

mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About Women & Men

Newville and Haller (2010) “compared **sex and drug risk behaviors** for 228 HIV+ patients [who were engaged in infectious disease care, enrolled in comprehensive mental health services, and assigned to one of] . . . four **diagnostic groups**: (1) no diagnosis; (2) psychiatric only; (3) substance dependence only; and (4) co-morbid psychiatric and substance dependence” (p. 1259). The investigators observed

significant group differences . . . for having multiple sex partners, condom use, and injection drug use (IDU), but not for sharing of injection equipment. Patients with co-morbid psychiatric and substance [dependence] disorders reported multiple sex partners most frequently, while substance dependence contributed to irregular condom use and IDU. Analysis by substance use subgroup (no dependence, alcohol dependence only, drug dependence only, co-morbid alcohol . . . and drug dependence) showed that alcohol dependence contributed to having multiple sex partners, while alcohol and drug dependence both contributed to irregular condom use. Meanwhile, only drug dependence contributed to drug risk. (p. 1259)

Newville and Haller point out that

in isolation, psychiatric disorders contributed minimally to risk behavior in this population. However, when combined with a substance dependence disorder, a synergistic effect was observed. . . . The relationship [of] . . . substance dependence . . . [to] risk behavior was more straightforward. Individuals with substance dependence diagnoses (with/without co-morbid psychiatric disorders) were less likely to reliably use condoms. Among substance abusers, those with drug dependence (with/without co-morbid alcohol dependence) evidenced the highest rates of both sex and drug risk behaviors. (pp. 1263-1264)¹

The investigators suggest that “brief screening tools could be helpful in determining which patients might require more intensive interventions, thereby increasing their chances for successfully decreasing risk behavior” (p. 1267). Findings further sug-

¹ Newville and Haller (2010) note that “the University of Michigan Composite International Diagnostic Interview [UM-CIDI] was used to assess participants for common Axis I disorders including major depression, dysthymia, generalized anxiety disorder, agoraphobia, panic attack, alcohol, and drug dependence in the past 12 months. Psychotic disorders were not assessed” (p. 1260). “Additionally, the UM-CIDI assesses for alcohol and drug dependence, but not abuse; heavy users and those with abuse diagnoses were thus included in the no diagnosis and psychiatric groups” (p. 1267).

gest that

HIV+ patients with severe alcohol and/or drug abuse problems (reflected in a dependence diagnosis) are at increased risk for continued risk behavior, despite active participation in HIV primary care. Formal drug treatment thus is indicated. Both substance abuse counseling and pharmacotherapy should be considered. While this study focused on patients with severe addiction problems, it is important to understand that many participants were actively drinking and/or using drugs but did not receive a dependence diagnosis. These patients were assigned to the no diagnosis quadrant, making findings even more striking. Although recreational users displayed lower levels of transmission risk behavior than those meeting diagnostic criteria, this sub-group might benefit [from] brief motivational interventions that include personalized feedback about potentially hazardous substance [use] and the relationship between substance use and trans-

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mission [risk], along with advice to change [behaviors]. (pp. 1266-1267)

Pence et al. (2010) “assess[ed] the association between **incident stressful life events** (e.g., sexual and physical assault; housing instability; and major financial, employment, and legal difficulties) and unprotected anal or vaginal sexual intercourse (unprotected sex)” (p. 720) over a 27-month period among 611 consecutively recruited men and women engaged in HIV primary care at eight sites situated in a five-state region of the southeastern U.S. “This analysis compared the frequency of stressful events from a given 9-month interval and sexual risk behaviors from the same interval; it was unknown whether the specific stressful events preceded or followed the risky behaviors” (p. 724). The investigators specify that “incident stressful events reported at one third or more of interviews included major illness, injury or accident (non-HIV-related); major illness of a family member/close friend; death of a family member/close friend; financial stresses; and relationship stresses” (p. 720) and that these experiences “were associated with increased sexual transmission risk behaviors. In particular, participants who experienced a short-term increase in stressful life events above their norm were more likely to report unprotected sex with HIV-negative and serostatus-unknown partners, HIV-

positive partners, and all partners during the same time interval (within-person associations, i.e., each participant serving as his own control)” (p. 724). “Although only 2% of participants in this sample experienced incident sexual assault during 27 months of prospective follow-up, the average participant experienced 9.9 stressful life events during the same time period – and these stressful events were associated with increased sexual risk behaviors” (p. 725).

These findings “suggest that an individual with a low ‘background’ level of stressors who experiences an unusual number of acute life events may be at risk of subsequent higher risk behaviors. Accordingly, added attention to sexual risk reduction counseling should focus not only on individuals with high background levels of stressors but also on individuals with low background levels but experiencing acute difficulties” (p. 724). Moreover, Pence and colleagues “observed associations of moderate stressful events with unprotected sex but not severely stressful or traumatic events.² It is

² “Moderate stressors included experiences such as relationship difficulties; death or serious illness of a close friend or family member; employment difficulties (e.g., loss of job); and non-HIV-related serious illnesses, injuries, and accidents. Severe stressors included divorce/separation, death or illness of an immediate family member, major financial problems (e.g., foreclosure), more than a week in prison, and

possible that the types of events classified as severe or traumatic have different relationships with sexual transmission risk behaviors. Alternatively, the low frequency of severely stressful and traumatic events may have hampered [the investigators’] ability to estimate their association with risk behaviors with the necessary precision” (p. 725).

Pence and colleagues conclude that “incident stressful events are exceedingly common in the lives of [people living with HIV/AIDS] and are associated with increased unprotected sex. Efforts to either prevent the occurrence of such events (e.g., financial or relationship counseling) or address their sequelae (e.g., coping skills or other behavioral counseling) may help reduce secondary HIV transmission” (p. 720).

“To determine if a behavioral intervention can reduce HIV/sexually transmitted disease (STD) risk behaviors among African American HIV serodiscordant couples,” El-Bassel et al. (2010), writing for the NIMH Multisite HIV/STD Prevention Trial for African American Couples Group, conducted “a cluster randomized controlled trial . . . in Atlanta, Georgia; Los Angeles, California; New York, New York; and Philadelphia, Pennsylvania; with African American HIV serodiscordant heterosexual couples who were eligible if both partners were at least 18 years old and reported unprotected intercourse in the previous 90 days and awareness of each other’s serostatus” (p. 1594). In all, 535 couples “were randomized to 1 of 2 interventions: **couple-focused Eban HIV/STD risk-reduction intervention** or attention-matched individual-focused health promotion comparison. The primary outcomes

sexual and physical assault. [The investigators] further considered as traumatic events those severe stressors that would satisfy criterion A (1) of the definition of posttraumatic stress disorder . . . : sexual and physical assault and death of a spouse/partner or child” (Pence et al., 2010, p. 721).

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were the proportion of condom-protected intercourse acts and cumulative incidence of STDs (chlamydia, gonorrhea, or trichomonas). Data were collected preintervention and postintervention, and at 6- and 12-month follow-ups" (p. 1594).

Elaborating on the background, structure, and content of the experimental intervention, El-Bassel and colleagues share the following:

The Eban HIV/STD risk-reduction intervention . . . incorporates *Eban*, a traditional African concept meaning "fence," a symbol of safety, security, and love within one's family and relationship space. It was developed drawing on components from a previous couple-based HIV prevention intervention . . . and group-based HIV prevention interventions . . . that were found to be efficacious. It integrated components of social cognitive theory, historical and cultural beliefs about family and community preservation, and an Afrocentric paradigm into a relationship-oriented ecological framework. . . . The focus was on multilevel risk and protective factors associated with HIV/STD risk reduction among African American HIV serodiscordant couples. . . .

Eban consisted of 8 weekly structured 2-hour sessions delivered by male and female African American cofacilitators who had at least a bachelor's degree and 2 years of clinical experience in HIV prevention or related fields. They received 40 hours of centralized facilitator training. The intervention included 4 sessions with individual couples and 4 with groups of couples. In the first half of session 1, a group of couples met with their cofacilitators; in the second half, participants met in single-sex groups with the same-sex facilitator. In sessions 2, 3,

4, and 8, each couple met separately with their cofacilitators. In sessions 5 to 7, group sessions were held.

Skills taught in individual couple sessions were reinforced in group sessions. Individual couple sessions were designed to address interpersonal factors associated with sexual risk reduction, including communication, problem solving, monogamy, and negotiation skills. Group sessions were designed to address community-level factors, including (1) increasing positive peer norms for condom use by emphasizing the threat of HIV to African American communities; (2) reducing the stigma associated with being African American couples affected by HIV; and (3) increasing social support for HIV risk reduction. The principles of *Nguzu Saba* (i.e., unity, self-determination, collective work and responsibility, purpose, creativity, cooperative economics) were woven into the theme and content of the sessions and used to motivate couples to use condoms consistently to protect each other and their community.

The health promotion comparison intervention . . . was designed . . . to reduce the likelihood that effects of . . . Eban . . . could be attributed to nonspecific features, including group interaction and special attention. Guided by social cognitive theory, this intervention was structurally similar to . . . Eban . . ., containing the same number, type, duration, and sequencing of sessions implemented by African American male and female cofacilitators. It focused not on risk of STD, but on behaviors linked to risk of heart disease, hypertension, stroke, and certain cancers. It was designed to increase fruit and vegetable consumption,

physical activity, and medical adherence, including HIV medication adherence. Unlike the Eban HIV/STD risk-reduction intervention, it focused on the participants as individuals, not as couples. (pp. 1596-1597)

El-Bassel and colleagues report that

the intervention had significant effects, averaged over the 1-year follow-up period, on . . . the proportion of condom-protected sex, and the percentage of couples practicing consistent condom use, and the number of unprotected sex acts in which couples engaged. The overall magnitude and consistency of findings across the sexual behavior outcomes strengthen confidence in the intervention's efficacy. . . . The findings strengthen the accumulating evidence on the efficacy of couple-based HIV/STD prevention strategies . . . and expand the repertoire of efficacious interventions for couples. (pp. 1598-1599)

The investigators believe that "this is the first randomized controlled intervention trial to report significant reductions in HIV/STD risk behaviors among African American HIV serodiscordant couples" (p. 1594). Moreover, this study "shows that couples at high risk of transmitting HIV can be recruited for such interventions, are willing to attend multiple intervention sessions, and can be retained for follow-up efficacy assessments. . . . Future studies must explore the generalizability of the findings to couples irrespective of serostatus and in settings where individuals and couples are not aware of their risks for HIV transmission . . . but whose relationships can be supported as they learn to minimize risks for themselves and each other" (p. 1600).

