Substance Use and Mental Health Concerns with HIV: A Case for Integrated Care

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Three-Part Breakfast Menu

1. Overview of Common Mental Health and Substance Use Concerns with Persons Living with HIV

2. Integrated Mental Health Care
   – Team models
   – Shared Medical Appointments

3. Case Discussions
Objectives

Upon completion of this presentation, learners should be better able to:

1. Explain common comorbid mental health and substance use concerns in HIV-positive persons

2. Identify the value of integrated mental health and substance use care in HIV clinical settings
Who’s in the Room?

• Type of provider

• Work setting

• How many ACTHIV conferences attended
COMMON SUBSTANCE USE AND MENTAL HEALTH CONCERNS
## Rates of Co-morbid Mental Health Conditions for Veterans with HIV in VHA Care

<table>
<thead>
<tr>
<th>Co-morbid Condition</th>
<th>Number with <em>Ever</em> Diagnosis</th>
<th>Percent <em>Ever</em> with Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar</td>
<td>2,646</td>
<td>10%</td>
</tr>
<tr>
<td>Depression</td>
<td>15,556</td>
<td>57%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>8,946</td>
<td>33%</td>
</tr>
<tr>
<td>PTSD</td>
<td>5,021</td>
<td>18%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1,730</td>
<td>6%</td>
</tr>
<tr>
<td>Any Mental Illness</td>
<td>17,534</td>
<td>64%</td>
</tr>
<tr>
<td>HCV</td>
<td>6,670</td>
<td>26%</td>
</tr>
</tbody>
</table>

*HCV*
# Rates of Co-morbid Substance Use Disorders for Veterans with HIV in VHA Care

<table>
<thead>
<tr>
<th>Co-morbid Condition</th>
<th>Number with <em>Ever</em> Diagnosis</th>
<th>Percent <em>Ever</em> with Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance Use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>9,147</td>
<td>33%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>4,476</td>
<td>16%</td>
</tr>
<tr>
<td>Opioids</td>
<td>3,053</td>
<td>11%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>7,414</td>
<td>27%</td>
</tr>
<tr>
<td>Tobacco</td>
<td>13,091</td>
<td>48%</td>
</tr>
<tr>
<td>Other/Unspecified Drug Use</td>
<td>6,792</td>
<td>25%</td>
</tr>
</tbody>
</table>

[Source](http://vaww.hiv.va.gov/data-reports/ccr2014/Cond-ComEverInCare-Jan15-HIVPARV-2014-All.asp)
Depression

- Among HIV+ Veterans in VA care, 57% have a history of being diagnosed with depression (most common co-morbidity)

- Pts who screened positive for major depression in the HIV Cost and Services Utilization Study (HCSUS) – 5x greater than general population sample

- Often under-diagnosed and under-treated

- Diagnostic interviews on 1,140 HIV+ patients
  - 37% had Major Depressive Disorder (MDD)

- MDD associated with:
  - Accelerated HIV progression
  - Nonadherence to medication
  - Increase in risk behavior

Substance use

• ETOH
  – Associated with
    • Decreased ART uptake
    • Poorer viral suppression
    • Poorer adherence
    • Increased risky sexual behaviors

• Methamphetamines/Stimulants
  – High risk sexual behavior → Transmission risk, STD risk
  – Influence on adherence

• Cigarette Smoking
  – 2-3x more likely to be smokers than age-matched HIV-negative counterparts

Nurutdinova, 2012, AIDS; Chander, 2006, Drugs
Adherence

• vs. compliance

• For ART, >95%

• Necessary to
  – Achieve viral suppression
  – Avoid viral resistance
  – Prevent recurrence of OIs

• Nonadherence factors
  – Psychiatric, mental health concerns
  – Difficulty getting pill into routine
  – Lack of patient education
  – SEs
  – Pill burden
  – Substance use
  – Psychosocial concerns

Springer, 2012, AIDS Behavior
Increasing Adherence

• Supportive, nonjudgmental approach
• Acknowledgement that adherence is difficult
• Promote dialogue; open-ended questions
  – “How has it been with taking your medications?”
• Assess missed doses
• Assess barriers and support strategies
  – “When is it most difficult for you to take your meds?”
• Assess continually
Cognitive Impairment in HIV

- Presence and extent of neuropsychological impairment during asymptomatic stages remain difficult to assess

- Many contributing factors
  - Aging
  - HIV/AIDS
  - Comorbid medical concerns
  - Comorbid psychiatric concerns
  - Impact of medications
  - Substance use; current and past
Trauma

History of trauma can lead to:

• Approximately twice the negative health outcomes compared to people without
• Increased high risk behavior
• Disengagement in care

Populations particularly at risk

• Women
• Low socioeconomic status (SES)
• Homeless
• Elderly
• Transgender

Houston-Hamilton, 2013, HIV Specialist
The “Second HIV Epidemic”: HIV stigma

• Stigma is when an attribute is unfairly attached to a person, leading to a “spoiled identity”; Deeply discrediting a person by reducing him/her “from a whole and usual person to a tainted, discounted one” (Goffman, 1963)

