Mental Health Services	Pg
Service Category Definition – DSHS State Services	**1**
Mental Health Care Chart Review, The Resource Group 2018	**5**
Mental Health Problems in Adolescents with HIV - Infectious Disease Advisor, October 2018	**13**
Loneliness Associated with Poorer Cognitive Function, Mental Health and Physical Health in Older People with HIV - aidsmap, September 2018	**16**
Mental Health, a Crucial Component to Ending HIV Epidemic - mdmag.org, March 2018	**18**

Local Service Category:	**Mental Health Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Mental Health Services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers. Mental health counseling services includes outpatient mental health therapy and counseling (individual and family) provided solely by Mental Health Practitioners licensed in the State of Texas. Mental health services include: • Mental Health Assessment • Treatment Planning • Treatment Provision • Individual psychotherapy • Family psychotherapy • Conjoint psychotherapy • Group psychotherapy • Psychiatric medication assessment, prescription and monitoring • Psychotropic medication management • Drop-In Psychotherapy Groups • Emergency/Crisis Intervention General mental health therapy, counseling and short-term (based on the mental health professionals judgment) bereavement support is available for family members or significant others of people living with HIV.
Local Service Category Definition:	**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 person living with HIV. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise people living with HIV, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV 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) **(TRG Only)**:	**Individual and Family Crisis Intervention and Therapy:** A unit of service is defined as an individual counseling session lasting a minimum of 45 minutes. **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.

	A minimum of three (3) clients must attend a group session in order for the group session to eligible for reimbursement. **Consultation:** One unit of service is defined as 15 minutes of communication with a medical or other appropriate provider to ensure case coordination.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	For individual therapy session, person living with HIV or the affected significant other of an person living with HIV, resident of Houston HSDA. Person living with HIV must have a current DSM diagnosis eligible for reimbursement under the State Medicaid Plan. 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. 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 a person living with HIV or the significant other of person living with HIV. Affected significant other is eligible for services only related to the stress of caring for an person living with HIV.
Agency Requirements **(TRG Only)**:	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. Must provide 24-hour access to a licensed counselor for current clients with emotional emergencies. 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. 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. Must comply with the State Services Standards of Care. Must provide a plan for establishing criteria for prioritizing participation in group sessions and for termination from group participation. Providers and system must be Medicaid/Medicare certified to ensure that Ryan

	White funds are the payer of last resort.
Staff Requirements:	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). At least two years experience working with HIV disease or two years work experience with chronic care of a catastrophic illness. Counselors providing family sessions must have at least two years experience in family therapy. Counselors must be covered by professional liability insurance with limits of at least $300,000 per occurrence.
Special Requirements **(TRG Only)**:	All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on Federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information. 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. Agency should develop services that focus on the Special Populations identified in the *2012 Houston Area Comprehensive Plan for HIV Prevention and Care Services* including Adolescents, Homeless, Incarcerated & Recently Released (IRR), Injection Drug Users (IDU), Men who Have Sex with Men (MSM), and Transgender populations. Additionally, services should focus on increasing access for individuals living in rural counties. Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Mental Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