In a separate paper, the NIMH Multi-

site HIV/STD Prevention Trial for African American Couples Group (2010) reports on “the **prevalence of child[hood] (CSA) and adult (ASA) sexual abuse** among [these] 535 African American HIV serodiscordant couples . . . , and its relationship to personal and **couple related vulnerabilities** and HIV risk factors” (p. 1032). The investigators found that “HIV[-]positive women were significantly more likely to report one kind of abuse (32.32%), either before or since age 18[,] or both (32.6%). HIV-positive men (34.9%) were significantly more likely to report CSA than HIV-negative men (22.0%). Overall, 72% of couples reported that one or both had CSA histories” (p. 1032). Moreover,

when sexual risk taking among couples was examined, there were different patterns noted for individuals who reported abuse over their life course versus those who reported abuse only in childhood or adulthood. Individuals who reported histories of CSA and ASA tended to report psychological vulnerability, including psychological distress, and histories of being in drug and residential treatment programs. In addition, they were also more likely to: (1) report having had sex in exchange for money, food or drugs; (2) have an STI [sexually transmitted infection]; (3) be HIV positive; and (4) . . . be women. These findings suggest that economic problems that impacted daily living were associated with histories of abuse. HIV[-]positive female partners with this pattern across time seem to be the most psychologically impacted and at risk for STI and HIV transmission among women. (pp. 1041-1042)

Women who presented with histories of CSA, but not ASA, “reported a different constellation of sexual risks, including engaging in unpro-

tected sex . . . [,] less frequent vaginal sex with their primary partner . . . [, and] more concurrent partners. . . . Individuals who reported histories of ASA, but not CSA, were more likely to use condoms when engaging in sexual encounters” (p. 1042).

These findings “underscore the heightened emotional vulnerability, and STI and HIV transmission risk taking practices, associated with sexual abuse. Sexual abuse histories among couples should be assessed to better understand how these histories may contribute to couples dynamics and risk-taking practices” (p. 1032).

About Adolescents & Young Adults

“CSA . . . has been associated with HIV/AIDS risk behavior; however, much of this work is retrospective and focuses on women,” according to Jones et al. (2010), who modeled longitudinal data on 844 youth (48.8% male, 51.2% female) from five sites “to examine **the link between trajectories of CSA** (2 to 12 years old) **and HIV/AIDS risk behavior** at age 14 (i.e., sexual intercourse [and] alcohol use)” (p. 668). As expected, “trajectory analyses revealed a link between a history of CSA and the development of risky behavior. In addition, trajectories for physical and emotional abuse, but not neglect or witnessed violence, contributed to risky behavior over and above the role of CSA. Child gender did not moderate the findings” (p. 668). Jones and colleagues conclude that these findings corroborate

prior primarily retrospective work with adult women demonstrating that CSA is associated with HIV/AIDS risk behavior. Building upon prevention programs targeting adults with HIV and CSA histories (Sikkema et al., 2008 [summarized in the [Summer 2008](#) issue of *mental health AIDS*]), the findings suggest that pro-

grams aiming to prevent the development of risky behaviors in youth should target both girls and boys with CSA histories. In addition, failing to assess the broader context of maltreatment in which CSA may occur, particularly physical and emotional abuse, may lead to an underestimation of the vulnerability for risky behavior in targeted youth. (p. 678)

“Studies of ethnically diverse young adults have identified a number of possible condom negotiation strategies, including risk information (citing risks of unprotected sex), commands or requests, withholding sex (. . . refusing to have sex without a condom), nonverbal introduction of condoms, emotional coercion (threatening negative consequences), seduction (using sexual arousal to distract partner), and deception (. . . using false information)” (p. 255), according to Tschann, Flores, de Groat, Deardorff, and Wibbelsman (2010), who interviewed 694 heterosexually active Latino youth between the ages of 16 and 22 years “to examine which **condom negotiation strategies** are effective in obtaining or avoiding condom use **among Latino youth**” (p. 254). Among the 574 youth who indicated that they wanted to use or to avoid condoms with their main sex partner, the investigators found that

young men who wanted to use condoms were more likely to do so, compared with young women. Risk information and direct verbal/nonverbal communication were effective strategies to obtain condom use, even among youth who perceived their sexual partners as not wanting to use condoms. Ignoring condom use was an effective condom avoidance strategy, even when youth thought their partners wanted to use condoms. Unexpectedly, young men who expressed dislike of condoms had higher rates

of condom use than young men not using this condom avoidance strategy. (p. 254)

Tschann and colleagues suggest that “condom negotiation strategies that are tactful and respectful may be more acceptable and effective in Latino groups, compared to more confrontational condom negotiation strategies. Because direct verbal and nonverbal communication is effective, health care providers could encourage Latino youth to use this condom negotiation strategy” (p. 259). Yet,

young women may be concerned that if they request condom use, their partner might refuse to have sex or end the relationship. . . . In particular, those who have been victims of physical violence are often afraid that suggesting condom use would cause their partners to become angry. . . . Thus, providers should screen for risk of violence and elicit concerns that young women may have about proposing condom use.

[Additional] findings revealed several gender differences hinting at complex relationship dynamics between young Latino sexual partners. Participants perceived young women as wanting to use condoms more often than young men; nonetheless, young men who wanted to use condoms engaged in more strategies to obtain condom use and reported more actual condom use than young women. Thus, young men appear to be more effective than young women in obtaining condom use. However, when partners had differing condom use desires, young women who insisted on condom use were more effective than young men. [The investigators] speculate that young Latina women may hesitate to engage in condom negotiation strategies. . . . [but] when they do propose condom use, their partners may

respond more positively than they expected. This is an additional reason for providers to encourage young Latina women to negotiate condom use. (pp. 259-260)

About Men

Charnigo, Crosby, and Troutman (2010) set out “to determine associations between **condom-related psychosocial constructs** and condom use among a [convenience] sample of [266] young, heterosexual, **African American men** newly diagnosed with a[n STD]” (p. 303). The investigators’

controlled findings suggest that young, heterosexual, African American men newly diagnosed with an STD may be more likely to use condoms if they perceive fewer partner-related barriers to performing this behavior. . . . Although other studies of high-risk African American men are needed, the findings from this study imply that young African American men, newly diagnosed with an STD, may indeed benefit from behavioral intervention designed to teach condom negotiation skills that may be needed to resolve condom use issues with their female partners. The assumption that men have volitional control over condom use may indeed be flawed given the finding from this study. This is a potentially critical observation given that sexual risk reduction interventions for men have traditionally ignored the possibility that their female partners may pose barriers to condom use. Indeed, [these] findings suggest that intervention efforts for young, heterosexually active, African American men may need to include components designed to help them successfully negotiate partner-related resistance to condom use.

Controlled findings also suggest

that condom use among young, heterosexual, African American men may be more likely when condom-specific attitudes are favorable. . . . [Notably, t]he value of condom-use self-efficacy in predicting men’s condom use was usurped by men’s perceptions about partner-related barriers and their condom-specific attitudes. Similarly, men’s sensation-related barriers to condom use also failed to achieve significance in the presence of measures pertaining to their perceptions about partner-related barriers and their condom-specific attitudes. However, from the perspective of intervention design the relatively greater value of partner-related barriers and condom-specific attitudes should not preclude teaching skills designed to promote condom-use self-efficacy or addressing sensation-related barriers to condom use. (pp. 308-309)

HIV Assessment News

Psychiatric Assessment & Intervention

British investigators (Theuninck, Lake, & Gibson, 2010) “examined the relationship between the experience of various HIV-related events (receiving the diagnosis, receiving treatment, experiencing physical symptoms, self-disclosing HIV positive status, and witnessing HIV-related death) and **posttraumatic stress symptoms** in a sample of 100 gay men living with HIV” (p. 485). Theuninck and colleagues found that 65% of study participants “met criteria for having experienced a traumatic event in accordance with the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR)* posttraumatic stress disorder (PTSD) criterion A.”³

³ “The *DSM-IV-TR* conceptualizes a traumatic event as involving physical threat and evoking strong emotional distress (criterion A for PTSD). This is more specifically defined as meeting subcriteria A1 and A2. According to A1 ‘the person experienced,

The experience of shame, humiliation, or guilt during an event was measured but not found to be a significant indicator of having been traumatized. A total of 33% qualified for a PTSD diagnosis” (p. 485).

These findings “support the view that HIV-related PTSD is primarily associated with fear, helplessness, or horror as opposed to shame, humiliation, or guilt” (p. 490). Additional analysis “showed that receiving medical treatment, experiencing physical symptoms, and witnessing HIV-related death were most associated with HIV-related PTSD symptoms” (p. 485). Interestingly,

the hypothesis that being diagnosed with HIV would be the seminal traumatic event . . . was not supported, despite the greatest proportion of participants (55%) rating the event as traumatic. This suggests that receiving the diagnosis may be more in keeping with the definition of an “information stressor” that does not constitute an imminent threat to life and physical integrity, but signals a future threat, . . . whereas physical symptoms, treatment, and witnessing death may bring to mind a more immediate threat posed by HIV. (p. 488)

“Given that multiple HIV-related events are potentially traumatic, the screening, assessment and treatment for HIV-related PTSD may need to be considered by HIV services” (p. 485), according to the investigators. Moreover,

individuals who rate themselves as feeling intensely fearful, help-

witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others,’ and according to A2 ‘the person’s response involved intense fear, helplessness, or horror” (Theuninck, Lake, & Gibson, 2010, p. 485).

less or horrified during an HIV-related event may be at risk of developing posttraumatic stress symptoms that include reexperiencing the event, behavioral avoidance or emotional numbing, and hypervigilance to threat cues. The experience of such heightened emotions may therefore offer the treating clinician a potential screening indicator for individuals who may be at risk of developing HIV-related PTSD.

