

Mental Health Needs of Persons Living with HIV/AIDS and Pathways to Mental Health Care

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Mental Health and HIV: Background

- **Mental health disorders are treatable**
- **Untreated disorder has negative impact on individuals and communities**
 - Causes suffering, impairs quality of life
 - Barrier to treatment access
 - Reduced uptake of HAART
 - Lower rates adherence
 - Less virological suppression, higher mortality
 - Increased health care cost and social burden

Presentation Goals

- **What are indicators of mental health needs among persons living with HIV/AIDS in NYC?**
- **What are patterns of mental health service utilization?**
- **What predicts entry into mental health services among those with need?**

Need/ Meeting Need for MH Services

- **Most existing studies limited**
 - service utilization data
 - clinic or treatment samples
 - single population e.g. MSM, IDU, women
 - cross-sectional

The C.H.A.I.N. Project

Community Health Advisory & Information Network (CHAIN) Project

Goal of the research is to provide a profile of persons living with HIV in New York City that will assess:

- **Need for health and social services**
- **Availability and accessibility of services**
- **Quality of services**
- **Consumer evaluation of services**
- **Impact of services on health status and quality of life**

Methods: Data Collection

- **Multi-stage probability sampling**
 - Stage 1: HIV health and social service agencies
 - Stage 2: Random selection from lists or sequential enrollment
- **Initial recruitment 1994-95, n=700**
Refresher cohort 1998, n=268
Cohort II 2002, n=693
Refresher II 2010, n=316
- **Separate ethnographic effort to interview 'unconnected'**
 - 1995 (n=48), 1998 (n=24), 2004 (n=25)
- **In-person comprehensive (2-3hr) interview** every 6–12 mos
- **High retention rate:** 80%- 95% of elig respondents at each wave
- **Compares to AIDS surveillance data:** gender, race/ethnicity, risk

Value of Longitudinal Survey Research

- Population-based
- Can collect evidence to establish causal chains in non-experimental settings
- Can include contextual variables and ecological characteristics including policy-driven funding streams
- Repeated observations over time can control for historical and secular trends
- Learn how need and services experienced by patients and clients

Measures: Mental Health Functioning

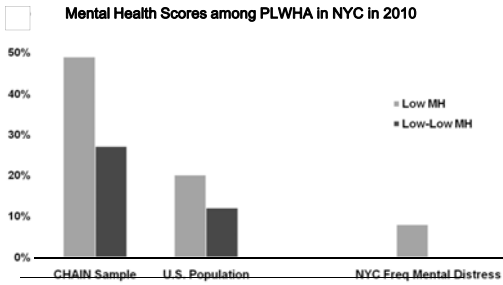
- Standardized instrument: MOS SF-36
- Subscales measure symptoms (depression, anxiety) and functional impairment
- Clinical cut-points established:
 - < 42.0 = clinically relevant psychiatric symptoms
"Low" mental health
 - < 37.0 = mean score psychiatric in-patients
"Very Low" mental health

Indicators of Need for MH Services

	Agency Sample	Unconnec'd Sample
1998 ORIG COHORT INTERVIEWS	(638)	(14)
Low Mental Health (<42.0)	40%	79%
Very Low Mental Health (<37.0)	26%	64%
Dual Diagnosis*	17%	79%
2002 NEW COHORT INTERVIEWS	(684)	(25)
Low Mental Health (<42.0)	48%	89%
Very Low Mental Health (<37.0)	36%	89%
Dual Diagnosis*	20%	78%
2010 COHORT INTERVIEWS	(690)	na
Low Mental Health (<42.0)	49%	--
Very Low Mental Health (<37.0)	27%	--
Dual Diagnosis*	14%	--

* MH <42.0 and problem drug use past 12 months

Comparison of Mental Health Scores



Experience of Trauma and Violence

	Women	Men
	n= (206)	(291)
Lifetime experience of violence or trauma	92%	90%
Mean (sd) number traumatic events	4.80 (3.0)	3.72 (2.5)
Experience childhood trauma or loss event	69%	64%
Experienced physical or sexual violence	67%	49%
Witnessed serious assault, injury, or violent death	73%	72%
Parental death or perm separation, death of child or spouse/partner	76%	66%
Other traumatic events: fire, disaster, other	42%	40%

CHAIN 2010 Cohort, n=497

Self-Reported Need for MH Services

	1998 Cohort	2002 Cohort	2010 Cohort
TOTAL SAMPLE (n=)	(652)	(693)	(690)
Answered "yes" to questions about emotional or psychological difficulties need for mental health services past 6 months	7%	13%	15%
SUB SAMPLE WITH VERY LOW MH* (n=)	(201)	(248)	(170)
Answered "yes" to questions about emotional or psychological difficulties need for mental health services past 6 months	15%	23%	26%

