BRIDGING THE GAPS BETWEEN HIV AND MENTAL HEALTH

The San Antonio Area HIV Health Services Planning Council conducted a study on mental health and HIV with the goal of determining the current state of services for the clients served by the Ryan White Program, as well as any barriers that may impact clients receiving services. This study will be used as a tool to help improve the mental health system for clients with HIV/AIDS.

A Study on Mental Health Services for HIV/AIDS Clients

Conducted by:
The San Antonio Area HIV Health Services Planning Council

2013-2014

ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

In March 2013, the Ryan White Planning Council began its study of the mental health continuum in the San Antonio Transitional Grant Area, as it relates to the HIV community. Using the socio-ecological based model, the study looked at various levels of influence on health outcomes and behaviors, including the individual, interpersonal, organization and social institutions, community and policy levels. It was important to study mental health services and need in the San Antonio area because mental health rates are higher in the HIV population than the general population. Additionally, severe mental illness has been associated with more rapid and harder to treat progression of HIV.

The mental health study employed a mix of qualitative and quantitative data collection that included surveys, interviews and focus groups. Mental health providers, case managers, and consumers responded. All instruments were developed by the Planning Council's Needs Assessment Committee with the assistance of the Administrative Agency staff. The study also included a literature review on the current state of mental health in the San Antonio and Bexar County region.

Although the participants varied in their opinions on barriers and the current state of mental health services, several themes emerged across the groups. These common themes included high levels of need for mental health services; a lack of client knowledge regarding the purpose of the methods of mental health care therapy and counseling services; a perceived disconnect with services outside of the Ryan White Program care system; a shortage of psychiatry services; and a reluctance of clients to be harnessed with a mental health diagnosis or admit they need mental health services.

MENTAL HEALTH RECOMMENDATIONS:

- **Increase Clients' Knowledge of Services**
- **Reduce Stigma Associated with a Mental Health Diagnosis**
- **Increase and Identify the Options Available for Psychiatric Services**
- **Promote the Coordination of Mental Health Services Between Ryan White Providers and the General Community**
- **Ensure Adequate Funding for Mental Health Services Not Covered By Health Insurance Programs**

Based on these overarching themes, the following recommendations are being presented to further improve mental health services available for the HIV community in the SATGA: Increase clients' knowledge of services available; reduce stigma associated with a mental health diagnosis; identify and increase the options available for psychiatric services, promote the coordination of mental health services between Ryan White providers and the general mental health community; and ensure adequate funding for Ryan White mental health services not covered by health insurance programs.

The Planning Council will assemble a workgroup to develop strategies addressing each recommendation with the goal of strengthening the mental health continuum and ensuring the availability of quality services to all those requiring them in the HIV community.

BACKGROUND

Purpose of the Study

The San Antonio Area HIV Health Services Planning Council (Planning Council) was established in 1994 when the San Antonio Transitional Grant Area (SATGA) became eligible to receive Ryan White Part A funds. The Bexar County Department of Community Resources (DCR) acts as the Administrative Agency (AA) for the SATGA Ryan White Program. The Planning Council, in conjunction with the Bexar County DCR, is responsible for assessing the need for and planning services that support retention in HIV medical care among people living with HIV/AIDS (PLWHA) in the four-county region of Bexar, Comal, Guadalupe, and Wilson counties.

The Ryan White HIV/AIDS Program requires periodic needs assessments to be conducted in the service area. These needs assessments must "determine the size and demographics of the population of individuals with HIV/AIDS," as well as "determine the needs of such populations, with particular attention to: individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services; and disparities in access and services among affected subpopulations and historically underserved communities."[1]

For the 2013 needs assessment, the Needs Assessment Committee (NAC) of the Planning Council elected to do a mental health study rather than a traditional needs assessment. This decision was guided by the 2012-2015 Ryan White Comprehensive Plan (Plan). In the Plan, there were many action steps related to the mental health continuum of care that were charged to the NAC for completion, including the following:

- Report the mental health services continuum of care available in the San Antonio Health Administration Services Area and providers offering these services to PLWHA in conjunction with mental health stakeholders.
- Identify and coordinate data sources regarding service and geographic gaps.
- Review all available needs assessment information to identify consumer perceptions of gaps in mental health care therapy and counseling services.
- Review barriers to accessing mental health therapy and strategies to overcome barriers.
- Develop recommendations to expand and enhance the available mental health continuum of care throughout the SATGA.
- Support and advocate for the recommendations outlined in order to develop strategies to expand the mental health continuum of care, increasing access and reducing barriers for PLWHA throughout the SATGA.

