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MENTAL HEALTH Issue Brief

HIV AND MENTAL HEALTH: THE CHALLENGES OF DUAL DIAGNOSIS

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To address the complex issues that inextricably link mental health and HIV/AIDS, NASTAD collaborated with the American Psychological Association (APA) Office on AIDS to develop this Issue Brief. NASTAD extends its gratitude to APA and health department staff in the three profiled states (California, Colorado, and Rhode Island) for the articles they provided for this issue brief.

WHAT DOES MENTAL HEALTH HAVE TO DO WITH HIV PREVENTION?



AMERICAN
PSYCHOLOGICAL
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A solid working knowledge of mental health and substance abuse issues is essential for understanding how to help people protect themselves from HIV infection, how to help those who are already infected from transmitting the virus to others, and how to reduce adverse health consequences among those living with HIV.

Working with people who have both mental health and substance abuse disorders is a common and difficult challenge for those working on the front lines of HIV prevention.

Front line prevention workers are often confused about how to identify problems and prioritize goals. In part, this confusion arises from the fact that the relevant service delivery systems (i.e., medical care, mental health care, substance abuse treatment, and prevention services) each have their own goals, language, and set of assumptions about what is best for their clients. Until recently, these four service delivery systems have worked in relative isolation and as a consequence, their assumptions about the best care for their clients have remained largely unstated until conflict arises over how to address the needs of a particular client.

Nature and Scope of the Problem

Eric Bing and his colleagues (2001) used data from the HIV Cost and Services Utilization Study (HCSUS) to examine mental health and substance use in a large, nationally representative probability sample of adults receiving care for HIV in the U.S. Study participants were administered a brief instrument that screened for mental health disorders and drug use during the previous 12 months. Nearly half of the sample screened positive for a mental health disorder, nearly 40% reported using an illicit drug other than marijuana, and more than 12% screened positive for drug dependence. More than one-third of the study sample screened positive for major depression and over a quarter of the sample screened positive for a less severe form of depression called dysthymia. The proportion of people screening positive for mental health and substance abuse disorders in the HCSUS sample is considerably higher than that obtained from general population samples. For example, the proportion of people screening positive

**TABLE 1:
COMPARISON OF PERSONS SCREENING
POSITIVE BY CONDITION**

Condition	HCSUS (1) (N=2,864)	NHSDA (2) (N=22,181)
Major Depression	36.0%	7.6%
Anxiety Disorder	15.8%	2.1%
Panic Attack	10.5%	2.5%
Drug Use	50.1%	10.3%

(1) HCSUS: HIV Cost and Service Utilization Survey

(2) NHSDA: National Household Survey on Drug Abuse

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for major depression in HCSUS is nearly five times greater than the proportion found in the National Household Survey on Drug Abuse (NHSDA) (SAMHSA, 1996) (see Table 1 for other comparisons).

HCSUS findings highlight the high proportion of people receiving HIV-related care who also have mental health and substance abuse problems. In addition to their negative impact on quality of life (Sherbourne et al, 2000), mental health and substance use disorders have been consistently associated with increased HIV risk behavior (Hutton et al, 2004; Booth et al, 1999) as well as poor access and adherence to antiretroviral treatment for HIV/AIDS (Cook et al, 2002; Tucker et al, 2003). Although mental health and substance abuse disorders are highly treatable, they must first be identified and individuals referred to appropriate services. Unfortunately, stigma and lack of knowledge about these disorders often prevent this from happening (Cooper et al, 2003; Kessler et al, 2001).

Clients resist seeking care for mental health issues because they view them as personal weaknesses and do not want to be viewed as “crazy.” According

to Aidala et al. (2004), client under-recognition of problems is even more problematic with individuals who are also using drugs. Often people do not recognize the role mental health problems have played in their drug use until they have maintained recovery for a prolonged period. In an ongoing study of a representative sample of HIV-infected New York City residents, Messeri and colleagues (2002) found that clients’ self-perception of mental health problems and the need for treatment was the most significant predictor of accessing care. Unfortunately, the need for treatment is seldom acknowledged by those who need it — three in four persons with mental health symptoms answer “no” to direct questions about emotional or psychological problems or the need for mental health services (Aidala & Lee, 2001).

The problem of client under-recognition of mental health problems is compounded when HIV providers lack the experience to adequately assess mental health needs. Primary care providers are notoriously unreliable when it comes to diagnosing and treating common mental health disorders (Staab et al, 2001). Additionally, prevention workers

and prevention case managers typically receive few guidelines and minimal training in the systematic assessment of mental health and substance use disorders. Fortunately, during the past few years, effective diagnostic screening tools have been developed (e.g., Aidala et al, 2004) for use by non-mental health professionals in HIV/AIDS service settings, and training is now provided for prevention workers on the front lines.

There are numerous mental health and substance abuse disorders and issues that affect HIV/AIDS risk behavior. Although a review of these disorders and issues, and how they affect HIV/AIDS risk behavior is beyond the scope of this document, a few topics deserve highlighting.

