

***Bringing It All Together:
What HIV Clinicians Need to Know
About Integrated Treatment***

Trainer Guide



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Bringing It All Together:

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Background Information

The purpose of the HIV Integration Training Package is to provide HIV clinicians (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) with an overview of integrated treatment for individuals living with HIV. The main focus of the training is the integration of mental health and substance use disorder treatment services with HIV care. The presentation will also touch on the integration of services to address other conditions that affect individuals with HIV, as well as some information on policy changes that will facilitate integration under healthcare reform. The package was developed for the Pacific AIDS Education and Training Center, based at Charles R. Drew University of Medicine and Science. Principle authorship was by Howard Padwa, Ph.D., UCLA Integrated Substance Abuse Programs (UCLA ISAP), Beth Rutkowski, M.P.H., Associate Director of Training of UCLA ISAP, and Thomas Freese, Ph.D., Director of Training of UCLA ISAP and Principal Investigator/Director of the Pacific Southwest ATTC. We wish to acknowledge Phil Meyer, LCSW, Jennifer McGee, MPHc, and Tom Donohoe, MBA from the PAETC.

The duration of the training is approximately 90-120 minutes (1 ½-2 hours), depending on whether the trainer chooses to present all of the slides, or a selection of slides. Depending on your audience, you may not need to present all of the information contained in these slides. For example, **slides 20-23** are included for audiences with little or no knowledge of mental health disorders, and **slides 24-29** are included for audiences with little or no knowledge of substance use disorders. If you are presenting the package to an audience that is knowledgeable about these issues, you may decide to skip these slides.

“Test Your Knowledge” questions have been inserted at the beginning and end of the presentation to assess a change in the audience’s level knowledge after the key content has been presented. An answer key is provided in the Trainer’s notes for **slides 4-6** and **slides 99-101**.

Audience Response System can be utilized, if available, when facilitating the Test Your Knowledge question sessions.

In addition, discussion activities have been inserted in the presentation at **slide 43**, **slide 68**, and **slide 77** to encourage dialogue among the training participants, and to illustrate how the information contained within the presentation can be used in practice.

What Does the Training Package Contain?

- PowerPoint Training Slides (with notes)
- Trainer's Guide with detailed instructions for how to convey the information and conduct the interactive exercises
- Two-page fact sheet entitled, *"Bringing It All Together: What HIV Clinicians Need To Know About Integrated Treatment"*

What Does This Trainer's Guide Contain?

- Slide-by-slide notes designed to help the trainer effectively convey the content of the slides themselves
- Supplemental information for select content to enhance the quality of instruction
- Suggestions for facilitating the "Test Your Knowledge" questions and case studies

How is This Trainer's Guide Organized?

For this manual, text that is shown in bold italics is a ***"Note to the Trainer."*** Text that is shown in normal font relates to the "Trainer's Script" for the slide.

It is important to note that some slides in the PowerPoint presentation contain animation. Animations are used to call attention to particular aspects of the information or to present the information in a stepwise fashion to facilitate both the presentation of information and participant understanding. Getting acquainted with the slides, and practicing content delivery are essential steps for ensuring a successful, live training experience.

General Information about Conducting the Training

The training is designed to be conducted in small- to medium-sized groups (10-40 people). It is possible to use these materials with larger groups, but the trainer may have to adapt the small group exercises (case studies) to ensure that there is adequate time to cover all of the content.

Materials Needed to Conduct the Training

- Computer with PowerPoint software installed (2003 or higher version) and LCD projector to show the PowerPoint training slides.
- When making photocopies of the PowerPoint presentation to provide as a handout to training participants, it is recommended that you print the slides three slides per page with lines for notes. Select “pure black and white” as the color option. This will ensure that all text, graphs, tables, and images print clearly.
- Flip chart paper and easel/white board, and markers/pens to write down relevant information, including key case study discussion points.

Overall Trainer Notes

It is critical that, prior to conducting the actual training, the trainer practice using this guide while showing the slide presentation in Slideshow Mode in order to be prepared to use the slides in the most effective manner.

Icon Key



Note to Trainer



Activity



References



Audience Response System
(ARS)-Compatible Slide

Bringing It All Together:

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Slide-By-Slide Trainer Notes

The notes below contain information that can be presented with each slide. This information is designed as a guidepost and can be adapted to meet the needs of the local training situation. Information can be added or deleted at the discretion of the trainer(s).



Slide 1: Title Slide




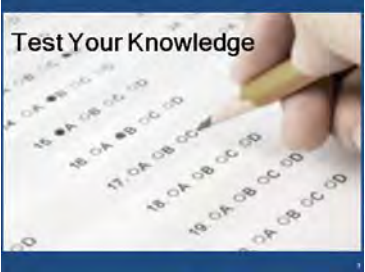

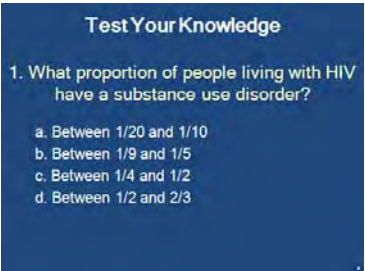

Welcome participants and take care of housekeeping announcements, such as location of restrooms, turning off cell phones, participating actively, etc.

The purpose of this introductory training is to provide HIV clinicians (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) with an overview of integrated treatment for individuals living with HIV. The main focus of the training will be the integration of mental health and substance use disorder treatment services with HIV care. The presentation will also touch on the integration of services to address other conditions that affect individuals with HIV, as well as some information on policy changes that will facilitate integration under healthcare reform.

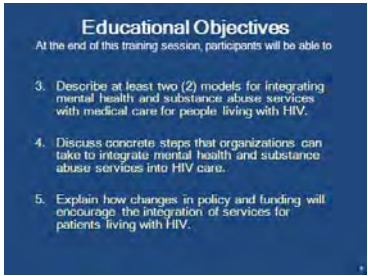

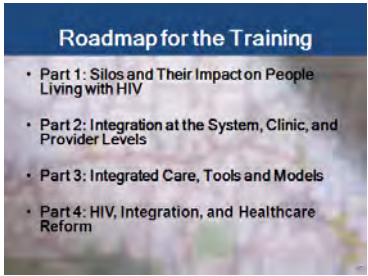
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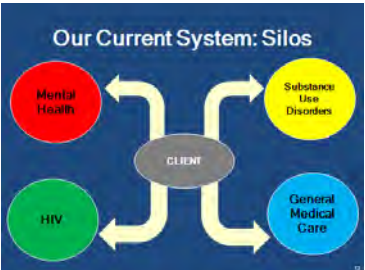

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In addition, discussion activities have been inserted in the presentation at slide 43, slide 68, and slide 77 to encourage dialogue among the training participants, and to illustrate how the information contained within the presentation can be used in practice.

 <p>Training Collaborators</p> <ul style="list-style-type: none"> • Pacific AIDS Education and Training Center <ul style="list-style-type: none"> – Charles R. Drew University of Medicine and Science – University of California, Los Angeles • Pacific Southwest Addiction Technology Transfer Center • UCLA Integrated Substance Abuse Programs 	<p>Slide 2: Training Collaborators</p> <p>This PowerPoint presentation, Trainer Guide, and companion fact sheet were developed by Howard Padwa, Ph.D. (UCLA Integrated Substance Abuse Programs), Beth Rutkowski, M.P.H. (Associate Director of Training of UCLA ISAP) and Thomas Freese, Ph.D. (Director of Training of UCLA ISAP and Principal Investigator/Director of the Pacific Southwest ATTC) through supplemental funding provided by the Pacific AIDS Education and Training Center, based at Charles R. Drew University of Medicine and Science. We wish to acknowledge Phil Meyer, LCSW, Jennifer McGee, MPHc, and Tom Donohoe, MBA, from the PAETC.</p>
	<p>Slide 3 [Transition Slide]: Test Your Knowledge Questions</p> <p><i>The purpose of the following three questions is to test the current level of HIV integration knowledge amongst training participants. The three questions are formatted as multiple choice questions.</i></p>  <p><i>Read each question and the possible responses aloud, and give training participants time to jot down their response before moving on to the next question.</i></p> <p><i><u>Do not</u> reveal the answers to the questions until the end of the training session (when you re-administer the questions that appear on slides 100-102).</i></p>
	<p>Slide 4: Test Your Knowledge Question #1</p> <p>Answer Key:</p> <p>Correct response: C (Between 1/4 and 1/2)</p>  <p>**Audience Response System (ARS)-compatible slide</p>

<div data-bbox="110 268 472 541"> <h3>Test Your Knowledge</h3> <p>2. Integrated Services for HIV care can include....</p> <ol style="list-style-type: none"> Screening for mental health and substance use disorders Conducting hour long mental health assessments for all clients Adaptation of mental health treatment techniques for use with HIV clients A and C A, B, and C </div>	<p>Slide 5: Test Your Knowledge Question #2</p> <p>Answer Key:</p> <p>Correct response: D (A and C)</p> <div data-bbox="524 386 613 520"> </div> <p>**Audience Response System (ARS)-compatible slide</p>
<div data-bbox="110 667 472 940"> <h3>Test Your Knowledge</h3> <p>3. Healthcare reform will do the following:</p> <ol style="list-style-type: none"> Extend health insurance coverage to some people with HIV who are currently uninsured Provide better coverage to help some people pay for their HIV medications Place limits on mental health and substance abuse services for people living with HIV A and B A and C </div>	<p>Slide 6: Test Your Knowledge Question #3</p> <p>Answer Key:</p> <p>Correct response: D (A and B)</p> <div data-bbox="524 785 613 919"> </div> <p>**Audience Response System (ARS)-compatible slide</p>
<div data-bbox="110 1066 472 1339"> <h3>Introductions</h3> <ul style="list-style-type: none"> What is your name? Where do you work and what do you do there? Who is your favorite musician or performer? What is one reason you decided to attend this training session? </div>	<p>Slide 7: Introductions</p> <div data-bbox="558 1066 639 1184"> </div> <p><i>In an effort to break the ice and encourage group interaction, take a few minutes to ask training participants to briefly share the answers to these four questions. You can ask for several volunteers to share their responses if the size of your audience prevents all participants from sharing.</i></p>
<div data-bbox="110 1486 472 1759"> <h3>Educational Objectives</h3> <p>At the end of this training session, participants will be able to</p> <ol style="list-style-type: none"> Describe the impact of mental health and substance use disorders on people living with HIV/AIDS. Discuss why is important to integrate mental health and substance abuse services with medical care for people living with HIV/AIDS. </div>	<p>Slide 8: Educational Objectives</p> <div data-bbox="558 1486 639 1604"> </div> <p><i>Briefly review each of the educational objectives with the audience.</i></p>

	<p>Slide 9: Educational Objectives, continued</p>  <p><i>Continue by briefly reviewing the remaining two educational objectives with the audience.</i></p>
	<p>Slide 10: Roadmap for the Training</p> <p>Part 1 of the training will discuss the siloed structure of the current health care system, and how it is divided into separate systems for mental health, substance abuse, HIV, and medical care. This is problematic not only because it makes care less holistic, but because it increases the chances that MH, SUD, and medical conditions other than HIV will go unaddressed. If these conditions are not treated adequately, they have negative impacts not only on clients' overall health, but also on the progression of their HIV. This section will also provide a brief overview of the different types of conditions and how they interact with one another.</p> <p>Part 2 will look at what integration is, and how it can occur at the level of service delivery systems, clinic organizations, and individual providers. The focus of this section will be on the organizational aspects of integration, what steps need to be taken to integrate, some of the barriers that may come up during integration, and potential solutions to them.</p> <p>Part 3 will focus on what integrated services are, and how they can be delivered effectively. The focus of this section will be on some of the challenges involved in the delivery of integrated services, and give some examples of programs that have successfully integrated services for HIV clients.</p> <p>Part 4 will provide a brief overview of the impact that the Patient Protection and Affordable Care Act (healthcare reform) will have on services for people living with HIV. As this section will show, beyond covering more services, healthcare reform will encourage more integrated care for clients living with HIV.</p>

	<p>Slide 11 [Transition Slide]: Part 1 – Silos and Their Impact on People Living with HIV</p> <p>The first segment of the training will discuss the structure of the current healthcare system, and how it is divided into separate systems—or silos—for HIV, mental health, substance abuse, and medical care. The information in this section will highlight why this separation of services is problematic.</p>
	<p>Slide 12: Our Current System - Silos</p> <p>In our current system, care is not integrated. Clients who have multiple needs receive care in different systems and the care is not integrated. While the services offered in each system is good, its focus is narrow. In HIV care the main focus is HIV; in mental health the focus is MH, and so on. Thus care for clients is divided into siloes—“siloes of excellence” They are very good at treating disorders, but not necessarily treating PEOPLE.</p>
	<p>Slide 13: The Trouble With Silos</p> <p>One of the main problems with silos is access: there are barriers to getting different types of care. Some of the most common obstacles include that clients need to be very ill to receive services, that there may be long waits to get care, or that funding restricts who can receive what kind of services. Coordination is also difficult in systems that have silos. Providers in different systems rarely talk because they are focused on just one problem, not a person’s overall health. For example, a mental health provider is not paid to worry about clients’ HIV care, so they may not coordinate with HIV providers. Silos also make things more difficult by clients by forcing them to coordinate their own care in terms of appointments, insurance, remembering medications, etc. The main problem is that care provided in silos only addresses one issue, rather than clients’ overall care. It addresses problems, but not always people.</p>

<div data-bbox="110 268 470 541" data-label="Complex-Block"> <h3>The Trouble With Silos and HIV</h3> <ul style="list-style-type: none"> It is rare for people living with HIV to need <u>only</u> HIV services... <ul style="list-style-type: none"> Nearly half meet diagnostic criteria for anxiety or depression 25%-45% have a substance use disorder 25% are infected with Hepatitis C If HIV care is its own silo, clients' other health needs may not be adequately addressed </div>	<p>Slide 14 [Transition Slide]: The Trouble With Silos and HIV</p> <p>The first segment of the training will discuss the structure of the current healthcare system, and how it is divided into separate systems—or silos—for HIV, mental health, substance abuse, and medical care. The information in this section will highlight why this separation of services is problematic.</p>
<div data-bbox="110 667 470 940" data-label="Complex-Block"> <h3>The Trouble With Silos and HIV</h3> <ul style="list-style-type: none"> HIV, mental health problems, substance abuse, and other medical conditions interact and exacerbate each other Neglecting conditions other than HIV leads to worse health and premature death for people living with HIV Providers should be able to identify/treat both HIV and other conditions that put people living with HIV at risk </div>	<p>Slide 15: The Trouble With Silos and HIV</p> <p>Not only do large numbers of HIV clients have many health problems, but these problems interact and make each other worse. Research shows, for example, that problems with substance abuse make mental health and HIV care more difficult. Because of this, ignoring other conditions elands to worse health and premature death for people living with HIV. To provide the best service possible for their clients, HIV providers need to be able to identify and treat both HIV and other conditions that can compromise clients' well-being.</p>
<div data-bbox="110 1066 470 1339" data-label="Complex-Block"> <h3>HIV (Human Immunodeficiency Virus)</h3> <ul style="list-style-type: none"> A virus that attacks CD4 cells, which the body uses to fight off infections and disease Transmitted through sexual contact or blood If HIV is untreated, destruction of CD4 cells leads to Acquired Immunodeficiency Syndrome (AIDS) AIDS leaves body vulnerable to life-threatening infections and cancers  </div>	<p>Slide 16: HIV (Human Immunodeficiency Virus)</p>  <p><i>This slide and the following 22 slides will review each of the four silos that will be covered in this training: HIV, mental health disorders, substance use disorders, and other medical conditions that affect clients living with HIV.</i></p> <p>Human Immunodeficiency Virus (HIV) is a virus that attacks cells the body uses to fight off infections and diseases. HIV is transmitted through sexual contact or blood. If left untreated, HIV leads to Acquired Immunodeficiency Syndrome (AIDS), which leaves the body vulnerable to life-threatening infections and cancers that it could normally fight off.</p>

