



FIVE BOROUGH AIDS MENTAL HEALTH ALLIANCE

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Mental Health and Substance Use Disorders in People Living with HIV/AIDS: *Common Co-morbidities and Implications for Treatment*

Submitted by: Theresa Keane, Ph.D.

Although there are few large-scale studies of mental health problems in people living with HIV/AIDS, the results of those studies point to the need for continued vigilance with regard to assessing

mental health and substance use disorders among people living with HIV/AIDS (PWHAs). This article will

explore the mental health problems that appear to be most prevalent among persons living with HIV/AIDS and will provide information on symptom pictures and treatments available. Before turning to people living with HIV/AIDS specifically, it is important to highlight the prevalence of mental health problems in the U.S. population at large. The U.S. Surgeon General's report released in the year 1999 stated that at any given time, twenty two percent (22%) of Americans have a diagnosable mental health disorder (U.S. Department of Health and Human Services, 1999). The report also

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A Letter from the Editor:
Tim Hunt,
CSW, CASAC

Greetings! The summer 2004 edition of the Five Borough AIDS Mental Health Alliance (FAMHA) newsletter focuses broadly on the prevalence of mental health problems in people living with HIV/AIDS. The articles that we include consider the high proportion of mental health problems in people living with HIV/AIDS. More specifically, the articles detail the importance of providers maintaining a high degree of vigilance for the presence of mental health problems when caring for clients living with HIV/AIDS in a wide variety of settings. Recent literature supports the contention that untreated mental health problems and their associated symptoms cause a great deal of distress and subsequently have a deleterious effect on a person's day to day quality of life. The articles included here discuss some of the many variables that may make people living with

HIV/AIDS vulnerable to mental health problems. The costs involved in untreated mental health problems are high. One important negative impact of

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Theresa Keane, Ph.D.

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From the Desk of Lloyd I. Sederer, M.D., Executive Deputy Commissioner, Division of Mental Hygiene at the New York City Department of Health and Mental Hygiene

*(We bring you this article as a
follow up to our Winter Issue
interview with Philip Glotzer,
Executive Director, ACQC.)*

**AIDS Center of Queens County
(ACQC): A Closer Look**
Services to the community and
program services for injection drug
users with co-occurring disorders.

Submitted by: Anthony Perri,
Director of Development, ACQC

ACQC was established in 1986 and is the principal provider of HIV/AIDS outreach, prevention and care services in the borough of Queens. ACQC engages over 10,000 individuals a year through street and community outreach, and provides individual and group risk reduction counseling and education to hundreds of individuals at high risk for acquiring HIV infection in Queens. ACQC's education department also offers the Community HIV/AIDS Training (CHAT) program, training dozens of peer educators yearly from affected communities.

ACQC provides comprehensive and intensive case management services to over 700

household/families currently living with and affected by HIV disease in the borough, and serves over 3,000 individuals yearly. ACQC provides a range of housing services to people living with HIV in Queens, from scattered site apartment to housing placement assistance. Legal services for HIV+ individuals and affected families are also offered; in 2003 over 450 individuals were provided a range of service from brief advice to entitlement and housing advocacy and court representation. Finally, ACQC in partnership with New York Hospital-Queens provides access to HIV primary medical care services in Rego Park, Jamaica and Far Rockaway. This last programmatic effort serves over 500 individuals annually (since 2000).

Along with HIV services, ACQC offers vital programs of benefit to the entire community. The agency operates a New York State licensed mental health outpatient clinic, providing therapy and psychiatric assessment to 650 individuals at three sites in 2003. At four sites in Queens, ACQC offers emergency food pantry assistance, serving over 1400 households on a monthly basis.

A strong focus of service has been the development and delivery of interventions for injection drug users, other substance users and their risk partners, along with programming for individuals affected by multiple challenges (HIV/AIDS/mental health/chemical dependency). These services include:



- Prevention case management (PCM) for injection drug users, which focuses on individual and group behavioral counseling to decrease risk behaviors, 111 individuals utilized this service in 2003;
- Clinical harm reduction/recovery readiness services for HIV+ substance users involving clinical therapy and behavioral counseling, auricular acupuncture, recreation and educational activities; 100 individuals utilized this service in 2003;
- Scattered site housing targeting HIV+ persons affected by mental illness and chronic chemical dependency - Second Chances - this project serves up to 75 individuals per year
- With pending approval from New York State, ACQC will conduct sterile syringe exchange services in Long Island City, with future sites in Jamaica, Far Rockaway and Elmhurst/Corona to be applied for. Currently ACQC is an approved Expanded Syringe Access Project provider, allowing for disposal and acquisition of syringes at sites in Rego Park, Jamaica and Far Rockaway.