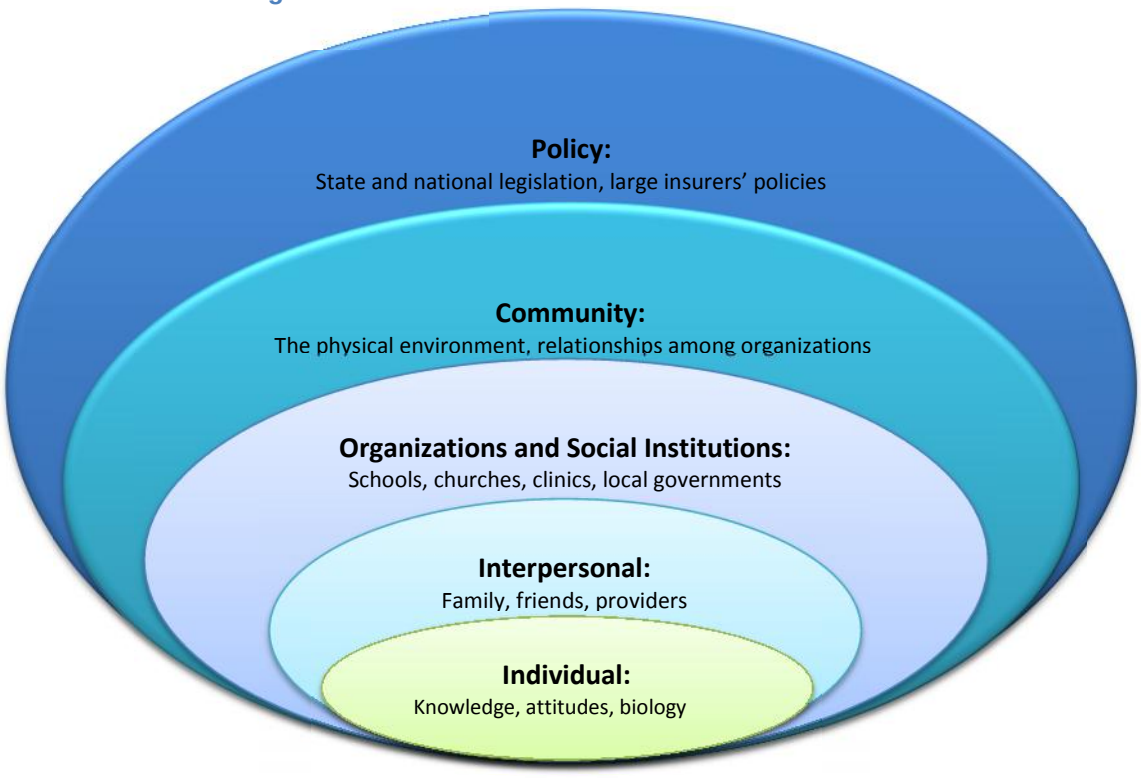
The Planning Council has addressed each of these action steps to complete the mental health study.

[1] U.S. Department of Health and Human Services. (2013). *Ryan White HIV/AIDS Program Part A Manual*. Available at: http://hab.hrsa.gov/tools2/PartA/parta/ptAsec7chap1.htm.

The Socio-Ecological Model

This mental health study was based on the socio-ecological model of health, which was developed by Kenneth R. McLeroy, et al. in 1988 and is built on the concept that health behaviors affect and are affected by multiple levels of influence.[2] This model was developed in response to the health behavior models of the 1970's and 1980's, which tended to focus on the individual's health-related knowledge, attitudes, and behaviors without considering the larger social world in which they were embedded. This led to a "blame the victim" approach in which individuals were seen as responsible for their own poor health without consideration of their social and physical environments. By contrast, the socio-ecological model considers multiple levels of influence on health outcomes. At the center remains the individual, with his or her own biology, knowledge, and attitudes. At the next level is the interpersonal, which includes social interactions and influences such as family and friends' cultural beliefs, interactions with health providers, and even the interaction with pharmacy clerks. Organizations exert the next level of influence, including schools, churches, clinics, and local governments. At the community level are components such as the physical community and proximity to such health resources as parks, clinics, and pharmacies, as well as the relationships among organizations such as churches and schools. At the policy level, state and national legislation and policies of many entities, including large insurers, shape the health landscape. The socio-ecological model is often visualized as a series of concentric circles, as in Figure 1, below.

Figure 1. The Socio-Ecological Model



[2] McLeroy, K.R., Bibeau, D., Steckler, A., Glanz, K. (1988). An Ecological Perspective on Health Promotion Programs. *Health Education Quarterly 15(4):351-377.*

The Interrelationship between HIV and Mental Health

What is Mental Health?

In order to discuss mental health, it is helpful to have a better understanding of what mental illness and its associated terms mean.

- According to the World Health Organization, mental health is defined as, "A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." [3]
- The National Association on Mental Illness (NAMI) defines mental illness as "A medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning." [4]
- NAMI notes that serious mental illness (SMI) includes major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder. [4]

Mental illness affects people of every age, income, race, gender, sexual orientation, and religion. It is not a result of poor character, poor upbringing, or personal weakness. There is not a cure for mental illness, but it is treatable. Common factors of mental illness include family history, genetic factors, stressful life events, and psychological factors including difficulty in managing feelings and unhealthy thinking patterns.

According to NAMI, one in four Americans experience mental illness in any given year. Among the general population, suicide, a potential by-product of mental illness, is the tenth leading cause of death in the U.S. Adults living with serious mental illness on average die 25 years earlier than those without mental illness. This is largely due to treatable medical conditions that have gone untreated. In addition, NAMI reports that mood disorders, such as depression, are the third most common cause as hospitalization in the U.S. for individuals 18-44 years of age. [5]

In 2012, the Institute of Mental Health reported the following estimates of mental illness in the general population: general anxiety disorder, 3.1%; OCD, 1.0%; panic disorder, 2.7%; PTSD, 3.5%; social phobias, 6.8%; bipolar disorder, 2.6%; and major depressive disorder, 6.7%. It should be noted that the onset of symptoms is often seen while the individual is in their twenties or early thirties. [6]

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[3] World Health Organization. *Strengthening Mental Health Promotion*. Geneva, World Health Organization (Fact sheet no. 220), 2013.

[4] National Association on Mental Illness (NAMI). No date. *Mental Illness: What You Need to Know.* Available online at: www.nami.org

[5] National Association on Mental Illness (NAMI). (2013). *Mental Illness Facts and Numbers.* Available online at: www.nami.org.

[6] National Institute of Mental Health (NIHM). (2012). *The numbers count: Mental disorders in America.* Retrieved from: http://www.nimh,nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml.

