the patient was 2 weeks late picking up her medications and had relapsed on heroin, the team decided that it was in her best interest to stop the medications. "She was on a very fragile regimen and risked developing drug resistance in a short window," said Salaam. "We are here to support her now and when she is ready to resume treatment."

➔ ***"The medication regimen can be very stressful. Our patients may be asking themselves, 'Am I taking the medications correctly?' and 'What will my results show?'"***

 **PSYCHIATRIC DISORDERS COMMONLY ASSOCIATED with HIV and AIDS³²**
MOOD DISORDERS³³

Major depression	A disabling condition characterized by a persistent sad mood; a diminished sense of well-being; and feelings of guilt, anxiety, or self-loathing. Symptoms interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities, and they prevent normal functioning.
Dysthymia	Chronic, mild depression that can prevent normal functioning and persists for at least 2 years in adults or 1 year in children.
Bipolar disorder	Dramatic mood swings from overly "high," irritable, or both to sad and hopeless, and then back again, often with periods of normal mood in between. The periods of highs and lows are called episodes of mania and depression, respectively.

ANXIETY DISORDERS³⁴

Generalized anxiety disorder	Chronic anxiety, exaggerated worry, and tension accompanied by a variety of physical symptoms.
Panic disorder	Unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, dizziness, or abdominal distress.
Posttraumatic stress disorder	Persistent frightening thoughts and memories of a terrifying event or ordeal in which grave physical harm occurred or was threatened. Symptoms include sleep problems and feelings of detachment or numbness.

OTHER

Adjustment disorders	A psychological response from an identifiable stressor or group of stressors that causes significant emotional or behavioral symptoms, including anxiety and depressed mood, but does not meet criteria for more specific disorders. ³⁵
HIV-associated dementia or AIDS dementia complex	Progressive illness that is the result of HIV's impact on the central nervous system. May affect behavior, cognition, mood, and motor skills. Patients may develop ambulation or gait problems, mania, panic, psychosis, social isolation, or anxiety. ^{36,37}
Personality disorders	A group of mental disorders characterized by inflexibility, rigidity, and inability to respond to the changes and demands of life. People with personality disorders tend to have a narrow view of the world and find it difficult to participate in social activities. ³⁸
Substance abuse	Abuse or dependence on anything that is ingested to produce a high, alter one's senses, or otherwise affect functioning. ³⁹

 ONLINE RESOURCES

The MST team also pays close attention to the mental health–related side effects of the anti-HIV medications. For example, some medications can exacerbate ADHD and bipolar disorder. “In matching patients up with a medication regimen, it is important to screen for those medications that may impact or trigger their mental health issues as well as [for] those that may interact with antidepressants,” says Salaam. HIV medications and psychiatric medications may interact or be contraindicated and should therefore be chosen with consideration for adverse effects and potential interactions.^{40,41} (See the online resources box for a guide to interactions.)

OPENING AVENUES to TREATMENT

“Look to the client, and see what they identify as helpful,” says Armando Smith, chief program officer of Chicago’s Vital Bridges, in discussing how to work with clients who need mental health treatment but are resistant to getting care. “It is important to both recognize that there are differences in how people view mental health treatment and to help folks understand that seeing a mental health professional is just another tool in the toolbox along with churches, support groups, and friends and family.”

In addition to linking clients to mental health professionals, Vital Bridges, which is a Ryan White HIV/AIDS Program–funded agency that provides support services at five locations in the Chicago area, also uses what Smith calls “low-key” mental health interventions. An art therapy group and a Friday afternoon movie group give clients a chance to gather and be with their peers, to talk about issues they are facing, and interact with a mental health professional in a less traditional setting.

Although the art therapy program was conceived as a structured group, it has found more success as a drop-in program with both regular and occasional participants. It is located next to one of the agency’s grocery programs and meets when the pantry is open. Members may “talk for a minute or 10 minutes or not at all. It’s a break, it’s fun, and it serves a purpose in their lives,” says Smith, who also notes that some participants have now asked to see the therapist individually.