Depression and HIV in Relationship to Other Psychosocial Factors

Ickovics and her colleagues (2001) found that depressive symptoms among women with HIV are associated with HIV disease progression, even when the effects of key clinical, substance use, and sociodemographic characteristics are controlled. Symptoms of depression are also associated with unprotected sexual intercourse, multiple sex partners, trading sex for money or drugs, and contracting sexually transmitted diseases (see Hutton et al, 2004 for review). It is important to note that depression may combine with the effects of other psychosocial factors to produce a phenomenon known in the public health literature as a “syndemic,” defined as a highly interrelated set of health problems experienced by a single population (Stall et al, 2003). Stall and his colleagues analyzed data from a large-scale, household-based sample of urban men who have sex with men (MSM) to test whether an additive interplay among a specific set of psychosocial health conditions (i.e., depression, polydrug use, childhood sexual abuse, and partner violence) is driving the HIV/AIDS epidemic among MSM. Results indicated that all four of

these psychosocial health problems were independently related to a greater likelihood of high-risk sexual behavior and of having HIV. However, results also indicated that individuals with depressive symptoms, polydrug use, and childhood sexual abuse were at higher risk than those with only depressive symptoms and polydrug use. Furthermore, individuals with depressive symptoms and polydrug use were at higher risk than those with depressive symptoms alone.

It is clear that the additive interplay of psychosocial factors can magnify the risk of a particular population for HIV disease and other serious health conditions. Coates (2004) outlined the possible pathways in which depression may interact with other psychosocial variables to produce increased HIV risk in the following passage:

...certain experiences in childhood and adolescence predispose people to adult depression. The need to treat depression leads people to use various substances — some by prescription and some off the street — to make themselves feel better. Depression makes it difficult to form friendships and intimate relationships, which buffer people from many life difficulties; the lack of these connections makes people feel more depressed. In response, depression may lead some people to use sexual encounters to make themselves feel better. The combination of substance use and such “palliative” sexual encounters may result in unsafe sexual encounters and a greater chance of catching or transmitting HIV (p. 6).

Childhood Sexual Abuse and Adult HIV Prevention

Many studies have shown a strong relationship between childhood sexual abuse and HIV sexual risk behavior in both adult women and men (see Whitmire, Harlow, Quina et al, 1999; and, Paul, Catania, Pollack et al., 2001 for reviews). Not surprisingly, there is a broad range of

reactions to childhood sexual abuse. Some show few effects while others experience pervasive symptomatology. According to Paul (2003), an examination of the reported effects of childhood sexual abuse highlights potential intervening variables that may increase HIV risk. Paul (2003) points out that studies of survivors of childhood sexual abuse have found higher rates of depression, higher rates of self-destructive behaviors or attitudes, increased use of alcohol and other drugs, dissociative symptoms (compartmentalizing aspects of one’s consciousness), difficulties with sexual functioning and intimacy, greater numbers of sexual partners, more frequent sexual activity, and less attention to risk.

Although effective interventions exist to address the negative effects of childhood sexual abuse that may lead to increased HIV risk, these interventions typically require extensive clinical training and long-term commitments that are generally beyond the scope of most HIV prevention programs. However, as Paul (2003) points out, it is possible for HIV prevention programs to implement approaches that are more suitable to their capacities. The approaches include routine client screening upon request for services, client reassessment over the course of service delivery, basic psychoeducation about childhood sexual abuse, staff support and training, and referral for mental health and substance abuse treatment (Paul, 2003).

Sexual Compulsivity

A growing literature suggests that sexual compulsivity represents a discrete clinical problem (Carnes, 2001; Goodman, 1998; Raymond, Coleman & Miner, 2003). Generally, people with sexual compulsivity report strong urges for sex, preoccupation with sexual thoughts, loss of control over sexual activity, and spending disproportionate amounts of time engaged in sexual thoughts and behavior. It is important to note that people with sexual compulsivity display high rates of mood disorders, anxiety disorders, and

substance use disorders (Raymond, Coleman & Miner, 2003). Several studies using samples of HIV-positive people and MSM have found that those who score higher on measures of sexual compulsivity are significantly more likely to engage in unprotected sexual behaviors (see Muench & Parsons, 2004 for a review). In their review, Muench and Parsons (2004) outline several reasons why sexual compulsivity may be related to HIV risk: (1) higher numbers of sexual partners; (2) loss of control over sexual behavior; (3) the interrelationship between sexual compulsivity and substance use; (4) people with sexual compulsivity may place themselves at greater risk in order to increase their sexual repertoire; and, (5) people with sexual compulsivity may be more likely to engage in sexual encounters with other sexually compulsive individuals.

The association between sexual compulsivity, unprotected sex, and HIV risk clearly warrants significant attention. Unfortunately, knowledge about sexual compulsivity and its treatment has yet to be integrated widely into either clinical settings or prevention programs. While implementing proper screening and identification procedures is clearly the first step, learning about and linking with qualified community resources to treat these types of problems may require intensive outreach and networking.

HIV/AIDS and the Seriously Mentally Ill (SMI)

Persons living with a severe mental illness (SMI) are disproportionately vulnerable to infection with HIV and other sexually transmitted diseases.

In a recent review, Weiser and his colleagues (2004) document HIV seroprevalence rates ranging from 3% to

23% among patients with an SMI. Epidemiological studies make clear that persons living with an SMI are more likely to be victims of sexual coercion and intimate partner violence, to live in risky environments, to have unstable partnerships in high-risk sexual networks, to use substances that impair decision making, and to lack the emotional stability, judgment, and interpersonal skills needed to avoid risk (Carey et al, 2001; Carey, Carey & Kalichman, 1997). Despite these many vulnerabilities, recent evidence suggests that even persons living with the most disabling mental illnesses — including schizophrenia and other psychotic disorders — can reduce their risk through group-level behavioral risk reduction interventions (see Carey, 2005 for a review).