The Substance Abuse and Mental Health Services Administration (SAMHSA) found that 34.8% of people with any mental illness and 61.1% with serious mental illness received prescription medication in the past year[7]. The same survey found that 3.2% of people with any mental illness and 8.5% with serious mental illness received inpatient care in the past year. The US Agency for Healthcare Research and Quality found that in the South region of the US, 13% of people with mental health diagnoses are hospitalized in a year. [8]

Options for Treatment of Mental Illness

Several terms are also used throughout the study regarding the types of treatment available for mental illness. Because there can be confusion between the terms, a short explanation was placed in the survey materials for non-professionals. For this study, the following briefly describe the four types of treatment for mental illness:

- Individual counseling including psychotherapy and therapy – a form of one on one counseling between an individual and trained mental health professional. This type of treatment helps individuals understand their behaviors, emotions, and ideas and how to modify them; understand and identify life problems or events; regain a sense of control and pleasure in their life; and learn problem solving skills and coping techniques. Sessions generally take 45-60 minutes.
- Psychiatry – a form of one-on-one treatment between an individual and a psychiatrist or a medically trained professional who can prescribe medication. Although a psychiatrist can provide counseling, generally sessions are 5-15 minutes long and the focus of the dialogue is on prescribing or discussing the effects of currently prescribed medications.
- Group counseling – a form of counseling where two or more individuals work with a trained mental health professional. Group therapy helps by providing a peer group of individuals that are currently experiencing similar symptoms or problems and allows individuals to share their experiences and learn that others may feel the same way and/or have had similar experiences.
- Support group – a less structured meeting of various individuals to discuss a particular issue and the group is not usually led by a trained mental health professional. As with group counseling, the goal is to help individuals learn from each other to handle challenges, cope with changes, and maintain new changes. Support from other members allows for a sense of belonging, universality as there are others with similar challenges, socialization to combat isolation, companionship, and networking. Although support groups are held for a multitude of topics/reasons, in this study the term of support group will always reference specifically mental health support groups.

Vulnerability of People with Mental Illness to HIV

Concerns regarding transmission of HIV and mental health have been studied for years and HIV prevention strategies have shown that mental illness can pose a challenge to these interventions.

[7] SAMHSA, 2010 National Survey on Drug Use and Health; available at http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/.
[8] Data is available at http://hcupnet.ahrq.gov.

Some mental illnesses, including mania and borderline personality disorder, have been associated with high risk sexual behaviors. Clinically significant symptoms of depression have the potential to interfere with an individual's ability to critically think and be able to weigh the pros and cons of practicing safe sex habits[9]. In regards to severe mental illness, studies have shown that transmission is higher among individuals with untreated severe mental illness. It is estimated that rates of HIV infection and transmission are 76 times higher among this group than that of the general population. The higher risk rates are possibly attributed to higher rates of alcohol or other substance abuse and high risk sexual activity that may occur in this population. [10]

Importance of Mental Health Services in the HIV-positive Population

The largest national survey of HIV infected individuals, the HIV Costs and Services Utilization Survey (HCSUS) was completed from 1994-2000. It is estimated that approximately 48% of HIV-infected individuals have a probable psychiatric disorder with higher rates being reported in Whites, those that are unemployed or disabled, those with a co-occurring substance abuse disorder, and those with more HIV-related symptoms. Of those in the HCSUS study, 36% screened positive for depressive symptoms, 45% had a diagnosis of major depression that was not documented in their medical record, 16% had a generalized anxiety disorder, and 10% reported panic.[11] Other studies estimate the HIV positive individuals have a 60% chance of having a depressive episode at some point during the disease stage.[12] In the HIV-positive population, major depression and depressive disorders have been found to be highly predictive of suicidal ideation, attempted suicide, and completed suicide. [13]

Other stressors for the HIV-positive population can include difficulty in accessing services, loss of social support, difficulty in coping with a chronic illness, loss of employment, having to reveal their status to others, changes in physical appearance, dealing with loss and grief, stigma, and managing the effects of HIV medications. A 2009 study by the RAND Corporation found that PLWHA who screened positive for mental illness were typically under the age of 35, lived alone, were unemployed or disabled, experienced more HIV-related symptoms, and used illicit drugs besides marijuana.[14]

To complicate matters further, some HIV medications, including Sustiva, Zerit, Retrovir, and AZT, can have side effects that cause depression and other psychological symptoms. Sustiva, for example, has been linked in some cases to decreased concentration, depression, nervousness, and

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[9] Shared Action. (no date). *Addressing mental health issues to improve HIV prevention intervention outcomes.*
[10] America Psychiatric Association. (No date). *HIV Mental Health Treatment Issues: HIV and People with Severe Mental Illness.* Available at http://www.psychiatry.org/AIDS.
[11] Whetten, K., Reif, S., Whetten, R., Murphy-McMillan, L.K. (2008). *Trauma, Mental Health, Distrust, and Stigma Among HIV-Positive Persons: Implications for Effective Care. Psychosomatic Medicine, 70:*531-538.
[12] HRSA Care Action. (2009). *Mental health matters.* Available online at www.hrsa.gov.
[13] American Psychological Association. (2013). *HIV and psychiatric comorbidities: What do we know and what can we do?. Psychology and AIDS Exchange Newsletter.* Available at: www.apap.org.
[14] HRSA Care Action. (2009). *Mental health matters.* Available online at www.hrsa.gov.

nightmares.[15] This does not mean that these medications are ineffective in HIV treatment and should not be used, or that every individual taking the medication will report having the noted side effects.