 <p>HIV Treatment</p> <ul style="list-style-type: none"> • There is no “cure” for HIV, but it can be managed with antiretroviral therapy (ART) <ul style="list-style-type: none"> – Involves taking 3+ anti-HIV medications from two different drug classes daily – Prevents HIV from multiplying and attacking CD4 cells – Reduces viral load (amount of HIV in blood) and increases CD4 cell count – Helps body fight off infections/cancers, prevents advancement from HIV to AIDS – Reduces risk of transmitting HIV to others – Helps people to live longer and healthier lives with HIV 	<p>Slide 17: HIV Treatment</p> <p>There is no cure for HIV, but the condition can be managed with antiretroviral therapy (ART). ART involves taking three or more anti-HIV medications daily. These medications prevent HIV from multiplying and attacking CD4 cells. By doing this, they reduce the amount of HIV in the blood and increase CD4 cell count. ART helps the body fight off infections, prevents the development of AIDS, reduces the risk of transmitting HIV to others, and helps people live longer and healthier lives with HIV.</p>
 <p>HIV Treatment: Adherence</p> <ul style="list-style-type: none"> • Strict adherence to ART is essential for people living with HIV <ul style="list-style-type: none"> – Need to take correct dose of each medication as prescribed – Skipping even occasionally gives HIV opportunity to multiply – Missed doses increase likelihood HIV will mutate and become resistant to ART • 95% medication adherence is optimal • Improving ART adherence 10% can improve HIV outcomes 	<p>Slide 18: HIV Treatment – Adherence</p> <p>To avoid premature death and maintain a high quality of life, individuals living with HIV need to take their ART medications regularly, almost never skipping. Even missing doses of ART occasionally increases risk that HIV will multiply and cause serious health problems. Improving adherence to ART is a great way to improve outcomes for people living with HIV.</p>  <p><u>REFERENCE:</u></p> <p>Safren, S.A., O’Cleirigh, C., Tan, J., et al. (2009). A randomized controlled trial of Cognitive Behavioral Therapy for Adherence and Depression (CBT-AD) in HIV-infected individuals. <i>Health Psychology</i>, 28(1),1-10.</p>
 <p>Conditions that Increase Risk for People Living With HIV</p> <ul style="list-style-type: none"> • Conditions that decrease adherence to ART <ul style="list-style-type: none"> – Mental Health Disorders – Substance Use Disorders • Conditions that are complicated by HIV <ul style="list-style-type: none"> – Tuberculosis – Hepatitis 	<p>Slide 19: Conditions that Increase Risk for People Living With HIV</p> <p>Two types of conditions can put people living with HIV at risk for complications. The first is a condition that makes them less likely to take their medication—conditions such as mental health disorders and substance use disorders. The second is a condition that is made biologically more difficult to treat by HIV. Two of the more prevalent ones that can be treated effectively are tuberculosis and hepatitis.</p>

Decreased Adherence to ART: Mental Health Disorders (MHD)

- Conditions marked by significant changes in cognition, mood, perception, and behavior
 - Anxiety disorders
 - Mood disorders (depression, bipolar)
 - Adjustment Disorders
 - Schizophrenia

Slide 20: Decreased Adherence to ART – Mental Health Disorders (MHD)

Mental health disorders are conditions that involve significant changes in how people understand things, their mood, their perceptions, and the way they behave. Some of the more common mental health disorders are anxiety disorders—where people become extraordinarily anxious even when there is no immediate danger. While **anxiety** is normal in certain situations, it becomes both irrational and disabling for people with anxiety disorders. **Mood disorders** involve dramatic changes in one's mood in ways that significantly alter behavior. While it is normal for people to become sad sometimes, people with depressive disorders become depressed for long periods of time, and it interferes with their functioning. People with bipolar disorder experience depression mixed with manic episodes, where people experience dramatic shifts in energy, activity, sleep, and behavior.

Adjustment disorders are emotional and behavioral responses to stressful events or major life changes. These disorders are common among HIV clients, especially in the period immediately after they learn their diagnosis. **Schizophrenia** is a chronic, severe, and potentially disabling brain disorder. People with schizophrenia may experience hallucinations, delusions, and have difficulty carrying out normal daily activities.

Additional Information for the Trainer(s)

There are several different types of **anxiety disorders**. Panic Disorders are disorders that cause sudden attacks of terror, usually accompanied by a pounding heart, sweatiness, weakness, faintness, or dizziness. Panic attacks usually produce a sense of unreality, a fear of impending doom, or a fear of losing control.

Obsessive-Compulsive Disorder involves persistent, upsetting thoughts (obsessions) and the use of rituals (compulsions) to control the anxiety these thoughts produce. For example, if people are obsessed with germs, they might develop a compulsion to wash their hands repeatedly. Or if they are obsessed with being robbed, they may lock and relock their doors several times before going to bed at night. Post-Traumatic Stress Disorder comes when an individual lives through major physical harm or the threat of major physical harm, either to themselves or someone close to them. People with PTSD may startle easily, become emotionally numb, lose interest in things they used to enjoy, have trouble being affectionate, and become irritable, aggressive, or violent. Social Anxiety Disorder is diagnosed when people become overwhelmingly anxious and self-conscious in normal social situations. One of the main signs of social anxiety disorder is a strong, persistent, and chronic fear of being watched or judged by others. People with this disorder also have a strong fear of embarrassment.

(Notes for Slide 20, continued)

Slide 20: Decreased Adherence to ART – Mental Health Disorders (MHD)

Generalized Anxiety Disorder causes exaggerated worry and tension, even if there is little or nothing to be worried about. People with this disorder often worry about disaster even when things are normal. They are also overly concerned about their health, money, family problems, or problems at work.

The most common mood disorder is depression. Depression is more than just feeling sad or blue for a short period of time—it lasts longer, is more intense, and can be more disabling.

Symptoms of depression include feelings of sadness, hopelessness, or helplessness; loss of interest in activities or hobbies; fatigue; difficulty concentrating; too much/too little eating; too much/too little sleeping. People with major depression are unable to function normally or participate in activities the way they normally do.

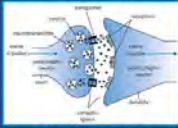
Another mood disorder is bipolar disorder, which is also known as manic-depressive disorder. People with bipolar disorder experience unusually intense emotional states in distinct periods called “mood episodes.” Overly joyful and excited states are called manic episodes, and overly sad and hopeless states are called depressive episodes. People with bipolar disorder can also experience what is called a “mixed state,” where they have symptoms of both mania and depression. People with bipolar disorder also may be explosive and irritable during a mood episode. Dramatic changes in energy, activity, sleep, and behavior usually accompany mood episodes. People with bipolar disorder may also become explosive or irritable during these episodes. Sometimes people with bipolar disorder experience long-lasting periods of unstable moods rather than separate episodes of depression or mania.

Adjustment disorders are emotional and behavioral reactions that develop within 3 months of a life stress. These are stronger or greater than expected reactions for the type of event that occurred. Symptoms include feelings of agitation, changes in behavior, depressed mood, and physical complaints. In severe cases, people with adjustment disorders contemplate suicide. Symptoms usually begin within 3 months of the stressor, and usually do not last longer than 6 months, unless the stressor continues to be present. It is not uncommon for clients to experience adjustment disorders upon learning about their HIV diagnosis.

<p><i>(Notes for Slide 20, continued)</i></p>	<p>Slide 20: Decreased Adherence to ART – Mental Health Disorders (MHD)</p> <p>Schizophrenia is a chronic, severe, and disabling brain disorder. The symptoms of schizophrenia fall into three broad categories: positive symptoms, negative symptoms, and cognitive symptoms. Positive symptoms include hallucinations, where people see, hear, smell, or feel things that nobody else can see, hear, smell, or feel. The most common type of hallucination people with schizophrenia experience is hearing voices that talk to them about their behavior, order them to do things, or warn them of dangers. People with schizophrenia may also experience delusions (false beliefs), or thought disorders (dysfunctional ways of thinking). There are also negative symptoms of schizophrenia. These involve disruptions to normal emotions and behaviors. One common negative symptom is a flat affect, when a person's face does not move or he/she talks in a dull or monotonous voice. Another negative symptom is difficulty with planned activities. Because of the challenges associated with the negative symptoms, some people with schizophrenia need help with basic everyday tasks and personal hygiene. Schizophrenia also has many cognitive symptoms, including difficulty paying attention, focusing, and making decisions. Though the symptoms of schizophrenia can be very disruptive, people with schizophrenia can lead rewarding and meaningful lives in the community with proper treatment.</p>
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Biology of Mental Health Disorders

- **Neurotransmitters:** Chemical messengers within the central nervous system
- **Changes to neurotransmission** occur in behavioral health disorders



Slide 21: Biology of Mental Health Disorders



As you go through each of the key points, refer the audience to the diagram to help them visualize how neurotransmitters work.

Mental health disorders affect the central nervous system—particularly in the way that chemical messengers called **neurotransmitters** work within the nervous system. The central nervous system is composed of specialized cells called **neurons**. Neurons do not touch each other and the gap between them—called the **synaptic space**—needs to be bridged for messages to get from one neuron to the next. To get messages across the space, neurons release chemicals, or neurotransmitters. On the neuron that is receiving the neurotransmitters, there are special proteins called **receptors** that neurotransmitters will bind to, similar to the way a key fits a lock. After a neurotransmitter has bound to a receptor, proteins called **transporters** or **reuptake pumps** will carry neurotransmitters back to the neurons that released them.

The reason this process is important is that certain neurotransmitters and receptors are associated with specific emotional and functions. Any changes to these steps—the way neurotransmitters are released, the way receptors work, or the way transporters or reuptake pumps work—can have profound effects on sensation, perception, thought, mood, and behavior. When people have mental health disorders, these processes are altered, leading to changes in the way they feel and behave.

Risks for Mental Health Disorders

- **Genetic:** interaction of several genes may trigger disorders.
- **Experiences:** head injury, poor nutrition, exposure to toxins increase risk.
- **Social factors:** trauma, stress, neglect, abuse

Slide 22: Risks for Mental Health Disorders

While neurochemistry plays a key role in mental health disorders, we also know that other factors are also important, especially when it comes to who is at risk for developing these problems. Genetics play a big part, as the interaction of several different genes can either trigger disorders or increase risk for developing them. Experiences that can affect the development of the brain and the body are correlated with mental health problems. Head injuries, malnutrition, or exposure to chemicals that can affect the neurological system—are correlated with mental health disorders. Social problems are also highly correlated with mental health disorders. Exposure to trauma or violence, heavy stress, neglect, and abuse are all common among individuals with mental health and substance use disorders. These causes are not mutually exclusive, and in most cases several factors combine to cause mental health disorders.

Mental Health Disorders: Diagnosis and Treatment

- **Diagnosis**
 - There is no biological “test”
 - Through observation and interview
 - Criteria laid out in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*
- **Treatment**
 - Psychotherapy
 - Talk to learn about condition, moods, thoughts, and behavior
 - Learn better coping and stress-management skills
 - Medications
 - Work by altering neurotransmitter activity

Slide 23: Mental Health Disorders: Diagnosis and Treatment

There is no way to formally “test” if someone has a behavioral health disorder or not. There is no blood test for any of these conditions. Diagnoses are made by asking clients about their symptoms and observe their behavior. It often involves a judgment call. The diagnostic criteria for behavioral health disorders clinicians consult with the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*. One of the main ways mental health disorders are treated is through the use of **psychotherapy**. Psychotherapy is a general term for the process of treating mental illness by talking. Psychotherapy can take place one on one, or in groups. There are also medications physicians can prescribe for mental health disorders. They work by affecting neurotransmitter processes in the brain.

Additional Information for the Trainer(s)

Diagnosis of Mental Health Disorders: Each mental health disorder has its own characteristic symptoms. However, there are some general warning signs, including: (1) marked personality change; (2) inability to cope with problems and daily activities; (3) strange or grandiose ideas; (4) excessive anxieties; (5) prolonged depression and apathy; (6) marked changes in eating or sleeping patterns; (7) thinking or talking about suicide or harming oneself; (8) extreme mood swings—high or low; (9) abuse of alcohol or drugs; and (10) excessive anger, hostility, or violent behavior.



REFERENCE:

National Institute of Mental Health. (2012). *Information about Mental Illness and the Brain*, available at:

<http://science.education.nih.gov/supplements/nih5/mental/guide/info-mental-a.htm>.

The most recent edition of the DSM is the DSM-IV TR, which was released in 2000. The next edition, DSM V, will be released in 2013.

Treatment with Psychotherapy: During psychotherapy, clients discuss their emotions, and learn about their condition, their moods, feelings, thoughts and behavior. Using the insights and knowledge gained in psychotherapy, clients can learn coping and stress-management skills. Psychotherapy often can be successfully completed in a few months, but in some cases, long-term treatment may be helpful.

<p><i>(Notes for Slide 23, continued)</i></p>	<p>Slide 23: Mental Health Disorders: Diagnosis and Treatment</p> <p>Treatment with Medications: Some of the medications used to treat Mental Health Disorders include the following:</p> <p>Antidepressants are medications used to treat various types of depression and sometimes other conditions. They help individuals experiencing sadness, hopelessness, lack of energy, difficulty concentrating and lack of interest in activities. The most commonly prescribed antidepressants are selective serotonin reuptake inhibitors (SSRIs). Mood stabilizers are most commonly used to treat bipolar disorder. Sometimes mood-stabilizing medications are added to antidepressants to treat depression. Anti-anxiety medications, as their name suggests, are used to treat anxiety disorders. They may also be useful in helping reduce agitation and insomnia. These medications are typically fast acting, helping relieve symptoms in as little as 30 minutes. A major drawback, however, is that they have the potential to cause dependency. Antipsychotic medications, also called neuroleptics, are typically used to treat psychotic disorders such as schizophrenia. They can also be used to treat certain mood disorders.</p>
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Decreased Adherence to ART: Substance Use Disorders (SUD)

- Individuals with SUD consume alcohol/drugs compulsively, even when faced with negative consequences
- SUD fall on a continuum of alcohol and drug use

Slide 24: Decreased Adherence to ART: Substance Use Disorders (SUD)



ANIMATION INSTRUCTIONS

Please note the animation contained within this slide. Trainers should practice delivering the material on this slide in advance of the training, so they are comfortable with the order in which the animation and text appear on the slide. Use the graphic to illustrate the continuum of risky substance use, explaining that the left side of the graphic/arrow represents someone who uses unhealthy amounts of drugs or alcohol, or uses them in a risky manner. People at this end of the continuum can stop using substances if faced with negative consequences. However, as people proceed further along the continuum (left to right) they develop more serious conditions—substance abuse and substance dependence—which are classified as SUDs.

Substance use disorders fall on a continuum of problematic alcohol and drug use. Highly problematic levels of substance use—called substance abuse and substance dependence—are defined as “disorders,” instead of just “problematic” substance use. A substance use disorder is a state in which an individual compulsively uses alcohol or drugs even when faced with negative consequences. This behavior is reinforcing, or rewarding. A major feature of a substance use disorder is the loss of control in limiting intake of the addictive substance.

How Psychoactive Substances Work

- Because of their chemical structure, alcohol and drugs have dramatic effects on neurotransmitters in CNS.
- Effects on:
 - Mental processes
 - Behavior
 - Perception
 - Alertness

Slide 25: How Psychoactive Substances Work

Most substance use disorders involve **psychoactive substances**. A psychoactive substance affects human behavior by interfering with brain chemistry and neurotransmitter activity. Alcohol and drugs that are commonly abused are psychoactive because of their chemistry. When absorbed into the body, alcohol and drugs interact with and modify the way many cells, organs, and systems. Because of their chemical structure, they have particularly dramatic effects on neurotransmitters in the Central Nervous System. Some drugs, such as marijuana and heroin, have chemical structures that are similar to neutral neurotransmitters, so they can lock on to and activate receptor cells. Other drugs, such as amphetamine or cocaine, cause neurons to release abnormally large amounts of neurotransmitters, or prevent their reuptake. By interfering with the way neurotransmitters function, drugs and alcohol affect many mental processes and behavior. Things like memory, attention, behavior, perception, and alertness are all changed because of what drugs and alcohol do to the neurotransmitters in the CNS.