There is a unique and important opportunity to promote the health of individual clients and that of the larger public through implementation of HIV risk reduction interventions for persons with an SMI. This population routinely comes into contact with a variety of service delivery systems. Thus, there are numerous opportunities to access persons with an SMI.

If resources do not allow for evidence-based, group-level interventions, then referral to mental health providers with experience in sexual health promotion and risk reduction is a worthwhile alternative.

Summary

HIV prevention program managers and policymakers must realize that to effectively prevent the transmission of HIV, front line prevention providers must learn to effectively identify and

refer clients with mental health and substance use disorders. Furthermore, prevention interventions must be developed that consistently address mental health and substance use issues in an integrative and systematic way.

CALIFORNIA — POSITIVE CHANGES

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Positive Changes was initially funded through a CDC grant (Prevention for HIV-Infected Persons Project- PHIPP) for five years. It is a psychologically-focused approach grounded in harm reduction theory, motivational interviewing, and short-term, solution-focused therapy. Positive Changes operates within an HIV care setting, California's HIV Early Intervention Program (EIP). EIP, a program of the California Office of AIDS, serves 10,000 clients in 34 sites serving 48 Local Health Jurisdictions (LHJs). Founded in 1987 on the public health model first used by the CDC to eliminate smallpox worldwide, EIP has been one of the few HIV care and treatment programs to include prevention for HIV-positive persons as an essential part of its standard of care. EIP uses a team-centered approach, in which client care is not parceled out into separate categories or referral systems. Instead, client needs are addressed from a holistic perspective that integrates primary care, psychosocial services, health education, and HIV risk reduction counseling.

While EIP's prevention approach is successful for many clients, there are some for whom traditional risk reduction counseling does not lead to any significant change in risk behavior. EIP, like all HIV prevention and care programs, faces significant challenges in

trying to intervene with established risk behavior patterns, especially when these are complicated by factors such as substance use, mental disorder, language or cultural barriers, marginalized social status, or homelessness.

Of the clients enrolled in EIP, some 60-70% present with substance abuse problems and/or current mental health issues, and both of these factors have a significant impact on HIV transmission risk. Many EIP clients have histories that include prior attempts at mental health and substance abuse treatment, while others have never received any treatment at all.

Positive Changes focuses on EIP clients at very high risk for HIV transmission. Based on an improved understanding of the dynamics of risk behavior and on the acknowledgement that traditional public health approaches were largely ineffective with these clients, the decision was made to hire

These are clients with very complex lives and they have many inherent strengths, though they may not always know how to access them.

Mental health professionals must help them become more conscious of their capabilities and to learn to apply them in ways that lead to greater resiliency, better health, a more satisfying life, and lower risk of HIV transmission.

licensed mental health providers to implement the program.

The goal of Positive Changes is to provide an intensive, individualized risk reduction for EIP clients at high risk for

transmitting HIV. The intervention focuses on long-term behavior change by building on incremental steps in order to maximize success and motivation for further change.

Prior to the implementation of Positive Changes, most HIV care sites, including EIP, utilized a more traditional public health approach that emphasized psychoeducational and basic counseling interventions to support transmission risk reduction. While some referrals to psychotherapists were available, very few practitioners were trained to address both the needs of HIV-positive persons along with the often complex dynamics of HIV transmission risk reduction.

An example illuminates the difference between a traditional public health approach and the psychologically-based approach used by Positive Changes to conduct prevention interventions. When meeting with a client who engages in high-risk sexual behavior, the public health approach might be to do a brief assessment, offer the client a referral to a support group or substance abuse treatment, encourage the client to use condoms, and perhaps demonstrate their use.

The approach used in Positive Changes acknowledges that risk behavior takes place within a web of individual, cultural, and social influences. Interventions must be based on the reality that risk behaviors may be integrated within strong family or support networks, may have profound survival value to clients, and will not simply disappear with strategies that rely solely on education, referrals, or “prevention messages.” Positive Changes focuses on developing a clear understanding of the context of risk for that particular client and on building an alliance with the client that is based on trust. Once the provider has established a relationship with the client, the focus is on developing a mutually agreed-upon set of steps toward behavioral and/or cognitive changes that will lead to an improvement in life circum-

stances and reduced risk of HIV transmission. Behavior change steps must be small — both client and counselor are discouraged from setting grandiose goals that may set clients (and counselors!) up for failure.

“Use a condom every time”
or “stop using meth” are,
for example, end-point goals
that may not be achievable
by clients when they first
enter the program.

Goals represent changes that the clients themselves are interested in achieving to improve their lives: the Positive Changes intervention operates on the assumption that most, if not all, risk behaviors are connected to aspects of clients’ lives that the client wants to improve. While no client is likely to be very interested in “risk reduction counseling,” all clients are interested in finding ways to enhance the quality of their lives — typically clients want to improve their relationships, stabilize their housing, family, legal, or employment situations, and feel better about themselves — all of these goals can include factors that can be directly linked to risk reduction.

The approach of Positive Changes is not to offer “risk reduction counseling,” but to ask clients to consider what changes they would like to make in their lives. Goals for change are identified and integrated within a plan for improving the quality of the client’s life, while emphasizing factors or cofactors that contribute to HIV transmission risk. Goals are then broken down into small, achievable steps that allow clients to experience success. A client’s inability to achieve a goal is not framed as failure, but rather as an indication that client and counselor simply need to set a slightly different goal at the time.