For more information about ACQC's services contact either Phillip Glotzer, Executive Director or Anthony Perri, Director of Development at 718 896-2500. 97-45 Queens Boulevard, Rego Park, NY 11374.

MENTAL RETARDATION AND MENTAL ILLNESS: A DUAL DIAGNOSIS OFTEN OVERLOOKED

Submitted by: Bobra Fyne, MSA, CSW

Mental illness does not discriminate! The combination of psychiatric and developmental disabilities cut across all socio-economic and cultural/ethnic groups and, unfortunately, the stigma of these disabilities often prevent people from accessing the same resources and supports as the general population.

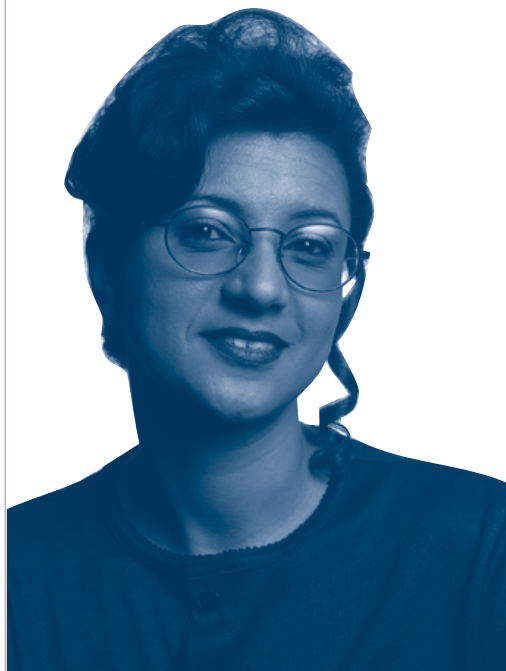
A wide gap exists between the fields of mental retardation and mental illness. Professionals have traditionally held that the two conditions are conceptually different, with mental retardation characterized by emotional

impairment (Ollendick & Ollendick, 1982). Professionals have, commonly and mistakenly, believed that precisely because of their mental retardation, individuals with mental retardation are not vulnerable to emotional and psychological problems (Potter, 1922). According to this view, a person with mild mental retardation cannot develop mental illness because they do not have "worries," while people with severe mental retardation are unable to express feelings or experience emotional stress (Fletcher, 1988).

In addition, few mental health professionals have specialized training in the diagnosis and treatment of mental retardation, and even fewer are versed in the diagnosis and treatment of mental illness in mentally retarded individuals (Campbell & Malone, 1991). Furthermore, in most jurisdictions in the United States including New York State, mental health services and mental retardation services function independently of each other and have separate funding mechanisms (Campbell & Malone, 1991; Matson & Sevin, 1994).

Research has consistently shown that individuals with mental retardation do indeed experience emotional and psychological problems and, in fact, the prevalence rate for psychopathology among people with MR/DD is higher than in non-mentally

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NEWS YOU CAN USE

SYMPTOMS OF POST TRAUMATIC STRESS IN PERSONS WITH HIV AND MEDICATION ADHERENCE DIFFICULTIES

A study examined the frequency and correlates of self-reported symptoms of posttraumatic stress among patients with HIV who had medication adherence problems. Self-report data revealed that more than half of participants met diagnostic criteria for posttraumatic stress disorder (PTSD) according to the Posttraumatic Diagnostic Scale (PDS). Death anxiety was associated with overall PTSD symptom severity scores as well as severity scores for re-experiencing, avoidance, and arousal symptoms. The association between death anxiety and total PTSD severity, reexperiencing and avoidance symptom scores remained after controlling for depression and satisfaction with social support. The authors recommended that anxiety, as manifested by PTSD symptoms, should be routinely assessed among patients with HIV, and variables such as death anxiety, social support, and depression are appropriate targets for mental health interventions.

Safren, S.A., Gershuny, B.S., & Hendriksen E. (2003). *AIDS Patient Care STDS*. 17(12), 657-64.

MENTAL RETARDATION AND MENTAL ILLNESS: A DUAL DIAGNOSIS OFTEN OVERLOOKED

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retarded individuals (Borthwick-Duffy, 1994; Campbell & Malone, 1991). This dually diagnosed population is among the most underserved of all those in need of psychiatric services in the United States (Campbell & Malone, 1991). This is in spite of the suffering that is endured by people with MR/DD due to serious psychiatric conditions such as schizophrenia, depression, anxiety, and behavioral disorders. These disorders co-occur with, and interact with, the individual's diagnosis of mental retardation.