<p><i>(Notes for Slide 25, continued)</i></p>	<p>Slide 25: How Psychoactive Substances Work</p> <p>Additional Information for the Trainer(s)</p> <p>When absorbed into the body, drugs interact with and modify cells, organs, and bodily systems by:</p> <ul style="list-style-type: none"> • Altering the way the body normally functions (increasing, slowing, or enhancing bodily processes, or level or quality of functioning), • Altering the operation of tissues, organs, and systems, • Affecting hormones and enzymes, and • Impacting processes such as digestion, respiration, circulation, and mental functioning.
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Commonly Used Psychoactive Substances	
SUBSTANCE	EFFECTS
Alcohol (liquor, beer, wine)	euphoria, stimulation, relaxation, lower inhibitions, drowsiness
Cannabinoids (marijuana, hashish)	euphoria, relaxation, slowed reaction time, distorted perception
Opioids (heroin, opium, many pain meds)	euphoria, drowsiness, sedation
Stimulants (cocaine, methamphetamine)	exhilaration, energy
Club Drugs (MDMA/Ecstasy, GHB)	hallucinations, tactile sensitivity, lowered inhibition
Dissociative Drugs (Ketamine, PCP)	feel separate from body, delirium, impaired motor function
Hallucinogens (LSD, Mescaline)	hallucinations, altered perception

Slide 26: Commonly Used Psychoactive Substances



The purpose of this slide is to provide an overview of the most commonly used psychoactive substances—alcohol and other drugs. Review each substance and its main effects with the audience. Tell the audience that this chart in daily practice: if they notice clients acting unusually energetic, tired, or odd, it could be because they are under the influence of one of these substances.

Additional Information for the Trainer(s)

Alcohol: Many Americans drink alcohol at least occasionally. For many people, moderate drinking is probably safe. Moderate drinking is one drink a day for women or anyone over 65, and two drinks a day for men under 65. Some people should not drink at all, including children, pregnant women, people on certain medicines and people with some medical conditions. Anything more than moderate drinking can be risky. Binge drinking - drinking five or more drinks at one time - can damage health and increase risk for accidents, injuries and assault. (Source: National Institute of Health, Medline Plus: Alcohol).

Alcohol can cause neurotransmitters to relay information too slowly, creating feelings of drowsiness. It can trigger mood and behavioral changes, including depression, agitation, memory loss, and seizures. Long-term, heavy drinking causes alterations in neurons that can affect motor coordination, temperature regulation, sleep, mood, learning, and memory. One neurotransmitter particularly susceptible to even small amounts of alcohol is glutamate, which affects memory. Researchers believe that because it interferes with glutamate, alcohol causes some people to temporarily “black out,” or forget much of what happened during a night of heavy drinking. Alcohol also causes an increased release of *serotonin*, another neurotransmitter, which helps regulate emotional expression. (Source: NIAAA, *Beyond Hangovers*).

(Notes for Slide 26, continued)

Slide 26: Commonly Used Psychoactive Substances

Marijuana is derived from a plant containing more than 400 chemicals. Tetrahydrocannabinol (THC) is the main psychoactive ingredient in marijuana. It binds to cannabinoid (CB) receptors, which are highly concentrated in areas of the brain that control pleasure, memory, thought, concentration, sensory and time perception, appetite, pain, and movement coordination. This is why marijuana can have wide ranging effects, including: short-term memory loss, difficulty learning/retaining information, slowed reaction time, impaired motor coordination, impaired judgment and decision-making, an increased heart rate, and an altered mood. Long-term marijuana abuse can lead to dependence, poorer educational outcomes and job performance, respiratory problems, and cognitive impairment. For some people, it can also increase risk of psychosis. *(Source: National Institute on Drug Abuse, Topics in Brief: Marijuana).*

Opioids resemble natural chemicals that have binding sites on receptors. Opioids affect parts of the brain that control emotions, and create feelings of pleasure, relaxation, and contentment. They also act on the brainstem, which controls automatic body functions, and they affect the spinal cord as well. If swallowed as pills, opioids take longer to reach the brain. If they are injected, they act faster and can produce a quick, intense feeling of pleasure followed by a sense of well-being and a calm drowsiness. While prescription pain relievers can be highly beneficial if used as prescribed, opioids as a general class of drugs have a high potential for abuse. *(Source: NIDA Mind Over Matter: Opiates).*

Stimulants: Cocaine is a powerfully addictive stimulant drug that can be snorted or dissolved in water and then injected. Crack is the street name given to the form of cocaine that can be smoked. The term “crack” refers to the crackling sound produced by the rock as it is heated. Injecting or smoking cocaine produces a quicker, stronger high than snorting. Cocaine works by acting on the neurotransmitter dopamine, which is associated with pleasure and movement. Normally dopamine is released by a neuron in response to a pleasurable signal (e.g., the smell of good food), and then recycled back into the cell that released it. Cocaine works by preventing dopamine from being recycled, so the pleasurable feelings caused by dopamine become amplified. With repeated use, cocaine can cause long-term changes in brain, which may eventually lead to abuse or dependence. *(Source: NIDA InfoFacts, Cocaine).*

(Notes for Slide 26, continued)


Slide 26: Commonly Used Psychoactive Substances

Methamphetamine is a white, odorless, bitter-tasting crystalline powder that easily dissolves in water or alcohol and is taken orally, snorted, injected, or smoked. Methamphetamine increases the release of dopamine and blocking its reuptake. Dopamine is involved in reward, motivation, the experience of pleasure, and motor function. Methamphetamine's ability to release dopamine rapidly creates an intense euphoria, or "rush." Chronic use leads to structural and functional changes in areas of the brain associated with emotion and memory, causing many emotional and cognitive problems for chronic users. *(Source: NIDA Infofacts, Methamphetamine).*

MDMA (Ecstasy) is a synthetic, psychoactive drug that is chemically similar to the stimulant methamphetamine and the hallucinogen mescaline. The drug produces feelings of increased energy, euphoria, emotional warmth, and distortions in time, perception, and tactile experiences. MDMA is taken orally, usually as a capsule or tablet. MDMA gets its main effects by acting on neurons that use the neurotransmitter serotonin. The serotonin system plays an important role in regulating mood, aggression, sexual activity, sleep, and sensitivity to pain. MDMA binds to the serotonin transporter, thus increasing and prolonging the serotonin signal. MDMA has similar effects on another neurotransmitter—norepinephrine, which can cause increases in heart rate and blood pressure. MDMA also releases dopamine, but to a much lesser extent. The drug can produce confusion, depression, sleep problems, drug craving, and severe anxiety. MDMA can be harmful to the brain, causing long-lasting damage to neurons. *(Source: NIDA Infofacts, MDMA/Ecstasy).*

GHB (Xyrem) is a central nervous system (CNS) depressant. It has been approved for use in the treatment of narcolepsy. GHB acts on at least two sites in the brain: the GABA_B receptor and a specific GHB binding site. At high doses, GHB's sedative effects may result in sleep, coma, or death. *(Source: NIDA Infofacts: Club Drugs).*

Ketamine is a dissociative anesthetic that distorts perceptions of sight and sound, and can produce feelings of detachment. Ketamine acts on a type of glutamate receptor in the brain. Low-dose intoxication results in impaired attention, learning ability, and memory. At higher doses, ketamine can cause dreamlike states and hallucinations; and at very high doses still, ketamine can cause delirium and amnesia. *(Source: NIDA Infofacts: Club Drugs).*

<p>(Notes for Slide 26, continued)</p>	<p>Slide 26: Commonly Used Psychoactive Substances</p> <p>Hallucinogens: Compounds found in some plants and mushrooms (or their extracts) have hallucinogenic effects, causing profound distortions in perceptions of reality when consumed. Under the influence of hallucinogens, people see images, hear sounds, and feel sensations that seem real but are not. Some hallucinogens also produce rapid, intense emotional swings. While the exact mechanisms that make hallucinogens work are unclear, research shows that these drugs work, at least partially, by temporarily interfering with neurotransmitters and receptors. The most common hallucinogens are LSD, peyote, psilocybin, and PCP. <i>(Source: NIDA InfoFacts: Hallucinogens).</i></p>
	<p>Slide 27: Why People Use Psychoactive Substances</p> <p>While there are many reasons for the initiation into and continued use of alcohol and drugs, key motivators pivot around the main factors included in the slide. People may start to experiment because of peer pressure, or for medical reasons—particularly as a way to alleviate physical pain. After initiation to alcohol/drug use, there are many reasons people continue to use these substances—they may be good ways to relieve stress or pain, or ways to help people function better in specific situations. For example, alcohol may help some people feel more at ease in social situations, while stimulant drugs like cocaine may help some people stay alert and focused while working. Also, because of their effects on neurotransmitters, these substances may help alleviate the symptoms of mental health disorders for some individuals. These motivators are not mutually exclusive. They may co-occur for many people.</p>



Slide 28:[No Title]

While drugs and alcohol may have positive effects at first, continued heavy use changes the structure of the brain and how it works. Because of this, it also affects behavior. These changes to the brain can be long lasting, and can lead to the harmful behaviors seen in people who abuse alcohol or drugs. When a person has a substance use disorder, their ability to exert self-control can become seriously impaired. Brain imaging studies from addicted individuals show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control. Scientists believe that these changes alter the way the brain works, and may help explain the compulsive and destructive behaviors of individuals with substance use disorders.

Additional Information for the Trainer(s)

At first, people may perceive what seem to be positive effects with drug use. They also may believe that they can control their use; however, drugs can quickly take over their lives. Over time, if drug use continues, pleasurable activities become less pleasurable, and drug abuse becomes necessary for abusers to simply feel "normal." Drug abusers reach a point where they seek and take drugs, despite the tremendous problems caused for themselves and their loved ones. Some individuals may start to feel the need to take higher or more frequent doses, even in the early stages of their drug use. The initial decision to take drugs is mostly voluntary. However, when drug abuse takes over, a person's ability to exert self-control can become seriously impaired. Brain imaging studies from drug-addicted individuals show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control. Scientists believe that these changes alter the way the brain works, and may help explain the compulsive and destructive behaviors of addiction.

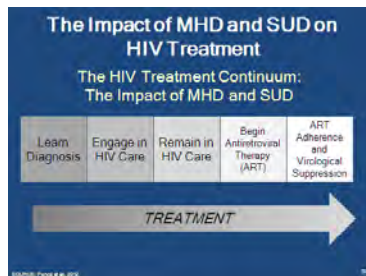


Slide 29: Substance Use Disorders – Diagnosis and Treatment

As with Mental Health Disorders, there is no physical test for a Substance Use Disorder—these disorders are also identified through observation and interview, and criteria are laid out in the DSM. Much of the treatment of Substance Use Disorders involves behavioural interventions. Some of the more common ones are 12 step groups and many of the interventions used when working with people who have Mental Health Disorders. Medications can help improve the effectiveness of behavioral interventions. It is important to remember that medications are not a **substitute** for behavioral interventions, but **adjuncts** to them. Currently, there are medications available for the treatment of alcohol and opioid dependence. Even though many people in recovery from Substance Use Disorders look down on the use of medication in treatment, it works for many clients who may not be able to recover otherwise (see additional information below).

Additional Information for the Trainer(s)

Some audience members may hold negative perceptions about the use of medications to treat SUD. Many of these ideas are rooted in traditions from 12-step programs and other traditional forms of substance abuse treatment that view medications as “other ways of getting high” instead of “real” sobriety. In particular, many Narcotics Anonymous groups are hostile to the use of medications for the treatment of opioid dependence. However, medications are effective adjuncts to other forms of treatment. When used properly, these medications do not cause the euphoric effects, or “highs” of alcohol or drugs that are being abused. It is also not true that the use of medications is irreconcilable with the effective treatment substance use disorders. Medication is used in the treatment of many chronic diseases, including substance use disorders. While some members of traditional programs (Alcoholics Anonymous, Narcotics Anonymous) are hostile to the use of medications, their opposition is not rooted in these organizations’ guiding texts. In fact, Alcoholics Anonymous literature endorses the use of medicines as prescribed for the treatment of medical conditions. In Chapter 9 of the Big Book of Alcoholics Anonymous, it reads: “...this does not mean that we disregard human health measures. God has abundantly supplied this world with fine doctors, psychologists, and practitioners of various kinds. Do not hesitate to take your health problems to such persons. Most of them give freely of themselves, that their fellows may enjoy sound minds and bodies. Try to remember that though God has wrought miracles among us, we should never belittle a good doctor or psychiatrist. Their services are often indispensable in treating a newcomer and in following his case afterward.”



Slide 30: The Impact of MHD and SUD on HIV Treatment



****ANIMATION INSTRUCTIONS****

Please note the animation contained within this slide. Trainers should practice delivering the material on this slide in advance of the training, so they are comfortable with the order in which the animation and text appear on the slide. Review the first two points, and then click once before making the final point.

Mental health and substance use disorders are particularly problematic for HIV clients because of their impact on HIV treatments—in particular on antiretroviral therapy (ART). The normal course of HIV treatment with ART is illustrated in the slide. Upon learning about HIV diagnosis, HIV clients are then engaged in care; once they have been established in HIV care, they begin ART. If they are adherent to ART, they can have a successful suppression of the HIV virus. MHD and SUD disrupt this process of care, keeping clients from properly addressing their HIV.



REFERENCE:

Pence et al. (2012). *Contemporary Clinical Trials*, 33(4), 828-38.

The Impact of MHD and SUD on HIV Treatment	
Engage in HIV Care	<ul style="list-style-type: none"> Decreased/delayed access to treatment associated with depression, use of alcohol and most drugs
Begin Antiretroviral Therapy (ART)	<ul style="list-style-type: none"> Decreased prescription to ART associated with depression, use of alcohol and most drugs
ART Adherence and Virological Suppression	<ul style="list-style-type: none"> Decreased adherence to ART associated with depression, anxiety, use of alcohol and most drugs Less virological suppression and slower CD4 cell response rate due to poor ART adherence

Slide 31: The Impact of MHD and SUD on HIV Treatment

MHD and SUD disrupt several steps of the antiretroviral treatment process. Depression, alcohol use and drug use make it less likely that people with HIV will engage in treatment. These conditions are also associated with lower rates of prescription to ART. They are also associated with decreased adherence to ART amongst those who receive it. This leads to worse outcomes, including less virological suppression and slower CD4 count response to ART.



REFERENCES:

1. Chandler, G., Himelhoch, S., & Moore, R.D. (2006). Substance abuse and psychiatric disorders in HIV-positive patients: Epidemiology and impact on antiretroviral therapy. *Drugs*, 66, 769-789.
2. Gonzalez, J.S., Batchelder, A.W., Psaros, C., & Safren, S.A. (2011). Depression and HIV/AIDS treatment nonadherence: A review and meta-analysis. *Journal of Acquired Immune Deficiency Syndromes*, 58, 181-187.
3. Altice, F.L., Kamarulzaman, A., Soriano, V., et al. (2010). Treatment of medical, psychiatric, and substance-use comorbidities in people infected with HIV who use drugs. *Lancet*, 376(9738), 367-387.
4. Blashill, A.J., Perry, N., & Safren, S.A. (2011). Mental health: A focus on stress, coping, and mental illness as it relates to treatment retention, adherence, and other health outcomes. *Current HIV/AIDS Reports*, 8, 215-222.
5. Tegger, M.K., Crane, H.M., Tapia, K.A., Uldall, K.K., Holte, S.E., & Kitahata, M.M. (2008). The effect of mental illness, substance use, and treatment for depression on the initiation of highly active antiretroviral therapy among HIV-infected individuals. *AIDS Patient Care and STDs*, 22, 233-243.

The Impact of MHD and SUD on HIV Outcomes

- Depression associated with severity of HIV illness, CD4 cell count decline, and increased mortality.
- Early mortality among HIV clients significantly increases if they have SUD
- Among patients hospitalized for HIV/AIDS medical complications:
 - 31% have major depression
 - 19% have a substance use disorder
 - 16% have bipolar disorder
 - 13% have anxiety disorder

Slide 32: The Impact of MHD and SUD on HIV Outcomes

People with depression often have more severe HIV illness, greater decline of CD4 cell counts, and higher mortality. HIV clients are also more likely to die early if they have a substance use disorder. Among people whose HIV illness leads them to be hospitalized, behavioral health disorders are quite common (read statistics on slide).

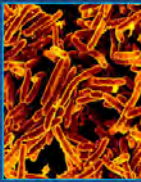


REFERENCES:

1. Chandler, G., Himelhoch, S., & Moore, R.D. (2006). Substance abuse and psychiatric disorders in HIV-positive patients: epidemiology and impact on antiretroviral therapy. *Drugs*, 66(6), 769-789.
2. De Lorenze, G.N., Weisner, C., Tsai, A.-L., et al. (2011). Excess mortality among HIV-infected patients diagnosed with substance use dependence or abuse receiving care in a fully integrated medical care program. *Alcoholism, Clinical and Experimental Research*, 35(2), 203-210.
3. DeLorenze, G.N., Satre, D.D., Quesenberry, C.P., et al. (2010). Mortality after diagnosis of psychiatric disorders and co-occurring substance use disorders among HIV-infected patients. *AIDS Patient Care and STDs*, 24(11), 705-712.
4. Safren, S.A., O'Cleirigh, C., Tan, J., et al. (2009). A randomized controlled trial of Cognitive Behavioral Therapy for Adherence and Depression (CBT-AD) in HIV-infected individuals. *Health Psychology*, 28(1), 1-10.
5. Ferrando, S., Evans, S., Goggin, K, et al. (1998). Fatigue in HIV illness: relationship to depression, physical limitations, and disability. *Psychosomatic Medicine*, 60(6), 759-764.