With HIV now being viewed as more of a chronic disease, it is even more important to look at how mental illness and HIV together affect quality of life, how it affects treatment adherence and how risky behaviors sometimes associated with mental health impact care and prevention. Studies have shown that poor mental health has been associated with a lower likelihood of HIV positive individuals receiving antiretroviral medication and poor medication adherence. [9, 10, 16, 17] One study found that the rates of treatment adherence are three times higher in individuals without depression than those with depression.[18] Additionally, severe mental illness has been associated with more rapid and harder-to treat progression of the HIV disease. Possible reasons for this include non-adherence to medications which leads to a worsened immune system, increased viral replication that causes higher viral loads, and the development of drug resistance as a result of non-adherence to medication regimens.[11] Anxiety has also been linked as a major cause in non-compliance in treatment adherence.[8] Treatment adherence for HIV positive individuals is critical for optimal health outcomes, including increased CD4 count and sustained viral load suppression, which often reduce the possibility of an opportunistic infection and of infecting others. The risk of transmission to others is higher in individuals who engage in risky behaviors, do not attend medical appointments, do not take medications as prescribed, or have elevated viral loads.[19] Addressing mental health issues by improving medical care, reducing risky behaviors, and community interventions such as increased guardianship and group homes to reduce stigma and isolation, may in turn lead to a reduction in negative sexual health behaviors and improvements in HIV treatment adherence.[7]

The benefits of mental health treatment include symptom relief, improved overall functioning, improved ability to adhere to HIV treatment including medication adherence, overall improved physical health, and a reduction in the costs of care.[8, 9, 13] Behavioral therapy, which includes individual and group counseling, an individualized treatment plan, and medications have been shown in studies to improve quality of life. Many leaders in the field suggest a combination of behavioral and medication treatment. According to NAMI, in the general population, 70-90% of individuals using both forms of treatment report a significant improved quality of life.[2] In a recent study of 3,000 patients with depression, clients taking certain depression medications and HIV medication demonstrated increases in CD4 counts and decreased vial loads.[10] In a meta-

[15] America Psychiatric Association. (No date). *HIV Mental Health Treatment Issues: HIV and Anxiety*. Available at http://www.psychiatry.org/AIDS.

[16] Kumar, V., Encinosa, W. (2009). Effects of antidepressant treatment on antiretroviral regimen adherence among depressed HIV-infected patients. *Psychiatric Quarterly*, 80, 131-141.

[17] Fairfield, K.M., Libman J., Davis, R.B., Eisenberg, D.M., Phillips, R.S. (1999). *Delays in protease inhibitor use in clinical practice. J Gen Intern Med; 14*:395-401.

[18] Sin, N.L., DiMatteo, M.R. (2013). *Depression treatment adherence to antiretroviral therapy: a Meta-Analysis. Annals of Behavioral Medicine*. DOI 10.1007/s12160-013-9559-6.

[19] Sikkema, K.J., Watt, M.H., Drabkin, A.S., Meade, C.S., Hansen, N.B., & Pence, B.W. (20120). *Mental health treatment to reduce HIV transmission risk behavior: A positive prevention model*. AIDS & Behavior, 14(2), 252-262. DOI: 10.1007/s10461-009-9650-y.

analysis of 29 studies, the odds of a person adhering to antiretroviral therapy were improved if a patient diagnosed with depression received treatment. There were greater improvements found in samples with lower beginning CD4 counts and more severe depression with interventions specifically targeted towards depression.[16]

The Local Context

Mental Illness in Texas

The American Psychological Association reports that among HIV-positive Texans, mood disorders, particularly depression, are the most common mental illnesses; studies show rates range as high as 22% compared to 5-15% in the general population.[11] Another study reported that the prevalence of SMI in PLWHA in Texas is between 1% and 24%.[20] In regards to anxiety and anxiety-related disorders, general anxiety disorder (GAD) is estimated at 15.8% and panic disorders in 10.5% of the population.[8] Anxiety has been shown to occur both pre- and post-diagnosis of HIV.[13]

In 2009, it was estimated that the Texas public mental health system provided services to only 21% of the adults living with a serious mental illness.[21] According to the Texas Health Institute, in 2012, 3.1 million adults in Texas had a diagnosable mental illness[22] and the *2011 Census Bureau's American Community Survey 3-Year Estimates* deduced that 3.2% of the residents in Bexar County suffer from a cognitive disability.[23] In the *2012 National Survey on Drug Use and Health Report*, 4.33% of all residents of Texas have had a serious mental illness in the past year, which equates roughly to 90,250 individuals in the SATGA general population.[24]

In 2013, lawmakers increased mental health spending by $259 million from the previous biennial budget for a total of $1.77 billion allocated to mental health care. This same study showed that Texas ranked 49th on mental health spending per capita. This is an increase in rank as Texas was ranked last in the nation in per-capita spending for mental health from 2006-2009 and in 2010 was moved up a few slots when the per capita spending was raised to $39.[25]

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[20] DeHert, M., Cohen, D., Bobes, J., Cetkovich-Bakmas, M., Leucht, S., Ndetei, D.M., et al. (2011). *Physical illness in patients with severe mental disorders. World Psychiatry, 10*, 138-151. Retrievable at http://www.ncbi.nlm.nih.giv/pubmed/21633691.

[21] National Association on Mental Illness (NAMI). (2013). *State Advocacy 2010: Texas.* Available online at: www.nami.org

[22] Texas Health Institute. (2012). *Mental Health.* Retrieved from http://www.texashealthinstitute.org/programs.mental.php.

[23] U.S. Census Bureau. (2012). *2011 American Community Survey 3-Year Estimate: Disability Characteristics.* Retrieved from http://factfinder2.census.gov/faces/nav/isf/pages/index.xhtml.

[24] Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings,* NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

[25] Mitchell, Mitch. "Texas Lawmakers Increase Funding For Mental Health." *Star-Telegram.* July 14, 2013.Web. Oct. 2013.

The Mental Health Care System in the SATGA

The SATGA consists of four counties, of which three are rural. The majority of PLWHA live in Bexar County, and therefore access services in the major metropolitan area of San Antonio. Table 1 below includes the estimated general population of each county in the SATGA.

TABLE 1. GENERAL POPULATION ESTIMATE IN 4-COUNTY SATGA, 2012

County	*Estimated General Population – 2012*	*% of 4-County SATGA*	*# of PLWHA per county*	*% of PLWHA in 4-County SATGA*
Bexar	1,785,704	86%	4,990	94.6%
Comal	114,384	5%	139	2.6%
Guadalupe	139,841	7%	115	2.2%.
Wilson	44,370	2%	30	0.6%
San Antonio TGA	2,084,299	100%	5,274	100%

Each of the counties in the SATGA is served by separate mental health authorities. Please see **Table 2** below for the name and description of each. According to the Texas Department of State Health Services, these community mental health centers provide services in designated counties and are required to serve designated populations.[26] They are also required to develop comprehensive plans on how to deliver services in a fiscally and medically effective manner.