Success in achieving behavior change goals is celebrated and built upon in creating the next set of goals, ultimately leading to substantive and long-term changes.

As with any program, challenges face providers in the Positive Changes program. Most Positive Changes staff have not received sufficient training to implement the program at the time of hire. For new staff, training has included strategies for developing solution-focused methods for supporting behavior change, assessing which aspects of behavior a client is ready to change and wants to change, and practice in translating this into achievable goals. It has been important to provide ongoing training in working with sexual impulsivity and sexual compulsion, working with specific subpopulations (for example, young gay men, injection drug users, Latino men who have sex with men) and training in specific substance use and abuse patterns (e.g., methamphetamine, “party drugs,” opiates, etc.).

Funding for the program is currently secure, but may be a challenge in the future. Funding from the CDC PHIPP grant ended in 2004. Because preliminary evaluation of the program showed good results, and a fiscal analysis demonstrated that the program was cost-effective in terms of preventing future cases of HIV, the California Office of AIDS committed funding for another three years.

Staff turnover has also been an issue — relatively low salary scales compared to other employment settings can make it difficult for some EIP sites to hire and retain licensed mental health providers for the Positive Changes Program. Some hired recent graduates who were not yet licensed. As a result, it was necessary to provide professional development for Positive Changes staff, and to make sure that all sites understood the importance of providing appropriate clinical supervision. In an effort to enhance collaboration, prevent

burnout, and reduce turnover, Positive Changes providers from across the state are brought together three to four times a year. At these meetings, providers are able to meet with colleagues to discuss difficult cases, participate in trainings, learn more about particular subpopulations, and earn continuing education credit at no cost.

Integrating a psychological model into care and treatment programs, where the medical model dominates, has also been a struggle. Finally, there has been a significant dropout and attrition rate for the program, though this was not entirely unexpected: the clients served by Positive Changes are typically the most challenging to present in any HIV care setting, and often have a very difficult time establishing and maintaining relationships and consistent contact with care providers.

Marketing of the program has been relatively simple. Any member of the EIP provider team who believes one of their clients may be at high risk for HIV transmission can refer a client to the program or they may suggest that the Positive Changes counselor initiate contact with the client. There is also a pilot underway to test the effectiveness of the program in a non-EIP care setting.

While there have been challenges to overcome, in the end there have been many successes. The program has produced sustained behavior change and prevented HIV transmission among the clients who are at greatest risk for transmitting HIV. The program counsels clients with whom few providers want to work or are able to work, and as a result, these clients' lives have been improved. In fact, 70% of those clients with the highest risks indicated significant change in behavior, including increased and consistent use of condoms, decreased use of methamphetamine, amyl nitrate, cocaine, alcohol, and heroin, decreased sharing of injection equipment, decreased binge drinking, and decreased diagnosis of STDs. The program clearly seems to meet a pressing need.

COLORADO — HIV PREVENTION, MENTAL HEALTH, AND SUBSTANCE ABUSE SERVICES: THE CHALLENGE AND NEED FOR COORDINATION

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When Brad S. began seeing his prevention case manager (PCM), he seemed very eager to address the problems in his life associated with HIV risk. Now, several months later, the PCM feels frustrated that Brad has not really followed through on anything. He has begrudgingly described his history — living with HIV for five years, childhood abuse, in and out of jail since adolescence, chronic unemployment, no support system — but he frequently misses appointments and becomes belligerent when confronted. He has said his partners “get what they deserve if they assume he is HIV negative.” The PCM wonders if a referral is needed, but she's not sure what type of service Brad would accept.

Until recently, Kyle W. was one of the most dependable peer leaders in his Mpowerment group. Lately, though, he's been “acting out” during the meetings. He's told the HIV educator that he has a new boyfriend who “likes to party,” so he spends most of the weekends and several nights during the week out at the bars. His boss is “being a jerk;” he's in danger of losing his job because of tardiness. In the group meetings, he ridicules any ideas for get-togethers that don't involve partying. Some of the other group members now dismiss Kyle as a “tweaker.” When the group proposes arranging a weekend retreat — alcohol and drug free — Kyle gets angry and leaves the meeting early. He hasn't returned since.

In jurisdictions similar to Colorado, these may be common scenarios. In Brad's case, he shows clear signs of antisocial personality disorder, but the PCM has not been trained to screen for this. It is doubtful that Brad will ever respond to the same HIV prevention techniques that work for other PCM clients, leading to frustration and wasted resources. The PCM may even place herself in harm's way. In Kyle's case, he shows signs of drug dependence, but the health educator and his peers seem unprepared to deal with his deepening problems, which no doubt involve HIV-risk behaviors.

To illustrate the significance of this issue, consider research recently published in the *American Journal of Psychiatry* and the *American Journal of Public Health*. In a study conducted by Hutton and his colleagues, approximately 45% of STD clinic attendees were found to meet criteria for a current *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV) Axis I disorder (predominantly a substance use disorder) and 29% for an Axis II personality disorder (predominantly antisocial personality disorder [ASPD], identified in 29.4% of the men sampled) (Hutton, et al, 2004). With gay men, Ron Stall and his colleagues made the following observation, based on their large-scale, multi-site study:

Compared with the group of men reporting no psychosocial health problems, greater numbers of [psychosocial] health problems were significantly and positively associated with HIV infection and current high-risk sexual practices. (2003)

If, indeed, a large percentage of today's highest-risk HIV prevention program clients have significant mental health and substance use problems that drive their risk behaviors, what role is implied for such programs? At a minimum, it seems prudent to re-examine

the basic assumptions that have driven HIV prevention for decades. Mental health professionals often assume that clients have freely chosen to take risks, and can freely choose safety instead.