Where individuals develop such symptoms within 1 month of the event, routine monitoring . . . and supportive care . . . [are] appropriate on a watchful waiting basis. However, specialized psychological care for posttraumatic stress within the first month is possibly contraindicated. In fact, specialist trauma intervention or “critical incident debriefing” during this first month is not recommended and has been shown to delay recovery from posttraumatic stress symptoms. . . . However, individuals who continue to experience posttraumatic stress symptoms beyond this first month may benefit from specialist trauma assessment and evidence-based intervention. . . .

Patient care may therefore be enhanced by education initiatives that enhance care professionals’ awareness of the link between HIV and PTSD, [and teach providers] how to identify vulnerability, offer . . . follow-up, and refer . . . for specialist psychological treatment for PTSD. Individuals living with HIV may also benefit from education to help them recognize their vulnerability and identify symptoms of PTSD. Noting that PTSD often goes unrecognized especially . . . [among patients with] physical illnesses, . . . this research highlights the potential value of taking a proactive approach given the significant

number of individuals who do report HIV-related PTSD symptoms. (p. 489)

Similarly, Beckerman and Auerbach (2010) screened 186 clients “who were receiving HIV services from community-based settings in the New York City area. With the use of the **PTSD Checklist** (PCL) [(Blanchard, Jones-Alexander, Buckley, & Forneris, 1996)], this study determined that more than half of the sample tested positively for PTSD” (p. 687). The investigators emphasize that

PTSD screening, assessment, and referrals for PTSD evidence-based treatments should be a standard inclusion in HIV settings, emergency rooms, clinics, physicians’ offices, and other health care settings. Symptoms such as “repeated disturbing memories,” “feeling distant and cut off from others,” and “feeling that their future will be cut short” are significant indicators of PTSD for clinicians working with this population to look out for.

. . . In addition to assessment and referrals for individual psychotherapy, . . . clinicians should be aware that other modalities of treatments such as group therapy, Eye Movement Desensitization & Reprocessing (EMDR), hypnosis, psychopharmacology, and even couple’s therapy ha[ve] . . . proved effective for those suffering from PTSD. . . . Regardless of what treatment approach is chosen, the worker must be sure to provide the client with a sense of control, allowing choices to be made by him/her whenever possible, and going at a pace that is both tolerable to and desired by the client in order to empower him/her and foster a sense of self-efficacy. (pp. 698-699)

Neuropsychological Assessment

As Minor, Jones, Stewart, Hill, and Kulesza (2010) write: "Psychomotor slowing is an early symptom of HIV-associated dementia. The Modified HIV Dementia Scale (MHDS) is a fast, reliable measure of HIV-associated dementia. However, literacy may influence the psychomotor speed subscale (MHDS-PS). Psychomotor speed might be more accurately assessed using the **Coin Rotation Test (CRT)**" (p. 225).⁴ Minor and colleagues "examined the CRT's validity in assessing psychomotor speed in [204] HIV+ patients by comparing it with the MHDS-PS" (p. 225). The investigators discovered "good convergent validity between the CRT and MHDS-PS. Gender did not significantly affect CRT performance but did affect MHDS-PS performance. CRT performance was less affected by education than MHDS-PS performance" (p. 225). Additionally, the investigators "calculated substitution scores for the CRT to correspond with the MHDS and determined that a cut score of < 20 rotations is predictive of a positive MHDS screen" (p. 226).

Minor and colleagues conclude that "the CRT is a fast, reliable, cost-efficient, and valid measure of psychomotor speed in HIV+ patients. It is free from gender effects and less influenced by education when compared with the MHDS-PS, suggesting that the CRT may be a more accurate method of identifying individuals with psychomotor speed impair-

⁴ "The MHDS . . . contains three subtests: (1) recall of 4 words after 5 minutes (MHDS-recall), (2) timed copy of a Necker cube [a wire-frame cube without depth cues] (MHDS-construction), and (3) timed alphabet writing (MHDS-PS). . . . The CRT has participants rotate a U.S. quarter (0.955 inch diameter coin) 180° as many times as possible in 10 seconds (dominant hand first, followed by nondominant hand). . . . Both the MHDS-PS and CRT have been validated against the Grooved Pegboard Test, . . . the gold standard measure of psychomotor speed. . . . Administration time is approximately 10 minutes for the MHDS and 1 minute for the CRT" (Minor et al., 2010, p. 226).

ments. The CRT is especially useful in clinics that have patients with low literacy and may help to reduce false positives" (p. 227). Minor and colleagues suggest that "using the CRT either in place of or in addition to the MHDS-PS subtest is a way of minimizing education-related confounds" (p. 226). Needless to say, "neither the CRT nor MHDS-PS is an appropriate measure of psychomotor speed when there are conditions that reduce manual dexterity (e.g., arthritis)" (p. 227).

HIV Treatment News

Medical Care

Rosenberg et al. (2010) tested an intervention "designed to facilitate **integrated infectious disease programming in mental health settings** and to increase acceptance of such services among clients" (p. 885). "To establish efficacy for this intervention, and to ensure feasibility in an urban, ethnically diverse setting, [the investigators] conducted a randomized controlled trial in urban Baltimore, Maryland. The STIRR intervention was compared with enhanced treatment as usual (the control condition, which continued existing brokered case management services and augmented them with education and referral) across four publicly funded community mental health services sites" (p. 886). The study was conducted among 236 clients who were predominantly from racial/ethnic minority groups; all participants had received a psychiatric diagnosis of schizophrenia spectrum disorder, major depressive disorder, or bipolar disorder, as well as a current or lifetime diagnosis of a substance use disorder.

As the investigators describe it,

the STIRR intervention – which entails *Screening* for HIV and HCV [hepatitis C virus] risk factors; *Testing* for HIV, HBV [hepatitis B virus], and HCV infection; *Immunization* against HAV

[hepatitis A virus] and HBV; *Reducing* risk through counseling; and *Referring* for medical treatment persons who test positive for HIV and HCV . . . – was developed to overcome barriers to providing recommended infectious disease services to clients with co-occurring disorders by bringing services to the clients' usual source of care: publicly funded community mental health providers. To overcome provider barriers, STIRR was delivered by an external team of specialists with the knowledge, skills, and confidence to deliver these services. To overcome client barriers, STIRR is brief, requiring about one hour of client contact over three sessions. The motivational approach is health promotion and personal empowerment, which involves recruiting the client as partner and agent in improving his or her own medical well-being. (p. 886; italics added)

Rosenberg and colleagues found that "clients randomly assigned to the STIRR intervention had high levels (over 80%) of participation and acceptance of core services. They were more likely to be tested for HBV and HCV, to be immunized against [HAV] and HBV, and to increase their knowledge about hepatitis and reduce their substance abuse. However, they showed no reduction in risk behavior, were no more likely to be referred to care, and showed no increase in HIV knowledge. Intervention costs were \$541 per client (including \$234 for blood tests)" (p. 885). The investigators conclude that "STIRR appears to be efficacious in providing a basic, best-practice package of interventions for clients with co-occurring disorders" (p. 885). Rosenberg and colleagues add, however, that "for STIRR to become an evidence-based practice, it should be replicated in other sites, with more culturally diverse populations, with interviewers blinded to control versus

Tool Box

Resources

Amorosa, V.K. (2010). New frontiers of HCV therapy in HIV/HCV co-infection. *Current HIV/AIDS Reports*, 7(3), 117-126.

"Hepatitis C virus (HCV) leads to disproportionate morbidity and mortality in the HIV-positive population. A new era of anti-HCV therapeutics is emerging, with many direct antiviral agents and immunomodulating drugs in clinical development. This review discusses HCV treatments in development, with special attention to four agents being studied actively among HIV/HCV-co-infected persons" (p. 117).¹

Fierer, D.S. (2010). Epidemic of sexually transmitted hepatitis C virus infection among HIV-infected men. *Current Infectious Disease Reports*, 12(2), 118-125.

"Sexual contact is thought to be an inefficient mode of . . . HCV . . . transmission" (p. 118). Nevertheless, "an epidemic of sexually transmitted HCV infection among HIV-infected MSM [men who have sex with men] has emerged in Northern Europe, the United States, and Australia largely since 2000. Acquisition of HCV infection was associated with unprotected receptive sex and this 'risky' behavior may have been fueled by recreational drug use. Early spontaneous clearance occurred relatively rarely, but early treatment has cured about two thirds of patients. There is evidence of accelerated liver fibrosis early in infection, underscoring the importance of early diagnosis and treatment to prevent progression of liver disease to cirrhosis. HIV-infected MSM are a new risk group for HCV infection and

¹ For more information on the challenges associated with HIV/HCV coinfection, see the **Tool Boxes** entitled "HIV & Hepatitis C: Coping with Coinfection" in the [Spring 2010](#) (Part 1) and [Summer 2010](#) (Part 2) issues of *mental health AIDS*.

treatment assignment and in situations in which the STIRR team is not recruited and paid by the study team. Cost-effectiveness of the intervention should be assessed, entailing evaluation of medical out-

comes over time" (p. 890).

Kalichman, S.C., Hudd, K., & DiBerto, G. (2010). Operational fidelity to an evidence-based HIV prevention intervention for people living with HIV/AIDS. *Journal of Primary Prevention*, 31(4), 235-245.

"This study examined the delivery of intervention components (operational fidelity) of a widely disseminated HIV prevention program designed for people living with HIV/AIDS named *Healthy Relationships*" (p. 235). The researchers found that "a majority of AIDS service providers trained to deliver *Healthy Relationships* implemented the program. . . . Altering core elements to improve community fit of *Healthy Relationships* did not appear to impact any perceptions of effectiveness. However, research is needed to determine whether fidelity to core elements is related to real world efficacy. Greater guidance is needed for implementing *Healthy Relationships* to maximally adhere to its principles while also maximizing its fit to community needs" (p. 244).