[26] http://www.dshs.state.tx.us/mhsa/lmha-list/

TABLE 2. MENTAL HEALTH AUTHORITIES IN THE SATGA		
County	**Agency Name**	**Description**
Bexar	Center for Health Care Services	Serves as the safety net for patients who have severe psychiatric disorders and are unable to obtain services elsewhere. CHCS offers a broad array of services including psychiatric services and methadone maintenance. CHCS services are provided only to those with bipolar disorder, schizophrenia, and major depression. CHCS offers crisis care and outpatient mental health services at various locations throughout Bexar County, which specialize in different populations. 3031 IH 10 West San Antonio, TX 78201 (210) 731-1000
Comal	Hill Country Mental Health & Developmental Disabilities Centers	Provides treatment of major depression, bipolar and/or schizophrenia disorders. Services provided at Comal County MH Center 358 Landa Street, Suite 300 New Braunfels, TX 78130 (888) 648-3947
Guadalupe	Bluebonnet Trails Community Services	Provides treatment of major depression, bipolar and/or schizophrenia disorders. 325 Wallace Street Seguin, Texas 78156 (830) 379-8222
Wilson	Camino Real Community Services	Camino Real Community Services offers a wide array of services designed to meet the needs of individuals with mental illness. These services include Screening, Assessment, Referral, Case Management, Medication Related Services, Counseling, Crisis Intervention, and a full range of Rehabilitative Services, and Family Support. Camino Real serves persons of all ages. 1005 B. Street Floresville, TX 78114 (830) 216-4326

Bexar County – San Antonio

The SATGA has a fragmented mental health system that has been underfunded in recent years due to significant cuts in funding from the State Legislature during the 2011 session. This significant cut in funding for services led to an increase in the utilization of inpatient and crisis services, such as emergency rooms and jails, because people were unable to maintain care without assistance. The cuts in funding were restored during the 2013 Legislative Session to reduce waiting lists at state mental health authorities. According to a Methodist Health Care Ministries study, the State of Texas provides resources for the mental health authority in San

Antonio to provide psychiatric services to 3,775 individuals with severe and persistent mental illness, which only serves 8.5% of the communities need.[27] However, in other Texas cities, 33.6% of adults with serious and persistent mental illness receive services through the local mental health authority.

A Kronkosky study released in 2013 examined the mental health system in San Antonio and Texas. They found that a 2009 report by NAMI gave Texas a "D" when grading the mental health system.[28] Some of the issues with the mental health system were disparities in funding local mental health authorities, difficult access to all mental health services, a high number of uninsured mentally ill persons, a deficiency in cultural competence, and a work force shortage, which all contributed to Texas' decline in providing acceptable mental health services.

A study conducted by the Methodist Health Care Ministries found that there is an oversupply of inpatient beds, however, there is an undersupply of beds available to low income/indigent patients. For outpatient services, the number of psychiatrists, psychologists, social workers and counselors in San Antonio is currently lower than the average for the United States.[29]

Supplementing the safety net provided by the mental health authorities is a system of organizations that provide free or reduced-cost mental health counseling, including the local Federally Qualified Health Centers – CentroMed and Communicare; Counseling and Consultation Center; the Ecumenical Center for Religion and Health; Family Services Association; Jewish Family Services; Methodist Healthcare Ministries; the Clarity Center; and La Paz Community Health Center.

Those with severe mental illnesses that require hospitalization and have no other sources of funding or cannot be treated at other hospitals are referred to the San Antonio State Hospital (SASH) or the Kerrville State Hospital depending on location. State hospitals provide intensive inpatient diagnostic, treatment, and referral of the seriously mentally ill persons from South Texas. The SASH takes both voluntary and involuntary admissions.

In San Antonio, there are several local organizations and facilities that offer mental health treatment for those able to pay or have private insurance, including Laurel Ridge, Nix Behavioral Services, and the University Health System Psychiatric Outpatient Services.

Finally, there are private mental health providers which include both psychiatrists and licensed counselors. Many private providers do not accept private insurance, Medicare or Medicaid. This creates a situation where clients would be required to pay for mental health services out of pocket, often incurring significant costs. For example, based on a local survey conducted by the

[27] System of Care for Behavioral Health in Bexar County

[28] National Alliance on Mental Illness (NAMI). (2009). Grading the States 2009. Retrieved from http://www.nami.org/Content/NavigationMenu/NAMILand/POLgts2009.pdf.

[29] System of Care for Behavioral Health in Bexar County

HIV Planners, an intake for psychiatry can cost from $210 to $350, with follow-up visits ranging from $110 - $150.

To address the gaps in the mental health care system, a Mental Health Consortium funded by the Hogg Foundation for a period of two years was convened in 2012 by the Bexar County Department of Community Resources. The main goal of the Consortium was to create a seamless, integrated system of care, and a safety net for the mentally ill having multiple points of entry; coordinated programs, providers and services; and sufficient community resources to prevent relapse. This Mental Health Consortium brought together individuals from the local mental health system to help address these problems. The recommendations that came forth from the Consortium were to plan and coordinate mental health services as a community; make mental health a public health priority; prioritize funding and workforce development; and ensure a coordinated system.[30] Outcomes of the Mental Health Consortium included the appointment of a Mental Health Director for Bexar County to continue the efforts of the Mental Health Consortium, a report assessing the current state of mental health in Bexar County, a mental health mobile app that citizens of Bexar County can easily access to locate mental health services, and a comprehensive bilingual mental health resource guide. The Mental Health Resource Guide has been disseminated throughout the San Antonio area and provides information for both mental health and social services. The full report and the resource guide are available on the Planning Council's website, HIV210.org.