The value of social interactions is echoed by Jeff Levy of Live Oak, also in Chicago. Levy, who has been working with PLWHA for many years, says, “I believe that some of my patients have gotten more from their connection with others through community-based supports than sitting with me for an hour. Many of those I see suffer

HIV and Mental Health Clinical Guidelines from the New York State Department of Health AIDS Institute
www.hivguidelines.org/Content.aspx?pageID=261

mental health AIDS
<http://mentalhealthaids.samhsa.gov/index.asp>

Mental Health Screening: A Quick Reference Guide for HIV Primary Care Clinicians
www.hivguidelines.org/Content.aspx?pageID=466

Mental Illness and Health
www.aids-etc.org/aidsetc?page=et-30-18

Psychiatric Medications and HIV Antiretrovirals: A Guide to Interactions for Clinicians
www.aids-ed.org/aidsetc?page=etres-display&resource=etres-283

from isolation [that is] often related to changes in their bodies and their appearance, and they need more ways to connect with other people.” Ideas for decreasing social isolation include strengthening connections with family, participating in 12-step meetings, or joining community groups unrelated to HIV.

Levy identifies the aging PLWHA population, many of whom are long-term survivors, as a growing mental health concern. Age is closely linked to issues of isolation, which may be heightened by the loss of significant others and friends to HIV. A study comparing social networks and social isolation in older and younger PLWHA bore out those concerns. The study found that older adults were more likely to live alone; it also found that 38 percent of older adults and 54 percent of older adults of color were at risk for social isolation, compared with 25 percent of study participants ages 20 to 39.⁴²

Whether old or young, newly diagnosed or long-term survivors, many PLWHA will confront mental health challenges. But as Chase-Brexton’s Haltiwanger notes, an HIV diagnosis can spur psychological health: “It can present an opportunity to repair damaged relationships and improve communication. If patients work with a mental health provider, they can cope with their diagnosis and heal those issues that preceded their diagnosis.”