* MCS <37.0

Use of MH Services among Clients with Low MH Scores

	1998 Cohort (257)	2002 Cohort (331)	2010 Cohort (311)
<i>Among Sub Sample with Low MH (< 42.0)</i>			
At least 1 visit past 6 months*			
Mental health professional such as psychiatrist, psychologist, CSW	38%	33%	46%
Case manager / social worker for counseling or mh services	9%	26%	13%
Clergy or religious counselor	3%	3%	1%
HIV/AIDS support group	28%	38%	17%
No Use of Any Mental Health Services	47%	39%	48%

* Multiple response possible

Differences by Client Characteristics

Most distinct:	Low MH Score	Any MH Services ¹
Age: 20-34 yrs old	63%	47%
Gender: Women	52%	62%
Race/ethnicity: White	59%	58%
Education: < HS Grad	53%	64%
Drug Use: Past 12 months	59%	61%
Housing Status: Homeless	58%	62%
Health Status: Asymptomatic	39%	55%

1. Any visits with mental health professional, supportive counseling, participating in support groups among those with low mental health score (< 42.0) indicating clinically relevant symptoms

Organizational Location of Services

Service Site	MH Professional ¹	Case Mgr Counselor ²
HHC Hospital Clinic	13%	5%
Voluntary Hospital Clinic	47%	21%
Community Health Center	14%	12%
Private Doctor's Office	6%	1%
Social Service Agency	13%	44%
AOD Program	4%	7%
Other	3%	9%

1. Percent of all visits T1-T3 with mental health professional, n= 654
2. % of all visits T1-T3 with case manager, non-CSW social worker, or counselor n=401

Referral Patterns for Mental Health Services

	% of All Visits with MH Professionals
Were you referred?	
Went to mh professional on my own	41%
Was referred to mh professional	58%
Was taken there/ already there	2%
If Referred: Who referred you?	
Medical provider	63%
Case manager	16%
Friend, family member	4%
Other	17%

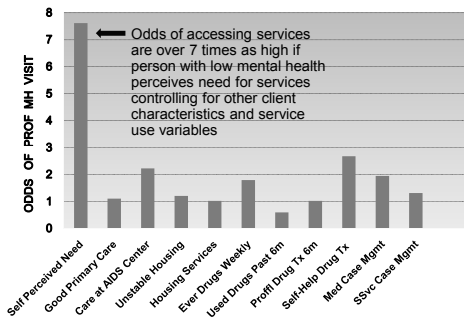
Asked of PLWHA with 1+ visit to MH Professional past 6 months
 No information if individual was referred but did not follow through with visit

Increasing the Odds of Accessing MH Services among Clients with Mental Health Need

	OR	AOR
HIV Primary Care meets clinical practice standards	1.12	1.11
Receives care at AIDS Designated Center	1.45	2.23#
Homeless/ unstable housing past 6 months	0.99	1.21
Received housing services past 6 months	1.48	1.03
Frequent drug user: lifetime	0.90	1.80
Used drugs past 6 months	0.65	0.60
Received professional drug treatment	1.07	1.03
Self-help drug treatment	2.15#	2.68*
Medical case management	2.08*	1.95
Case management for social services	1.65#	1.32
Self-perceived need for mental health services	8.62***	7.67***

(n=252) # p ≤ .10 *p ≤ .05 **p ≤ .01 ***p ≤ .001
 Among clients with MCS < 42.0 at prior interview. Also controlling for demographics, risk exposure, health status, insurance

Increasing the Odds of Accessing MH Services by Next Interview among Clients with Low MH and No Services



Among clients with MCS < 42.0 at prior interview. Also controlling for demographics, risk exposure, health status, insurance

Summary

- Continued high prevalence of need for mental health services and treatment
- Access to professional mental health services appears to have increased among PLWHA in NYC
- Yet many PLWHA with mental health symptoms or diagnoses are not receiving any services
- Why? Patient and Provider factors
- Clients self-perception of mental health needs is the most significant predictor of accessing care – but many don't perceive or are unwilling to acknowledge need

Potential Provider Factors

- Limited expertise in assessing complicated co-occurring mental health and substance abuse needs in many service settings
- Systematic screening using validated tools is not standard practice in many HIV care and services
 - Ask: Ever hospitalized for psychiatric reasons, take meds etc
 - Problem for those never had psychiatric treatment
- Inadequate resource allocations for services at the local level
 - Lack time, qualified personnel
 - Medicaid reimbursement barriers?

Some Solutions

- Institute routine screening for mental health and substance abuse needs as component of all HIV services
- Expand availability of mental health services in 'intercept' service settings – e.g. drug treatment, homeless service providers
- Collaborative care models that include supportive services to facilitate client engagement
- Consider 'patient navigator' models to improve readiness for treatment?
- Provide reliable and valid tools and training for non-mental health professionals – e.g. CDQ?

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