Conditions Complicated by HIV: Tuberculosis

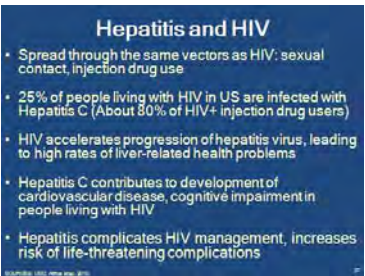

- Airborne bacterial infection caused by *Mycobacterium tuberculosis*
- 5-10% of infected persons will develop disease
- Symptoms:
 - Bad cough 3 weeks+
 - Cough up blood/mucus
 - Weakness/fatigue
 - Fever/chills
- Lethal if not treated properly (antibiotics for 6-12 months)
- Multi-drug resistant TB: Antibiotics for up to two years, poor prognosis.



Slide 33: Conditions Complicated by HIV – Tuberculosis

Tuberculosis is an airborne bacterial infection, and 5-10% who are infected with the bacteria will develop the diseases. The symptoms include severe coughing, as well as weakness, fatigue, and fevers. If not treated properly, it can be lethal. Normal treatment for TB involves antibiotics for 6-12 months. In cases where a multi-drug resistant form of TB is causing the infection, the prognosis is poor, and antibiotics should be taken for up to two years.



<div data-bbox="110 268 472 541" data-label="Complex-Block"> <p>Tuberculosis and HIV</p> <ul style="list-style-type: none"> • Spread person to person: Increased exposure to the bacteria in crowded settings (healthcare settings, correctional facilities) • People with HIV are at 20-30 times the risk of having TB become active • People with TB and HIV are more likely to die from TB than from AIDS • HIV complicates TB diagnosis because TB tests are affected by weakened immune system <p><small>SOURCE: CDC, HIV Resource, 2013</small></p> </div>	<p>Slide 34: Tuberculosis and HIV</p> <p>HIV clinicians need to be aware of TB because many clients are at increased risk for exposure to it. The bacteria spread person-to-person, and people who spend time in crowded and poorly ventilated settings are at high risk for TB exposure. Some places where HIV clients may spend time—places like hospitals and correctional facilities—are places where TB is likely to spread. Having HIV dramatically increases the likelihood that TB will become active. Because of weakened immune system, people who have HIV and TB are actually more likely to die from TB than from AIDS. It is difficult to identify TB in HIV clients because the test for TB relies on immune responses. When the immune system is weakened by HIV, someone with TB may screen negative on a test.</p> <div data-bbox="532 701 630 800" data-label="Image"> </div> <p><u>REFERENCE:</u></p> <p>Altice, F.L., Kamarulzaman, A., Soriano, V., et al. (2010). Treatment of medical, psychiatric, and substance-use comorbidities in people infected with HIV who use drugs. <i>Lancet</i>, 376(9738), 367-387.</p>
<div data-bbox="110 1136 472 1409" data-label="Complex-Block"> <p>Tuberculosis and HIV: What to Do</p> <ul style="list-style-type: none"> • Test all newly diagnosed HIV clients for TB • Test people living with HIV for TB every year • If TB+, start treatment ASAP • Treatment from providers with expertise managing both conditions • Take steps to ensure TB medication adherence • Treatment important since it also prevents spread of the disease <p><small>SOURCE: CDC, HIV Resource, 2013</small></p> </div>	<p>Slide 35: Tuberculosis and HIV: What to Do</p> <p>Test all people who are newly diagnosed with HIV for TB as well. People with HIV should be continually tested, since the less advanced the HIV, the more likely the TB test is to work. If HIV clients do have TB, they should begin treatment as soon as possible, and receive treatment from provider who have experience managing both conditions. As with HIV, medication adherence is critical for clients with TB. Medication support to help clients begin and remember to complete their course of medicine may be necessary. Treatment is also important from a public health perspective—if not treated, clients can spread TB to others.</p>
<div data-bbox="110 1570 472 1843" data-label="Complex-Block"> <p>Conditions Complicated by HIV: Hepatitis</p> <ul style="list-style-type: none"> • Viruses that lead to liver inflammation, causing: <ul style="list-style-type: none"> – Abdominal Pain – Abdominal swelling – Fatigue – Fever – Loss of Appetite – Vomiting • Can lead to liver cirrhosis, liver cancer • Can be treated with antiviral medications for 24-48 weeks • Some cases require liver transplant • Vaccines for Hepatitis A and B <div data-bbox="313 1629 456 1822" data-label="Image"> </div> <p><small>SOURCE: CDC, HIV Resource, 2013</small></p> </div>	<p>Slide 36: Conditions Complicated by HIV: Hepatitis</p> <p>Several forms of hepatitis exist, each of which are viruses that lead to liver inflammation. If untreated, these can lead to liver cirrhosis or cancer. It can be treated with antiviral medications for 24-48 weeks, though some cases require a liver transplant. Vaccines are available for two types of hepatitis—hepatitis A and hepatitis B.</p>

 <p>Hepatitis and HIV</p> <ul style="list-style-type: none"> • Spread through the same vectors as HIV: sexual contact, injection drug use • 25% of people living with HIV in US are infected with Hepatitis C (About 80% of HIV+ injection drug users) • HIV accelerates progression of hepatitis virus, leading to high rates of liver-related health problems • Hepatitis C contributes to development of cardiovascular disease, cognitive impairment in people living with HIV • Hepatitis complicates HIV management, increases risk of life-threatening complications 	<p>Slide 37: Hepatitis and HIV</p> <p>HIV clients are at risk for hepatitis because the disease spreads the same way as HIV—through sexual contact and injection drug use. About 25% of people living with HIV in the US have Hepatitis C. This number is close to 80% for injection drug users who have HIV. HIV worsens the prognosis for people with hepatitis, as it accelerates the progression of the disease, leading to more liver problems. HIV clients who have hepatitis are also at greater risk for cardiovascular problems, and the development of cognitive problems. Hepatitis also complicates the management of HIV, and increases the risk of HIV-related complications.</p>
 <p>Hepatitis and HIV: What to Do</p> <ul style="list-style-type: none"> • Test all HIV clients for hepatitis B and hepatitis C. • Treatment from health care providers with expertise managing both infections • Counsel HIV clients on drug interactions and side effects of hepatitis and HIV treatments • Provide support to help clients complete course of hepatitis treatment 	<p>Slide 38: Hepatitis and HIV: What to Do</p> <p>The CDC recommends testing all HIV clients for Hepatitis B and C. If clients screen positive, they should receive treatment from a healthcare provider with expertise managing both infections. HIV clients should be counseled on the interactions between HIV medications and hepatitis medications, as well as the side effects of both. It is important to provide supports—from pharmacists, peers, or in groups—to help clients complete course of hepatitis treatment, which can sometimes have difficult side effects.</p> <p>Additional Information for the Trainer(s)</p> <p>Though some people experience few or no side effects from hepatitis treatments, a substantial number to experience serious side effects, including: anxiety, depression, or sadness; fatigue; headaches and fevers; muscle and body aches; poor appetite; nausea; or rashes.</p>

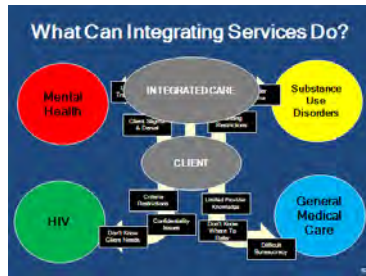
<div data-bbox="110 270 470 541"> <p>Clients Need Services beyond HIV Care, but there are Obstacles</p> <p><u>System Level</u></p> <ul style="list-style-type: none"> - Criteria to receive services based on severity, financial resources - Restrictions on what services will be reimbursed - Restrictions on sharing health information across systems </div>	<p>Slide 39: Clients Need Services beyond HIV Care, but there are Obstacles</p> <p>While it is clear that clients need services for all of these problems other than HIV (mental health, substance use disorders, other medical problems) they can be difficult to access. At the system wide level, there are barriers that make it difficult for clients to receive services. Often, criteria restrict who can receive certain kinds of services—only if they have severe problems, or if they have few financial resources. Restrictions also exist regarding who can bill for providing what services; it can be difficult for certain providers to deliver mental health services for example. And there are also privacy rules that prevent providers in different health systems from sharing clients’ health information. In particular, HIPAA, which covers mental health information, and federal regulation 42 C.F.R., which covers substance abuse treatment records, make it difficult to share information concerning mental health and substance use disorder treatment.</p> <p>Additional Information for the Trainer(s)</p> <p>42 CFR Part 2 is generally more stringent than the HIPAA regulations concerning mental health. For more information on these issues, see SAMHSA’s 2004 pamphlet <i>The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs</i>, available online at: http://www.samhsa.gov/HealthPrivacy/docs/SAMHSAPart2-HIPAAComparison2004.pdf and a 2011 SAMHSA presentation about 42 CFR Part 2 available at: http://www.integration.samhsa.gov/workforce/Clark Westley II 508 Read-Only Compatibility Mode.pdf.</p>
<div data-bbox="110 1306 470 1577"> <p>Clients Need Services beyond HIV Care, but there are Obstacles</p> <p><u>Clinic/Provider Level</u></p> <ul style="list-style-type: none"> - Lack of knowledge of areas outside specialty - Stigma - Don't know how to identify client needs - Don't know where to refer clients who need specialty services - Poor linkage/follow-up mechanisms </div>	<p>Slide 40: Clients Need Services beyond HIV Care, but there are Obstacles</p> <p>Major obstacles exist to providing these services at the provider level. Many providers don’t have much knowledge outside of their specialty area—for example, many HIV providers may not know much about mental health. Because of this, they may carry stigmas about certain conditions. Providers may also have difficulty identifying clients’ who need other services, especially if it involves asking personal questions about mental health or substance use. Also, even if providers find out that clients have a problem with something like mental health or substance abuse, they may not know what to do about it.</p>

<div data-bbox="110 268 470 541"> <p>Clients Need Services beyond HIV Care, but there are Obstacles</p> <p><u>Client Level</u></p> <ul style="list-style-type: none"> - Difficulty navigating bureaucracy - Logistical/transportation issues - Stigma/reluctance to access services </div>	<p>Slide 41: Clients Need Services beyond HIV Care, but there are Obstacles</p> <p>Major barriers exist at the level of the individual client that prevents access to needed services. Clients may have difficulty navigating through the bureaucracy of different health systems. Transportation can be an issue, particularly if different providers are located in different parts of town. Also, many clients carry stigma about certain conditions—especially mental health and substance use conditions. Since they are afraid of being labeled “crazy” or “an addict,” many are reluctant to ask for help or access services even if they need them.</p>
<div data-bbox="110 667 470 940"> <p>Our Current System: Barriers</p> </div>	<p>Slide 42: Our Current System – Barriers</p> <div data-bbox="560 667 641 793"> </div> <p>**ANIMATION INSTRUCTIONS**</p> <p><i>Please note the animation contained within this slide. Trainers should practice delivering the material on this slide in advance of the training, so they are comfortable with the order in which the animation and text appear on the slide. Click once to begin the animation. Point out that all of these barriers together block clients from getting the services they need.</i></p>
<div data-bbox="110 1184 470 1457"> <p>Share Your Experience</p> <ol style="list-style-type: none"> 1. What has your experience been getting HIV clients appropriate services to address their... <ul style="list-style-type: none"> a. mental health? b. substance use behaviors? c. general health or other physical conditions? 2. Was it difficult to figure out what their needs were? How did you get this information? 3. Did you encounter any barriers trying to get them services beyond HIV care? What were they? </div>	<p>Slide 43: Share Your Experience</p> <div data-bbox="516 1184 641 1289"> </div> <p>INSTRUCTIONS</p> <p><i>Break the audience into groups, and have them discuss the questions on the slide for 5-7 minutes. After the discussion is complete, reconvene the group to discuss what the audience’s experience with integration has been. Note major points that come up on a whiteboard or flipchart.</i></p>

<div data-bbox="110 268 472 541" data-label="Image"> </div>	<p>Slide 44 [Transition Slide]: Part 2 – Integration at the System, Clinic, and Provider Levels</p> <p>This section will look at what integration is, and how it can occur at the level of service delivery systems, clinic organizations, and individual providers. The focus of this section will be on the organizational aspects of integration, what steps integration entails, some of the barriers that may come up during integration, and potential solutions to them.</p>
<div data-bbox="110 667 472 940" data-label="Image"> </div>	<p>Slide 45: Integrated HIV Care – A Definition</p> <div data-bbox="560 667 641 793" data-label="Image"> </div> <p><i>Read the definition featured on this slide, emphasizing the underlined sections. At the conclusion of this slide, highlight that for the rest of the presentation, discussions of integration will focus on integration of HIV care with mental health and substance use disorder services.</i></p> <div data-bbox="535 1003 630 1108" data-label="Image"> </div> <p><u>REFERENCE:</u></p> <p>Soto, T.A., Bell, J., Pillen, M.B., et al. (2004). Literature on integrated HIV care: a review. <i>AIDS Care</i>, 16(Sup 1), S43-S55.</p>

<div data-bbox="110 268 470 541" data-label="Complex-Block"> <p>What Integration Does</p> <ul style="list-style-type: none"> • Strengthens organizational linkages between medical and behavioral health care • Improves access by expanding availability of services and removing barriers (administrative, transportation) • Improves coordination of services • Identifies service needs and links clients to appropriate treatment • Blends interventions to treat whole person rather than isolated problems or disorders  </div>	<p>Slide 46: What Integration Does</p> <p>Integrated care can strengthen organizational linkages between existing medical care, mental health care, and substance abuse treatment services. These affiliations may facilitate referral and improve care coordination by decreasing administrative and financial barriers. Providers can assist in identifying care needs and linking patients to appropriate treatment. Having different kinds of providers in one location can improve access to care by reducing transportation barriers and making it easier for patients to see the most relevant clinicians. Integrated care also allows providers to blend appropriate aspects of different interventions to serve the specific needs of clients. Rather than treating disorders, it allows the focus of care to shift to the whole person.</p> <div data-bbox="532 703 630 798" data-label="Image"> </div> <p><u>REFERENCE:</u></p> <p>Ohl, M.E., Landon, B.E., Cleary, P.D., et al. (2008). Medical clinic characteristics and access to behavioral health services for persons with HIV. <i>Psychiatric Services</i>, 59(4), 400-407.</p>
<div data-bbox="110 1134 470 1407" data-label="Complex-Block"> <p>The Four Keys to Integrated Services</p> <ul style="list-style-type: none"> • Identifying clients' needs • Meeting their needs if you can • Getting them to someone who can meet their needs if you can't • Assuring that services are as coordinated or integrated as possible  </div>	<p>Slide 47: The Four Keys to Integrated Services</p> <div data-bbox="560 1134 641 1255" data-label="Image"> </div> <p><i>Review the four points on the slide.</i></p>
<div data-bbox="110 1528 470 1801" data-label="Complex-Block"> <p>Integration Involves a Major Change to "Business As Usual"</p> <ul style="list-style-type: none"> • Requires working around silo walls, or tearing them down • Reorienting care from specific disorders and service systems to more holistic care <ul style="list-style-type: none"> – Physical health – Mental health/substance abuse – Socioeconomic factors that impact health • Involves change at several levels of service delivery <ul style="list-style-type: none"> – System level (federal, state, county) – Clinic level (service delivery organizations) – Provider level (doctors, nurses, social workers, case managers, etc.) </div>	<p>Slide 48: Integration Involves a Major Change to "Business as Usual"</p> <p>Integration often means making major changes to the way treatment is currently being provided. The main change involves shifting care from services that address specific disorders (HIV, mental health, etc) to more holistic care for the whole person: this involves addressing clients' physical health needs, mental health needs, their substance use behaviors, and the socioeconomic factors (things like poverty and housing) that may adversely affect their health. This involves change at several levels—at the system level, the clinic level, and the provider level. Each of these will be discussed in greater detail in the following three slides.</p>