Organic models (i.e., structural brain abnormalities, biochemical and genetic factors) account for the majority of cases of severe and profound mental retardation (Crome & Stern, 1972). Brain damage in these individuals has been shown to affect behavior, language, personality, and affect. The functional impairment is dependent upon the site of the damage and the developmental stage during which the damage occurred (Reid, 1985). Brain damage due to various conditions has been associated with childhood psychosis (Donaldson & Menolascino, 1977), eating disorders (Bregman, 1991), autism (Lund, 1988), depression (Zubenko & Mossy, 1988), and self-injurious behaviors (Nyhan, 1976).

Behavioral models of the etiology of dual diagnosis include classical conditioning, social learning and operant conditioning models (Matson & Sevin, 1994). Classical conditioning and social learning models of the development of anxiety disorders seem to apply equally to people with mental retardation and to the general population (Ollendick & Ollendick, 1982). Bijou (1966) outlined four operant conditioning principles that appear to be relevant to the

etiology of mental illness in dually diagnosed individuals. These include inadequate reinforcement of pro-social behaviors, inappropriate punishment, reinforcement of deviant response sets, and altered stimulus-response sets due to abnormal anatomical structure and physiological functioning. These principles seem to be associated with the development of depression (Lewinsohn, 1974), anxiety (Hagerman & Sobesky, 1989), negative self-statements, hallucinations, anorexia, pica and aberrant sexual behaviors (Matson & Sevin, 1994).

Contrary to popular belief, the diagnosis of mental retardation in an individual does not protect them from developing mental illnesses.

Developmental models suggest that individuals with mental retardation go through the same developmental stages as individuals who are not mentally retarded, but at a slower pace. Hence, the rate with which they display behaviors such as fears and phobias is higher when compared with same-aged peers, but normal when compared with people at similar developmental stages (Matson & Barret, 1982).

Sociocultural theorists submit that individuals with mental retardation are exposed to an excessive number of negative social experiences. These include segregation due to restrictive placement or over-protection by caretakers, rejection by peers, ridicule, infantilization, labeling, poverty and dependency due to restricted access to

employment, as well as other sources of social disruption (Reiss & Benson, 1984). Prolonged exposure to negative social conditions paired with a decreased capacity to cope with stress may very well adversely affect an individual's mental health (Matson & Sevin, 1994).

In summary, individuals with mental retardation are highly vulnerable to psychiatric illness, due, in part, to many of the same conditions contributing to their mental retardation. Contrary to popular belief, the diagnosis of mental retardation in an individual does not protect them from developing mental illnesses. Thus, these individuals must contend not only with the demands and stressors of mental retardation but also with the added dimension of mental illness, which often go unrecognized and untreated.

Bobra Fyne, CSW is the Senior Supervisor of AIDS Training at YAI/National Institute for People with Disabilities. She is also in private practice specializing in the social-sexual relationships of people with mental retardation and other developmental disabilities. For more information about YAI and/or our HIV/AIDS trainings, call 212-273-6202.

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NEWS YOU CAN USE

THE IMPACT OF PSYCHIATRIC SYMPTOMS, DRUG USE, AND MEDICATION REGIMEN ON NON-ADHERENCE TO HIV TREATMENT

A study sought to identify which mental disorders, substance use, and regimen factors influence non-adherence. These variables were viewed by the authors as critical steps in the development of patient-customized interventions. In a cross-sectional study, 120 adults living with HIV and taking antiviral therapy completed interviews and questionnaires on their medication regimen, adherence behaviors, mental distress, and substance use patterns. Access to medical records for measures of immune health was also provided to the research team. Demographic characteristics, regimen factors, mental health indicators, and substance use variables were evaluated as predictors of four dichotomous non-adherent behaviors: running out of medications, not always taking medications as directed, taking below 95% of protease inhibitor doses, or having notations of non-compliance in the medical record. Non-adherence was prevalent and was related to immune health. Recent crack cocaine use was a risk factor for both taking a low proportion of Protease inhibitor medication and charted non-compliance notations. Heroin use and screening positive for social phobia were risk factors for running out of medication. Screening positive for any anxiety disorder was a risk factor for failing to take medications as directed. The study recommends that clinicians caring for patients with HIV should screen for non-adherence using multiple behavioral indicators, and assess and treat substance use and anxiety disorders to reduce the risk of non-adherence.