Letteney, S. (2010). Disrupted caregiving and maternal HIV disease: A proposed model for evaluating HIV-affected children's psychosocial adjustment. *Social Work in Health Care*, 49(8), 753-763.

"The objective of this article is to propose a model of the HIV disease-related disruption of care on children's psychosocial adjustment. The schematic model can be used to evaluate the mechanisms by which maternal HIV disease may influence the psychosocial adjustment of elementary school-age children" (p. 753).

Lichtenstein, B., & Malow, R.M. (2010). A critical review of HIV-related interventions for women prisoners in the United States. *Journal of the Association of Nurses in AIDS Care*, 21(5), 380-394.

Psychiatric/Psychological/ Psychosocial/Spiritual Care Adherence to Treatment

"Despite research concerning barriers

"This article reviews the literature on HIV-related interventions for U.S. women prisoners, with a focus on identifying strategies that enabled women to practice safer sex, reduce drug use, and . . . avoid recidivism. . . . Four interventions for incarcerated women achieved successful outcomes regarding self-empowerment and safer sex skills; 3 prison-release interventions resulted in less recidivism if not reduced HIV risk. Each intervention was nominally women-centered, with prison-release programs lacking protocols that were designed specifically for women. Based on evidence that women-centered interventions were desirable for this population, such interventions should be given high priority in criminal justice policy and care provision during the HIV epidemic" (p. 380).

McCree, D.H., Jones, K.T., & O'Leary, A. (Eds.). (2010). *African Americans and HIV/AIDS: Understanding and addressing the epidemic*. New York: Springer.

From the publisher: "*African Americans and HIV/AIDS* . . . [provides] an analysis of the historical, psychosocial, economic, and political issues related to HIV transmission in the black community, and offer[s] . . . a wealth of evidence-based and emerging interventions (including behavioral interventions, and counseling and testing strategies) tailored to specific sub-populations."

Mugavero, M.J., Davila, J.A., Nevin, C.R., & Giordano, T.P. (2010). From access to engagement: Measuring retention in outpatient HIV clinical care. *AIDS Patient Care & STDs*, 24(10), 607-613.

"This article provides a synthesis of five commonly used measures of retention in HIV care, highlighting their methodological and conceptual strengths and limitations, and suggesting situations where certain measures may be preferred over others.

ers and facilitators of ARV [antiretroviral] adherence behavior, relatively little is known about specific challenges faced by HIV-positive persons who report 'taking a break' from their ARV medications," according to

The five measures are missed visits, appointment adherence, visit constancy, gaps in care, and the [Health] Resources and Services Administration HIV/AIDS Bureau (HRSA HAB) performance measure for retention in HIV care. As has been noted for antiretroviral [(ARV)] medication adherence, there is no gold standard to measure retention in care, and consideration of the advantages and limitations of each measure, particularly in the context of the desired application, should guide selection of a retention measure” (p. 607).

Shindler, S., & Tangelder, M. (2010). Beneath the mask: A group therapy model supporting children infected with and affected by HIV/AIDS. *Social Work with Groups*, 33(4), 308-322. “In 2007 a study was conducted to identify the outcomes of an activity-based psychosocial intervention called Leading the Way, a program designed for children infected with and/or affected by HIV/AIDS, based in Toronto, Canada. . . . The ethical dilemmas involved in serving populations of children who have not been disclosed to regarding their own or a family members’ HIV status came to light in the development of the program and are discussed in the analysis of data” (p. 308).

Solórzano, L., & Glassgold, S. (2010). Powerful Youth: Determining successful participation in an HIV support group for youth. *Social Work with Groups*, 33(4), 288-303. “Given the significant benefits of group-level interventions and the ongoing need for support services, education, and secondary prevention for HIV-positive youth, staff in the Risk Reduction Program within the Division of Adolescent Medicine at Childrens Hospital Los Angeles implemented a psychoeducational and social support process group for youth ages 18 to 25 living with HIV” (p. 288). “The goal of this article is to describe this ongoing

HIV support group called Powerful Youth and review the results of a focus group conducted to assess its success regarding youth participation and reported satisfaction” (p. 291). “Specific recommendations for better serving the needs of this population through group interventions are suggested” (p. 288).

Tennille, J., Solomon, P., & Blank, M. (2010). Case managers discovering what recovery means through an HIV prevention intervention. *Community Mental Health Journal*, 46(5), 486-493.

Tennille and colleagues “present findings from focus groups and in depth interviews with case managers following an HIV prevention clinical trial [involving persons with severe mental illness (SMI)]” (p. 486). The investigators report that “beyond confirming previously established barriers to case manager delivery of HIV prevention interventions for persons with SMI, most noteworthy was the finding that case managers were generally unskilled in conducting assessments and tended to focus on ‘spoiled identity’ and illness parts of their consumers. Experimental case managers revealed that they had been transformed by the training experience in a manner permitting them to both understand and work from a recovery model. Implications and directions for further study are discussed” (p. 486).

Underhill, K., Operario, D., Skeer, M.R., Mimiaga, M.J., & Mayer, K.H. (2010). Packaging PrEP to prevent HIV: An integrated framework to plan for pre-exposure prophylaxis implementation in clinical practice [Commentary]. *Journal of Acquired Immune Deficiency Syndromes*, 55(1), 8-13.

“Pre-exposure prophylaxis (PrEP) . . . entails providing HIV-negative individuals with ARV drugs, and it is widely anticipated as one of the most promising new prevention strategies” (p. 8). “This Commentary has proposed a

5-part structure for optimizing PrEP implementation in clinical practice. The HIV prevention literature reflects a keen awareness that PrEP will require support services, and including these services in a unified implementation framework can help to organize these discussions. We believe that taking an expanded view of PrEP – including an optimal package of PrEP prescription, safety screening, behavioral intervention, integration of PrEP with other healthcare services, and population-level monitoring – will help clinicians and policymakers prepare more effectively for implementation” (p. 12).

Walkup, J.T., Akincigil, A., Amin, S., Hoover, D., Siegel, M., & Crystal, S. (2010). Prevalence of diagnosed HIV disease among Medicaid beneficiaries with schizophrenia in U.S. metropolitan areas. *Journal of Nervous & Mental Disease*, 198(9), 682-686.

“Numerous reports suggest HIV may be elevated among those with [SMIs] such as schizophrenia or bipolar illness, but this has been studied in only a limited number of sites. Medicaid claim’s files from 2002 to 2003 were examined for metropolitan statistical areas (MSAs) in 8 states, focusing on schizophrenia. . . . Individuals receiving Medicaid in these states represented 51% of Medicaid beneficiaries nationally. In 2001, these 8 states included 66% of the cumulative AIDS cases in the United States. . . . Across 102 MSAs, 1.81% of beneficiaries with schizophrenia had received diagnoses of HIV/AIDS. MSA rates ranged widely, from 5.2% in Newark, NJ, to no cases in 16 of the MSAs. . . . By providing suggestive evidence regarding the epidemiology of HIV/schizophrenia comorbidity in a large number of MSAs, we expand the foundation for follow-up research and prevention efforts” (p. 682).

– Compiled by
Abraham Feingold, Psy.D.

Norton et al. (2010), who “employed the Information-Motivation-Behavioral [(IMB)] Skills Model of ARV adherence as a framework for understanding adherence-related barriers that may differentiate between **non-ad-**

herent patients who report ‘taking a break’ versus those who do not report ‘taking a break’ from their ARV medications” (p. 979). Among

327 HIV-positive patients who re-

ported less than 100% adherence to their ARV medications during the [previous] 3-4 weeks, 8.9% ($n = 29$) reported currently “taking a break” from their HIV medication(s) without first talking

with their healthcare provider. Few differences were observed between participants classified as intentional (i.e., "taking a break") versus unintentional (i.e., not "taking a break") non-adherers on basic demographic variables, adherence-related information, or motivation. However, numerous differences were observed between groups on adherence-related behavioral skills. (pp. 984-985)

More specifically, "intentional (versus unintentional) non-adherers reported greater difficulty in managing their medication side effects . . . ; taking their medications because the pills are hard to swallow or taste bad . . . ; incorporating their medications into their daily life . . . ; taking their medications when they do *not* feel well emotionally . . . ; taking their medications when they feel well physically . . . ; taking their medications when they do *not* feel well physically . . . ; and talking to their healthcare provider about their medications" (p. 983).

Norton and colleagues remind readers that "the theoretical predictions of the IMB model of ARV adherence . . . specif[y] . . . that deficits in behavioral skills constructs may thwart adherence even in the context of appropriate levels of adherence-related information and motivation. For some individuals, it appears that greater deficits in medication-taking behavioral skills may be associated with intentional non-adherent behavior" (p. 985). Although preliminary,

the current results point to the need for adherence-promotion programs to include skills-building and self-efficacy enhancing intervention modules in order to address "taking a break" behavior that could occur in about 10% of a clinic sample. . . . At minimum, some attention must be given at the intervention and clini-

cal care level to foster open collaborative discussions with patients about plans to modify or experiences with intentionally altering one's prescribed ARV regimen, since patients in the present study reported "taking a break" without first discussing it with their healthcare provider. Based on the present findings, patient-provider discussions should also include an exploration of how limitations in behavioral skills may be influencing HIV-positive patients' conscious awareness of and decision to "take a break" from ARV medications. (p. 986)

Wrubel, Stumbo, and Johnson (2010) analyzed "relationship dynamics concerning [ARV] therapy (ART) adherence among HIV+ seroconcordant and serodiscordant male couples" (p. 553) through "narrative accounts of **offered and accepted support and nonsupport for adherence to ART**" (p. 554). The investigators interviewed 40 study participants (i.e., 20 couples interviewed separately) and described "patterns of relationship dynamics and support preferences" (p. 553) that emerged from these data.

Wrubel and colleagues

found two basic orientations to ART adherence in the sample: *Personal Responsibility* and *Couple's Responsibility*. The *Personal Responsibility* group viewed adherence as an individual's responsibility and unconnected to the relationship. Within this group were two subgroups: *My Responsibility* and *His Responsibility*.