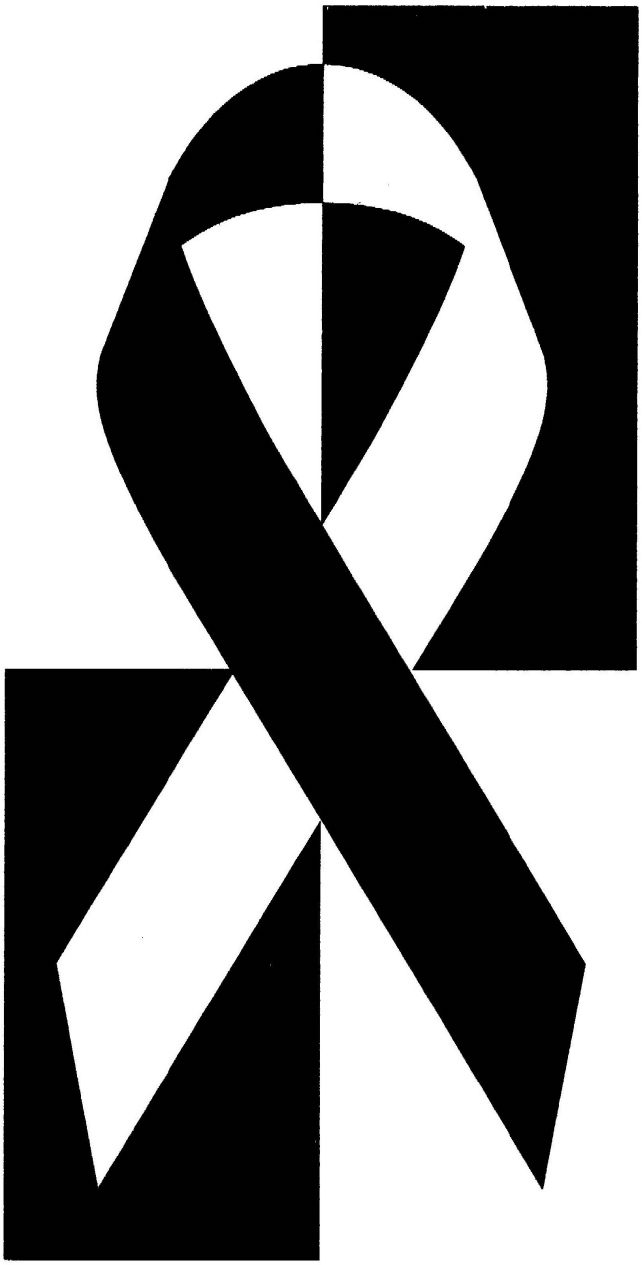
FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300%
1.	
2.	
3.	



MENTAL HEALTH SERVICES
2018 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 HDSA 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 care 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 216 who accessed mental health services in the measurement. The records of 51 clients were reviewed, representing 24% of the unduplicated population. The demographic makeup of the providers was used as a key to file sample pull.

NOTES: DSHS modified their review process to exclude indicators that were <51% in last years this year. As a result, only one (1) indicator was reviewed in 2018. The results listed below are from 2017, with the exception of the one (1) indicator reviewed.

Demographics- Mental Health

2017 Annual

Total UDC: 293 Total New: 104

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	5	1.71%
25 - 44 years	116	39.59%
45 - 64 years	159	54.27%
65 years or older	13	4.44%
Unknown	0	0.00%
	293	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	10	3.41%
Male	278	94.88%
Transgender FTM	0	0.00%
Transgender MTF	5	1.71%
Unknown	0	0.00%
	293	100%
Race/Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	131	44.71%
Black	94	32.08%
Hispanic	67	22.87%
Asian	1	0.34%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	0	0.00%
Unknown	0	0.00%
	293	100%

From 01/01/17 - 12/31/17

2018 Annual

Total UDC: 216 Total New: unk

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	4	1.85%
25 - 44 years	73	33.80%
45 - 64 years	127	58.80%
65 years or older	12	5.55%
Unknown	0	0.00%
	216	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	20	9.26%
Male	196	90.74%
Transgender FTM	0	0.00%
Transgender MTF	5*	2.31%
Unknown	0	0.00%
	216	100%
Race/Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	138	63.89%
Black	73	33.80%
Hispanic	38*	17.59%
Asian	2	0.93%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	1	0.46%
Multi/Unknown	2	0.93%
	216	100%

From 01/01/18 - 12/31/18

RESULTS OF REVIEW

Psychosocial Assessment

Psychosocial Assessment completed no later than third counseling session.

	Yes	No	N/A
Clients with psychosocial assessment completed no later than the 3rd appt.	59	-	-
Client records reviewed that included in this measure.	59	-	-
Rate	**100%**	-	-

Psychosocial Assessment: Required Elements

Psychosocial Assessment included assessment of all elements in the Mental Health Standards.