Ingersoll K. (2003). *AIDS and Behavior*, 7(1), 29-40.

Mental Health and Substance Use Disorders in People Living with HIV/AIDS: *Common Co-morbidities and Implications for Treatment*

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estimated that more than half of people who could benefit from mental health treatment do not access it. The barriers to treatment cited include the role of stigma, lack of insurance, and lack of recognition of the disorder.

As a backdrop to discussing the kinds of mental health challenges encountered by people living with HIV/AIDS, it is important to consider the kinds of stressors that the population faces. These stressors are circumstances that may increase a person's vulnerability to developing a mental health disorder. One important stressor is the finances of people living with HIV/AIDS. Many HIV-infected persons, as our reviews of studies that follow will illustrate, are living on incomes at or below poverty level. In addition, the advent of highly active anti-retrovirals has led to longer life expectancy, making HIV/AIDS a chronic medical illness that is often characterized by variability in the way a person feels on a day-to-day basis. The course of the illness can be impacted by behaviors such as one's success with adhering to complex HIV protocols. With specific reference to women, HIV-infected women are often single parents with substantive childcare and family responsibilities (Mellins & Ehrhardt, 1994). Several qualitative studies have described the substantive barriers to both medication adherence and attendance at medical appointments that such responsibilities present to HIV-infected mothers (Roberts & Mann, 2000). These are just a few of the psychosocial stressors that people with HIV/AIDS confront.

Gaining a better understanding of mental health problems in people living with HIV/AIDS has widespread implications for individuals and communities. First, one's quality of life is adversely affected by ongoing, untreated mental health problems. Another important outcome of treating mental health problems in people living with HIV/AIDS may include

optimizing adherence to medications (Bing, Kilbourne, Brooks, and Senak, 1999) and minimizing unsafe drug-taking and sexual behaviors that increase risk of transmission (Chesney, Barrett and Stall, 1998).

Bing and colleagues (2001) reported on a large study that looked at psychiatric disorders in a nationally representative sample of 2864 HIV-infected adults in the United States. The sample consisted of 2017 men and 847 women. Forty-nine percent (49.2%) were white, 32.8% were African American and 14.8% were Hispanic. Forty-six percent (46%) reported incomes of \$10,000 or less and almost 20% were uninsured. The study participants were administered a brief psychiatric screening instrument. The results of the study indicated that nearly 50% of the sample screened positive for 1 or more of 4 psychiatric disorders in the twelve month period preceding the interview. The most common diagnosis was depression. More than one-third of the population screened positive for major depressive disorder and more than one-quarter screened positive for a chronic kind of depression known as dysthymia. Almost 16% met the criteria for Generalized Anxiety disorder. Twelve percent (12%) screened positive for drug dependence during the same twelve month period. The authors reported that screening for a disorder was more likely in people who lived alone or lived with someone with whom they were not romantically linked.

In a study examining the impact of mental health and substance use problems and their relationship to medical treatment adherence in a group of HIV-infected women, Mellins and colleagues (2002) studied a group of 128 HIV-infected mothers. Fifty-eight percent (58%) of the 128 participants were African American and 35% were Latina. Seventy percent (70%) were single parents and 76% of the women reported living below the poverty line (mean annual income = \$11,256 to support an average of 3 people). On average, the women were caring for one to two



children (range was 0 to 8). Their mean education was 10th grade and 52% had not completed high school. Their ages ranged from 22-66 years (mean=38). The women had known their diagnosis for an average of five years.

The results indicated that 49.6% of the sample met screening criteria for a current psychiatric disorder. The most common diagnoses included Post Traumatic Stress Disorder (35%), Depression (29%), and other Anxiety disorders (24%). Among these women, 67% reported previously, and 35% current, mental health treatment. Thirty-two (25%) of the women met the criteria for a substance abuse disorder in the past six months and 21(17%) met criteria for a substance abuse disorder in the past 30 days. With regard to adherence, 69% of the women reported that they were on antiretroviral medication, 16 were on monotherapy, 72 on two or more medications, and 44 on Protease Inhibitors. Seventeen of these 88 women (19%) reported missing pills in the past two days and 43% of the entire sample (n=128) reported missing medical appointments in the past year.

An important finding was that the strongest predictor of non-adherence to pills was the presence of a current psychiatric diagnosis and the presence of a current substance

abuse diagnosis. These variables were more strongly associated with non-adherence than education, income, and family factors. The study suggested that mental health functioning is critical to the issue of adherence to medical treatment and speaks to the potential importance of evaluation and treatment of mental health problems in the delivery of state-of-the-art HIV medical care.