The *Couple's Responsibility* group viewed adherence as falling to the couple and how they defined their relationship. This group integrated adherence support practices into the relationship. This group also

contained two subgroups: *Consensual Dominance* and *Mutuality*.

Only the *His Responsibility* subgroup contains all serodiscordant couples. All other groups include both seroconcordant and serodiscordant couples. It is not the seroconcordance or serodiscordance that drives the offering and/or the acceptance of adherence support. In the *Personal Responsibility* group, personal meanings concerning autonomy or HIV appeared to determine adherence support. Either accepting or offering ART adherence support was distinct from other couple dynamics. By contrast, couple dynamics in the *Couple[s] Responsibility* group shaped the acceptance and the offer of support, even though some partners held personal meanings concerning autonomy. (pp. 559-560)

The investigators also identified "a third group [that] was in the process of ending their relationships[, within which] . . . adherence support was one-sided or withdrawn altogether" (p. 553).

Wrubel and colleagues believe that

this close look at support or non-support for ART adherence in male same-sex partner relationships highlights the usefulness of examining the dynamic nature of enacted social support. The study also underscores the value in studying a group with good adherence and exploring the various pathways by which adherence is maintained, instead of comparing good and poor adherers. Of immediate clinical implication is that only asking the patient about ART adherence represents the oversimplification of a complex situation. For instance, it may be helpful to discuss the partners' attempted sup-

port that may not be noticed by the patient. Likewise, it may be helpful for providers to ask both partners about the perceived relationship consequences of providing or receiving adherence support. In addition, relationship termination may generate adherence risks for patients, depending on personal and couple responsibility for adherence.

The next logical step is to determine how relationship dynamics

and partner provision of adherence and clinical outcomes over time. Such data could assist researchers and program developers interested in including a relationship partner in an ART adherence intervention. This analysis also demonstrates that a couples-based adherence intervention may be more complex than inviting the partner to participate. Couples' interventions may need to account for relationship stabil-

ity, individual- and couple-level preferences for giving and receiving support, and the general rhythms of dyadic interactions. Such intervention approaches have the potential to increase survival, quality of life, and relationship satisfaction among couples affected by HIV and other illnesses. (p. 569)

“Evidence on efficacy must be supplemented with evidence on

(Biopsychosocial Update is continued on Page 16)

Tool Box

Measuring the Quality of Mental Health Care for Persons Living with HIV

“Quality measures are vital for ensuring the uptake and delivery of evidence-based care. Quality of care cannot be improved without monitoring how such care is delivered, from its organization to processes and, ultimately, to patient outcomes. Measuring quality using quality indicators derived from evidence-based practice guidelines is an important step toward implementation of evidence-based care and monitoring quality improvement efforts.”

— Kilbourne, Keyser, & Pincus, 2010, p. 551

Recent publications disclose an increasing focus on the quality of HIV care in the United States. These publications describe the establishment of “a single, aligned set of quality measures reflecting care processes and outcomes for HIV-infected individuals” (p. 737) to serve as “national HIV/AIDS performance measures for individual patient-level and system-level quality improvement” (Horberg et al., 2010, p. 732), as well as “the first report of performance rates for a national health care system on most of the[se] NQF [National Quality Forum] measures for HIV/AIDS care” (Backus et al., 2010, p. 1244), “using available electronic data for the large, diverse population with HIV in the Department of Veterans Affairs” (p. 1239). Concurrently, the Health Resources and Services Administration HIV/AIDS Bureau devoted its entire August 2010 issue of *HRSA CareAction Newsletter* to the role of treatment guidelines and performance measures in supporting quality management programs developed and implemented by Ryan White HIV/AIDS Program grantees and providers.

With all this attention to the quality of routine medical care for persons living with HIV, one might ask about parallel developments regarding the quality of HIV-related mental health care.

Develop-Mental Delays

Bozzette (2010) writes that

the foundation for thinking about health care quality was laid out many years ago by a physician named Avedis Donabedian. . . . The key elements were the *structure of care*, including the physical and human environment and administrative systems; the *process of care*, or what is done for the patient; and the *outcomes of care*. Despite the increasing emphasis on outcomes (especially at the health care system level), outcomes are notoriously difficult to use for the individual level, because it is so difficult to define the unimprovable outcome in the individual case. The structure of care is outside of the provider-patient interaction. Therefore, process of care measures dominate quality measurement in most settings.

Quality process of care is assessed by first establishing the elements or criteria for high-quality care. Next, measures of quality are developed that include details such as the content of the numerator and denominator (i.e., which patients should be included). Finally, standards are established to define the range of acceptable variation for a measure, because it is unrealistic and inappropriate to expect that good care will always include 100% fulfillment of a particular measure. Quality of care measures and standards now exist for dozens of conditions. (p. 739)

Yet, according to Kilbourne, Keyser, and Pincus (2010),

worldwide, the mental health services sector lags behind in the development and implementation of performance measures and strategies for implementing them as tools to improve quality and outcomes. . . . There are 3 key reasons for this lag: lack of a sufficient evidence base through which to develop specific, valid, and clearly defined measures . . . ; inadequate infrastructure to develop and implement quality measures and capture elements of mental health services; and lack of a cohesive strategy to apply mental health quality measurement across different settings in the service of improving care. . . . Data elements necessary to measure quality of mental health care are incomplete or even missing in

(Tool Box is continued on Page 12)

(Tool Box -- continued from Page 11)

many settings, and, even when data collection does occur, it tends to be inconsistent across different organizations. Moreover, mental health programs and providers have not fully embraced quality measurement, owing to infrastructure and policy barriers intrinsic to mental health, including providers' concerns regarding patient privacy, so-called cookbook medicine, and the silos across different provider types and credentialing requirements. Finally, in many countries, the mental health sector is far behind the rest of health care in the use of health information technology. (p. 550)

Follow the Leader

Despite the many challenges outlined by Kilbourne and colleagues (2010), efforts have been made to identify quality indicators for the delivery of mental health care to persons living with HIV/AIDS. At the forefront of these efforts has been the work of the New York State Department of Health AIDS Institute, within which the HIV Quality Management Program first convened Ryan White Title I- (now Part A-) funded mental health providers operating in the New York City metropolitan area to develop HIV mental health performance indicators in 2002, according to the agency's Web site. These [Quality Performance Indicator Definitions and Calculations for Part A Mental Health](#) service delivery were disseminated by the Part A HIV Quality Management Program (February 2005) to funded agencies providing licensed outpatient mental health services for people living with HIV/AIDS. The indicators have since been reviewed and "tweaked" periodically, most recently in December 2008. With assistance from the Part A HIV Quality Management Program of the New York State Department of Health AIDS Institute, the quality indicators currently in use (T. Hatton, personal communication, September 27, 2010) are presented for general dissemination [here](#).

The Next Big Thing

Referencing the Part A mental health quality indicators described above, Pyne et al. (2008) identified the need

New York State Department of Health AIDS Institute **Part A HIV Quality Management Program** **Quality Performance Indicator Definitions and Calculations** **for Part A Mental Health**

Review Eligibility: All clients enrolled in a mental health program during the past 12 months (calendar year).

1. Comprehensive Mental Health Evaluation and Reassessment

Cognitive Assessment

A cognitive assessment should be performed annually through the use of a Mini Mental Status Exam or another appropriate methodology that assesses:

- Orientation (place, date)
- Registration and recall (3 objects)
- Attention/calculation (serial 7s or world)
- Language: Naming
Repetition
Command (reading, writing, drawing)

Multi-axis Diagnosis

A multi-axis diagnosis should be performed annually and included in the client chart, with statements regarding all five axes as listed below:

- I - Clinical Disorders; Other conditions that may be a focus of clinical attention
- II - Personality Disorders; Mental Retardation
- III - General Medical Conditions
- IV - Psychosocial and Environmental Problems
- V - Global Assessment of Functioning

Assessment of Dangerousness

A baseline assessment of dangerousness should be performed and included in the client chart, including a history of suicidality and homicidality, as well as current suicidal and homicidal ideation or potential.

Current Medications

An assessment of current medications should be performed as part of the initial assessment.

Side Effects

An assessment of whether the client has experienced side effects from psychiatric medications should be conducted monthly, with statements concerning any side effects the client is experiencing or that the client is not experiencing any side effects.

Psychiatric History

A baseline psychiatric history should be performed, which includes the following elements: psychiatric treatment history, including psychiatric hospitalizations and past psychiatric medications.

2. Psychosocial Assessment

A psychosocial assessment should be performed annually and included in the client chart that includes, at a minimum, the following elements:

- Family/social support (family status, including children/other relationships)
- Financial issues (income/insurance/benefits)
- Educational background
- Occupational status
- History of physical or sexual abuse or neglect (including domestic violence)
- Housing status

3. Substance Use Assessment and Treatment

Indicator 3a: Identification and assessment of substance use disorders

An assessment for substance use disorders should be performed annually that includes a history of substance abuse, identifying first, last, and current substance use, as well as type, frequency, and route of use. The following substance use disorders should be documented as having been assessed: alcohol, cocaine/crack, and heroin.

Indicator 3b: Provision of care, or referral to appropriate care, for patients with co-

morbid active substance use

- Appropriate care should be provided to clients identified in the record as active substance users. This includes referral for treatment, with appointment specified, for substance use treatment, rehabilitation, detoxification, or methadone maintenance, OR documentation of provision of substance abuse treatment on site.
- If the client actively used substances within the last 6 months, client should have either been in treatment or received referral to treatment.
- If last use was prior to 6 months from the date of the review, but client had history of substance use within the last 2 years, relapse prevention or ongoing treatment should be discussed with the patient.
- If appropriate care is not provided directly by the mental health clinician, clients may be referred for appropriate care for management of active substance use. Documentation that indicates the substance use treatment provider has seen the client should be included in the client chart.

4. **Mental Health Treatment Services**

Eligibility: All clients

Mental health treatment services should include the following components:

- Initial treatment plan that addresses issues identified in the comprehensive mental health and psychosocial assessments.
- Quarterly treatment plan review. Documentation that the treatment plan was reviewed and/or updated on a quarterly basis will constitute sufficient documentation.
- Multidisciplinary care: psychiatrist, psychologist, social worker. Documentation can include progress notes, treatment plan notes, or case conference notes.