<div data-bbox="110 275 467 541"> <p>Reorienting Services: System Level</p> <ul style="list-style-type: none"> • Tear down silos • Broaden criteria of who can receive services where <ul style="list-style-type: none"> – Preventive care – Early intervention before conditions become acute or disabling • Loosen restrictions on what services are reimbursable in different service settings • Devise ways to share clinically important information while respecting client privacy <ul style="list-style-type: none"> – HIPAA – 42 CFR Part 2 </div>	<p>Slide 49: Reorienting Services – <u>System Level</u></p> <div data-bbox="558 275 639 394"> </div> <p><i>Review the points on the slide, which highlight some of the major changes that the health system will have to make to provide integrated care. Highlight that most of these changes are at the policy level, but there are still steps providers can make towards making integration happen at other levels.</i></p>
<div data-bbox="110 690 467 957"> <p>Reorienting Services: Clinic Level</p> <ul style="list-style-type: none"> • Establish services to screen/assess for problems outside of specialty <ul style="list-style-type: none"> – Identify clients' needs in all areas of health and health-related domains – Offer integrated services to address client needs if possible – Provide effective linkage and referral services in severe/complicated cases that require specialty care • Integrate case management into menu of services <ul style="list-style-type: none"> – Help clients navigate administrative/bureaucratic hurdles – Work with clients to address socioeconomic challenges that negatively impact health – Assist clients with logistical/transportation issues </div>	<p>Slide 50: Reorienting Services – <u>Clinic Level</u></p> <p>To provide integrated services, clinics will have to make several changes. They will need to establish protocols to identify and serve clients' needs the best they can, and provide linkage/referral services to specialty providers in severe cases that require specialty care. Case management services will need to be offered by providers who want to provide integrated care. Case managers are critical in helping clients navigate different health systems, and also with working on socioeconomic issues that may negatively impact their health.</p>
<div data-bbox="110 1087 467 1354"> <p>Reorienting Services: Provider Level</p> <ul style="list-style-type: none"> • Learn about areas outside specialty; overcome stigma and misunderstandings about certain conditions • Learn how to effectively communicate with providers from other disciplines/backgrounds • Learn how to screen and assess for a variety of conditions • Learn how to provide effective brief intervention services • Learn about resources available for clients who need specialty services • Learn how to effectively link clients to services they need </div>	<p>Slide 51: Reorienting Services – <u>Provider Level</u></p> <p>To deliver integrated services, providers will need to learn about conditions they are unfamiliar with, and overcome stigmas or prejudices they may have about them. Providers will also have to learn to effectively communicate with providers from other disciplines or in other systems. This will involve both understanding their terminology and what services they provide. Providers will need to learn how to conduct screenings and deliver brief intervention services. Providers will need to learn about what specialty services are available outside of their agency, and how to link clients to these services if necessary.</p>



Slide 52: What Can Integrating Services Do?

****ANIMATION INSTRUCTIONS****

Please note the animation contained within this slide. Trainers should practice delivering the material on this slide in advance of the training, so they are comfortable with the order in which the animation and text appear on the slide. Click once to activate the animation. As the animation is in motion, highlight that integration eliminates barriers to care, making it much easier for clients to access the services they need.

- Improve mental health
- Reduce drug/alcohol use
- Increase retention in medical care
- Improve health-related quality of life
- Improve adherence to ART, reduce viral load, increase CD4 Count
- Lower risk of premature death

Research shows that integrating services for HIV clients leads to improvements not only in HIV outcomes, but also in mental health and substance abuse outcomes (see points on the slide). By helping improve both HIV outcomes and other aspects of health, integrated HIV care can help lengthen the lives of HIV clients, and improve their health-related quality of life in the process.



1. Chandler, G., Himelhoch, S., & Moore, R.D. (2006). Substance abuse and psychiatric disorders in HIV-positive patients: epidemiology and impact on antiretroviral therapy. *Drugs*, 66(6), 769-789.
2. Yun, L.W.H., Maravi, M., Kobayashi, J.S., Barton, P.L., & Davidson, A.J. (2005). Antidepressant treatment improves adherence to antiretroviral therapy among depressed HIV-infected patients. *Journal of Acquired Immune Deficiency Syndromes*, 38, 432-438.
3. Safren, S.A., O'Leirigh, C., Tan, J., et al. (2009). A randomized controlled trial of Cognitive Behavioral Therapy for Adherence and Depression (CBT-AD) in HIV-infected individuals. *Health Psychology*, 28(1), 1-10.
4. DeLorenze, G.N., Satre, D.D., Quesenberry, C.P., et al. (2010). Mortality after diagnosis of psychiatric disorders and co-occurring substance use disorders among HIV-infected patients. *AIDS Patient Care and STDs*, 24(11), 705-712.
5. Ferrando, S., Evans, S., Goggin, K, et al. (1998). Fatigue in HIV illness: relationship to depression, physical limitations, and disability. *Psychosomatic Medicine*, 60(6), 759-764.
6. Ohl, M.E., Landon, B.E., Cleary, P.D., et al. (2008). Medical clinic characteristics and access to behavioral health services for persons with HIV. *Psychiatric Services*, 59(4), 400-407.
7. Proeschoed-Bell, R.J., Heine, A., Pence, B.W., McAdam, K., & Quinlivan, E.B. (2010). A cross-site, comparative effectiveness study of an integrated HIV and substance use treatment program. *AIDS Patient Care and STDs*, 24, 651-658.

(Notes for Slide 53, continued)

Slide 53: Integrating Services for HIV Clients – The Evidence



REFERENCES, continued:

8. Parry, C.D., Blank, M.B., & Pithey, A.L. (2007). Responding to the threat of HIV among persons with mental illness and substance abuse. *Current Opinion in Psychiatry*, 20(3), 235-241.
9. Blank, M.B., Hanrahan, N.P., Fishbein, M., Wu, E.S., Tennille, J.A., Ten Have, T.R., Kutney-Lee, A.M., Gross, R., Hines, J.M., Coyne, J.C., & Aiken, L.H. (2011). A randomized trial of a nursing intervention for HIV disease management among persons with serious mental illness. *Psychiatric Services*, 62, 1318-1324.
10. Parsons, J.T., Golub, S.A., Rosof, E., & Holder, C. (2007). Motivational interviewing and cognitive-behavioral intervention to improve HIV medication adherence among hazardous drinkers: A randomized controlled trial. *Journal of Acquired Immune Deficiency Syndromes*, 46, 443-450.



Slide 54: What Do Integrated Services Look Like?

Integration is more a process than a thing—it takes time, and it usually happens gradually. This continuum illustrates the steps organizations take as they integrate. When services are coordinated, they are given by separate medical and behavioral health providers, and in separate settings. When services are co-located, medical and behavioral health providers are still separate, but they work in the same location. And when services are integrated, medical and behavioral health providers are not only co-located, but they work together as a team to provide care that addresses both the physical and behavioral health needs of their clients. Different models and levels of integration are being used to better coordinate services will be discussed in greater detail in the five slides that follow.



REFERENCE:

Collins, C., Hewson, D.L., Mungar, R., & Wade, T. (2010). *Evolving Models of Behavioral Health Integration in Primary Care*. New York, NY: Milbank Memorial Fund.

What Do Integrated Services Look Like?

Minimal Integration

- Providers work in separate systems, separate facilities, rarely communicate
- MH/SUD consultation with HIV providers and vice versa, but not about specific clients
- Case managers coordinate care, provide transportation

HIV
Care

MH/SUD

Slide 55: What Do Integrated Services Look Like? – Minimal Integration

In systems with minimal integration, medical and MH/SUD providers work in separate systems, and rarely communicate with one another. Often, these setups involve consultation, with MH/SUD providers providing consultations to medical providers when they have general questions, but not regarding any specific clients. Many organizations using this approach utilize case managers from MH/SUD to coordinate clients' medical and behavioral health care. They can also provide transportation for medical and MH/SUD appointments.

Additional Information for the Trainer(s)

REAL WORLD EXAMPLE: A behavioral health agency has mental health case managers transport patients to primary care appointments. The agency has a formal policy stating that mental health providers must contact referring primary care providers. Administrative staff from both agencies meets annually to discuss ways to enhance communication and address common concerns.

What Do Integrated Services Look Like?

Basic Integration at a Distance

- Providers work in separate systems/facilities, but they communicate about shared clients.
- HIV provider consults with MH/SUD provider on how to serve specific clients' needs.
- Based on MH/SUD providers' input, HIV providers give screening and brief intervention services.



Slide 56: What Do Integrated Services Look Like? – Basic Integration at a Distance



****ANIMATION INSTRUCTIONS****

Please note the animation contained within this slide. Trainers should practice delivering the material on this slide in advance of the training, so they are comfortable with the order in which the animation and text appear on the slide. After bringing up the slide, click once to start the animation. The animation will run while you go through the key points.

In this model, MH/SUD and medical providers still work in separate systems and separate facilities, but they will communicate about clients that they have in common. Often in systems that use this setup, medical providers will consult with MH/SUD providers about specific clients. Based on input from the MH/SUD side, medical providers may actually provide some MH/SUD services by themselves.

Additional Information for the Trainer(s)

REAL WORLD EXAMPLE: Primary care doctors can access real-time telephone consultation from a psychiatrist. The primary care physician may also refer the patient for psychiatric evaluation and assistance with treatment planning. A team composed of a case manager, social worker, and psychiatrist provides consultation and training for primary care physicians. The team also helps with access to specialty care and offers direct services if there is a waiting list for specialty services.



Slide 57: What Do Integrated Services Look Like? – Basic Integration On-Site



****ANIMATION INSTRUCTIONS****

Please note the animation contained within this slide. Trainers should practice delivering the material on this slide in advance of the training, so they are comfortable with the order in which the animation and text appear on the slide. Click once to begin animation for the first point. Click a second time and then review the second point. Click a third time and then review the third point.

In this model, MH/SUD and medical providers still work in separate systems, but they provide services in the same physical location. Often, this involves sending a MH/SUD clinician to a medical setting, where they will screen patients for MH/SUD problems. If patients have minor problems, the clinician will provide services to them onsite. If they find that the patient is in need of more intensive services, they provide referrals and linkage services to ensure that clients can access higher levels of behavioral health care. In other systems, the approach is to have medical providers co-located in specialty MH or SUD settings, where they can provide basic medical screenings and services.

Additional Information for the Trainer(s)

REAL WORLD EXAMPLE: A large rural primary care practice works with a nearby psychiatric clinic mental health services to youth. Children are screened for mental health problems, and a nurse practitioner conducts assessments. A social worker is available to provide on-site counseling, and a psychiatrist is available for psychiatric evaluations and consultations. About two-thirds of identified children need treatment by only the physician or nurse practitioner. About 19 percent of identified children receive care from the social worker or psychiatrist. Only 13 percent of identified children require referral for specialty mental health care.



Slide 58: What Do Integrated Services Look Like? – Close Partially Integrated Services





****ANIMATION INSTRUCTIONS****



Please note the animation contained within this slide. Trainers should practice delivering the material on this slide in advance of the training, so they are comfortable with the order in which the animation and text appear on the slide. Click once to begin animation while reviewing key points.

MH/SUD and medical providers are co-located, and even though they don't work in the same systems, they do share many things, such as scheduling systems and medical records. This leads to better communication and collaboration between the two types of providers. These organizations often use case managers who specialize in working with individuals with MHD or SUD collaborating with medical providers on patient care.

Additional Information for the Trainer(s)

REAL WORLD EXAMPLE: A nonprofit system of outpatient clinics, hospitals, and health plans serves both children and adults. After a comprehensive assessment, patients are assigned to one of three types of care--low care, moderate care, or specialty care. In low care, patient care is managed by a physician with support from a care manager. In moderate care, the entire mental health team—including a mental health clinician and psychiatric consultant—is involved in care. High-need patients are referred to specialty care—with tools to facilitate communication and follow-up with the mental health agency.

<div data-bbox="110 275 469 543" data-label="Complex-Block"> <p>What Do Integrated Services Look Like?</p> <p>Fully Integrated Services</p> <ul style="list-style-type: none"> • MH/SUD and HIV providers work in the same facility, under the same system, and as part of the same team. • Client may experience MH/SUD treatment as part of regular care. • MH/SUD and HIV providers regularly consult on client care, can see clients together at the same time.  </div>	<p>Slide 59: What Do Integrated Services Look Like? – Fully Integrated Services</p>  <p>**ANIMATION INSTRUCTIONS**</p> <p><i>Please note the animation contained within this slide. Trainers should practice delivering the material on this slide in advance of the training, so they are comfortable with the order in which the animation and text appear on the slide. Click once to begin animation while reviewing key points.</i></p> <p>When services are fully integrated, MH/SUD and medical providers work in the same facility, under the same system, and as part of the same treatment team. In these setups, MH and SUD services are streamlined with the rest of medical care, so clients experience behavioral health treatment as a regular part of medical care. These setups encourage MH/SUD and medical providers to collaborate on client care, and they may even see clients together, as a team, at the same time.</p> <p>Additional Information for the Trainer(s)</p> <p>REAL WORLD EXAMPLE: A health center offers both comprehensive primary care service and specialized services for persons with serious mental illness. The mental health services include case management, day programs, and substance abuse services. Case managers work with adults and children with serious mental illness, as well as patients with chronic physical health problems. Co-location of services enables providers to collaborate informally. Treatment team meetings are held monthly for patients with complex mental and physical health needs, and sometimes primary care and behavioral health staff see patients together.</p>
<div data-bbox="110 1409 469 1677" data-label="Complex-Block"> <p>Making Integration a Reality: It's Not Easy</p> <ul style="list-style-type: none"> • As service integration becomes more intense, it requires more change at all levels • Integration may require action at all levels of service delivery (system, clinic, provider) • It may not be possible to make changes at every level at once </div>	<p>Slide 60: Making Integration a Reality – It's Not Easy</p> <p>As services become more integrated, things can become more challenging. Steps need to be taken at every level to make integration happen. It may not be possible to reach full integration quickly, so changes can be made incrementally at different levels.</p>

<div data-bbox="110 275 472 543"> <p>Making Integration a Reality: The System Level</p> <ul style="list-style-type: none"> • Establish mechanisms to facilitate collaboration and consultation across systems/organizations • Create integrated medical records and billing systems • Provide funding for integrated services • Set up mechanisms so providers can bill for integrated services </div>	<p>Slide 61: Making Integration a Reality – The System Level</p> <div data-bbox="558 275 639 390">  </div> <p><i>Review the points on the slide, explaining the changes that will need to occur at the system-wide level in order to make services more integrated.</i></p>
<div data-bbox="110 674 472 942"> <p>Making Integration a Reality: The System Level</p> <ul style="list-style-type: none"> • Devise ways for providers to share health information while complying with privacy regulations • Provide training providers need to deliver integrated services • Provide resources providers need to build integrated service capacity </div>	<p>Slide 62: Making Integration a Reality – The System Level</p> <div data-bbox="558 674 639 789">  </div> <p><i>Review the remaining points concerning the changes that will need to occur at the system-wide level in order to make services more integrated.</i></p>

Making Integration a Reality: The Clinic Level

- Establish partnerships with outside organizations
- Set up protocols for clinical collaboration and consultation
- Hire/train case managers
- Find space for co-located staff
- Integrate co-located staff into clinic culture and processes
- Establish effective referral and linkage protocols for clients referred to co-located services (warm handoffs)

Slide 63: Making Integration a Reality – The Clinic Level

At the clinic level, providers need to establish partnerships with other organizations to collaborate on client care. If staff is going to be co-located, space needs to be found for them to work, and they need to be integrated into the workplace. Case managers need to be hired, trained, and integrated into the organization. Protocols need to be established to make referral and linkage to integrated services run smoothly. In particular, clinics need to figure out a way to make “warm handoffs”—where HIV providers directly introduce clients to mental health/substance abuse providers—part of regular protocol.

Additional Information for the Trainer(s)

A warm handoff is important for several reasons: (1) It assures that clients actually go see the specialists they are referred to; (2) It establishes face to face contact between clients and MH/SUD providers, thus helping establish rapport; and (3) It communicates to the client that their HIV provider personally knows and trusts the specialty MH/SUD provider he/she is being referred to. By doing this, warm handoffs help confer the trust and rapport clients have with their HIV providers to their relationship with their MH/SUD providers.