• Correlates of HIV-related Stigma
  – Depression
  – Suicidal ideation
  – Increased anxiety
  – Poor adherence to HAART
  – Nondisclosure of HIV status
  – Missed medical clinic appointments
  – Less social support

• Individuals who belong to other stigmatized populations (i.e. substance use, MSM) receive multiple layers of stigma
Pain

• Increased age associated with greater pain
  – In 2015 it’s estimated that over 50% of people living with HIV will be over the age of 50

• Arthritis, neuropathy, broken bones, shingles, migraine headaches

• Pain related to OI’s and other medical co-morbidities

• Sleep and mood disturbances very often co-morbid with pain

Heckman, Heckman, Saenger, & Marconi, 2013, HIV Specialist
Other psychosocial issues

• Grief and bereavement
  – More likely to experience loss over the lifetime

• Anger and guilt
  – Anger at others, themselves
  – “Survivor’s guilt”

• Sexual functioning
  – ARVs can contribute to decreased sexual functioning
  – Decreased sexual desire

• Quality of life
  – Pill burden
  – Medical appointments
INTERDISCIPLINARY HIV CARE & INTEGRATED MENTAL HEALTH
• “If we expect our patients to come to us for their HIV care, go somewhere else for their primary care, go to a gastroenterologist for their hepatitis C care, go to an addiction specialist for their opioid addiction, and then go somewhere else for their mental health care, we’re setting them up to fail.”

-Dr. Marwan Haddad, medical director
Community Health Center, Middletown, CT
Team models

• Multidisciplinary team model:
  – Utilize skills and experience of individuals from across disciplines, with each discipline approaching the patient from their own perspective
  – Oftentimes includes coordination across disciplines

• Interdisciplinary team model:
  – Integrate and synthesize separate discipline approaches to improve patient care by increasing coordination of services
  – Tx decisions usually made as a team or “shared decision making”

• Co-located collaborative care model:
  – Provide behavioral health and medical services to primary care patients in the same setting
  – Makes behavioral health screening and follow-up a routine part of a patient’s general (primary) care

• What is it like where you work?
Successful Models of Integrated HIV Care

1. Patient centered, with integrated or co-located services
2. Diverse teams of clinical and nonclinical providers
3. A site culture that promotes a stigma reducing environment
4. Availability of comprehensive array of medical, behavioral health, and psychosocial services
5. Effective communication strategies
6. Focus on quality

Ojikutu et al., 2014, AIDS Care
Integrated HIV care in VA

• Qualitative study of patients and providers in 7 VA HIV clinics to assess implementation of integrated care principles
  – Patients in more integrated clinics reported higher satisfaction with their care
  – Increased stigma in less integrated clinics, more difficulty accessing care
  – Patients and providers reported better relationships with each other in more integrated care settings

• Patients seeking care in clinics which offered hepatitis, psychiatric, psychological and social services in addition to HIV primary care were 3.1 times more likely to achieve viral suppression than patients visiting clinics which offered only HIV primary care

• Creation of HIV/Liver integrated care fellowship
  – 10 psychology residents for 2015-2016

Fix, 2014, J Gen Intern Med; Hoang, 2009, Med Care; slide borrowed from Maggie Chartier, PsyD, MPH
Flexible, Adaptable MH Services

- Integrated care presentations
- Psychoeducational seminars on specific topics
- In-clinic consultation
- Out of clinic consultation
- Phone clinic
- Telemental health
- Support group
- Shared medical appointments
- Creating pamphlets, brochures, behavioral health handouts
- Behavioral health screening (e.g. depression, anxiety, etoh, PTSD)
- Pre-tx counseling (e.g. pre HCV treatment)
- Joint visits
- Individual therapy or brief behavioral health follow-up
  - Motivational interviewing
  - Harm reduction
Barriers and Workability

• What are barriers to integrated care at your facility?

• What if we don’t have integrated care professionals who address mental health/substance use concerns?
  
  – Work with what ya got!
  – Team approach
  – Training
    • From other professionals
    • Online courses and content
    • Send to conferences
Lessons from Guyana

- Using the resources that you do have
- Communication

Photo Credit: David Hamilton
SHARED MEDICAL APPOINTMENTS
Shared Medical Appointments (SMA)

• Multiple providers seeing multiple patients at one time in a group format

• Why SMA?
  – Diversify the way we communicate with patients
  – Patients’ growing frustration w/ brief encounters
  – In the setting of chronic illness/chronic care, many patients feel important questions are not answered, their opinions about treatment are not taken into account, and treatment goals are not made clear

SMA: +/-

• Benefits
  – increased duration of patient-provider contact
  – time and cost efficiency
  – maximize the expertise of providers and patients
  – Other benefits: personalized attention, self-care education, advice from peers, access to medication refills and physical exams

• Barriers/Cons
  – loss of personalized attention
  – loss of confidentiality
  – logistical barriers
HIV Peer Support