5. **Coordination of Care with Client's Primary Care Provider (Quarterly)**

Eligibility: All clients

Coordination of care between the mental health provider and the primary care provider should be documented in the client's mental health chart. Quarterly documentation in the form of a progress note is sufficient.

Primary Care Indicators

1. **Access to Primary Care**

Clients should have one visit with their primary care provider *at least* every 6 months.

- For clients who have not had a visit with their primary care provider in the first or last 6 months of the calendar year, there should be documentation of referral to primary care.
- For patients with a referral to primary care, there should be documentation of follow-up within 30 days to determine whether the primary care appointment was kept.
- If documentation of follow-up exists, there should be documentation that the client kept the appointment.

2. **Assessment of Whether Clients Eligible for ARV [Antiretroviral] Therapy Are Receiving It**

Clients will be reassessed for ARV status *at least* once every 6 months.

- For clients not on ARV therapy, is there information on viral load or CD4 test results?
- If yes, is the patient eligible for therapy based on viral load (> 100,000 copies) or CD4 count (< 350 cells)?
- If yes, is the patient referred to primary care for assessment of treatment eligibility?
- If yes, is there documentation of follow-up on patient's status within 30 days?
- If yes, was the patient placed on ARV therapy?

3. **Viral Load and CD4 Counts**

Clients will have lab work completed to assess their viral load and CD4 counts *at least* once every 6 months.

- For clients who have not had a CD4 or viral load test performed in the first or last 6 months of the calendar year, is there documentation of referral to primary care for these tests?
- For patients with a referral to primary care, was there documentation of follow-up within 30 days to determine whether the laboratory tests were performed?
- If documentation of follow-up exists, is there documentation that the client received the viral load and/or CD4 test?

for "a wider variety of HIV depression quality indicators (e.g., more diagnostic and treatment issues specific to HIV depression) than are available from the [New York State Department of Health] AIDS Institute website" (p. 1076). To that end, Pyne and colleagues "developed quality of care indicators for depression detection, diagnosis and treatment for patients with HIV based on an extensive literature review and the results from an expert panel that rated the validity and feasibility of these indicators" (p. 1076). The expert panel was convened in March 2006 "to construct a set of valid and feasible quality indicators for detecting and treating depression in patients with HIV" (p. 1076). As described by Pyne and colleagues,

the HIV depression quality indicators were divided into six chapters: general, bereavement, substance abuse, viral hepatitis, cognitive impairment and drug interactions. . . . The expert panel included HIV physicians, psychiatrists and a pharmacist, all with experience with HIV depression. The in-person eleven-member panel rated 80 candidate HIV-depression quality indicators. Indicators were evaluated using main and sensitivity analysis criteria for validity and feasibility. Seventy-four percent (59/80) of the quality indicators met *a priori* [based on logic] main analysis criteria for validity and feasibility and 61% met sensitivity analysis criteria. (p. 1075)¹

(Tool Box is continued on Page 14)

¹ "In the main analysis, indicators with a median validity score ≥ 7 and a median feasibility score > 3 [on a 9-point scale] were *a priori* designated as valid and feasible, respectively. In a sensitivity analysis, a score of ≥ 7 was considered valid and feasible. The lower feasibility score in the main analysis was used because [the investigators were] planning to use the results of the expert panel to evaluate the quality of HIV depression care in VA clinics and not all panelists were familiar with the VA electronic medical records. [The investigators] also reviewed the in-person ratings for evidence of disagreement (defined *a priori* as at least two votes in the 1-3 range and at least two votes in the 7-9 range) and did not find any that met this criterion" (Pyne et al., 2008, pp. 1077-1078).

Elaborating on the need for these more specific quality indicators, Pyne and colleagues observe that

the differences between depression quality indicators identified in this study and those for the general population reflect the variety of common comorbid conditions associated with HIV depression. From a clinical perspective, the quality indicators identified as valid and feasible that are more specific to HIV depression included: (1) a need for more targeted depression screening given the increased incidence and associated adverse outcomes associated with depression in this population; (2) increased vigilance about depression and related clinical issues in the context of comorbid HIV and hepatitis C; (3) the need to optimize depression and HIV treatment in the context of cognitive impairment; and (4) the need to start at lower antidepressant dosages, advance the dose slowly, but target the dose considered effective for the general population. This last point implies that an antidepressant treatment trial may be longer than the typical eight-week trial for the general population because it may take longer to reach the effective antidepressant dose.

From a quality of care perspective, the HIV depression quality indicators described in this paper are examples of case-based indicators, meaning that they can be used to describe the quality of HIV depression care or as part of a comprehensive library of quality indicators for a wide variety of conditions. To use these indicators in either case, a patient sample is selected at random and then the appropriate quality indicators are applied to each patient's care according to the individual patient's characteristics (e.g., by medical condition). The results of the individual patient assessments are then aggregated to provide an overall assessment of quality of care. Case-based indicators can

Complete List of HIV Depression Quality Indicators Found to be Valid and Feasible in Main and Sensitivity Analyses (Pyne et al., 2008)*

Chapter 1. General Indicators for Depression Treatment in Patients with HIV

Screening: If HIV patients have a previous history of depression, then they should be screened for depression at least 2 times per year.

Screening: If HIV patients have lost a significant other, then they should be screened for depression at the visit the clinician notes the recent loss.

Screening: If HIV patients present with substance abuse, then they should be screened for depression at least 2 times per year.

Screening: Clinicians should screen HIV patients for depression within 3 months of the first HIV diagnosis and/or the first HIV clinic visit.

Diagnosis: HIV patients with MDD [major depressive disorder] symptoms should receive a thorough diagnostic evaluation, including a history of the present illness and current symptoms.

Diagnosis: HIV patients with MDD symptoms should receive a thorough diagnostic evaluation, including a psychiatric history (including symptoms of mania and treatment history).

Diagnosis: HIV patients with MDD symptoms should receive a thorough diagnostic evaluation, including a general medical history.

Diagnosis: HIV patients with MDD symptoms should receive a thorough diagnostic evaluation, including a personal history (e.g., psychological development, response to life transitions).

Diagnosis: HIV patients with MDD symptoms should receive a thorough diagnostic evaluation, including a social, occupational, and family history.

Diagnosis: HIV patients with MDD symptoms should receive a thorough diagnostic

evaluation, including a review of systems. **Diagnosis:** HIV patients with MDD symptoms should receive a thorough diagnostic evaluation, including a mental status examination.

Diagnosis: HIV patients with MDD symptoms should receive a thorough diagnostic evaluation, including a physical examination.

Diagnosis: HIV patients with MDD symptoms should receive a thorough diagnostic evaluation, including diagnostic tests as indicated.

Diagnosis: If an HIV patient is diagnosed with depression, the presence or absence of alcohol or other drug abuse should be elicited and documented in the chart.

Treatment: In an HIV patient with depression, the presence or absence of suicidal ideation should be documented during the first visit at which diagnosis is made.

Treatment: Depressed HIV patients with suicidal ideation should be asked if they have specific plans to carry out suicide.

Treatment: Depressed HIV patients who have suicidal ideation and psychosis should be evaluated the same day by a mental health provider for possible hospitalization.

Treatment: Depressed HIV patients who have suicidal ideation and current alcohol or drug dependency should be evaluated the same day by a mental health provider for possible hospitalization.

Treatment: Depressed HIV patients who have suicidal ideation and specific plans to carry out suicide (e.g., obtaining a weapon, putting affairs in order, making a suicide note) should be evaluated the same day by a mental health provider for possible hospitalization.

Treatment: Depressed HIV patients who are diagnosed with substance dependence should be referred to specialty mental

* This list of HIV depression quality indicators was provided by the first author of the study, Jeffrey M. Pyne, M.D. For more information on this study, including the tables and list referenced among the quality indicators, please contact Dr. Pyne at jmpyne@uams.edu.

be used to assess the quality of care at multiple levels (health plan, delivery system, medical group, clinic or individual provider) and can be used by patients and advocacy groups to advocate for care and by administrators as the basis of pay for performance arrangements. (pp. 1080-1081)

Pyne and colleagues conclude that "the quality indicators identified in this study provide a useful tool for measuring and informing the quality of HIV-

depression care" (p. 1075).

Although the paper details selected quality indicators, the [Complete List of HIV Depression Quality Indicators Found to be Valid and Feasible in Main and Sensitivity Analyses](#) (J.M. Pyne, personal communication, September 27, 2010) is presented [here](#).

References

Backus, L.I., Boothroyd, D.B., Phillips, B.R., Belperio, P.S., Halloran, J.P., Valdiserri, R.O., & Mole, L.A. (2010). National Qual-

health care.

Treatment: Depressed HIV patients who are diagnosed with bipolar disorder (types I, II, and NOS) should be referred to specialty mental health care.

Treatment: Depressed HIV patients who are diagnosed with PTSD [posttraumatic stress disorder] should be referred to specialty mental health care.

Treatment: Depressed HIV patients who are diagnosed with schizophrenia should be referred to specialty mental health care.

Treatment: Once diagnosis of major depression has been made in a patient with HIV, treatment with antidepressant medication and/or psychotherapy should be offered to the patient within 4 weeks.

Treatment: If patient is < 65 [years of age], then antidepressants prescribed for HIV patients with depression should be prescribed at effective dosages (see table).*

Treatment: If a patient is physically compromised by a comorbid condition (e.g., hepatitis) or severe HIV symptoms, then he or she should be started at a lower antidepressant dose (see table).*

Treatment: If a patient is > 65 [years of age], then his or her antidepressant regimen should be adjusted appropriately (see table).*

Treatment: Benzodiazepines should not be prescribed as a sole agent for the treatment of depression in patients with HIV.

Follow-up: Persons with HIV who are hospitalized for depression should have follow-up with a mental health specialist or their primary care doctor within 4 weeks of discharge.

Follow-up: HIV patients with MDD who have medical record documentation of improvement of symptoms within 8 weeks of starting medication treatment should be continued on medication treatment for at least 6 additional months.