The results of both of these important studies support the notion that HIV/AIDS service providers should have a high index of suspicion for ongoing mental health and substance use treatment needs in people living with HIV/AIDS. The results also underscore the need for concurrent treatment of mental health and substance use problems, as they are often co-occurring problems. On a positive note, the disorders that appear to be most prevalent, including depression in its varied presentations and anxiety disorders, are highly treatable. Many types of psychopharmacological agents effectively target symptoms of these disorders and a wide range of psychotherapies are available as well. The provider's ability to recognize these problems with the use of screening tools or with the guidance of a mental health professional and, subsequently, engaging the client in a discussion that

highlights the benefits of treatment constitutes one of the most challenging aspects of working with this vulnerable population.

Theresa Keane, Ph.D., serves as the managing editor of the FAMHA newsletter as a consultant to Cicatelli Associates Inc. Dr. Keane's consultation service and private practice are based in Brooklyn, N.Y.

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NEWS YOU CAN USE

REDUCING HIV-RISK BEHAVIOR AMONG ADULTS RECEIVING OUTPATIENT PSYCHIATRIC TREATMENT: RESULTS FROM A RANDOM- IZED CONTROLLED TRIAL.

A study investigated the efficacy of a 10-session, HIV-risk-reduction intervention with 221 women and 187 men receiving outpatient psychiatric care for a mental illness. Patients were randomly assigned to one of three interventions: an HIV risk reduction intervention, a structurally equivalent substance use reduction (SUR) intervention, or standard care. Participants were assessed pre- and post-intervention and at 3- and 6-month follow-ups. Patients receiving the HIV-risk-reduction intervention reported less unprotected sex, fewer casual sex partners, fewer new sexually transmitted infections, improved HIV knowledge, positive attitude toward condoms, stronger condom use intentions, and improved behavioral skills relative to participants in the SUR and control conditions. Exploratory analyses suggested that female patients and patients diagnosed with a major depressive disorder were more likely to benefit from the HIV-risk-reduction intervention.

Carey, M.P., Carey, K.B., Maisto, S.A., Gordon, C.M., Schroder, K.E. & Vanable, P.A.(2004). *Journal of Consulting and Clinical Psychology*. 72(2), 252-268.

CONSUMER DIRECTED CARE

Inside Consumer-Directed Care has launched CDH-Chat, a new listserv where you can ask questions and share ideas, resources and information related to consumer-directed health care. Join your peers and other industry experts in the CD-care field as they discuss HSAs, HRAs, FSAs, plan designs, pharmacy benefits, vendors, cost-savings strategies, marketing and financing tactics, contracts and more. To sign up for the listserv, visit: www.aishealth.com/ConsumerDirected/CDListserv.html.

PWA Leadership Training Institute Initiates a Series of Forums Aimed at Increasing Awareness of the Mental Health Needs of PWHAs

Submitted by: John Hatchett, Director of the PWA Leadership Training Institute



Petra Berrios, Deputy Director, PWA LTI and John Hatchett, Director, PWA LTI

Some FAMHA readers may be aware of the existence of the New York State PWA Leadership Training Institute, a peer-led advocacy training program for PWHAs that has been based at Cicatelli Associates Inc. since 1999. The purpose of the project is to provide training to PWHAs who are interested in becoming involved in PWA leadership opportunities such as community mobilization events, Board membership at AIDS Service Organizations, etc. As Director of the PWA Leadership Training Institute, I am thrilled to have the opportunity to share information about a new initiative with our FAMHA readers.

Earlier this year, the NYSDOH AIDS Institute made funds available to create and deliver a curriculum that has as its goal increasing awareness about mental health needs in

PWA communities. The staff of PWA Leadership Institute, in conjunction with staff from CAI's behavioral health division and with close cooperation of NYSDOH AIDS Institute staff, worked together to create a comprehensive, consciousness-raising curriculum that will be rolled out in the Fall 2004. The forums have been conceptualized so that they are jargon free and accessible to a wide range of PWHAs. They will be delivered around the state and each forum will be led by a PWA peer educator who has been through a train-the-trainer curriculum and a mental health professional who has experience working with PWHAs.