• Support groups can be a way for HIV+ adults to:
  – Learn ways of coping with chronic illness
  – Have a space to discuss concerns related to health and wellness
  – Develop relationships with others; grow through sharing
  – Support each other through treatment process
Example of HIV SMA

- The patients:
  - Older (age range was 50-71), HIV+, gay or bisexual, living in Northern California rural communities

- The facilitators
  - Nurse practitioner, Mental health provider, Clinical Pharmacy Specialist

- Logistics
  - All seen by nurse for vitals or pending immunizations
  - SMA lasted 90 mins: mindfulness exercise, check-in, specific process topic, labs, med refills
  - Additional half-hour blocked for visits w/ any provider

- Topics
  - Med adherence, new med regimens, role of VA in care, substance use
Process Evaluation

• “I would like for this to continue on ongoing basis. I thought the range of topics was great. Wish there was more consistency with attendance.”

• “Will never forget this group and positive input from members of group. A truly great 6 months of thoughts and ideas. It really helped me improve my outlook as an HIV+ person.”

• “Please keep the group going after new staff is on board.”

• “One of the best experiences I have enjoyed in a long time. Great bunch of people”
Example of HCV SMA

• Team:
  – Nurse Practitioner or Clinical Pharmacy Specialist
  – Mental Health Provider
  – Nursing
  – Clerk

• Procedure
  – Verbal consent prior to first appointment (full team)
  – Labs, vital signs, PHQ-9, and sx checklist before each appointment
  – Pre-treatment outcomes questionnaire
  – Group consent, confidentiality + limits, group rules
  – Group check-in
  – SEs, symptom discussion; medical and behavioral mgmt
  – Topics explored: med adherence, sub use, well being, health, exercise
  – Self-management goal
  – Individual break out meeting with medical provider
  – Post-treatment outcomes questionnaire
Process Evaluation

Patient feedback:
– “I got to know other vets like me. We went through this thing together.”
– “I thought I was gonna hate it. It wasn’t so bad.”
– “It was the perfect way to get treatment.”

Provider feedback:
– “I wasn’t too sure about shared medical appointments, but now I only want to see patients in groups!”
SFVAHCS ID Team and MH Services

- Individual Therapy
- Groups/Classes
  - Healthy Living
  - Depression
  - Memory
  - Harm Reduction
- Assessment
  - Neurocognitive
  - Psychosocial
- Behavioral Health
- Joint visits
- Co-management
- Case mgmt
- Consultation
CASE DISCUSSIONS
“Miley”

- 85 yo, non partnered, gay-identified, White, HIV+ male vet referred by ID provider due to concerns about depression and functional decline

- Longstanding hx w/ on/off adherence to HIV regimen

- Has 26 year old live-in “caregiver”; crystal meth use together

- Pt has shown up to clinic w/ bruises around his eye, saying that he was accidentally hit by caregiver’s one yr old; is thin, appears malnourished

- Questions for all three case discussions:
  - What are your concerns?
  - How might you utilize integrated care approaches?
“Hank”

- 54 yo, African-American, HIV-positive veteran w/ hx of chronic homelessness, polysubstance abuse, and multiple hospitalizations for SI (no attempts) in the previous 2 yrs

- Pt is stuck in pattern where he participates in substance use and sex work to make money → shame, guilt, depression → more substance use → thoughts of SI → hospitalization → homelessness

- Tx issues (past and present):
  - Medical: HIV, HCV
  - Psychiatric: MDD, SI with hospitalizations, insomnia
  - Substance use: meth, etoh, marijuana
  - Psychosocial: housing, financial, social support
“Janet”

- 64 yo, Latina, coinfected (HIV/HCV), widowed, female veteran with chronic back and shoulder pain, MDD, and PTSD, who lives alone in a studio apartment.

- Pt’s provider gets a sense that she would like additional support (possible individual therapy) but declines warm-handoffs to the psychology team every time she comes in for her primary care visit.

- Pt previously received services through the PTSD clinic but has stopped ever since her last provider retired. PTSD sxes are mostly controlled, but in the last month, she has noticed herself feeling increasingly anxious, worried, and hypervigilant.
Resources

VHA National HIV Program:
www.va.hiv.gov

American Psychological Association: HIV Office of Psychology Education (HOPE) Training Modules:

American Psychological Association: HIV Integrated Care:

Mental Health Care for People Living With or Affected By HIV/AIDS: A Practical Guide:
http://www.samhsa.gov/hiv/docs/MHCareAIDS-PracticalGuide.pdf

Alcohol Use Disorder Identification Test (AUDIT-C):

Taking Patients’ Sexual and Substance Use Histories:

America Academy of HIV Medicine: HIV Specialist Special Issue on HIV and Mental Health:

American Psychological Association: Office of AIDS:

Slide borrowed from Maggie Chartier, PsyD, MPH
References


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• Houston-Hamilton, 2013. Trauma & HIV. *HIV Specialist, 5*:4 (14-17)


• Wagner EH (2007). Diversifying the options for interacting with patients. *Quality and Safety in Health Care, 16*, 322-323