 REFERENCES

- ¹Lesser J. Role of depression, stress, and trauma in HIV disease progression. *Psychosom Med*. 2008;70:539–45.
- ²Treisman GJ, Angelino AF, Hutton HE. Psychiatric issues in the management of patients with HIV infection. *JAMA*. 2001;286:2857–64.
- ³Lesser, 2008.
- ⁴Starace F, Ammassari A, Trotta MP, et al. Depression is a risk factor for suboptimal adherence to highly active antiretroviral therapy. *J Acquir Immune Defic Syndr*. 2002;31 (Suppl 3):S136–9.
- ⁵Whetten K, Reif S, Whetten R, et al. Trauma, mental health, distrust, and stigma among HIV-positive persons: implications for effective care. *Psychosom Med*. 2008;70:531–8.
- ⁶Cook JA, Grey D, Burke J, et al. Depressive symptoms and AIDS-related mortality among a multisite cohort of HIV-positive women. *Am J Public Health*. 2004;94:1133–40.
- ⁷Kalichman SC. Co-occurrence of treatment nonadherence and continued HIV transmission risk behaviors: implications for positive prevention interventions. *Psychosom Med*. 2008;70:593–7.
- ⁸Carrico AW, Antoni MH. Effects of psychological interventions on neuroendocrine hormone regulation and immune status in HIV-positive persons: a review of randomized controlled trials. *Psychosom Med*. 2008;70:575–84.
- ⁹Horberg MA, Silverberg MJ, Hurley LB, et al. Effects of depression and selective serotonin reuptake inhibitor use on adherence to highly active antiretroviral therapy on clinical outcomes in HIV-infected patients. *J Acquir Immune Defic Syndr*. 2008;47:384–90.
- ¹⁰Bing EG, Burnam A, Longshore D, et al. Psychiatric disorders and drug use among HIV-infected adults in the US. *Arch Gen Psychiatry*. 2001;58:721–8.
- ¹¹Lesser, 2008.
- ¹²New York State Department of Health. *Suicidality and violence in patients with HIV/AIDS*. 2007. Available at: www.hivguidelines.org/GuideLine.aspx?pageID=261&guideLineID=84. Accessed October 30, 2008.
- ¹³Whetten K, Reif S, Napravnik S, et al. Substance abuse and symptoms of mental illness among HIV-positive persons in the Southeast. *South Med J*. 2005;98:9–14.
- ¹⁴Whetten et al, 2008.
- ¹⁵Weiser SD, Wolfe WR, Bangsberg DR. The HIV epidemic among individuals with mental illness in the United States. *Curr Infect Dis Rep*. 2004;6:404–10.
- ¹⁶National Alliance of State and Territorial AIDS Directors. *Mental Health Issue Brief: HIV and mental health: the challenges of dual diagnosis*. 2005. Available at: www.nastad.org/Docs/Public/InFocus/200632_NASTAD_Mental_Health_final.pdf. Accessed October 15, 2008.
- ¹⁷Treisman et al, 2001.
- ¹⁸Ciesla JA, Roberts JE. Meta-analysis of the relationship between HIV infection and risk for depressive disorders. *Am J Psychiatry*. 2001;158:725–30.
- ¹⁹Horberg et al, 2008.
- ²⁰Horberg et al, 2008.
- ²¹Treisman et al, 2001.
- ²²Clare DM, Kissane DW. Demoralization: its phenomenology and importance. *Aust NZ J Psychiatry*. 2002;36:733–42.
- ²³Treisman et al, 2001.
- ²⁴HIV/AIDS Bureau, Health Resources and Services Bureau. *Tools for grantees: The Client Diagnostic Questionnaire (CDQ)*. n.d. Available at: <http://hab.hrsa.gov/tools/topics/cdq.htm>. Accessed October 21, 2008.
- ²⁵Pence BW, Gaynes BN, Whetten K, et al. Validation of a brief screening instrument for substance abuse and mental illness in HIV-positive patients. *J Acquir Immune Defic Syndr*. 2005;40:434–44.
- ²⁶Pence et al, 2005.
- ²⁷RAND Corporation. *Mental health and substance abuse among people with HIV: lessons from HCSUS*. Santa Monica, CA: Author; 2007. Available at: www.rand.org/pubs/research_briefs/2007/RAND_RB9300.pdf. Accessed October 15, 2008.
- ²⁸RAND Corporation, 2007.
- ²⁹Whetten et al., 2005.
- ³⁰New York State Department of Health. *Mental health care for people with HIV Infection: HIV clinical guidelines for the primary care practitioner*. Table 1-1: crisis points for HIV-infected persons. 2001. Available at www.hivguidelines.org/Content.
- ³¹Personal communication, Armando Smith, Chief Program Officer, Vital Bridges, October 2008.
- ³²New York State Department of Health. *The role of the primary care practitioner in assessing and treating mental health in persons with HIV*. 2001 Available at: www.hivguidelines.org/GuideLine.aspx?pageID=261&guideLineID=40&vType=text. Accessed November 3, 2008.
- ³³National Institute of Mental Health. *Depression*. 2007. Available at: www.nimh.nih.gov/health/publications/depression/summary.shtml. Accessed November 3, 2008.
- ³⁴National Institute of Mental Health. *Anxiety disorders*. 2008. Available at: www.nimh.nih.gov/health/publications/anxiety-disorders/introduction.shtml. Accessed November 3, 2008.
- ³⁵Clare & Kissane, 2002.
- ³⁶New York State Department of Health. *Cognitive disorders and HIV/AIDS: minor cognitive disorder, HIV-associated dementia, and delirium*. 2007. Available at: www.hivguidelines.org/GuideLine.aspx?pageID=261&guideLineID=44&vType=text. Accessed November 3, 2008.
- ³⁷Coffey, S, Ed. AIDS Education and Training Centers National Resource Center. *Clinical manual for management of the HIV-infected adult*. 2006. Available at: www.aidsetc.org/aidsetc?page=cm-00-00. Accessed November 3, 2008.
- ³⁸Mental Health America. *Fact sheet: personality disorders*. 2006. Available at: www.nmha.org/index.cfm?objectId=C7DF8E96-1372-4D20-C87D9CD4FB6BE82F Accessed November 3, 2008.
- ³⁹AllPsych Online. *Psychiatric disorders: substance related disorders*. Available at: <http://allpsych.com/disorders/substance/index.html>. Accessed November 3, 2008.
- ⁴⁰Smith, personal communication, 2008.
- ⁴¹New York/New Jersey AETC. *Psychiatric medications and HIV antiretrovirals: a guide to interactions for clinicians*. 2008. Available at: www.aids-ed.org/pdf/tools/nynj_psych-guide.pdf. Accessed November 3, 2008.
- ⁴²Emlet CA. An examination of the social networks and social isolation in older and younger adults living with HIV/AIDS. *Health Soc Work*. 2006;31:299–308.