The following are some useful tips on how to do warm handoffs to MH/SUD specialists: (1) Referrals to MH/SUD providers should be as directive as referrals to any other specialist. There should not be a noticeable difference in content or tone between a referral to a MH/SUD provider or a referral to a cardiologist or dermatologist. By making referrals seem a “normal” part of regular care, providers can help counteract much of the stigma or reservations clients have about accessing MH/SUD services. (2) Unless a client has directly said that they feel they need MH/SUD services (by saying something like “I’m depressed” or “I’m drinking too much”), it is best to not use terms that imply clients have a direct mental health or substance use problem. Often, clients need time to identify and come to grips with their mental health/substance use problems, and labels may make this process more difficult; (3) Similarly, it is better to use generic terms such as “provider” or “colleague” when referring to co-located MH/SUD staff. Words such as “counselor” and “therapist” may be stigmatizing for some clients.



REFERENCE:

Integrated Behavioral Health Project. (2012). *Warm Hand-Off Referrals by the Primary Care Provider*, available at:

<http://www.ibhp.org/index.php?section=pages&cid=122>.

<div data-bbox="110 275 472 543"> <p>Making Integration a Reality: The Provider Level</p> <ul style="list-style-type: none"> • Learn to look for signs/symptoms of issues outside of area of expertise that require consultation • Communicate effectively with providers from different backgrounds/disciplines • Collaborate/coordinate services with case managers when necessary • Learn screening and brief intervention methods </div>	<p>Slide 64: Making Integration a Reality – The Provider Level</p> <p>For integration to happen, providers need to learn how to look for signs and symptoms indicating that clients may need care in areas outside of their expertise. Providers also need to learn how to communicate effectively with other providers from different backgrounds/disciplines, and how to coordinate or collaborate in case when necessary. In addition, providers need to be trained on to provide screening and brief intervention services to help clients who do not need referral to other specialists.</p>
<div data-bbox="110 674 472 942"> <p>Barriers to Integrated Care</p> <p><i>"Integrated behavioral/primary care is like a pomegranate: overwhelmingly people say they like it, but few buy it."</i> (Cummings, 2009)</p>  </div>	<p>Slide 65: Barriers to Integrated Care</p> <div data-bbox="558 674 639 793">  </div> <p><i>Highlight that even though most people agree that integrating services is a good thing, barriers exist at all levels that get in the way of integration. Then read the slide, which highlights this point.</i></p>

Barriers to Integrated Care

- Different priorities
 - Many challenges to address, can they all be done at once?
- Different philosophies
 - Harm reduction vs. abstinence
 - Medical vs. Behavioral
- Differences in training
- Different funding streams
- Documentation and privacy issues

Slide 66: Barriers to Integrated Care

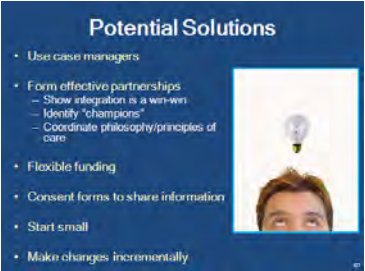
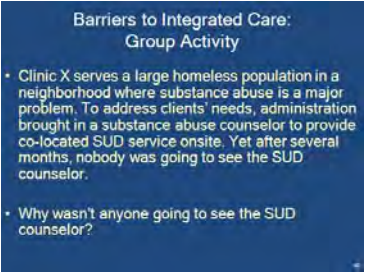

Differing priorities: For HIV clients with mental health and substance use disorders, there are many challenges and issues that need urgent attention. It can be difficult to coordinate them all in one treatment plan.

Different philosophies: Different providers come from different orientations. For example, some substance abuse counselors may want abstinence from drugs to be the goal of treatment, whereas many HIV clinicians prefer harm reduction. Also, some medical providers may want to focus services on treating symptoms of disease, while behavioral health may be more interested in changing clients' behavior. Differences in approach can make coordination difficult.

Differences in training: Medical providers may not be trained or comfortable dealing with MH/SUD issues, and vice versa. Stigma regarding MHD, SUD, and HIV can also hinder integration.


Funding: Though Ryan White grantees have more flexibility, other funding streams make it difficult to integrate care. For example, in some systems it may be difficult for a physician to be reimbursed for behavioral health screenings or brief interventions.

Documentation: Different funding sources require different paperwork, which can become overwhelming. Different systems also have different systems in place to protect client's private health information. At times privacy restrictions can be a barrier to the sharing of information that is needed to integrate services.

 <p>Potential Solutions</p> <ul style="list-style-type: none"> • Use case managers • Form effective partnerships <ul style="list-style-type: none"> – Show integration is a win-win – Identify “champions” – Coordinate philosophy/principles of care • Flexible funding • Consent forms to share information • Start small • Make changes incrementally 	<p>Slide 67: Potential Solutions</p> <p>Case managers are central to many integration protocols. They can help coordinate the services clients receive, assist clients in making and keeping appointments, and help them follow through on instructions and advice they receive from various providers. One effective strategy is to make the case for integration with potential partners. Show that it’s a win-win: both MH/SUD and medical providers can benefit from integration. Providers from different disciplines should discuss and coordinate their basic treatment principles, philosophies and goals. This can make treatment more coordinated and consistent for the client, no matter what kind of service they are receiving and who is providing it. When forming partnerships, it is also helpful to identify “champions” within the organizations of potential collaborators. If organizations have providers who are well-respected and willing to advocate for change from the inside, providers will be more likely to do the extra work necessary to make integration happen. Flexible sources of funding that are not tied to specific services (medical care, psychiatric care) are also important for integration. Changes under the ACA will create many more mechanisms to pay for integrated services.</p> <p>Consent forms: By using consent forms, providers can get client permission to share information in order to provide more integrated care.</p> <p>Another key lesson that organizations have learned when integrating is that it’s important to start small: since it is difficult to make so many changes at once, it is much better to integrate incrementally.</p>
 <p>Barriers to Integrated Care: Group Activity</p> <ul style="list-style-type: none"> • Clinic X serves a large homeless population in a neighborhood where substance abuse is a major problem. To address clients’ needs, administration brought in a substance abuse counselor to provide co-located SUD service onsite. Yet after several months, nobody was going to see the SUD counselor. • Why wasn’t anyone going to see the SUD counselor? 	<p>Slide 68: Barriers to Integrated Care – Group Activity</p>  <p>INSTRUCTIONS</p> <p><i>Tell the audience that the situation the slide describes is of a real clinic. Then read the slide, and ask the audience why they think nobody was going to the SUD counselor. As the audience responds, write their answers on the white board or flipchart.</i></p>

<p>Barriers to Integrated Care: What Happened at Clinic X?</p> <ul style="list-style-type: none"> • Some clinic X staff didn't know SUD services were available onsite • Clinic X staff who knew SUD services were available didn't know... <ul style="list-style-type: none"> – where the SUD counselor's office was – the SUD counselor's office hours – how to refer clients for assessment or services • When Clinic X staff made referrals... <ul style="list-style-type: none"> – they never received confirmation that clients went to the counselor – they never received progress reports on clients' substance use and recovery • Clinic X staff was uncomfortable asking clients about substance use, so they never found out who to refer to the SUD counselor 	<p>Slide 69: Barriers to Integrated Care – What Happened at Clinic X?</p> <p>INSTRUCTIONS</p> <p><i>Review the points on the slide, which are based on the experience at Clinic X. Some other suggestions from the audience may include:</i></p> <ul style="list-style-type: none"> • <i>Staff did not conduct warm handoffs,</i> • <i>Client stigma/reluctance to admit they had a problem with substance abuse,</i> • <i>Administrators did not make it clear to staff that they expected clients to be referred to the SUD counselor if they needed the services, or</i> • <i>Providers of different disciplines may have distrusted each other.</i>
<p>Barriers to Integrated Care: Small Changes Can Make a Big Difference</p> <ul style="list-style-type: none"> • Clinic X was able to address these problems at little cost: <ul style="list-style-type: none"> – Notified clinic staff of SUD services available onsite – Informed clinic staff of location of SUD services – SUD counselor posted office hours on door – Created disposition forms for SUD counselor to return to referring clinician – Educated Clinic X staff on techniques to talk about substance abuse and encourage clients to see the SUD counselor 	<p>Slide 70: Barriers to Integrated Care – Small Changes Can Make a Big Difference</p> <p><i>Review the points on the slide, highlighting that by making, small, incremental, and inexpensive changes, Clinic X was able to dramatically increase the number of clients who utilized its SUD services.</i></p>
<p>Part 3: Integrated Care: Tools and Models</p>	<p>Slide 71 [Transition Slide]: Part 3 – Integrated Care: Tools and Models</p> <p>This section will focus on what integrated services are, and how they can be delivered effectively. The focus of this section will be on some of the challenges involved in the delivery of integrated services, and give some examples of programs that have successfully integrated services for HIV clients.</p>

<div data-bbox="110 275 472 543"> <p>Tools Providers Need to Deliver Integrated Services</p> <ul style="list-style-type: none"> • Effective communication skills <ul style="list-style-type: none"> – Gather accurate information from clients – Assure clients understand information they receive – Communication with clients with MH/SUD can be difficult • Screening and assessment <ul style="list-style-type: none"> – Determine which clients need of integrated services • Brief intervention techniques <ul style="list-style-type: none"> – Deliver integrated services for clients with mild/moderate mental health/substance use problems </div>	<p>Slide 72: Tools Providers Need to Deliver Integrated Services</p> <p>One of the key things providers need to provide effective services is strong communication skills—an ability to gather accurate information from clients who may have MH/SUD disorders. This may be difficult, since clients with MH/SUD sometimes have difficulty communicating or are unwilling to open up about their mental health/substance use behaviors. Providers also need the skills to screen for potential mental health and substance use problems, and the tools to provide formal assessments if clients screen positive. If clients need services, but do not have severe or complicated mental health or substance use problems, providers should also have the skills to deliver brief intervention services, which can help prevent these issues from becoming more serious.</p>
<div data-bbox="110 787 472 1056"> <p>Effective Communication</p> <ul style="list-style-type: none"> • Clients with mental health or substance use disorders may have cognitive and/or emotional difficulties <ul style="list-style-type: none"> – Must be always be clear, ensure comprehension <ul style="list-style-type: none"> • Repeat key points: have clients repeat instructions in their own words • Teach science in simple terms • Use translator or sign language services if necessary • Use pictures and/or written material • Non-Judgmental <ul style="list-style-type: none"> – Gather and present information, be non-confrontational – Avoid value judgments </div>	<p>Slide 73: Effective Communication</p> <p>Clients with behavioral health disorders may have problems with cognition (understanding what you tell them or what information you are trying to get from them) and with their emotions, as they may be sensitive or emotionally volatile. Be sensitive to this when working with clients who have behavioral health disorders.</p> <p>To accommodate cognitive difficulties, be clear, simple, and ensure that clients understand what you are communicating. Having them repeat instructions in their own words is a good way to ensure they understand what you are trying to communicate.</p> <p>If oral communication is difficult, find a way that clients may be more comfortable with. If English is their second language, try to communicate in their native tongue. Use a translator if necessary.</p> <p>The use of written materials and pictures can help ensure client comprehension.</p> <p>It is important to be non-judgmental. Avoid judging clients—particularly when it comes to substance use behaviors—as this will make them more likely to be defensive and less likely to be honest.</p>

<div data-bbox="110 275 472 543" data-label="Complex-Block"> <p>Screening and Assessment</p> <ul style="list-style-type: none"> • Ask about mental health and substance use • Screening Instruments Used in Primary Care: <ul style="list-style-type: none"> – MHD: BDI, PHQ, GAD – SUD: CAGE, AUDIT, DAST • Recommended for HIV Clients: <ul style="list-style-type: none"> – Substance Abuse and Mental Illness Symptoms Screener (SAMISS) – Client Diagnostic Questionnaire (CDQ)  </div>	<p>Slide 74: Screening and Assessment</p> <p>The first step in addressing clients’ MH/SUD needs is to identify them—this is done by asking about mental health and substance use. There are several screening tools available. Many tools designed for use in primary care settings are also useful in HIV treatment programs.</p> <p>The BDI, PHQ, and GAD are designed to identify clients who have mental health problems. The BDI is relatively long, and there are different versions of the PHQ and GAD of different lengths. The most commonly used version of the PHQ is the PHQ-9, which is 9 questions, and the most common version of the GAD is the GAD-7, which is 7 questions. URLs for each of these are on the fact sheet that accompanies this training.</p> <p>The CAGE, AUDIT, and DAST are designed to elicit information concerning clients’ substance use. Each of these screening tools are available online, and come with guides on how to use them and interpret clients’ scores. URLs for each of these are on the fact sheet that accompanies this training.</p> <p>For HIV clients, two unified screeners—ones designed to elicit information concerning both mental health and substance use—are particularly helpful: the SAMISS and the CDQ. The CDQ is semi-structured and more open-ended than the SAMISS. The advantage of the CDQ is that is more in depth, but it requires more time from clinicians. URLs for these instruments are on the fact sheet that accompanies this training. The PAETC based at Charles Drew University of Medicine and Science offers a 90 minute training on the SAMISS if audience members are interested.</p>
<div data-bbox="110 1329 472 1598" data-label="Complex-Block"> <p>Screening and Assessment</p> <ul style="list-style-type: none"> • Be Aware of Overly Literal Answers • Be Sure To Get Information Pertinent to Symptoms: <ul style="list-style-type: none"> – Q: Have you had trouble concentrating on things such as reading the newspaper or watching television? – A: That doesn't apply to me. I don't read the paper and I don't have a TV. • Rephrase, or come up with other way to get at point regarding concentration (<i>"Have you had difficulty concentrating when people are talking to you?"</i>) </div>	<p>Slide 75: Screening and Assessment</p> <p>Remember that clients’ responses may not always give the information you need to do an accurate assessment. Some may answer questions literally instead of giving information that is helpful for assessing their mental health or substance use behaviors. This could be because they do not want to disclose information, or it could be because of cognitive difficulties understanding what certain questions are trying to ask.</p>

Screening and Assessment

- Be aware of tendency to minimize or deny socially undesirable behaviors; probe in non-confrontational manner
 - Denial may come across as inconsistent or contradictory information
 - Present follow up probes as attempts to clarify, not as challenges to accuracy of responses
 - Provide a non-threatening opportunity to correct or retract statements

Slide 76: Screening and Assessment

Given the stigma surrounding mental health and substance use disorders, many clients will minimize or deny their symptoms/behaviors. Because of this, it is important to probe to be sure that clients are not understating their problems. Often, denial or minimizing will come through as inconsistency—for example, a client may deny smoking marijuana, but then later in the interview mention that they used it last week. In these cases, it is best to probe, but in a non-confrontational way.

Additional Information for the Trainer(s)

To illustrate the point on how to probe in a non-confrontational way, use an example like the following: You are interviewing a client, and they say at the outset that they have “never used drugs.” Then later on during the interview, when you ask about recent drug use, they mention smoking marijuana at a party the previous week. How do you sort this out? The natural response, which is more confrontational, is to say something like “before you said you never smoked marijuana, now you’re telling me you smoked last week...which is it?” By phrasing the probe this way, the client is put on the defensive, being asked to account for misinformation. The same information can be gathered in a non-confrontational way, by presenting the inconsistency as a misunderstanding on your part. For example, you could say “I’m a little confused. I must have misunderstood, because earlier I thought you said you’ve never done drugs. I need to make sure that the information I have down here is correct? Did I have that right?” This opens the door for the client to clarify or correct earlier statements, but in a non-confrontational manner.

**Communication, Screening, Assessment:
Five-Minute Role Play**

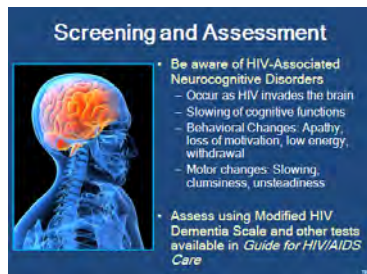
1. How did it make you feel asking about these personal issues like mental health and substance use? How did it make you feel being asked?
2. If discussing these issues made you uncomfortable, how did you handle this discomfort? Did it affect the way you acted during the conversation?
3. What strategies for talking about mental health and substance abuse issues seem to work? Which don't? Why?
4. How can you incorporate this knowledge into the way you talk about these issues with your clients?