The Ryan White System

According to the Health Resources and Services Administration the Ryan White HIV/AIDS Program is the largest federal program that is focused exclusively on HIV/AIDS care. The Ryan White legislation authorizes a series of programs also called Parts. The purpose of the various Parts is to provide flexible programs which meet the needs of various populations. Please see below a description of the Parts that allow mental health services.

Part A provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic.

Part B provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and 5 U.S. Pacific Territories or Associated Jurisdictions.

Part C provides comprehensive primary health care in an outpatient setting for people living with HIV disease.

Part D provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS.

[30] Bexar County Commissioners Court Mental Health Consortium Strategic Planning Sessions

For Parts A and Part B, mental health services are defined as:

Psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized in the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Mental health counseling services include intensive mental health therapy, and individual and family counseling provided solely by mental health practitioners licensed in the State of Texas. Counseling services may include general mental health therapy, counseling, bereavement support for clients. General mental health therapy, counseling and short-term bereavement support is available for non-HIV infected family members or significant others. Crisis counseling and referral will be available to clients and care givers. Medical services are provided by a licensed medical, board certified psychiatrist.

The Ryan White Legislation allows for non-mental health support groups, in the Psychosocial Support category. This category has never been highly prioritized or funded in the SATGA with Parts A and B funding. Previously, Part D funds were allowed to be used for psychosocial support, however, during recent years this service became disallowed. All support groups funded by the Ryan White Program in the SATGA must be led by a certified mental health professional and must be a process group.

The Planning Council, who develops the Standards of Care for the SATGA recognizes that HIV and mental health are linked. Therefore it is required that individuals be screened for mental illness during primary medical care, case management, and Early Intervention Services. This allows for multiple professionals to assess a client for depression or other mental health concerns. Case managers screen for mental illness using a standardized instrument, the Substance Abuse and Mental Illness Symptoms Screener (SAMISS). It should be noted that a client has the right to refuse the use of the screening instrument. This screening tool is not used to diagnose a client, but rather is a starting point to help case managers engage clients in dialogue about mental health issues and determine if further evaluation may be required by a mental health professional. If an individual has a positive screening, the case manager will then determine if the client is already in treatment or not. If not, the case manager will discuss various treatment options and locations where services are available, and allow the individual to determine if they are ready for services. If the individual opts to seek services, a referral will be made to the agency of the client's choice. Clients are referred to agencies in and outside of the Ryan White care system. If the client chooses not to seek services at that time, the case manager will remind them that at any time that they change their mind that the options are available and a referral can be made at that time.

The SATGA Ryan White mental health system consists of three providers: the Alamo Area Resource Center (AARC), CentroMed, and the University Health System – Family Focused AIDS Clinical Treatment Services (UHS – FFACTS) Clinic.

AARC provides one-on-one counseling, family counseling, and support groups. AARC employs five mental health providers, who are licensed professional counselors (LPCs) or LPC interns. To access services at AARC, clients can self-refer or be referred from another agency. Clients are screened for mental health needs through both case management and early intervention services. AARC operates on a philosophy of "wrap-around" services, providing both core and supportive services. AARC provides mental health services Monday through Friday, which are available in English and Spanish.

CentroMed offers psychiatric services provided through a psychiatric nurse-practitioner and counseling services offered by two licensed clinical social workers (LCSWs). CentroMed offers counseling services at their Santa Rosa Clinic Monday through Friday and psychiatric services Monday, Wednesday, and Thursday. Services are provided on Tuesdays at Centro Med's New Braunfels clinic, which is located in Comal County. Services are available in English and Spanish at both locations.

The UHS–FFACTS Clinic offers psychiatric services provided by a psychiatrist and counseling services offered by two LPCs, one of which is also a licensed chemical dependency counselor. New patients must be screened by the counselors before being referred to psychiatric services. Clients do not have to be medical patients of the UHS–FFACTS Clinic to receive mental health services; however, they must provide proof of medical care from another provider. Counseling services are provided Monday through Friday with psychiatry services offered on Thursdays. The psychiatrist is on call in cases of emergency. Psychiatric and counseling services are available in English and Spanish.

In the SATGA, there are pharmaceutical funds available to assist insured and uninsured clients with the costs of co-payments and full-price medications. The Ryan White Program medication formulary covers a full array of medications that treat mental illness.

Clients who live in the SATGA have varying options for securing their mental health medications depending on their insurance or medical financial assistance coverage. For clients with Medicaid, Medicare, or other private insurance who do not require co-pay assistance for their medications, they can access their medications from traditional pharmacy sources, to include but not limited to CVS, Walgreens, HEB, local pharmacies including Laurel Heights and Garza, as well as the pharmacy associated with their HIV medical care. For clients with insurance coverage who receive co-pay assistance for their mental health medications, the number of pharmacy locations available to the client are limited and generally do not include the larger chain pharmacies. For clients with Care Link, medications must be obtained through a University Health System clinic to include the FFACTS Clinic. For clients who do not have any medical coverage, provided that they continue to meet eligibility requirements, Ryan White is the primary source for medication assistance, but pharmacy locations are limited.

Both Ryan White medical providers have a pharmacy associated with their clinic that can provide Ryan White assistance for mental health medications. The FFACTS Pharmacy, located in the same building as the FFACTS Clinic, only provides medications to clients diagnosed with HIV who receive a prescription from a University Health System physician. For clients receiving medical care through CentroMed, medication assistance through Ryan White is only available through their pharmacy located at 918 Wagner on the Southside of San Antonio.

Funding and Utilization of Mental Health Services in the Ryan White System

The Ryan White Legislation charges the Planning Council with the task of setting priorities and allocating resources to various services, such as ambulatory care and medication assistance. Each year, the Planning Council reviews utilization data, trends in expenditures, needs assessments and other available resources to make decisions on how to allocate funding that will best meet the needs of people living with HIV/AIDS (PLWHA) in the SATGA. The Planning Council has identified mental health as a priority service needed by PLWHA, and as such, has consistently provided funding for this service category. Please see **Table 3** for Part A and Minority AIDS Initiative (MAI) funding levels from 2011 to 2014. Mental health services were also funded through Part B in FY 2013 at $47,487.