Follow-up: At least one of the following should occur if there is no or inadequate response (e.g., < 50% depression symptom improvement) after 8 weeks of depression treatment in a patient with HIV:

- a. Referral to psychiatrist, if not already seeing one
- b. Change or increase in dose of medica-

tion, if on medication

c. Addition of medication, if only using psychotherapy

d. Addition of psychotherapy, if only using medication or change in diagnosis documented in chart

Chapter 2. HIV and Bereavement

Diagnosis: If a patient is experiencing MDD symptoms secondary to the loss of a loved one, and he or she has experienced these symptoms for more than 2 months since the time of the loss, then he or she should be diagnosed with MDD.

Diagnosis: If an HIV patient is bereaved and presents with severe depression symptoms (e.g., current thoughts of suicide or significant functional impairment), then he or she should be diagnosed with MDD.

Treatment: If an HIV patient is bereaved and presents with severe depression symptoms, then he or she should be offered active treatment for depression (antidepressants and/or counseling).

Chapter 3. HIV and Substance Abuse

Treatment: If an HIV patient is diagnosed with substance dependence or abuse, then the provider should recommend referral to a substance abuse treatment program within 4 weeks.

Treatment: If an HIV patient is diagnosed with substance abuse, then the chart should document that he or she has been counseled at most visits to abstain or decrease substance use.

Treatment: If an HIV patient is diagnosed with substance abuse and the patient was not willing to abstain from substance use, then the chart should document that he or she has been counseled at most visits to reduce substance use.

Chapter 4. HIV and Viral Hepatitis

Screening: If an HIV patient is also positive for hepatitis C virus, then he or she should be screened for depression prior to starting interferon [IFN] therapy.

Screening: If an HIV patient is started on IFN therapy, then he or she should be screened for depression at each clinic visit.

Diagnosis: If a depressed patient is being

treated with IFN, then the clinician should order a baseline TSH [thyroid-stimulating hormone] level and repeat in 8 weeks if no/minimal response to depression treatment.

Diagnosis: If a depressed patient is being treated with IFN and ribavirin, then the clinician should test for anemia.

Treatment: If a patient presents with IFN-induced depression, the clinician should consider treating with antidepressants before lowering the IFN dose or discontinuing IFN treatment.

Chapter 5. HIV and Cognitive Impairment

Screening: If an HIV patient has newly diagnosed cognitive impairment or worsening cognitive impairment, then he or she should be screened for depression at that time.

Treatment: If an HIV patient has cognitive impairment, then he or she should be treated with HAART [highly active antiretroviral therapy].

Treatment: If a patient is cognitively impaired, then antidepressants should be started at 50% of the usual starting dose and increased slowly. The maximum dose may be the same as for the non-cognitively impaired population.

Chapter 6. HIV and Mental Health Drug Interactions

Drug-specific indicator: If ritonavir (*Norvir*) or lopinavir + ritonavir (*Kaletra*) is prescribed with sertraline, then the sertraline should be started at 50% of the usual starting dose and side effects to antidepressants should be documented in the chart (see list)* at every visit.

Drug-specific indicator: If ritonavir (*Norvir*) or lopinavir + ritonavir (*Kaletra*) is prescribed, then bupropion should not be prescribed.

Drug-specific indicator: If indinavir (*Crixivan*) is prescribed, then venlafaxine should not be prescribed.

Universal NNRTI indicator: St. Johns Wort should not be used with NNRTIs [non-nucleoside reverse transcriptase inhibitors].

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how [ART adherence] interventions were implemented in practice and on how that implementation varied across populations and settings,” write Leeman et al. (2010), who systematically reviewed 61 reports of “studies conducted in the United States . . . in the period 2001 to December 2008. Fifty-two reports were included in the final analysis: 37 reporting the effects of interventions and 15 reporting intervention feasibility, acceptability, or fidelity” (p. 1915). According to the investigators,

the final explanatory model suggests that individuals with HIV will be more likely to enrol in interventions that protect their confidentiality, to attend when scheduling is responsive to their needs, and both to attend and continue with an intervention when they develop a strong, one-to-one relationship with the intervener. Participants who have limited prior experience with [ART] will be more likely to continue with an intervention than those who are more experienced. Dropout rates are likely to be higher when interventions are integrated into existing delivery systems than when offered as stand-alone interventions. (p. 1915)

Leeman and colleagues elaborate on this explanatory model, which

is intended to identify factors that may help to explain strong and weak links in the process of implementing ART adherence interventions. For example, DOT [directly observed therapy] interventions are weak at the point of enrolment. However, when they are scheduled to be responsive to participants’ needs and are delivered by an individual committed to adherence, they have high rates of attendance and good rates of retention. Therefore,

people implementing a DOT intervention should be aware that, although it has strengths, they may need to offer an alternative as a large proportion of their patients may decline to participate.

The final model also points to areas in need of further research. [Leeman and colleagues] found that integrating an intervention into an existing delivery system may be associated with higher dropout rates. Stand-alone interventions typically have dedicated staff and resources. Dropout rates may be higher when interventions are integrated into existing systems because staff must balance time and resources across multiple other priorities. This presents a challenge to the broadly recognized need to embed interventions within existing systems to ensure their adoption and maintenance over time. . . . Further research might be conducted to explore the relative strengths of stand-alone versus integrated interventions, taking into account the potential differential effects on organizational versus patient maintenance of the intervention over time. Further research could also be conducted to explore ways to improve retention of patients in intervention programs when they are integrated into existing delivery systems. (pp. 1925-1926)

“The explanatory model developed in this study is intended to provide guidance to clinicians and researchers on the points in the implementation chain that require strengthening” (p. 1915), although Leeman and colleagues remind readers that “as the data reported were collected as part of . . . research stud[ies] . . . , the findings may not be generalizable to implementing an intervention in a practice setting. For example, [the investigators] do not know whether participants declined to enrol be-

cause they did not want to be part of a research study rather than because they objected to the particular intervention” (p. 1926).

Delving further into the undergirding of adherence, Kalichman and Grebler (2010) “examine[d] the association of **social, health, and poverty-related stressors** in relation to [ART] adherence in a [convenience] sample of [188] people with low-literacy living with HIV/AIDS in the southeastern United States” (p. 810). The investigators found that “two-thirds of the sample demonstrated adherence < 85% of pills taken. Multivariable analyses showed that food insufficiency and hunger predicted [ART] nonadherence over and above [self-reported] depression, internalized stigma, substance use, and HIV-related social stressors” (p. 810). Kalichman and Grebler suggest that these findings

raise questions about whether cognitive and behavioral approaches to medication adherence will demonstrate long-term benefits in the most disadvantaged populations of people living with HIV/AIDS. Although reducing depression, stigma, and social and health-related stress improves ART adherence in well-resourced populations . . . , the overwhelming effects of poverty, particularly food insufficiency and hunger, may overshadow the benefits of psychosocial interventions, such as stress management. . . . [S]ustained access to food should be considered an adherence intervention in all disadvantaged populations of people living with HIV/AIDS. (p. 814)

Serostatus Disclosure

Kennedy et al. (2010) interviewed a diverse sample of “33 HIV-infected parents . . . , 27 of their minor children, 19 adult children, and 15 caregivers about the process of . . . **parents’ disclos[ing] . . . their HIV**

status to their children” (p. 1095). Of note is the fact that

both parents and children reported unplanned disclosure experiences with positive and negative outcomes. Parents sometimes reported that disclosure was not as negative as they feared. However, within-household analysis showed disagreement between parents and children from the same household regarding disclosure outcomes. These findings suggest that disclosure should be addressed within a family context to facilitate communication and children’s coping. Parents should consider negative and positive outcomes, unplanned disclosure[,] and children’s capacity to adapt after disclosure when deciding whether to disclose. (p. 1095)

On this last point,

the wide range of ages of children in this study allowed [for the] . . . explor[ation of] . . . potential connections between age of child during disclosure and disclosure outcome. . . . [F]indings suggest that parents may be more aware of the negative aspects of disclosure than the negative aspects of nondisclosure, and they may over-estimate the effects of disclosure on younger children. For example, the descriptions of reactions of young children who did not understand HIV/AIDS at the time of disclosure were relatively innocuous. Also, older children who knew that HIV was a cause of death but not much else were strongly affected because they thought they were being told that their parents were about to die. The impact of disclosure often lasted a long time, despite explanations about the disease and treatment. Children who were told before they had much of an un-

derstanding of HIV remember knowing that their parents were sick, but not much else. These findings support the American Academy of Pediatrics’ recommendation for disclosure to younger children as long as the information is individualized based on their cognitive ability and developmental stage. . . . The findings of this study also suggest that parents make clear to older children that HIV does not equate with immediate death. (p. 1103)

Coping, Social Support, & Quality of Life

Persons, Kershaw, Sikkema, and Hansen (2010) examined “the **impact of shame** regarding both sexual abuse and HIV infection on HRQoL [**health-related quality of life**] among [129] seropositive [women and 118 seropositive men who have sex with men] with a history of CSA” (p. 572). Analyses were conducted “while controlling for traumatic stress symptoms, as well as other factors traditionally linked to HRQoL (e.g., demographic variables, HIV-related stress, HIV symptoms, social support, and perceived stress)” (p. 572). The investigators found that

in bivariate analyses [i.e., analyses that examine the relationship between two variables], shame regarding sexual abuse and HIV infection were each negatively associated with [HRQoL] and its components (physical well-being, function and global well-being, emotional and social well-being, and cognitive functioning). After controlling for demographic, clinical, and psychosocial factors, HIV-related, but not sexual abuse-related, shame remained a significant predictor of reduced [HRQoL], explaining up to 10% of the variance in multivariable [i.e., more than two variable] models for overall [HRQoL], [as

well as] emotional [well-being], function and global [well-being], . . . social well-being and cognitive functioning over and above that of other variables entered into the model. Additionally, HIV symptoms, perceived stress, and perceived availability of social support were associated with [HRQoL] in multivariable models. (p. 571)

On the basis of these findings, Persons and colleagues conclude that

within an HIV-positive population with a history of CSA, HIV-related shame was strongly associated with poorer overall HRQoL above and beyond other variables. Additionally, HIV symptoms and perceived stress were associated with poorer HRQoL, while perceived availability of social support was associated with better overall HRQoL. It is important to note that each of these predictors of HRQoL is modifiable with appropriate intervention. For example, with proper adherence to HIV medication and medical care, HIV symptoms can be successfully managed. . . . Additionally, myriad coping and stress management interventions have been developed for people living with HIV, and . . . these may be particularly salient for people experiencing HIV-related shame. Also, the number of empirically-supported behavioral interventions for people who have experienced childhood abuse is growing, including interventions that address shame and guilt, traumatic stress and sexual risk among HIV-positive adults, and HIV treatment adherence. . . .