	Yes	No	N/A
Clients with assessment completed no later than the 3rd appt.	59	-	-
Client records reviewed that included in this measure.	59	-	-
Rate	**100%**	-	-

Treatment Plan

(**NEW 2018**) Documentation of detailed treatment plan and services provided within client's primary record.

	Yes	No	N/A
Treatment plan and services detailed in client record.	38	12	1
Client records reviewed that included in this measure.	50	50	51
Rate	**76%**	**24%**	2%

Treatment Plan completed no later than third counseling session.

	Yes	No	N/A
Clients with treatment plans completed no later than the 3rd counseling session.	52	-	7
Client records reviewed that included in this measure.	52	-	59
Rate	**100%**	-	12%

Treatment Plan: Signed by Therapist

Treatment Plan was signed by the mental health professional who rendered service.

	Yes	No	N/A
Clients with treatment plans signed by the mental health professional rendering service.	52	-	7
Client records reviewed that included in this measure.	52	-	59
Rate	**100%**	-	12%

Treatment Plan: Reviewed/Modified

Treatment Plan was reviewed and/modified at least every ninety (90) days.

	Yes	No	N/A
Clients with treatment plans reviewed/modified every 90 days.	50	2	7
Client records reviewed that included in this measure.	52	52	59
Rate	**96%**	**4%**	12%

Services Provided: Required Elements

Treatment included counseling covering all elements outlined in the Mental Health Standards.

	Yes	No	N/A
Clients who received counseling covering all elements.	59	-	-
Client records reviewed that included in this measure.	59	-	-
Rate	**100%**	-	-

Services Provided: Psychiatric Evaluation

Treatment included psychiatric evaluation was conducted/referral completed if needed.

	Yes	No	N/A
Clients who psychiatric evaluation was conducted/referral completed if needed.	1	-	58
Client records reviewed that included in this measure.	59	-	59
Rate	**100%**	-	-

Services Provided: Psychiatric Medication

Treatment included psychotropic medication management services, if needed.

	Yes	No	N/A
Clients who documented psychotropic medication management service was provided if needed.	-	-	59
Client records reviewed that included in this measure.	59	-	59
Rate	**0%**	-	100%

Services Provided: Progress Notes

Progress notes completed for each counseling session and contained all elements outlined in the Mental Health Standards.

	Yes	No	N/A
Clients with progress notes complete and containing all elements.	59	-	-
Client records reviewed that included in this measure.	59	-	-
Rate	**100%**	-	-

Services Provided: Medical Care Coordination

Evidence that care was coordinated as appropriate across all medical care coordination team members.

	Yes	No	N/A
Clients with care coordinated across team.	59	-	-
Client records reviewed that included in this measure.	59	-	-
Rate	**100%**	-	-

Referrals: Referrals Made as Needed

Documentation that referrals were made as needed to specialized medical/mental health providers/services.

	Yes	No	N/A
Clients with referral needed and made.	27	-	32
Client records reviewed that included in this measure.	27	-	59
Rate	**100%**	-	-

Referrals: Referrals Outcome

Documentation is present in client's record of the referral and the outcome of the referral.

	Yes	No	N/A
Clients with referral document with outcome of referral.	27	-	32
Client records reviewed that included in this measure.	27	-	59
Rate	**100%**	-	-

Discharge Planning

Documentation is present that discharge planning was completed with the client.