As a note, in FY 2012, the Planning Council allocated additional resources to mental health; however, an agency was defunded midway through the grant period leaving mental health funds unspent. Additionally, the total number of unduplicated clients has decreased in recent years because of changes in program staffing, including a loss of a psychiatrist in 2011.

TABLE 3. MENTAL HEALTH AUTHORITIES IN THE SATGA

Year	Original Allocation	Expenditures	Unduplicated Clients
Ryan White Part A			
2013-2014	$238,569	$207,128*	496
2012-2013	$291,922	$216,307	526
2011-2012	$212,388	$196,019	609
*Pending Final Closeout			
Year	**Original Allocation**	**Expenditures**	**Unduplicated Clients**
Ryan White Part A Minority AIDS Initiative (MAI)			
2013-2014	$46,889	$55,570*	177
2012-2013	$67,933	$46,999	211
2011-2012	$94,088	$53,318	217

METHODOLOGY

The mental health study employed a mix of qualitative and quantitative data collection that included surveys, interviews, and focus groups. Mental health providers, case managers, and consumers responded. All instruments were developed by the Planning Council Needs Assessment Committee (NAC) with the assistance of the Administrative Agency (AA) staff. Most data collection was completed by the HIV Planners and the Planning Council Liaison. Service providers assisted in the gathering of survey data from clients.

The key concepts explored in each of the surveys, focus groups, and interviews were needs for services and barriers to accessing care and medication. Customarily, in Ryan White needs assessments, these terms refer to medical care; however, for the purpose of this report, needs and barriers refer to mental health services. A working definition of barriers to mental health care is "an obstacle(s) in the mental health system that prevents vulnerable individuals from getting needed health care, or that cause them to get inferior health care compared to other populations".[31] Consistent with the socio-ecological model of health behavior, participants were asked about barriers at the individual, interpersonal, institutional, community, and public policy levels. For this study, need is based on the survey respondent's answers.

Mental Health Providers

Survey of Direct Service Providers Funded by the Ryan White Program

Conducted in June 2013

The first stage of data collection involved a survey of Ryan White mental health providers developed by the NAC. The survey was designed to gain in-depth information regarding both the individual mental health provider and the clients they serve. The emphasis of these surveys included barriers to mental health services, how to improve mental health services, reasons clients access or do not access services and an inventory of support groups. Please see **Appendix A** for the full mental health provider survey. An electronic version of the survey was emailed to and completed by ten mental health providers representing each of the three SATGA Ryan White-funded agencies. Of the respondents, six were licensed professional counselors (LPC), two were licensed clinical social workers (LCSW), one was a psychiatrist, and one a psychiatric nurse practitioner. While all providers have been practicing for more than six years, only four have been working with PLWHA for six to 10 years, whereas four have worked with PLWHA for less than two years. For demographic information, please see **Table 11**.

The mental health provider surveys were followed up with more in-depth interviews that probed the responses from the surveys. The Planning Council Liaison transcribed all interviews. An HIV Planner and a professor from a local university analyzed the interview transcripts qualitatively using grounded-theory methods.

[31] http://www.amsa.org/programs/barriers/barriers2.html

Survey of Direct Service Providers Not Funded by the Ryan White Program

Conducted in November 2013

A survey of non-Ryan White providers was developed and distributed via Survey Monkey and distributed to the local Mental Health Task Force, which consists of individuals who are mental health professionals and mental health stakeholders. The survey covered the number of people with HIV these providers serve, their hours of operation, and basic information about their practices.

Survey of Case Managers in the Ryan White Program

Conducted in July - August 2013

A survey of local Ryan White case managers was conducted to obtain information regarding clients who may not be accessing mental health services. The Ryan White Standards of Care require case managers to assess clients for the need for mental health services. Case managers are often used as an alternative to mental health services because clients have developed relationships with these staff.

The survey of case managers explored their experience with clients who are least served by the existing mental health system and their perceptions on why these clients are underserved. The survey also identified assets and strengths to the mental health system and barriers to care. Please see **Appendix C** for the Case Manager's survey instrument.

The survey of case managers was sent to all 26 Ryan White case managers via email with a brief description of the purpose of the surveys. There were 13 respondents. Of the respondents, four were male and nine were female. Ten of the respondents were Hispanic and two were white. Except for the one respondent who has worked in HIV for 6-10 years, there was equal representation between less than 1 year, 1-2 years, 3-5 years, and more than 10 years working in HIV, with three each. The NAC chair summarized the surveys from case managers, and AA staff analyzed the quantitative and qualitative components.

Mental Health Consumers

HIV Consumer Advocates' Focus Group

Conducted in July 2013

Following the data collection from mental health providers, an HIV Planner and the Planning Council Liaison conducted a focus group with four key HIV consumer advocates. The consumers selected to participate were or are members of the Planning Council, Bexar County Ryan White Quality Management Committee, and/or other Consumer Advisory Boards and are well-known voices for the PLWHA community. The key consumer advocate focus group questions explored the Ryan White mental health system and what these advocates have observed in the community regarding the strengths and gaps in this system. Please see **Appendix B** for the Consumer Advocates' Focus Group survey instrument. Of the four consumers who participated, all have utilized Ryan White-funded mental health services; three were Hispanic males, and one was an African-American female. All four consumers were over 40 and are long-term survivors. The focus group was recorded and transcribed by the Planning

Council Liaison, and was analyzed qualitatively by an HIV Planner and a professor from a local university who serves on the NAC.