Decision-making and choice are very different for people who are chronically depressed, addicted, or compulsive. Such people require different kinds of support – perhaps only the highly specialized skills of mental health or addictions professionals will make a lasting impact.

Rather than admit the limits of our HIV prevention programs and strengthen partnerships with clinical providers, the great temptations among mental health providers are to either “make do” or “pretend otherwise.” Those who “make do” will acknowledge that the problems are serious but assume that very little can be done about the underlying mental illness or addiction. They will continue to provide the best HIV prevention services possible and hope that they can at least reduce the harms associated with the risky behaviors. Those who succumb to the second temptation, to “pretend otherwise,” will minimize the importance of mental health and substance abuse issues among their clients. They will reject formalized screening practices and only make referrals when clients ask for them spontaneously.

Fortunately, there are other options. In Colorado, while there is no full HIV/mental health/substance abuse system integration, progress has been

¹ See National Institute on Alcohol Abuse and Alcoholism Alcohol Alert, No. 56, April 2002. Available at <http://www.niaaa.nih.gov/publications/aa56.htm>

² More information about the CDQ can be found at: www.hab.hrsa.gov/tools/topics/cdq.htm

made in laying the foundation. It began by formalizing screening practices for potential substance abuse problems. Research identified several tools designed for use by non-clinicians in a busy setting; ultimately the jurisdiction settled on an instrument known as the CAGE.

Although this instrument has its drawbacks, the National Institute on Alcohol Abuse and Alcoholism summarizes its strengths as follows:

“The CAGE questionnaire has been evaluated in several studies, showing sensitivities ranging from 43 to 94 percent for detecting alcohol abuse and alcoholism. CAGE is well suited to busy primary care settings because it poses four straightforward yes/no questions that the clinician can easily remember and requires less than a minute to complete.” (2002)¹

Finding an equivalent instrument to screen for potential mental health issues has proven more challenging. Further research led to the Client Diagnostic Questionnaire (CDQ), developed through HRSA. The *CDQ User Guide* describes the instrument as follows:

“The CDQ was developed specifically to facilitate rapid and accurate recognition of mental health problems commonly seen in HIV/AIDS service settings:

CAGE

ASKS CLIENT ABOUT THE PAST YEAR:

C =Cutting down on drinking considered?
A =Annoyed you by criticizing drinking?
G =Guilt about your drinking?
E =Eye openers necessary?

- Designed to detect alcohol dependence
- Will miss up to 50% of at-risk drinkers

—Source: NIAAA

Depressive and Anxiety Disorders including PTSD, Alcohol and Drug Abuse Disorders. There is also a Psychosis screen. A validation study conducted by researchers at the Mailman School of Public Health at Columbia University demonstrated that the CDQ administered by agency staff with no prior mental health training accurately identifies clients with clinically significant mental health needs. The study also found that clients are receptive to the screening interview.”²

Although the CDQ is relatively brief (requiring an average of 15 to 20 minutes to complete), it is much more complex than the CAGE. Therefore, in Colorado, only PCMs utilize the full CDQ; counselors in HIV testing sites and other brief encounters use the CDQ introductory questions for screening purposes.

Colorado provided training to support these screening tools and prepare HIV prevention providers to deal with the ensuing referral and service delivery challenges. The state has teamed with the Office on AIDS of the American Psychological Association to review these practices and build further on this foundation.

The next steps will probably be difficult, but cannot be avoided to remain relevant. Mental health providers must make painful decisions about where to focus HIV prevention efforts. Most likely, a majority of clients do not have diagnosable mental health and substance use issues. The standard HIV prevention interventions will work for them. Other clients may have mild to moderate

mental health and substance use issues; perhaps they may need counselors with enhanced training, tailored interventions, and direct connections to referrals. Many clients with severe mental illness and long-standing addictions demand a lot of attention from HIV prevention programs, but respond only marginally or not at all. Mental health professionals must team with clinical partners, build capacity, and make active referrals. But, in simple terms, they must concentrate scarce resources where they are most likely to produce the best results. Mental illness and substance abuse are not rarities among clients. Programs may not work equally well for them and deficiencies in the mental health and drug treatment safety nets must be acknowledged.

A truly responsive HIV prevention system would include a full partnership with mental health and substance abuse services. Ideally, all three systems share a common philosophy, based on human dignity, cultural competence, and realistic, incremental behavior change. Additionally, clients would have access to what they needed, when they needed it. For some jurisdictions, this concept remains a possibility. In others, however, some or all of this may already be in place.

RHODE ISLAND — COMMUNITY PLANNING AND THE INTEGRATION OF HIV AND MENTAL HEALTH

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Introduction and Background: How Mental Health Issues Were Integrated Into Community Planning

Upon the release of its 1999 *Comprehensive HIV Prevention Plan*, the Rhode Island Community Planning Group (RICPG) for HIV prevention

received a letter from a community mental health provider expressing concern that the mentally ill population was not specifically identified as a target population for HIV prevention services.