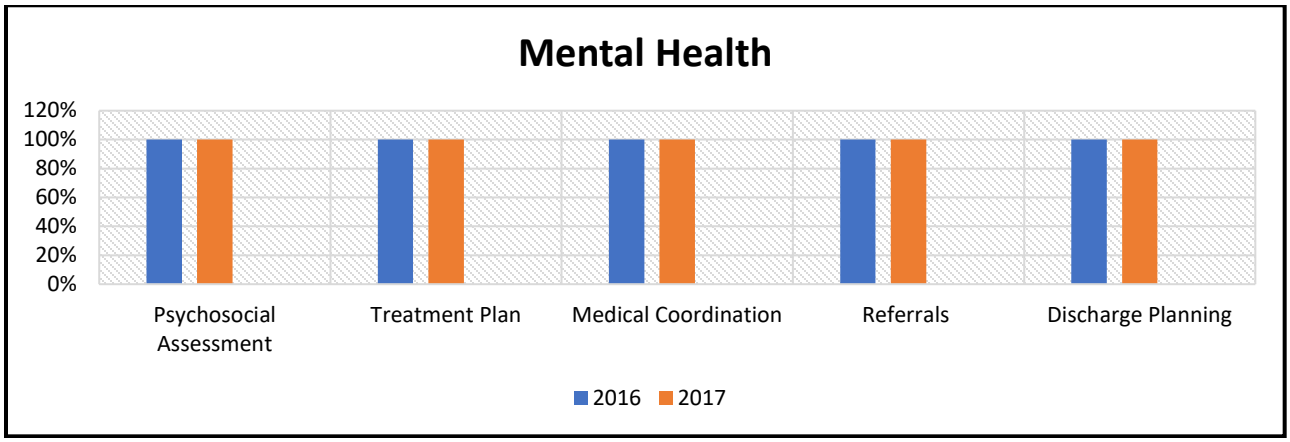
	Yes	No	N/A
Clients with documented discharge planning.	26	-	33
Client records reviewed that included in this measure.	26	-	59
Rate	**100%**	-	-

Discharge

Documentation is reason for discharge is located in the client's record and is consistent with agency policies.

	Yes	No	N/A
Clients with documented reason for discharge.	23	-	36
Client records reviewed that included in this measure.	23	-	59
Rate	**100%**	-	-

HISTORICAL DATA



CONCLUSION

Quality of mental health services continues to excellent. All clients reviewed (100%) completed a psychosocial assessment no later than the third counseling session, all clients had a treatment plan and medical care coordination was appropriate across all medical care coordination team members. Eleven data elements were met at 100%.

Mental Health Problems in Adolescents With HIV: Overview & Expert Interview - Infectious Disease Advisor

Substantially less mental health research has been conducted in young adults and adolescents compared with adults, and such evidence is especially sparse in resource-limited settings.[1] Noting that the burden of illness may be particularly pronounced in children and adolescents living with HIV, the authors of a recent review examined the available literature regarding mental health care access, treatment outcomes, and the role of mental health problems in the transition from pediatric to adult care in this patient population.[1]

Selected findings from the review are highlighted below.

- Mental health disorders including depression and anxiety are more common among perinatally HIV-infected adolescents vs those who are not infected. Adolescents infected with HIV have a greater risk for psychiatric hospitalizations compared with those not infected with HIV.
- A large cohort study found that 61% of perinatally-exposed youth (both infected and uninfected) had psychiatric disorders other than substance use.[2] Among HIV-positive adolescents involved in a 2000 US study, 53% had been diagnosed with psychiatric disorders and 44% had chronic depression.[3]
- High rates of depression have also been observed in HIV-infected children and adolescents in Kenya (17.8%), Malawi (18.9%), and Rwanda (25.0%).[4]
- There is a need for research comparing HIV-infected youth with other groups such as perinatally-exposed but uninfected youth and matched controls with no history of exposure.
- Some studies suggest a higher prevalence of mental health problems in female vs male HIV-infected youth, although results have been mixed overall.
- Mental health issues may interfere with indicators of successful transition from pediatric to adult care, such as taking ownership of medical care and adhering with medication and clinic visits.
- In general, there are few mental health treatment facilities devoted to children and adolescents.
- In the Adolescent Impact Study conducted in 3 US cities (n=164), 31% of HIV-infected adolescents demonstrated psychopathology.[5] However, nearly one-third of the patients reporting clinical symptoms did not receive care despite the availability of psychiatric medications, hospitalizations, counselling, or psychotherapy.
- Treatment access may be even lower for marginalized populations, with one study showing that black HIV-infected youth were less likely to receive mental health care than non-black youth.[6]

“Our review emphasizes the need for mental health issues to be addressed proactively for all HIV-infected youth and integrated into their overall HIV care,” the authors concluded.