The forums will cover general information such as definitions of mental health and mental illness, what stressors are common among PWHAs and what some of the barriers to seeking mental health care are. The forums will also contain more detailed

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**CASACONFERENCE: SO HELP ME
GOD: SUBSTANCE ABUSE, RELIGION
AND SPIRITUALITY**

09/22/2004

New York City

Sponsor: National Center for Addiction and Substance Abuse at Columbia University
CASA, 633 Third Ave., 19th Floor, New York City

Contact: William P. Coyle at 212-841-5277

Website: <http://www.casacolumbia.org/>.

The conference will explore the roles that spirituality and religion play in prevention of and in recovery from substance abuse.

**OVERCOMING STIGMA IN ASIAN
AMERICAN MENTAL HEALTH**

10/01/2004-10/02/2004

Sponsor: The New York Coalition for Asian American Mental Health, New York University School of Medicine and Hamilton Madison House

Location: The New York Academy of Medicine, 1216 Fifth Ave (@ 103rd Street), New York, NY

Contact: The New York Coalition for Asian American Mental Health

253 South Street, 3rd Floor

New York, NY 10002

Phone: (212) 720-4522

Email: stigma04@earthlink.net

Website: <http://www.asianmentalhealth.org>

A CME conference for primary care physicians, psychiatrists, psychologists, social workers, nurses, case managers, researchers, educators and primary care providers. The goal of this program, which will address stigma in the Chinese, Filipino, South Asian, Southeast Asian, Japanese and Korean communities, is to develop a greater understanding of what various Asian cultures and the different constituency groups within each Asian culture perceive to be the issues surrounding stigma.

UPCOMING EVENTS

**THE NORTHEAST MULTICULTURAL
CONFERENCE ON HIV/AIDS**

10/13/04-10/15/04

Sponsor: The New Haven Mayor's Task Force on AIDS

Location: Omni Hotel, 155 Temple Street, New Haven, Connecticut 06510

Contact: Phone: (203) 492-4866 ext. 24

Website: www.provisionsct.org

The conference goals are to provide cutting edge HIV/AIDS information on prevention, treatment, research, advocacy and services; as well as to empower people living with HIV/AIDS. Another goal is to share strategies for providing prevention and intervention services to HIV positive and HIV negative people affected by HIV/AIDS. The conference also provides an opportunity for networking and resources sharing and provides a road map for advocacy. The last goal is to translate community-based research into effective public policy practice.

**12TH ANNUAL CME COURSE:
CURRENT CHALLENGES IN HIV
DISEASE - A CASE-BASED, ADVANCED
COURSE ON HIV MANAGEMENT**

10/15/04

Sponsor: International AIDS Society - USA

Location: Millennium Broadway Hotel
New York, 145 W. 44th Street, NY, NY

Contact: International AIDS Society - USA,
425 California Street, Suite 1450, San Francisco, CA 94104

Phone: (415) 544-9400

Fax: (415) 544-9402

Email: cme@iasusa.org

Website: www.iasusa.org

Expert faculty will speak on timely and clinically relevant issues in HIV disease management, including: the state of the HIV epidemic and syphilis outbreak in New York City; recent released data from national and international HIV update meetings; strategies for managing drug failure, including issues in viral resistance and testing methods; strategies for managing therapeutic drug monitoring and drug-drug interactions; current challenges in antiretroviral therapy and management of HIV disease; and diagnosis and management of hepatitis C virus coinfection and immune reconstitution syndrome.

**BUPRENORPHINE AND OFFICE BASED
TREATMENT FOR OPIOID DEPENDENCE
TRAINING**

01/11/05

Sponsors: New York State Department of Health AIDS Institute, The Institute for Professional Development in the Addictions, NYC Department of Health and Mental Hygiene, NYC Health and Hospital Corps, The American Society of Addiction Medicine and the Community Health Care Association

Location: Nassau University Medical Center, East Meadow, New York

Contact: Kathleen VanSteen

Phone: (516) 572-4947 or (516) 572-6169

Email: kvanstee@numc.edu

Website: www.hivguidelines.org

This course is intended for physicians with experience and/or interest in treating opioid dependence. The program is also recommended for primary care, psychiatric, HIV and addiction medical physicians.

NEWS YOU CAN USE

SUICIDAL IDEATION AMONG PSYCHIATRIC PATIENTS WITH HIV: PSYCHIATRIC MORBIDITY AND QUALITY OF LIFE

A recent study explored suicidality among 190 (68% male) participants in an HIV mental health clinic. Twenty-six percent of participants had suicidal thoughts within 30 days of admission. The most prevalent diagnoses among those with suicidal ideation were major depression (64%), drug dependence (52%), and depressive personality disorder (50%). Data analyses revealed that individuals with major depression, dysthymia, substance abuse, thought disorder, posttraumatic stress disorder, and borderline and avoidant personality disorders were at increased risk for suicidality. In addition, six of seven quality-of-life variables were associated with suicidal ideation. These included a restricted social environment and unstable interpersonal relationships. The study concluded that at-risk individuals, especially those with "dual disorders," unstable interpersonal relations, and a restricted social environment, should be carefully screened for suicidality.