In response to this letter and the concerns raised within, mental health providers statewide were invited to the next scheduled RICPG meeting. Some of the issues raised included:

- Distinct needs for HIV prevention services focusing on the mentally ill.
- Lack of resources to provide social services for HIV positive persons who are mentally ill.
- Delivering HIV prevention services through mental health agencies appeared awkward and even strained.
- Referral systems and services were not in place for HIV positive persons with acute episodes of mental illness.
- The HIV prevention community and the mental health community do not seem to be working together.
- The mental health community needs to work with the RICPG in the area of data collection. Local data focusing on persons with mental illnesses must be collected and used in the development of the HIV epidemiologic profile.
- Cross training for HIV prevention (and other infectious diseases), substance abuse, and mental health staff was deemed as an essential missing piece.

As a result of this discussion, the RICPG formed the HIV Prevention Needs of the Mentally Ill Committee. The purpose of the Committee was to develop a position paper for presentation to the RICPG in the fall of 1999. Consistently, since that date, the RICPG specifically addresses and includes the needs of the mentally ill in their annual comprehensive plan. The notion of co-occurring disorders has been a prominent part of each plan.

The aforementioned concerns of the mental health providers that voiced their concerns at the 1999 RICPG meeting have been addressed in varying degrees. The complexities associated with addressing issues of access and availability of services for individuals with both HIV infection and who have mental illness is just one facet of the multi-dimensional concerns for this population. Although the RICPG had every intention of documenting gaps in the provision of care as well as prevention services for this population, they had no idea of how wide and deep they needed to cast the net to resolve these issues.

Community Planning In Rhode Island Identifies Issues Related to HIV Positive People and Their Access to Mental Health Services

When this CPG committee first began to meet in Rhode Island, it expected that the task at hand would be simple to accomplish and short term in duration. Members quickly discovered otherwise. While persons with mental illness who were also at risk for HIV were somewhat addressed through the prevention efforts of the RICPG, members realized that there were significant factors contributing to difficulties this population has in accessing services.

Soon the CPG realized that the current difficulties were partially attributed to a system of services designed at a time when the life expectancy of a person with HIV/AIDS was short. Observational studies revealed that mental health providers were still in the mode of short-term care for people living with HIV and attending to their needs on a long term basis was proving to be difficult.

The relevancy of this becomes more important, depending on the co-situational issues of the person living with HIV. For example, research has revealed that co-occurring disorders, for example, substance use and mental illness, create additional barriers and make it less likely to maintain a treat-

The following action steps were taken by the RICPG to integrate HIV prevention into mental health:

- Target populations identified by the RICPG now include mentally ill individuals who become HIV positive, as well as substance abuse clients who become HIV infected, particularly those on methadone maintenance.
- A collaborative effort to cross train professionals across infectious diseases, mental health, and substance abuse has been underway since 2004 and is conducted through RI's capacity building program, Project REACH.
- Questions involving HIV, STDs, TB, and Hep C have been included as part of a health risk assessment of mental health centers conducted by the Department of Mental Health, Retardation and Hospitals (MHRH).
- Community-based organizations including, Family Service, AIDS Care Ocean State and AIDS Project Rhode Island have been contracted by HEALTH-RI to provide case management to HIV positive clients.
- Rhode Island began to implement steps to quantify the extent to which individuals with mental health problems are at risk of acquiring or transmitting the HIV virus.
- A review of the licensing/regulations requirements for mental health facilities successfully included provisions for mandatory HIV prevention education and screening for those at risk for HIV in the year 2000. The Rhode Island Department of Mental Health, Retardation and Hospitals (MHRH) now requires all licensed and funded mental health programs to provide an array of HIV prevention, education and referral services. At a minimum, the goals for these HIV related interventions should include:
 - a) Assurance that all clients are routinely provided with a comprehensive assessment of risk factors related to HIV infection/transmission.
 - b) Training for team staff in HIV pre/post test counseling.
 - c) Providing all clients with education as to how the HIV virus is acquired/ transmitted.
 - d) Systematically providing all clients with information about and/or referral to available anonymous and confidential HIV testing options.
 - e) Providing data to MHRH and DOH regarding the number of active clients who are known to be HIV positive.
 - f) Providing cross training for HIV prevention educators and mental health workers.
 - g) Advocating for divisions within state departments to examine systems issues to facilitate access to services.
- HEALTH-RI began to collect data regarding the existence of severe and persistent mental illness or major mental health problems that are diagnosable (i.e. panic attacks, anxiety) in all persons diagnosed as HIV positive.
- HEALTH-RI developed a prevention case management curriculum and established standards for HIV education programs.
- HEALTH-RI began to identify sub-populations of individuals with mental health who may also be HIV positive into the following categories:
 1. Individuals already engaged by the mental health treatment system for the treatment of diagnosed mental health disorders.
 2. Individuals already engaged by the substance abuse treatment system for the treatment of diagnosed psychoactive substance use disorders.
 3. Individuals known to be HIV-positive who are receiving services from a traditional AIDS service organization (ASO).

ment regimen. Further, individuals who are not linked to care and/or treatment may be more likely to engage in risky behaviors that would transmit the virus to others. Additional complications come from sources of funding for medical care and whether the client has been

classified as an AIDS patient or as a mental health patient. Clients who receive no insurance or public insurance seem to have the most difficulty. Still other problems arise when mental health centers do not assess clients for health risk regarding HIV, STDs, TB, Hepatitis

C, and other infectious diseases; and/or when the restrictions of state and/or agency policies (i.e. restrictions regarding catchment areas) create barriers to accessing services.