To further explore the mental health challenges facing adolescents living with HIV, as

well as treatment implications and additional research needs, *Infectious Disease Advisor* interviewed Sarah M. Wood, MD, MSHP, instructor of pediatrics at the University of Pennsylvania Perelman School of Medicine, Philadelphia, and attending physician in the division of adolescent medicine at Children's Hospital of Philadelphia.

Infectious Disease Advisor: *What are some of the unique mental health challenges affecting adolescents with HIV?*

Dr Wood: Mental health and HIV are highly interconnected. When you look across a range of chronic illnesses in adolescents and young adults, such as diabetes or cystic fibrosis, rates of depression tend to be higher in [people with] those [diseases than] among the general adolescent population. This is certainly the case with HIV, where studies of adolescents and young adults living with HIV have demonstrated rates of depression that are much higher than in uninfected youth.

However, there are several unique characteristics of the relationship between mental health and HIV. For young people who acquire HIV through sex or injection drug use in adolescence, mental health may play a role in transmission risk, as depression is highly associated with lower condom use and higher rates of having multiple partners. After HIV diagnosis, mental illness, including depression, increases the risk for nonadherence to antiretroviral therapy and acts as a barrier to staying engaged in HIV care. Overall, the downstream effect of depression in youth living with HIV is increased morbidity and mortality.

On the flip side, HIV itself may increase the risk for depression. There is a growing body of research demonstrating that the neuropathogenic effects of HIV on the developing central nervous system may increase the risk for mental illness in adolescence and adulthood. My early research showed that adolescents with perinatally-acquired HIV who had early AIDS diagnoses were at higher risk for mental illness and cognitive impairment in adolescence.[7] This is of particular concern in young people with perinatally-acquired HIV in resource-limited settings like sub-Saharan Africa, who may have had unchecked central nervous system viral replication earlier in life.

Last, one highly important and unique challenge for youth living with HIV is stigma. Unfortunately, HIV-related stigma is still a stark reality for many youth living with HIV and can cause hesitance to disclose their HIV status to friends, family, or partners. This can lead to limited social support in managing one's HIV-related health care, including mental health care. The resulting isolation is a feedback loop that further increases stigma.

Infectious Disease Advisor: *How do such issues affect the care of these patients?*

Dr Wood: Depression commonly acts as a barrier to achieving optimal health status for a young person living with HIV. We are really fortunate to live in an era when HIV is a highly manageable condition. With antiretroviral therapy, my expectation is that my patients will live long, healthy, and productive lives. However, that end goal depends on young people being able to both adhere to daily antiretroviral medication and stay engaged in HIV care so that they don't have interruptions in treatment.

Depression is a known barrier to both of these care goals. Individuals with depression have a shorter time to HIV treatment failure and are more likely to be lost to follow-up.[8] Adolescents are already less likely than adults to be HIV tested, receive

antiretroviral therapy, be linked with HIV care, stay in HIV care, and have a suppressed viral load. My research demonstrates that youth living with HIV have high rates of treatment failure, up to 20% per year, even after initially achieving suppression of their HIV virus.[9] These data suggest that young people living with HIV are likely more vulnerable to the impact of mental illness than older adults, since they already experience worse care outcomes with respect to HIV infection. These data underscore the need to assure that mental health is integrated into HIV care for young people living with HIV.

Infectious Disease Advisor: *How should these issues be addressed (screening, treatment, etc.) by clinicians, as well as by healthcare systems at large?*

Dr Wood: To address mental health in youth living with HIV, the first step is improving our ability to identify youth at risk for mental illness through screening. Currently, the US Preventative Services Task Force recommends screening for major depressive disorder in all adolescents age 12 to 18 years, irrespective of HIV status. As HIV care providers, we see our patients every 3 months, so we have an opportunity to screen regularly. At Children's Hospital of Philadelphia, we screen all patients for depression, anxiety, and substance abuse at entry to care and at each visit.