Haller, D.L. & Miles, D.R. (2003), *AIDS and Behavior*, 7(2), 101-108.

MANY WITH CO-OCCURRING SUBSTANCE ABUSE AND MENTAL ILLNESS ARE UNAWARE THEY NEED TREATMENT

People with co-occurring serious mental illness and substance abuse often do not recognize that they need treatment. A new report from SAMHSA showed

that 61 percent of those with serious mental illness and a substance use disorder who had not received treatment for either illness, perceived no unmet need for treatment. The report estimated that 17.5 million adults were estimated to have serious mental illness in 2002. Of these, 4 million (23 percent) were also dependent on or abused alcohol or an illicit drug. To access this report: www.oas.samhsa.gov

**SAMHSA, Office of Applied Studies,
National Survey on Drug Use and
Health, 2002.**

TREATMENT ADMISSIONS INCREASE FOR OPIATES, MARIJUANA, METHAMPHETAMINE IN 2002.

The proportion of admissions to substance abuse treatment for abuse of narcotic prescription medications, heroin, marijuana and methamphetamine has increased in the past ten years, while admissions to treatment for cocaine abuse declined. Admissions for stimulants, mainly methamphetamine, increased from one percent to seven percent in ten years. Alcohol is still the most abused substance accounting for 43 percent of admissions in 2002. 45 percent of primary alcohol admissions report secondary drug abuse, as well.

**SAMHSA, Office of Applied Studies,
Treatment Episode Data Set (TEDS).
Highlights 2002. National Admissions to
Substance Abuse Treatment Services, DASIS
Series: S-22, DHHS Publication No. (SMA)
04-3946, Rockville, MD, 2004.**

PWA Leadership Training Institute Initiates a Series of Forums Aimed at Increasing Awareness of the Mental Health Needs of PWHAs

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information about what kinds of mental health problems are thought to be most prevalent among PWHAs, what types of treatment modalities are available and what to expect from a mental health provider.

We have high expectations for the initiative. The first forum held in New York City in late May was fully enrolled within days of its being announced, and PWA throughout the state have expressed interest in attending forums in their areas. Participant feedback reinforced our contention that there is a lack of information about mental health available for PWHAs. Indeed, one participant commented that she'd "been positive for 14 years, and [had] never discussed these issues with a provider." In addition to the above-stated goals, we hope that the initiative will help PWHAs view mental health problems and treatment as part of comprehensive health care, and to appreciate the potential benefits of treating mental health problems such as enhancing medication adherence and facilitating other self-care behaviors.

As a companion piece to the mental health forums, CAI will be developing a general discussion guide on mental health awareness for PWHAs that may be used in a variety of structured and informal group settings such as support groups and peer led groups. We hope that you will share this information with PWHAs that you work with! Training teams will deliver forums in six regions outside NYC (Western NY, Rochester, Central, Northeast, Hudson Valley and Long Island). In addition, eight trainings will be held in NYC for a total of 14 forums. **Please phone LTI's Program Assistant Jenny O'Brian at 212/594-7741 ext. 231 for more information.**

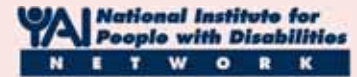
A Letter from the Editor

(continued from page 1)

untreated mental health problems among people living with HIV/AIDS is lack of adherence to HIV medical protocols including complex medication schedules. In order for mental health problems to be adequately treated, they must be recognized and thoroughly assessed. In many AIDS service organizations, the concrete service needs of people living with HIV/AIDS are often all-consuming and obscure other client needs including mental health needs. Also, it is often the case that staff in AIDS service settings assess a client's mental health needs by inquiring into a person's history of access to mental health treatment. The problem with this approach is that research shows that more than half of people who are in need of treatment do not access it. As such, a history of access to treatment is not a reliable indicator of ongoing need or current symptomatology. A more efficient approach to assessing a person's need for mental health treatment is for providers who are not qualified mental health professionals to utilize mental health screeners that consist of a symptom oriented assessment approach. Mental health screeners offer a good alternative for AIDS service organizations in that they are economical in terms of time and cost and can be implemented with a reasonable amount of staff training. Examples of such screeners include the Beck Depression Inventory and the Client Diagnostic

Questionnaire. The behavioral health staff of Cicatelli Associates Inc. are available to consult with agencies that need assistance in developing a mental health screening program.