Overall, the present study’s findings underscore the importance of HIV-related shame in HRQoL. . . . Identifying and addressing patient shame may be critical in eliciting full disclosure of symp-

toms, . . . and social service organizations and clinics serving seropositive individuals should be aware of and address HIV-related shame in the services they provide. The present study's findings also confirm and expand upon previous research linking stress to HRQoL in seropositive populations. The results provide evidence to suggest that stress-management interventions, which recognize the importance of managing HIV-specific stressors as well as more generalized stress, may be instrumental in improving HRQoL for seropositive individuals. Last, these results suggest that group interventions, and interventions aiming to improve social support among HIV-positive individuals, may be important, as social support was associated with multiple components of HRQoL. (p. 578)

Dutch investigators (Kraaij et al., 2010) explored "whether low-resource, cost-effective intervention programs can be effective in **improving depressed mood** in people with HIV. The efficacy of a **cognitive-behavioral self-help program (CBS)** and a **computerized structured writing intervention (SWI)** were tested in a pilot randomized controlled trial" (p. 200). Among the 73 study participants, "the mean age . . . was 49 years. The majority was male, single and had no children. Most respondents reported to be homosexual and on average people knew about their HIV-positive status for 10 years" (p. 201). "Participants were randomly allocated to CBS ($n = 24$), SWI ($n = 25$) or a waiting list condition (WLC, $n = 24$)" (p. 200). The CBS

self-help program consisted of a workbook, a work program and a CD-ROM. Participants were asked to work on the intervention 4 days a week (1 h[our]/day) for a period of 4 weeks. In the first

week participants were asked to do mindfulness-based relaxation exercises, and to continue these exercises in the following 3 weeks. In the second and third week participants learned to identify and change irrational cognitions and to practice counterconditioning. In the fourth week, they were guided to formulate a realistic, concrete goal and to improve their self-efficacy to reach this goal. (p. 202)

In the SWI, "study participants completed four weekly 30-min[ute] writing assignments over a period of 4 weeks. In each writing assignment, participants were instructed to describe their deepest thoughts and feelings regarding their HIV-positive status or any other emotionally significant topic. Participants were instructed to pay special attention to issues that they had not previously disclosed to others. All writing assignments were completed through a website that was especially designed for the present study" (p. 202).

Kraaij and colleagues found that

respondents who followed the CBS improved significantly compared to the WLC immediately post intervention. However, for people in the SWI condition no significant improvement on depression was found. . . . [This] pilot study demonstrated that HIV-positive individuals who received a self-help program at their home address and worked on relaxation, cognitive change and life goals for 4 weeks, reported significantly fewer depressive symptoms after completion of the program, compared to people on a waiting list.

In the present study the SWI seemed to have no effect on depressed mood compared to the WLC. This is not in line with an earlier study in which promising

results for the effects of structured writing were found for people with HIV. . . . Future studies should examine individual differences and the influence of increasing the frequency of sessions. . . . Future studies should [also] focus on which HIV-infected persons benefit from which type of treatment. (p. 203)

The investigators further note that "in the final sample the majority of the respondents (80%) had an undetectable viral load, while in the dropout/excluded group fewer people (45%) reported . . . an undetectable viral load. Future studies should examine how people with unfavorable health conditions can participate and benefit from minimal interventions" (p. 203).

Kraaij and colleagues stress that "given the growing prevalence of HIV, effective mental health interventions are urgently needed. The present study suggests that a low-resource, cost-effective self-help program can be effective in treating depressed mood in people living with HIV. Because self-help programs can be delivered through regular mail or through the Internet, a high number of people could be reached while overcoming geographical and social barriers to treatment" (pp. 203-204).

Extending this focus on self-help, Weibel (2010) set out "to test the impact of participation in a **peer-based intervention for symptom management for women living with HIV infection** on selected outcome measures[,] including . . . symptom intensity, medication adherence, viral control, and quality of life" (p. 1029). The convenience sample of 89 women living with HIV was "recruited from San Francisco Bay Area HIV outpatient clinics, HIV/AIDS specific housing, and HIV/AIDS-related community-based support/peer groups" (p. 1030). "Those participants randomized to the ex-

perimental condition attended seven, peer-led sessions over seven weeks. Participants randomized to the control condition received a copy of *HIV Symptom Management Strategies: A Manual for People Living with HIV/AIDS* [Wantland et al., 2008]. Participants completed four surveys assessing change over time in the aforementioned outcome variables” (p. 1029).

The experimental intervention used “the curriculum, Positive Self-Management Program (PSMP) as the content of the sessions. . . . The PSMP program contains seven, two-hour, scripted sessions that were delivered by two trained peer leaders to a group of approximately 10 participants each week for seven weeks. . . . This intervention was pilot tested in HIV positive men in 1998 and the investigators found a significant relationship between the intervention and decreased HIV viral load, decreased symptom intensity, and increased medication adherence” (p. 1030).⁵

In contrast, Webel found “no significant difference between groups across time in total symptom intensity score and medication adherence” (p. 1029) and, though the analysis discerned “a significant difference between groups across time for two of the nine subscales of [an HIV-targeted quality of life measure], . . . the differences between the two groups were only at baseline. Consequently, the significant results cannot be attributed to the intervention” (p. 1032). Webel concluded that “a peer-based symptom management intervention may not decrease total symptom intensity or improve medication adherence and quality of life in women living with HIV/AIDS, when compared to a control group

who received a symptom management guidebook” (p. 1035).

In explaining these findings, Webel points out that investigators in the original study on the PSMP

were working with a sample that was more recently diagnosed with HIV and compared the intervention group to usual care. The present sample had been living with HIV for many years and reported few symptoms at the beginning of this study. . . . Consequently, this may have led to a natural floor effect among those participating in the intervention because they were unable to report lower symptom intensity given the boundaries of the scale. Additionally, a more recent trial testing the effect of the symptom management manual, used as the control condition in the present study, yielded a [medium] effect size [or treatment impact]. . . . This . . . effect size for the control condition may explain the [very small] effect size in symptom intensity between the intervention and control groups over time. . . . [Moreover, t]he original study was tested in an all-male, relatively well-educated, mainly white sample. Additionally, the original study was completed in 1996. Consequently, the intervention was tested in a very different sample in a time when HIV/AIDS self and symptom management were very different. . . . While the intervention has been updated in the past decade, it was updated based on new medical interventions and not to specifically reflect the needs of women living with HIV/AIDS. For example, qualitative findings suggested that the intervention content could be modified to include topics on gynecological symptoms and menopause, childbearing/rearing, stigma, and sexual negotiation. (p. 1035)

Webel continues, pointing to the qualifications of the peer leaders as a potential source of the diminished impact of the intervention with a sample of women living with HIV:

In this study, the peer leaders were representative of the overall sample. They had a high-school diploma or General Educational Development Test (GED), identified as African-American or Latina, were single and had a history of substance abuse. While it is desirable to have peer leaders identify with the participants on these variables, the low education level was an impediment to delivering the scripted intervention as intended. For example, the peers had a hard time reading parts of the script and would often get flustered during the intervention sessions. Several of the qualitative comments supported this [aspect of the study design as a] barrier.

Finally, one potential reason for the small effect size is that the dose was not sufficient for this population. While the intervention was ongoing, there was a small, although not significant trend toward a decrease in symptom intensity . . . in the intervention group. However, this trend disappeared when the intervention sessions concluded. These findings are . . . consistent with a recent review suggesting that effective medication adherence interventions tend to last longer than 12 weeks. (p. 1036)

According to Webel,

despite the non-significant findings and limitations in this study, previous research does suggest that peer-based interventions may work to help increase symptom management and self-care. . . . Future work on similar interventions in comparable popula-

⁵ For more information on the PSMP, see the **Tool Box** in the [Fall 2007](#) issue of *mental health AIDS* entitled “Enlisting Service Consumers as Active Participants in HIV-Related Assessment & Care.”

tions should consider whether the content of the intervention addresses the more general needs of people living with multiple chronic diseases and in poverty. Future work should also consider using a combination of peers and professionals to help efficiently deliver the content when other barriers exist (i.e., limited literacy). It is also advisable to consider a larger intervention dose and longer follow-up period in order to test the long-term efficacy of future interventions. (pp. 1036-1037)

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Tool Box

A Note on Content

This publication is designed to help frontline providers of HIV-related mental health services, allied professionals, and consumers stay up to date on research related to HIV care in developed-world settings. The content for the "Biopsychosocial Update" is drawn from a variety of sources including, but not limited to the *CDC HIV/Hepatitis/STD/TB Prevention News Update* (<http://www.cdcnpin.org/news/NewsList.asp>); *Kaiser Health News* (<http://www.kaiserhealthnews.org>); and information provided by Florida International University researcher Robert M. Malow, Ph.D., ABPP. Other sources are identified when appropriate.

M.O. (2010). Male same sex couple dynamics and received social support for HIV medication adherence. *Journal of Social & Per-*

It is presumed that readers have at least a fundamental understanding of medical, psychiatric, psychological, psychosocial, and spiritual considerations when assessing and intervening with people who are living with HIV/AIDS and their families. For additional background information on these aspects of care, the following resources may be of assistance:

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Fernandez, F., & Ruiz, P. (Eds.). (2006). *Psychiatric aspects of HIV/AIDS*. Philadelphia, PA: Lippincott Williams & Wilkins.

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