However, screening alone doesn't change the course of mental health conditions. Integrating health systems so that treatment for depression can occur in the same setting as HIV treatment is also critical. When on-site treatment for mental health conditions isn't available, assuring linkage to mental health treatment through a medical case management model has also been shown to be effective. It is also important to ensure that youth living with HIV have uninterrupted access to insurance to cover mental health care, so that they can readily access treatment.

Infectious Disease Advisor: *What should be the focus of future research in this area?*

Dr Wood: Future areas for research include identifying optimal strategies for mental health and substance abuse treatment in adolescents living with HIV and better understanding of the neuropathogenesis of depression in youth living with HIV. Despite how common depression is in this population, there are few studies on how to best treat youth living with HIV. One recent study from the Adolescent Trials Network demonstrated that a 24-week cognitive behavioral therapy-based intervention plus pharmacotherapy was effective in reducing depressive symptoms.

In addition, there is some evidence that interventions to increase social support and reduce stigma may complement traditional depression therapies in youth living with HIV. It is also important to understand how the virus itself affects the developing brain to build strategies that can better protect the brain from the effects of HIV replication in the central nervous system.

References

1. Vreeman RC, McCoy BM, Lee S Mental health challenges among adolescents living with HIV. *J Int AIDS Soc.* 2017;20(Suppl 3):21497.
2. Mellins CA, Brackis-Cott E, Leu C-S, et al. Rates and types of psychiatric disorders in perinatally human immunodeficiency virus-infected youth and seroreverters. *J Child Psychol Psychiatry*. 2009;50(9):1131-1138.
3. Pao M, Lyon M, D'Angelo LJ, Schuman WB, Tipnis T, Mrazek DA. Psychiatric

diagnoses in adolescents seropositive for the human immunodeficiency virus. *Arch Pediatr Adolesc Med*. 2000;154(3):240-244.

4. Marhefka SL, Lyon M, Koenig LJ, et al. Emotional and behavioral problems and mental health service utilization of youth living with HIV acquired perinatally or later in life. *AIDS Care*. 2009;21(11):1447-1454.
5. Whiteley LB, Brown LK, Swenson R, Kapogiannis BG, Harper GW. Mental health care among HIV infected youth in medical care: disparities and equalities. *J Int Assoc Provid AIDS Care*. 2014;13(1):29-34.
6. Wood SM, Shah SS, Steenhoff AP, Rutstein RM, The impact of AIDS diagnoses on long-term neurocognitive and psychiatric outcomes of surviving adolescents with perinatally acquired HIV. *AIDS*. 2009;23(14):1859-1865.
7. Pence BW, Mills JC, Bengtson AM, Association of increased chronicity of depression with HIV appointment attendance, treatment failure, and mortality among HIV-infected adults in the United States. *JAMA Psychiatry*. 2018;75(4):379-385.
8. Wood SM, Lowenthal E, Lee S, Ratcliffe SJ, Dowshen N, Longitudinal viral suppression among a cohort of adolescents and young adults with behaviorally acquired human immunodeficiency virus. *AIDS Patient Care STDS*. 2017;31(9):377-383.
9. Brown LK, Kennard BD, Emslie GJ, Adolescent Trials Network for HIV/AIDS Interventions, Effective treatment of depressive disorders in medical clinics for adolescents and young adults living with HIV: a controlled trial. *J Acquir Immune Defic Syndr*. 2016;71(1):38-46.

Loneliness associated with poorer cognitive function, mental health and physical health in older people with HIV

Michael Carter
Published: 25 September 2018

Loneliness in older HIV-positive adults is associated with reduced cognitive function as well as poorer mental and physical health, according to Canadian research presented to the recent Aging and HIV Workshop in New York. Approximately two-thirds of study participants reported loneliness, which was associated with both HIV-related and lifestyle factors.