Slide 77: Communication, Screening, Assessment – Five-Minute Role Play



INSTRUCTIONS

1. ***Tell the audience to get into groups of 2 (if there is an odd number, partner with whoever does not have a partner).***
2. ***Participants will do a five-minute role play, with one playing the role of the provider asking about clients' mental health or substance use, and the other playing the role of the client. (note: the person pretending to be the client should play the role of a client who has been having mental health or substance use problems). Emphasize that participants need to try to elicit information from the client in just five minutes, since that is often all the time they will have when they do this in real life clinic settings.***
3. ***During the role play, participants should think about the questions posted on the slide.***
4. ***After five minutes, have the participant playing the role of client and the participant playing the role of provider switch roles.***
5. ***At the conclusion of the second role play, bring the group back together and review each of the questions posted on the slide. Have a discussion for 5-10 minutes, writing down major points and themes that emerge from the group discussion on the white board or flipchart.***



Slide 78: Screening and Assessment

When doing screening and assessment, it is important to be aware that some behavioral health disorders may look similar to some physical problems that are associated with HIV, particularly neurocognitive disorders. These are symptoms that occur as HIV invades the brain. It leads to the symptoms listed on the slide. These conditions can be assessed using the Modified HIV Dementia Scale and other tests available in the Guide for HIV/AIDS Care, which is available at the URL listed in the resources section at the end of the slide.

Additional Information for the Trainer(s)

HIV-Associated Neurocognitive Disorders (HAND): HIV invades the brain shortly after infection, and it can cause cognitive, behavioral, and motor difficulties. These problems can range in severity, from being very mild to severe and disabling; in moderate or severe cases, they cause minor cognitive motor disorder (MCMD) or HIV-associated dementia (HAD).

MCMD is thought to involve neuronal cell dysfunction. It causes mild impairment in functioning and can be difficult to detect. The more demanding the activities of a particular individual, the more likely that person would be to notice their difficulties. MCMD does not necessarily progress to dementia. HAD, on the other hand, often involves actual cell death, and is characterized by symptoms of cognitive, motor, and behavioral disturbances. Its symptoms are slowing of cognitive functioning, including concentration and attention, memory, new learning, sequencing, problem solving, and executive control. HAD also can cause changes to behavior, causing apathy, loss of motivation, poor energy, fatigue, and social withdrawal. Motor changes, including slowing, clumsiness, unsteadiness, increased tendon reflexes, and deterioration of handwriting may also occur in HAD.

The clients who are more likely to develop these disorders are older, female, have advanced HIV/lower CD4 count, high viral load, and histories of injection drug use or delirium.



REFERENCE:

HRSA. (2012). *HIV-Associated Dementia and Other Neurocognitive Disorders*, available at: http://hab.hrsa.gov/deliverhivaidscale/clinicalguide11/cg-802_dementia.html.

**Brief Intervention Techniques:
Motivational Interviewing**

- "A way of being with a client, not just a set of techniques for doing counseling" (Miller and Rollnick, 2002)
- Used to help clients facilitate positive behavior change or improve adherence.
- Do not lecture or advise, but stimulate change by identifying discrepancies between client's behavior and their goals.
- Goal is to elicit "change talk" from client

Slide 79: Brief Intervention Techniques – Motivational Interviewing



On this and the next seven slides, you will review some of the more effective tools used when working with HIV clients who have behavioral health disorders.

Motivational interviewing is an approach towards exploring issues clients may be ambivalent about, particularly making changes to their behavior or thinking. It is more a "way of being with a client" than a set of specific techniques. The key to MI is to stimulate change by identifying discrepancies between a clients' behavior and their goals. When a client understands how the consequences of their harmful behaviors are in conflict with their values or goals, the goal is for them to decide to change. For example, if a client is smoking cigarettes but wants to become a long distance runner, that is a discrepancy that can motivate the client to quit smoking. Throughout the key to MI is not to lecture or teach the client, but to identify discrepancies between what the client reports they are doing and what the client says he/she wants.

Brief Intervention Techniques: Motivational Interviewing

- Key principles
 - Express Empathy
 - Support Self-Efficacy
 - Roll With Resistance
 - Discover Discrepancies
- Key skills (OARS)
 - Open Ended Questioning
 - Affirming
 - Reflective Listening
 - Summarizing
- More information available at
<http://www.motivationalinterviewing.org>

Slide 80: Brief Intervention Techniques – Motivational Interviewing

No motivational interviewing “protocol” exists, but providers need to understand the key principles and skills of motivational interviewing. There are four key principles, and four key skills that can be remembered with the acronym OARS.

Expressing Empathy: Actively listen without being judgmental. If a client is not ready to change their behavior, the initial focus should be on building rapport and supporting the patient instead of suggesting change.

Supporting Self-Efficacy: Self-efficacy is a person’s belief in his/her ability to successfully carry out a task. Clinicians should support self-efficacy by highlighting examples of positive change and emphasizing the importance of taking responsibility.

Rolling with resistance: When faced with resistance or reluctance to change, clinicians should allow the resistance to be expressed. Do not tell clients they “need” to change. Instead, reflect the clients’ questions and concerns back to them so they can further examine possible alternatives. This allows the client to become the source of positive actions and makes them feel open to express their feelings.

Discover discrepancies: Once rapport has been established, discover and amplify discrepancies between present and past behavior and future goals. This is done by examining the consequences of an unhealthy behavior, and the potential advantages of behavior change.

Additional Information for the Trainer(s)

The following skills (OARS) are useful when using MI:

- **Open ended questions:** they invite more information than “yes/no questions” and encourage clients to explore motivators for change. The strategy lets clients know providers are interested in them, and allow the provider to learn about the clients’ situation and motivations.
- **Affirming** is a way for clinicians to recognize clients’ strengths.
- **Reflective listening** helps providers identify areas of ambivalence. It is important to reflect back any statements that indicate the client is motivated to change. Reflections can be **simple** (acknowledge clients statements and feelings), **double-sided** reflections acknowledge what clients say as well as their ambivalence), and **amplified** reflections both reveal and exaggerate ambivalence (to make it clear).

<p><i>(Notes for Slide 80, continued)</i></p>	<p>Slide 80: Brief Intervention Techniques – Motivational Interviewing</p> <p>Additional Information for the Trainer(s), continued</p> <ul style="list-style-type: none"> • Summarizing emphasizes main points of discussions and should capture both sides of client ambivalence. The summary can also be used to shift focus or direction when the client is expressing an impassable resistance (“I won’t stop drinking, end of story’). After summarizing, providers should invite clients to make any corrections. <p>For more information, participants should visit www.motivationalinterviewing.org.</p>
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Brief Intervention Techniques: Cognitive Behavioral Therapy

- Structured therapy with a limited number of sessions
- Focus on increasing awareness of inaccurate or negative thinking.
- Helps clients recognize challenging situations, avoid getting into them (if possible), and cope with them more effectively.
- Helps clients view challenging situations more clearly and respond to them effectively
- More information available at <http://www.nacbt.org>

Slide 81: Brief Intervention Techniques – Cognitive Behavioral Therapy

CBT is a form of psychotherapy with a limited number of sessions that focuses on the role of thinking in influencing feelings and behaviors. By changing the way clients think and approach challenges, CBT ultimately leads to improved feelings and better controlled behaviors. CBT helps clients become more aware of their thinking, especially the way they think in response to challenging situations. It then involves helping clients recognize challenging situations, how to avoid them (if possible) and how to cope with them.

Additional Information for the Trainer(s)

1. CBT is based on the idea that thoughts cause feelings and behaviors, not external things, like people, situations, and events. This means that we can change the way we think to feel or act even if the situation does not change. The average number of sessions clients receive in CBT is 16, though it can be modified to a smaller number of sessions. A smaller number of sessions will usually be necessary when CBT is being provided as a part of integrated care. Clients should understand at the very beginning of the therapy process that there will be a point when the formal therapy will end. CBT is not an open-ended, never-ending process. CBT is based on aspects of stoic philosophy, which teaches the benefits of feeling *calm* when confronted with undesirable situations. If someone is upset about problems, he has two problems -- the problem, and being upset about it. Most people want to have the fewest number of problems possible. So when we learn how to more calmly accept a personal problem, not only do we feel better, but we usually put ourselves in a better position to make use of our intelligence, knowledge, energy, and resources to resolve the problem. Cognitive-behavioral therapists have a specific agenda for each session. Specific techniques / concepts are taught during each session, with a focus on the client's goals. Cognitive Behavioral Therapists do not tell clients what their goals "should" be, or what they "should" tolerate. They do not tell their clients *what* to do -- rather, they teach their clients *how* to do. CBT is based on the assumption that most emotional and behavioral reactions are learned. Therefore, the goal of therapy is to help clients *unlearn* their unwanted reactions and to learn a new way of reacting.

(Source: National Association of Cognitive Behavioral Therapists, Cognitive Behavioral Therapy)

Medications

- Mental Health Medications
 - Antidepressants
 - Mood Stabilizers
 - Anti-anxiety medications
 - Antipsychotics
- Substance Use Disorder Medications
 - Alcohol dependence (naltrexone, disulfiram, acamprosate)
 - Opioid dependence (naltrexone, methadone, buprenorphine)

Slide 82: Medications

Medication is a key part of treatment for many individuals with mental health and substance use disorders. Review the different types of medications used to address mental health disorders. Point out that clients often need to be on several mental health medications at once. Review the different types of medications used to address substance use disorders involving alcohol and opioids. For both MH and SUD medications, it is important to remember that medication is always just part of treatment—it is most effective when provided with other behavioral interventions.

MH/SUD/HIV Medication Interactions

Antipsychotic Medications	Mood Stabilizers	Potential Clinical Effect and Management
Haloperidol	Bupropion (depression)	Possible reduction in bupropion effect. Monitor and adjust bupropion.
Risperidone	Disulfiram (alcohol dependence)	Increased disulfiram effect. Monitor and adjust disulfiram.
Aripiprazole	Alprazolam (anxiety)	Increased alprazolam effect. Avoid combination. Use caution if needed.
Ziprasidone	Bupropion (depression)	Decreased bupropion effect. Monitor and adjust bupropion.
Many HIV medications	Heroin (opioid dependence)	Possible reduction in heroin effect. Monitor and adjust heroin.
Quetiapine	Fluoxetine (anti-depressant)	Increased APV levels. Increased medication effect. No dose adjustment needed.

- Most interactions are clinically insignificant.
- Check UCSF Database of Antiretroviral Drug Interactions: <http://hivinsite.ucsf.edu/insite?pages=ar-00-02&post=7>

Slide 83: MH/SUD/HIV Medication Interactions

Though risk is minimal for most of these medications, they may negatively interact with HIV medications. This slide lists some of the many interactions mental health and substance abuse medications may have with HIV medications. In most cases, the interactions are minor, however, in some cases adjustments can be made to the medications used. For example, as the chart shows (in the third row), the anxiety medication alprazolam has increased effects when used at the same time as certain HIV medications. Because of this, it is recommended that different anxiety medications are used by clients taking certain HIV medications. To avoid complications, clinicians should refer to the University of California at San Francisco's data base of antiretroviral drug interactions at the website listed on the bottom of this slide.

Integration Example: Healthy Living Project for People Living With HIV

- Reduces substance use and risk of HIV transmission
- Cognitive behavioral approach, with facilitators working as "life coaches" with clients
- Help clients make changes in health behavior, become active participants in ongoing medical care, achieve personal goals
- Includes education, coping skills, problem solving training, and role play

Slide 84: Integration Example – Healthy Living Project for People Living with HIV



Review this and the following three slides, which provide examples of successful protocols for integrating mental health and substance abuse treatment services with HIV care. If you are running short on time, you can skip these slides and proceed to the information about healthcare reform and the Affordable Care Act on slide 88.

This is an intervention to reduce substance use and the risk of HIV transmission. It utilizes a cognitive behavioral approach to help clients make changes in health behavior, become more active in medical care, and achieve goals. The intervention also includes education, coping skills, problem solving training, and role-plays.

**Integration Example: PATH
(Preventing AIDS through Health)**

- For clients with serious mental illness
- Nurse provides in-home consultations and coordinates medical and mental health services
- Nurse partners with prescribing providers, pharmacists, case managers
- Helps client overcome barriers to medication adherence and promotes self-care

Slide 85: Integration Example – PATH (Preventing AIDS through Health)

This is an integration protocol for clients with serious mental illness, combines interventions normally provided in specialty mental health programs with HIV treatment. Since some clients may have challenges with transportation, a nurse provides both mental health and medical services where clients live. The nurse also coordinates with other members of the clients' care team, including pharmacists, case managers, and providers who are prescribing medications. This helps overcome barriers to medication adherence. During the home visits, the nurse is also able to encourage better self-care and health behaviors.



REFERENCE:

Blank, M.B., Hanrahan, N.P., Fishbein, M., Wu, E.S., Tennille, J.A., Ten Have, T.R., Kutney-Lee, A.M., Gross, R., Hines, J.M., Coyne, J.C., & Aiken, L.H. (2011). A randomized trial of a nursing intervention for HIV disease management among persons with serious mental illness. *Psychiatric Services*, 62, 1318-1324.

**Integration Example: SBIRT
Screening, Brief Intervention, and
Referral to Treatment**

- Screen using brief screening instruments
- If at moderate risk, conduct brief intervention or brief treatment
 - Education about risks associated with substance use
 - Motivational Interviewing
- If at high risk, refer to specialty SUD services

10/24/2015 Baber et al., 2007

Slide 86: Integration Example – SBIRT (Screening, Brief Intervention, and Referral to Treatment)

SBIRT is a protocol for identifying clients with substance use disorders, and providing appropriate services for clients who either have substance use disorders or are at risk. If clients are at risk for developing them, providers conduct brief interventions or treatments, utilizing a blend of education about substance use and motivational interviewing. If clients are at high risk or have a substance use disorder, clinicians facilitate entry into specialty substance abuse treatment through referral and linkage services.

Additional Information for the Trainer(s)

The core components of SBIRT include:

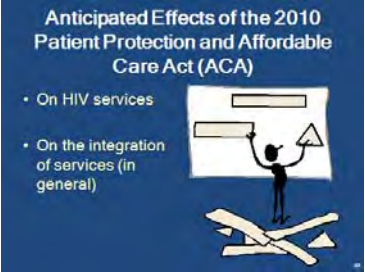

- Screening: Systematic screening as a preliminary procedure to evaluate the likelihood that an individual has a substance use disorder or is at risk of experience negative consequences from substance use.
- Brief intervention: A brief intervention is a time-limited effort to provide information or advice, increase motivation to avoid substance use, or to teach behavior change skills that will reduce substance use and the risk of experiencing negative consequences from substance use. These interventions are most effective for individuals at low to moderate risk.
- Brief treatment: Brief treatment is a time-limited, structured therapy for a substance use disorder by a trained clinician. It is usually delivered to those at higher risk or in the early stages of dependence and takes 2-6 sessions. It may also include the ongoing management of substance use disorders with medicines.
- Referral to treatment: The referral process facilitates access to care (including brief treatment) for clients who have more serious signs of substance dependence and require a level of care outside the scope of brief services.



REFERENCE:

Babor, T.F., McRee, B.G., Kassebaum, P.A., Grimaldi, P.L., Ahmed, K., & Bray, J. (2007). Screening, Brief Intervention, and Referral to Treatment (SBIRT): Toward a public health approach to the management of substance abuse. *Substance Abuse*, 28(3), 7-30.