In our current newsletter, the lead article, submitted by Theresa Keane, offers a review of the prevalence of specific mental health problems among people living with HIV/AIDS and outlines the impact of untreated mental health problems. We have also included a detailed article by Bobra Fyne, Supervisor of AIDS training at YAI, which addresses co-morbidities in people living with mental retardation/developmental disabilities. It points out that mental health problems in people with MR/DD are common and often minimized or unrecognized. As always, we have a submission by a representative of the N.Y.C. Department of Health and Mental Hygiene. In this column we follow up our winter interview with Philip Glotzer at AIDS Center of Queens County with a closer look at their services for co-occurring disorders. Finally, we describe a new initiative within the PWA Leadership Training Institute that is offering state-wide training for PWHAs with the goal of raising awareness about mental health problems within the various PWA communities. We hope our readers find the articles helpful. Please feel free to contact us with questions, comments or suggestions for future newsletters by emailing me at tim@cicatelli.org.



present

A One Day Conference THE MANY FACES OF HIV/AIDS: MULTIPLE NEEDS, MULTIPLE STRENGTHS

Admission:

NO COST to participants
(Registration required)

Date:

December 1st, 2004 - World AIDS Day

Time:

9:00am-4:30pm

Where:

Woodhull Medical Center
760 Broadway,
3rd Floor Conference Center
Brooklyn, NY 11206

Workshops may include focus on:

- Immigrants / Adolescents / Women / Elderly / MSM
- Long Term Survivors • Co-occurring disorders
- MR/DD • Criminal Justice • Spirituality

Advisory Committee to include:

Woodhull Medical Center - AIDS Center Program,
CAMBA, & the Brooklyn Multiple Needs Project

Funded by the New York City Department of
Health and Mental Hygiene through the
FIVE Borough AIDS Mental Health Alliance
(FAMHA)

SAVE THE DATE

For more information and to register
Please contact jbrown@cicatelli.org or
call (212) 594-7741 ext. 292

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THE FIVE BOROUGH AIDS MENTAL HEALTH ALLIANCE (FAMHA) is an educational project managed by Cicatelli Associates Inc. (CAI) and funded by the New York City Department of Health and Mental Hygiene. The project's mission is to provide training and technical assistance on subjects related to HIV/AIDS mental health including such topics as assessment and treatment of co-occurring mental health and substance use problems. A wide array of training and technical assistance programs is available for agencies providing services to people living with HIV/AIDS. Readers may request programs by completing the application for training form on the back cover of the newsletter and returning it to CAI. For further information, please contact behavioralhealth@cicatelli.org.



5 FAMHA Service Needs Assessment

To request a FAMHA program for your agency/organization, complete the following needs assessment and submit it by mail or fax to:

Cicatelli Associates Inc. • 505 Eighth Avenue, Suite 1601 • New York, NY 10018
phone: (212) 594-7741 • fax: (212) 629-3321 • e-mail: tim@cicatelli.org

Name _____

Agency/Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ E-mail _____

Desired Training Day(s)/Time(s) _____ Anticipated Audience Size _____

Attending Disciplines

(check all that apply)

- Clergy
- Counseling
- Marriage/Family Therapy
- Medicine
- Nursing
- Psychiatry
- Psychology
- Social Work
- Case Management
- Other (please identify):

Desired Training Format

(check all that apply)

- Grand Rounds
- Interactive Small Group
- Lecture

Desired Training Topic

(check all that apply)

- Treatment Update/Adherence Issues
- Harm Reduction Strategies
- Management for Active Substance Abusers

- Case Management for HIV-Infected Clients
- Issues Relevant to Culturally Competent Service Delivery
- Family-Focused Mental Health Services
- HIV Pre/Post-Test Counseling
- Building HIV Support Groups
- Stress Management
- Boundaries and Countertransference
- Suicide Assessment and Prevention

Technical Assistance:

Face-to-Face Skill Building/ Consultation with Agencies

(check all that apply)

- Making Referrals
- Cultural Diversity
- Behavior Change Models
- Human Resource Development
- Infrastructure Building
- Managed Care
- Implementation of Risk Reduction Groups in MICA Programming

- Special Needs Plans
- Condom Procurement for Clients on Medicaid
- Stress Reduction (Support Group Facilitation)
- Case Conference