Another significant problem is the apparent lack of communication among

physicians involved in the physical care of patients and psychiatrists prescribing psychotropic medications. There is also a lack of communication and collaboration among other providers of services, particularly substance abuse treatment, mental health and HIV treatment professionals. This poor communication affects the clients, who are unable to benefit from a comprehensive, integrated set of services designed to effectively meet their needs.

In the first Surgeon General's Report ever issued on mental health and mental illness (October 2000), Dr. David Satcher stated that "the mental health field is plagued by disparities in the availability of and access to its services." He also cited a person's financial status as a key disparity, referring specifically to those individuals with health insurance with inadequate mental health benefits or no insurance at all.

Data collected for the Satcher report indicated that "the impact of mental illness is the second leading cause of disability and premature mortality in the United States. It accounts for more than 15% of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer." According to Dr. Satcher, research has also supported two findings: 1) the efficacy of mental health treatments is well documented, and 2) a range of treatments exists for most mental disorders. While "treatment works" with regard to mental illnesses, situations still exist in which many individuals are unable to access services.

RICPG Creates Solutions to the Problems Identified

Some of the solutions to these problems lie in policy changes, both at the local and federal level. Many of the RICPG HIV Prevention Needs of the Mentally Ill Committee members agree that the implementation and coordination of efforts put forth by the RICPG, will begin to address some of the major barriers regarding access to services. One

solution is to require vendors receiving state and federal grants for the provision of mental health services to increase access for people at risk for HIV and HIV positive. Other solutions are relatively simple and involve education and training, not only for clients at risk for HIV, but also for all professionals involved in the care of persons with mental illnesses who are at risk for HIV.

As a result of the RICPG efforts, an interstate-agency workgroup was formed to address the issues isolated by the RICPG. The Departments of Health, and Mental Health, Retardation and Hospitals (the state agency responsible for substance abuse and mental health issues) met regularly and requested a capacity building grant from SAMHSA. RICPG also decided a more intensive effort was warranted to discuss the issues of hepatitis, substance abuse, HIV and mental health. Hence, this interagency work group was eventually extended to include two consultants from the Office of Addiction and Substance Abuse Services (OASAS) in New York. The technical assistance (TA) grant from SAMHSA, Center for Substance Abuse Treatment (CSAT) was for the purpose of writing an interagency plan and a joint position paper.

The Interagency Plan proved effective in mobilizing administrative support for the issues outlined as a result of the TA and capacity building meetings. The plan outlined the need for state agencies responsible for individuals living with HIV, substance abuse, and mental illness to enhance their communications, cross train staff, and review/develop new policies to better serve these communities.

Through this work and the capacity building assistance, a cross training for mental health, substance abuse, and infectious disease (e.g., HIV prevention staff, clinical staff in hospitals and health centers, etc.) professionals is now delivered through the in-state HIV prevention capacity building program.

Conclusion

The Rhode Island experience has outlined the complexities associated with integrating mental health into the HIV prevention planning process. As indicated, an up-front commitment from CPG members is essential to this integration. This first step and commitment was evidenced by the Committee from within the CPG to work on these issues. Next, state staff affiliated with these populations must be on board as well. Integrating and navigating through the myriad system issues of state government requires commitment from this end as well.

Although many issues regarding care and treatment access and availability for individuals who have co-occurring disorders have yet to be resolved, the critical aspect of getting these issues on the agenda of professionals through cross training has been accomplished. Professionals who take part in the training are asked to develop case scenarios based on real clients they have counseled. They are then asked to create "care plans" by which to develop ways to enhance their clients' experiences in accessing care and treatment, as well as prevention services.

As in any systemic change, impact results from a group of caring and dedicated people. Such is the case in Rhode Island.

RESOURCES FOR INTEGRATING MENTAL HEALTH INTO HIV/AIDS PROGRAMS

Many, if not all, HIV/AIDS programs would benefit from working more closely with their mental health and substance abuse counterparts. This is particularly the case, given the manner in which these issues are inextricably linked to one another. More often than not, the dearth of resources (financial or otherwise) makes it difficult for the well-intentioned to go forward with this

often-times challenging but ultimately rewarding work. This section highlights some of the resources that are made available to health departments and other relevant providers. Please note that some regions and particular jurisdictions have locally-available TA and training providers to assist agencies providing mental health and HIV/AIDS services, including health departments.

AIDS Education Training Centers (AETC)

(on the web at: www.aids-ed.org)

The AIDS Education Training Centers (AETCs) provide training and education on a variety of topics including mental health. An array of documents can be found on the AETC website under the clinical topics tab. These documents include: guidelines, clinician support tools, curricula, training of trainer materials, reference materials, slide sets self-study materials, newsletters, and online trainings.

Behavioral and Social Science Volunteer (BSSV) Program at the American Psychological Association

(on the web at: www.apa.org/pi/aids/bssv.html)

The Behavioral and Social Science Volunteer (BSSV) Program is a national HIV prevention TA program directed by the American Psychological Association (APA) Office on AIDS, and funded by the Centers for Disease Control and Prevention (CDC), through a subcontract with ORC/Macro. The driving purpose of the Program is to establish a national network of behavioral and social science volunteers to assist with HIV prevention efforts in their communities.