“The results support that physical symptoms (e.g. pain, fatigue), apathy, stigma, and restricted social network contribute to loneliness,” concluded Marianne Harris and colleagues. “Loneliness has consequences for reduced activity, poor lifestyle choices, impaired cognition, stress, and depression, all of which contribute to poor quality of life.”

Loneliness has been associated with poor health in the general population, especially in older individuals. However, little is known about the prevalence of loneliness, its risk factors and impact on health and quality of life in people with HIV. People with HIV may be at increased risk of loneliness because of stigma, depression, substance use, lack of social connections and physical symptoms.

To establish a clearer understanding of these issues, investigators analysed cross-sectional data from participants in the Positive Brain Health Now cohort. Participants were HIV-positive people aged 35 years and older who received outpatient care between 2013 and 2016 at five HIV outpatient clinics in Vancouver, Toronto, Hamilton and Montreal.

Data were collected using interviews and self-report questionnaires. Loneliness was assessed using a single question, “Do you find yourself feeling lonely: quite often, sometimes or almost never?” Cognitive function, mental health, self-rated health and quality of life were measured using validated tests.

All the participants had been diagnosed with HIV for at least one year. Individuals with dementia or a central nervous system disorder were excluded. A total of 836 people were included – most (85%) were men, approximately three-quarters were Caucasian and the mean age was 52 years.

Almost two-thirds (64%) reported loneliness, including 18% who said they were quite often lonely and 46% who were lonely some of the time.

People were more likely to report loneliness if they were not having enough money to meet basic needs ($p < 0.001$). Loneliness was more common in individuals with a higher number of HIV-related symptoms ($p < 0.001$), more severe symptoms ($p < 0.001$), weakness as a symptom ($p < 0.001$) or lung disease ($p < 0.05$).

Several lifestyle factors were also associated with loneliness, including reduced physical activity ($p < 0.001$), watching more hours of TV ($p < 0.05$) and opioid use ($p < 0.05$).

Loneliness was associated with poorer cognitive function and more self-reported cognitive concerns (both $p < 0.001$). On four different validated scales, people who were quite often lonely had poorer mental health and wellbeing (all $p < 0.001$), including symptoms of depression, stress and anxiety.

Relatively few people who were often lonely rated their health as very good or excellent (25.0%), compared to those who were never lonely (61.3%). Similarly, quality of life was rated as very good or excellent by 37.8% of

those who were quite often lonely and 89.8% of those who were never lonely.

The investigators developed a model to better understand how loneliness was associated with poorer health in people with HIV:

- **Contributors to loneliness:** stigma, having fewer than five close friends or relations, pain, fatigue, and not working or volunteering.
- **Consequences of loneliness:** reduced physical activity, more hours spent watching TV, opioid use, reduced cognitive function, increased stress, and poorer mental health.
- **Downstream effect:** poorer self-rated health and poorer quality of life.

The investigators acknowledge that their findings are limited by the composition of the study population (mostly male and white). The cross-sectional design meant they were unable to definitively determine the direction of the association between loneliness and poorer outcomes.

They call for more research, especially qualitative studies assessing experiences of loneliness from the perspective of patients.

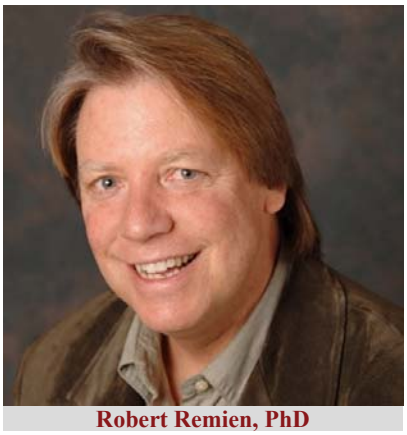
The authors also believe their findings have clear implications for models of HIV care, showing the importance of enhanced social care for people with HIV, especially older individuals. Interventions to engage people in socially meaningful activities should be developed for older adults living with HIV, they say.

Reference

Harris M et al. *Associations of loneliness with cognitive function and quality of life (QoL) among older HIV+ adults*. 9th International Workshop on HIV & Aging, New York, oral abstract 12, 2018.