<div data-bbox="110 275 472 546"> <p>Integration Example: Buprenorphine and HIV Services</p> <ul style="list-style-type: none"> • Clinician prescribing ART also provides buprenorphine • SUD specialist provides buprenorphine therapy at HIV clinic • Hybrid model: Induction by SUD specialist and maintenance by HIV care provider </div>	<p>Slide 87: Integration Example – Buprenorphine and HIV Services</p> <p>Another way behavioral health services have been integrated with HIV care has been through the integration of behavioral health medications with HIV treatment. Management of these medications for individuals receiving HIV medications is critical, so integrating and coordinating their administration is important. This slide reviews models for integrating buprenorphine, a medication used in the treatment of opioid dependence, with HIV care. Buprenorphine provides an interesting example because it can only be prescribed by physicians who have undergone special training. In some clinics, the same clinician who oversees antiretroviral therapy can go through the training so they can also prescribe buprenorphine. In other clinics, a clinician who focuses on prescribing and managing buprenorphine can be co-located in an HIV clinic, but not provide HIV services. In these setups, clients will have two prescribing doctors—one for buprenorphine, one for their HIV medications. Alternatively, an SUD specialist can oversee the induction of buprenorphine (helping clients begin treatment with the drug), and then once the client is stabilized, hand over care to the HIV provider who is providing antiretroviral treatment.</p> <div data-bbox="534 953 630 1045"> </div> <p><u>REFERENCE:</u></p> <p>Basu, S., Smith-Rohberg, D., Bruce, R.D., & Altice, F.L. (2006). Models for integrating buprenorphine therapy into the primary HIV care setting. <i>Clinical Infectious Diseases</i>, 42,716-721.</p>
<div data-bbox="110 1367 472 1638"> <p>Part 4: HIV, Integration, and Healthcare Reform*</p> <p><small>* Please note that the implementation of healthcare reform (the Affordable Care Act) may differ in some states.</small></p> </div>	<p>Slide 88 [Transition Slide]: Part 4 – HIV, Integration, and Healthcare Reform</p> <p>This section will provide a brief overview of the impact that the Patient Protection and Affordable Care Act (healthcare reform) will have on services for people living with HIV. As this section will show, beyond covering more services, healthcare reform will encourage more integrated care for clients living with HIV. Please note that some states may implement the Affordable Care Act in different ways, though it is anticipated that most states will implement it in the way described here.</p>

 <p>Anticipated Effects of the 2010 Patient Protection and Affordable Care Act (ACA)</p> <ul style="list-style-type: none"> • On HIV services • On the integration of services (in general) 	<p>Slide 89: Anticipated Effects of the 2010 Patient Protection and Affordable Care Act (ACA)</p> <p>Once fully implemented, the ACA will have a particularly dramatic impact on clients living with HIV. It will impact services for all clients living with HIV. It will also encourage service integration, both for the general population and for clients living with HIV.</p>
 <p>The ACA and HIV: Improved Access to Health Coverage</p> <ul style="list-style-type: none"> • Pre-ACA: <ul style="list-style-type: none"> – 17% of people living with HIV have private insurance, 30% have no insurance at all – Most funding from Medicaid, Medicare, Ryan White • What ACA Will Do: <ul style="list-style-type: none"> – Insurers can no longer deny coverage to children living with HIV/AIDS – Pre-existing Condition Insurance Plan to cover people now considered “uninsurable” – In 2014, insurance companies cannot deny coverage or impose limits on coverage – Expand Medicaid coverage – Insurance subsidies for people up to 400% of poverty level 	<p>Slide 90: The ACA and HIV – Improved Access to Health Coverage</p> <p>One of the major changes that will come about from the ACA is the expansion of coverage. Currently only 17% of people living with HIV have private insurance, and 30% have no insurance at all. Most HIV services today are funded from public sources—Medicaid, Medicare, and Ryan White funding. The ACA will encourage the expansion of insurance coverage to many people with HIV who are uninsured. Children with HIV can no longer be denied coverage, people with HIV diagnoses will no longer be considered “uninsurable,” coverage cannot be limited, and Medicaid will be expanded to cover many individuals who do not currently qualify (people at up to 133% of the current poverty level). The ACA will also make private insurance available to many people who do not have it now, offering subsidies to purchase insurance for people with income between 133% and 400% of the current poverty level.</p> <p>Additional Information for the Trainer(s)</p> <p>The 2012 federal poverty level is \$11,170 for an individual, and \$23,050 for a family of four. 133% of the federal poverty level is \$14,856 for an individual and \$30,657 for a family of four. 400% of the federal poverty level is \$44,680 for an individual and \$92,200 for a family of four. What this means is that under the ACA, any individual with an income of under \$14,856 or a family of 4 with an income of \$30,657 will qualify for Medicaid; and an individual with an income between \$14,857 and \$44,680 and a family of 4 with an income between \$30,658 and \$92,200 would qualify for subsidies for private insurance coverage.</p>

<div data-bbox="110 275 472 543" data-label="Complex-Block"> <p>The ACA and HIV: Covering the Medicare Part D "Donut Hole"</p>  <ul style="list-style-type: none"> • Medicare Part D Standard Benefit: <ul style="list-style-type: none"> – Enrollees pay \$310 deductible plus 25% of medication expenses up to \$2,530 each year. – Covers 95% of medication expenses once enrollees reach \$6,445.50 in medication costs. – No coverage from \$2,840.01-\$6,445.49 • Leaves a \$3,607.50 "donut hole" uncovered </div>	<p>Slide 91: The ACA and HIV – Covering the Medicare Part D “Donut Hole”</p> <p>Before the ACA, many HIV medications that clients needed were not covered because of the Medicare Part D “donut hole.” The donut hole has little to do with HIV medications specifically, but prescription coverage in general. Before the ACA, Medicare would provide 25% coverage for the first \$2,530 in medication expenses each year. And it would cover 95% of medication expenses once enrollees hit \$6,445.50 in medication costs each year. This left a gap of over \$3,600 that was uncovered for individuals who needed expensive medications. A problem for HIV clients since their medications are very expensive; the average cost of antiretroviral therapy is about \$13,000 per year. The donut hole is particularly troublesome for low-income clients, who could not afford to cover these costs. Because of this, some low (and even medium) income clients with HIV cannot afford their HIV medications. And as discussed earlier, not taking HIV medications regularly and consistently is critical for clients on ART.</p> <div data-bbox="532 821 630 926" data-label="Image"> </div> <p>REFERENCE:</p> <p>HIV Medicine Association. (2012). <i>HIVMA Policy Statement: Solutions Needed to Address the HIV Public Health Crisis in the United States</i>, available at: http://www.hivma.org/uploadedFiles/HIVMA/Policy_and_Advocacy/HIV_Public_Health_Crisis_in_the_US.pdf.</p>
<div data-bbox="110 1283 472 1556" data-label="Complex-Block"> <p>The ACA and HIV: Covering the Medicare Part D "Donut Hole"</p>  <ul style="list-style-type: none"> • What ACA Will Do: <ul style="list-style-type: none"> – Provide rebates and discounts to help cover the donut hole – Will consider AIDS Drug Assistance Program benefits part of out of pocket spending, creating better coverage for medication costs. </div>	<p>Slide 92: The ACA and HIV – Covering the Medicare Part D “Donut Hole”</p> <p>The ACA will take two steps to fix the problem of HIV medication coverage under Medicare Part D. It will provide rebates and discounts to help cover the donut hole. It will consider medications paid for by state AIDS Drug Assistance Programs to be “out of pocket” spending that counts towards total drug costs. This means that clients will reach the \$6,445.50 mark in drug spending quicker, at which point they will get better coverage for their medication costs.</p>

**The ACA and Integration:
Behavioral Health Coverage**

- Will define “essential benefits” for insurance plans participating in exchanges.
- Among the “essential benefits” are:
 - Chronic disease management
 - Mental health services
 - Substance abuse services
- Parity: No caps on MHD/SUD spending below spending on medical services

Slide 93: The ACA and Integration – Behavioral Health Coverage

The ACA will also improve coverage for mental health and substance use disorder treatment, and encourage their integration with the rest of health care. One way it will do this is by making MH, SUD, and chronic disease management services are among the ten “essential benefits” covered by insurance plans. It also enforces “parity,” meaning that insurance companies cannot cover behavioral health any less than they cover physical health.

The ACA and Integration: Medical Homes

- Enhances coordination and integration of behavioral health, medical care, and community supports.
- Interdisciplinary team interacts directly and coordinate care
 - Physicians and nurses
 - Behavioral health professionals
 - Social workers
 - Chiropractors, alternative medicine
- A “whole person” approach: identify needs and either meet them or provide linkage to someone who can.

Slide 94: The ACA and Integration – Medical Homes

The ACA will also provide strong financial support and create Medicaid state options to create **medical homes**. Medicaid beneficiaries with chronic conditions and serious behavioral health conditions will be able to designate a provider as a “health home.” In a medical home, different types of providers—medical, behavioral health, social work, and even alternative medicine—will interact directly to coordinate care. The focus of medical homes is to be “the whole person,” not the illness. Providers are expected to either deliver medical, behavioral health, and case management services directly, or provide linkage to these services.

Additional Information for the Trainer(s)

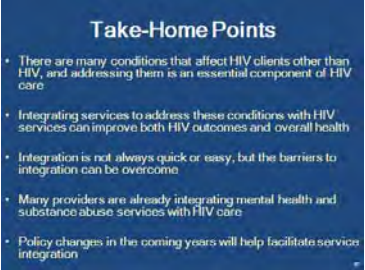

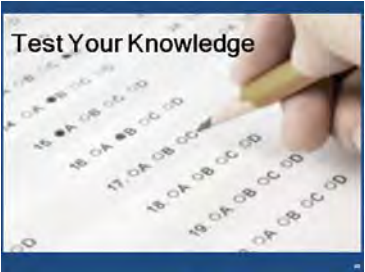

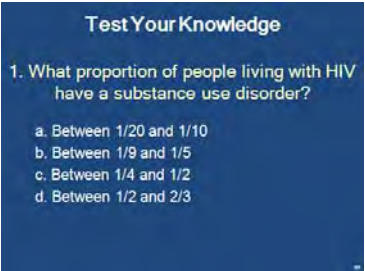



Health home services can be delivered in three types of arrangements: (1) a designated provider; (2) a team of health care professionals that links to a designated provider; or (3) a health team. Designated providers can be physicians or physician practices, group practices, rural health clinics, community health centers, and community mental health centers, home health agencies, and any other entity or provider determined appropriate by the state and approved by the HHS Secretary. A “team of health care professionals” can consist of a physician and other professionals including a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any other professionals deemed appropriate by the state. The ACA requires the HHS Secretary to define “health team,” but specifies that the team should be interdisciplinary and inter-professional and must include medical specialists, nurses, pharmacists, dieticians, social workers, behavioral health providers, chiropractors, licensed complementary and alternative medicine practitioners, and physician assistants.







REFERENCES:

1. Kaiser Family Foundation. (2011). *Medicaid’s New Health Home Option*, available at: <http://www.kff.org/medicaid/8136.cfm>.
2. Croft, B. & Parish, S. L. (2012). Care integration in the Patient Protection and Affordable Care Act: Implications for behavioral health. *Adm Policy Mental Health*. Online First; February 28, 2012. PDF available at: <http://www.springerlink.com/content/8j48330521w01046/?MUD=MP>.

<div data-bbox="110 275 472 543" data-label="Complex-Block"> <p>The ACA and Integration: Medical Homes</p> <ul style="list-style-type: none"> • Encouraged by 90% FMAP to states for first eight quarters • For patients with: <ul style="list-style-type: none"> – Two chronic medical conditions – One chronic condition and risk for another – A serious or persistent mental health condition • HIV providers can apply to become Health Homes. Assistance is available from the Target Center's HIV MHRC at www.careacttarget.org/ta_providers.asp. </div>	<p>Slide 95: The ACA and Integration – Medical Homes</p> <p>The ACA will encourage health homes by offering a 90% federal match for health homes. This means the federal government will contribute \$9 for every \$1 the state contributes for health homes. This matching rate is temporary, in effect for the first eight quarters a state's health home plan takes effect. Health Homes will be important for clients living with HIV because of their eligibility requirements. People will qualify for medical home services if they have two chronic medical conditions, if they have one chronic condition or are at risk for another, or if they have a serious and persistent mental health disorder. Resources are in place to help HIV providers to become classified as "health homes." HRSA is sponsoring a HIV Medical Homes Resource Center (MHRC) to give HIV providers information and assistance if they are interested in becoming a medical home. For more information, see the website listed on the slide.</p>
<div data-bbox="110 867 472 1136" data-label="Complex-Block"> <p>The ACA and Integration: Innovations</p> <ul style="list-style-type: none"> • Accountable Care Organizations <ul style="list-style-type: none"> – Groups of healthcare providers that will enter collaborative agreements to improve quality and lower costs – MH/SUD treatment providers may join • Primary Care/Behavioral Health Co-Location Grants • Home and Community-Based Services </div>	<p>Slide 96: The ACA and Integration - Innovations</p> <p>Other aspects of the ACA will also facilitate the integration of behavioral health with medical services. One is the creation of Accountable Care Organizations, which will involve groups of providers entering collaborative agreements to improve quality and lower costs. Behavioral health providers may be a part of Accountable Care Organizations. The ACA will also allocate funding for the co-location of primary care and specialty behavioral health services in community-based behavioral health settings. The ACA will allow states to offer home and community-based services for Medicaid enrollees with low income and high need. These services could meet the needs of many clients with mental health and substance use disorders.</p> <div data-bbox="532 1255 630 1356" data-label="Image"> </div> <p>REFERENCES:</p> <ol style="list-style-type: none"> 1. Shortell, S.M., Casalino, S.P., & Fisher, E.S. (2010). How the Center for Medicare and Medicaid innovation should test Accountable Care Organizations. <i>Health Affairs (Millwood)</i>, 29, 1298. 2. Druss, B.G. & Mauer, B.J. (2010). Health care reform and care at the behavioral health-primary care interface. <i>Psychiatric Services</i>, 61, 1087-1092. 3. Kaiser Family Foundation. (2011). <i>Medicaid's New Health Home Option</i>, available at: http://www.kff.org/medicaid/8136.cfm.

 <p>Take-Home Points</p> <ul style="list-style-type: none"> • There are many conditions that affect HIV clients other than HIV, and addressing them is an essential component of HIV care • Integrating services to address these conditions with HIV services can improve both HIV outcomes and overall health • Integration is not always quick or easy, but the barriers to integration can be overcome • Many providers are already integrating mental health and substance abuse services with HIV care • Policy changes in the coming years will help facilitate service integration 	<p>Slide 97: Take-Home Points</p>  <p><i>To emphasize the major take-home points of the training, review the points on the slide. Also remind participants in the training that they can access more information on these issues, as well as a list of useful websites, on the fact sheet that they received at the beginning of the training.</i></p>
 <p>Test Your Knowledge</p>	<p>Slide 98: Test Your Knowledge</p>  <p><i>The purpose of the following three questions is to test the change in HIV integration knowledge amongst training participants. These questions are identical to the questions that appear on slides 4-6. Read each question and possible responses aloud, and give training participants time to jot down their response. Reveal the answers to each question once participants have had a chance to indicate their responses to each question.</i></p>
 <p>Test Your Knowledge</p> <p>1. What proportion of people living with HIV have a substance use disorder?</p> <ol style="list-style-type: none"> Between 1/20 and 1/10 Between 1/9 and 1/5 Between 1/4 and 1/2 Between 1/2 and 2/3 	<p>Slide 99: Test Your Knowledge Question #1</p> <p>Answer Key:</p> <p>Correct response: C (Between 1/4 and 1/2)</p>  <p>**Audience Response System (ARS)-compatible slide</p>
 <p>Test Your Knowledge</p> <p>2. Integrated Services for HIV care can include...</p> <ol style="list-style-type: none"> Screening for mental health and substance use disorders Conducting hour long mental health assessments for all clients Adaptation of mental health treatment techniques for use with HIV clients A and C A, B, and C 	<p>Slide 100: Test Your Knowledge Question #2</p> <p>Answer Key:</p> <p>Correct response: D (A and C)</p>  <p>**Audience Response System (ARS)-compatible slide</p>

<div data-bbox="110 270 470 541"> <p>Test Your Knowledge</p> <p>3. Healthcare reform will do the following:</p> <ul style="list-style-type: none"> a. Extend health insurance coverage to some people with HIV who are currently uninsured b. Provide better coverage to help some people pay for their HIV medications c. Place limits on mental health and substance abuse services for people living with HIV d. A and B e. A and C </div>	<p>Slide 101: Test Your Knowledge Question #3</p> <p>Answer Key:</p> <p>Correct response: D (A and B)</p> <div data-bbox="524 386 613 520"> </div> <p>**Audience Response System (ARS)-compatible slide</p>
<div data-bbox="110 672 470 942"> <p>Thank You For Your Time!</p>  <p>For more information:</p> <p>Tom Freese: tfreese@mednet.ucla.edu Beth Rutkowski: brutkowski@mednet.ucla.edu Jennifer McCoo: jenn@HIVtrainingODU.org Pacific Southwest ATTC: www.psalto.org PAETC Training calendar: www.HIVtrainingCDU.org</p>    </div>	<p>Slide 102: Final Slide</p> <div data-bbox="560 672 636 791"> </div> <p><i>This concludes the presentation. Thank the participants for their time and address any last-minute questions about the content. Encourage participants to reach out to the Pacific Southwest ATTC or Pacific AETC, should they have questions or concerns following the training session.</i></p>

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The opinions expressed herein are the views of the authors and do not reflect the official position of the PAETC/HRSA or the Pacific Southwest ATTC/SAMHSA-CSAT. No official support or endorsement of the PAETC/HRSA or the Pacific Southwest ATTC/SAMHSA-CSAT for the opinions described in this document is intended or should be inferred.