This national network of psychologists, sociologists, anthropologists, education and public health experts, among others, is organized and trained to offer free and ongoing TA to community-based organizations (CBOs), health

departments, and HIV prevention community planning groups (CPGs) that want state-of-the-science prevention for their communities.

The BSSVs can offer health departments assistance with evaluations, strengthening requests for proposals as well as with presentations and trainings. BSSVs can offer assistance to CPGs on: using theory, defining goals and objectives, needs assessments, evaluations, sitting on CPGs, prioritizing populations, identifying effective interventions and presentations/trainings. Finally, CBOs can benefit from assistance from BSSVs in many of the same ways CPGs can benefit but also in adopting or adapting proven interventions and even intervention designs.

The HIV Office on Psychology Education (HOPE) at the American Psychological Association

(on the web at: www.apa.org/pi/aids/hope.html)

The HIV Office on Psychology Education (HOPE) is funded through a contract with the Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA) and provides HIV-related continuing education workshops, seminars, and conferences for psychology and other mental health professionals, in both traditional and non-traditional mental health settings.

Since its beginning in 1991, more than 450 HOPE Program Regional Trainers have provided continuing education to more than 20,000 psychologists and other mental health professionals, using a 'train-the-trainer' model.

HOPE has three primary goals. The first is to educate mental health professionals on how to effectively and ethically deliver mental health services to HIV infected and affected clients and to subsequently improve HIV treatment and prevention services for these clients.

Second, the program seeks to increase the number of psychologists who are able and willing to work with clients infected and affected by HIV/AIDS. Third, HOPE strives to improve HIV education in graduate programs for psychology students and internship opportunities in the field of HIV and mental health.

HOPE Program staff provides TA to HOPE Regional Trainers who deliver HIV/AIDS workshops and develop and update state-of-the-science curricula related to HIV/AIDS and mental health. Once per contract cycle (3-5 years) the HOPE Program recruits new doctoral-level psychologists and, through a two-track National Training Conference, prepares new trainers to join the cadre of veteran trainers around the nation, as well as updates veteran trainers.

The HOPE program offers 10 areas of professional development, including: HIV virology, clinical course, medical treatments, epidemiology and antibody testing; integrating primary and mental health HIV/AIDS care; biopsychosocial-spiritual assessment; HIV/AIDS mental health provider interventions; prevention issues for the HIV/AIDS mental health provider; issues of concern to the HIV mental health provider; HIV and families; work in the lives of people living with HIV disease; HIV, mental health and prisons; and Ethical Issues in HIV/AIDS Mental Health Practice.

NASTAD Technical Assistance

(on the web: www.NASTAD.org)

NASTAD provides peer-based TA to state HIV/AIDS programs and community planning groups (CPGs) on many topics, including substance abuse and mental health issues. This TA program is funded through a cooperative agreement from CDC. NASTAD calls upon a roster of self-identified health department 'peers' to deliver TA to requesting jurisdictions. NASTAD peers work in

HIV/AIDS agencies within state health departments; as such, they have vast and varied experience in addressing the HIV/AIDS epidemic as it exists in their jurisdiction. This experience, when shared, helps other jurisdictions to better address their own epidemic. When it comes to mental health and substance abuse issues, many jurisdictions are dealing with similar concerns and can benefit from the experience and advice peers may share about programs and approaches that have been developed in other jurisdictions, such as the jurisdictions profiled in this issue brief.

***The Office of HIV
Psychiatry at the American
Psychiatric Association***

(on the web at: www.psych.org/AIDS)

Since 1987, the American Psychiatric Association has provided varied services and education on the “mental health dimensions of HIV/AIDS” to psychiatrists and other mental health professionals, as well as other health providers and the general public. Included among the services and educational documents available through the Office of HIV Psychiatry are TA, clinical resources, and

regional trainings provided through a network of clinical experts. Training curricula are available on the website covering topics ranging from HIV and Anxiety Disorders, HIV-Related Mood Disorders, HIV and People with Severe Mental Illness and Pain and HIV/AIDS.

***Substance Abuse and Infectious
Disease: Cross Training
for Collaborative Systems
of Prevention, Treatment
and Care***

*(on the web at: [www.treatment.org/
topics/infectious.html](http://www.treatment.org/topics/infectious.html))*

This program from the Center for Substance Abuse Treatment (CSAT) within the Substance Abuse, Mental Health Services Administration (SAMHSA) provides training and TA to the gamut of health care delivery systems. This includes public health, substance abuse, mental health, and criminal justice programs. The purpose is to help these entities collaborate to better serve clients with multiple diagnoses who may be seen in several of the above-mentioned health care delivery systems. The program’s web page claims, “Only one in seven individuals experiencing problems

with alcohol and other drug abuse may seek treatment. Yet these individuals are seen daily in STD clinics, public health clinics, and hospital emergency rooms.” Cross training health care delivery professionals to recognize co-existing disorders is clearly in the client/patients’ best interest.

Cross training health care delivery professionals in infectious diseases, including STDs, TB, HIV/AIDS, and viral hepatitis, substance abuse, and mental health better equips these professionals to recognize concurrent conditions and subsequently make the appropriate referrals. These trainings bring professionals together from throughout the continuum of prevention and care for infectious diseases, substance abuse, mental health and criminal justice. Once these professionals are together, the cross training allows “the acquisition of knowledge and enhancement of skills by persons who provide services to individuals at high-risk for multiple diagnoses.” The cross training program is designed to foster a collaborative environment on the part of the providers that leads to a continuum of care for clients and patients.

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