Mental Health, a Crucial Component to Ending HIV Epidemic

March 07, 2018
Jenna Payesko


Robert Remien, PhD

At the 25th Conference on Retroviruses and Opportunistic Infections, Robert Remien, PhD, stressed in his presentation that addressing mental health is a critical component to ending the HIV epidemic and achieving the UNAIDS 90-90-90 goals.

Despite all of the medical advances made to this day, there are still significant gaps along the HIV care continuum. Mental health problems, including substance abuse are one of the most significant areas of co-morbidity for people living with HIV and are more prevalent than the general population.

Among adolescents and young adults living with HIV, more than 60% of the population have some type of mental disorder. An estimated 50% of people living with HIV meet criteria for one or more mental or substance use disorder, which is associated with suboptimal HIV treatment outcomes that includes late antiretroviral therapy (ART) initiation and a delayed viral suppression.

“We know that we need to do better at all of the steps on the continuum to achieve our desired goals for better health outcomes as well as reduce incidence,” Remien said. “Integration of services to screen and manage mental health and substance use disorders into HIV care settings is a promising strategy to improve mental health and HIV treatment outcomes among people living with HIV/AIDS, including in resource-constrained settings.”

Mental illness, according to Remien, is indeed a risk factor for HIV acquisition. In the US, the HIV prevalence among those with a serious mental illness (2–6%) compared to the general population (0.5%) is significantly higher.

Mental health impairment contributes to increased risk behaviors, delayed or lack of HIV testing and care initiation, poor retention in care, delayed ART initiation and poor ART adherence.

When there’s comorbid disorders, and other disorders, like mood disorders and alcohol and substance abuse, there’s a synergistic effect on HIV outcomes. In a study Remien discussed, that focused on 4295 men who have sex with men (MSM) from 6 US cities, when there are co-occurring conditions like depressive symptoms, heavy alcohol use, stimulant use, poly drug use and childhood sexual abuse, the probability of

staying HIV negative decreases significantly as the number of conditions increases.

In the context of PrEP adherence, depression is associated with higher sexual risk behavior and poorer adherence, indicating that screening and treating may be key to maximizing PrEP efficacy.

Depression is associated with increased mortality, and mortality rates for those living with HIV having a major depressive disorder (MDD) is twice as high for those without MDD. Relatively large cohorts of women have been studied over time and found that depression is associated with 2–3 times risk of mortality, compared to women without depressive symptoms, when on ART.
In the US WIHS prospective cohort (n=858), chronic depressive symptoms were associated with >3 times the hazard of mortality (women on ART) and >7 times the hazard of mortality (women not on ART) compared to those on ART with no depression.

The stigma embodied in discriminatory social structures, policy and legislation results in a disparity between physical and mental health care services with lower accessibility, availability and quality of services.

Integration of screening and management services into HIV care settings is a promising strategy, according to Remien, to improve mental health and HIV treatment outcomes, including in resource-constrained settings.

Positive mental health is associated with improved physical health outcomes across a range of chronic illnesses, but in addition to negative psychological responses to an HIV diagnosis, disease progression, associated stigma and loss of social support, chronic inflammatory response to HIV is estimated to contribute to elevated rates of mental health problems among patients.

Treatment for mental disorders and adherence interventions has an additive effect to those with HIV, positively affecting HIV health outcomes like PrEp treatment, reducing depression and anxiety, and ultimately increasing quality of life.

Challenges remain, specifically for meeting the high demand in resource-limited settings where HIV is most prevalent. Addressing mental health co-morbidities in the context of HIV prevention and care is essential for achieving optimal outcomes along the prevention and treatment continua.

“We may have the biological tools to ‘end AIDS,’ however we will not be able to achieve ‘ending the epidemic’ (EtE) goals, if we do not address mental health co-morbidities among our most vulnerable populations,” Remien concluded. "Integrating mental health assessment and treatment into HIV care should be routine and is essential to achieving “90 90 90 and EtE goals.”