HIV Consumers' Focus Group

Conducted in October 2013

A consumer focus group was held to further probe into the themes found in the survey results. To gather members for the focus group, Ryan White mental health providers were enlisted and provided with guidance on the process. After identifying possible participants, the provider gave the client the telephone number for the Planning Council Liaison and had the client call to RSVP. Each of the three providers was given four slots to fill, with the target goal of 12 participants. However, because of the sampling technique and time available to recruit participants there were only six participants. One agency was unable to locate participants, another agency had one client, and the final agency provided five clients. The focus group revealed that many of the participants attended counseling sessions at one agency and obtained psychiatric services at the other agency.

Of the six participants, five were men and one was a woman. There were three African Americans, two Hispanics, and one White participant. Further, the age of the participants varied from their early 20's to late 50's, providing diversity in viewpoints. The length of diagnosis also varied from recently diagnosed to long-term survivor.

Consumer Surveys

Conducted in October-November 2013

The largest portion of data collection involved the development and distribution of consumer surveys. To be eligible to be included in the analysis, consumers had to have both a self-reported HIV diagnosis and a mental health diagnosis. The consumer survey was developed in both English and Spanish. Flyers with a Survey Monkey link and hard copies of the survey were placed at all Ryan White agencies and other HIV service providers, as well as the local mental health authority, Metropolitan Community Church of San Antonio, and the Veterans Administration Audie Murphy Clinic. Provider staff helped clients who needed assistance with completing the survey. Surveys were also distributed at community events such as the Planning Council's People's Caucus consumer group meetings, an agency's consumer educational groups, and a local hot meal program for PLWHA. There were no incentives provided to participants. The flyers included a Quick Response Code for consumers to scan with their smart phones. There were only 10 respondents who filled out the survey online, of who three met the criteria for the survey and were included in analysis. The rest of the eligible surveys were completed on paper.

There were a total of 268 surveys collected from all events and sites. Of these 268 surveys, 161 met the criteria for inclusion in the analysis. This represents 20% of all people accessing mental health services through the Ryan White Program (RWP) as documented through the AIDS Regional Information and Evaluation System (ARIES), which is the uniform data reporting

system for the State of Texas. The database for the surveys was developed by the NAC chair. This data was imported into Statistical Product and Service Solutions (SPSS), a statistical software package, and analyzed quantitatively by an HIV Planner. Please see **Appendix D** for the consumer survey instrument in English and Spanish.

As shown in **Table 4**, the survey sample is representative of both RWP mental health clients and PLWHA in the four-county SATGA in terms of gender. The sample is also representative of RWP mental health clients in terms of age. The sample is not representative of either population in terms of ethnicity; Hispanics were underrepresented while Whites were somewhat overrepresented.

TABLE 4. SAMPLE AND POPULATION CHARACTERISTICS

Study Respondents			*Ryan White Mental Health Clients In the SATGA 2012*			*People Living with HIV/AIDS In the SATGA 2012*		
	N*	Percent*		N	Percent*		N	Percent*
Gender			Gender			Gender		
Male	113	70.2	Male	588	73.2	Male	4,433	84.1
Female	26	16.1	Female	200	24.9	Female	841	16.0
Transman	1	0.6	Transman	0	0	Transman	-	-
Transwoman	3	1.9	Transwoman	15	1.9	Transwoman	-	-
Missing	18	11.1						
Age			Age			Age		
18-24	5	3.1	18-24	48	6.0	13-24	292*	5.5
25-44	63	39.1	25-44	373	46.5	25-44		42.8
45-60	73	45.3	45+	382	47.6	45+	2,259	51.3
61+	4	2.5						
Missing	16	9.9					2,706	
Race / Ethnicity	73	45.3	Race / Ethnicity			Race / Ethnicity		
Hispanic	39	24.2	Hispanic	505	62.9	Hispanic	3,044	57.7
White	26	16.1	White	152	18.9	White	1,231	23.3
Black	5	3.1	Black	135	16.8	Black	799	15.2
Other	18	9.9	Other	11	1.4	Other	38	0.7
Missing								

* May not total 161 or 100% due to missing values, multiple responses, and/or rounding.

Limitations

In conducting the Mental Health study, the following limitations were noted:

Consumer Survey

- The use of a convenience non-random sampling for the client surveys has both advantages and limitations. This method of sampling is less costly and requires less time than does a random sample, and in this case, produced a large number of surveys. However, the sample is less likely to be representative of the target population.
- Of the nine consumer surveys completed in Spanish, there is no way to confirm whether each respondent was a monolingual Spanish speaking individual, or was bilingual and preferred to fill out his/her survey in Spanish.

- Those without a mental health diagnosis were excluded, which means that everything that was included in the analysis had at least one visit with a physician or mental health provider where they were diagnosed. Because of this limitation it is possible that those who are completely unconnected to care and have the most barriers to care were excluded.
- The surveys were collected from participants with a self-reported mental health and HIV diagnosis. There is no way to confirm that the individual had either diagnosis. However, because the surveys were distributed at HIV providers and HIV consumer events there is a strong likelihood that those who responded had an HIV diagnosis.
- There is a slight possibility of individuals answering the survey multiple times. Individuals distributing surveys tried to ensure respondents only answered the surveys once.
- Respondents were not asked which county they resided in; therefore, it is unknown whether we received responses from clients living in all four counties of the SATGA.
- All sites where the written surveys were distributed were located in Bexar County.
- Despite the explanation regarding the types of treatment in the survey, as mental and health and substance abuse often overlap and people have preconceived notions of what treatment is, the responses may have included areas beyond the specific intent of the mental health treatment options listed.
- The survey asked consumers if there were services that they needed but did not receive; however, it did not ask whether or not consumers asked for the services they needed.

Case Management Survey

- The case management survey was unable to be placed on Survey Monkey, possibly limiting the number of respondents.

SURVEY AND FOCUS GROUPS FOR MENTAL HEALTH CONSUMERS

Respondent Characteristics

Of the 268 persons who completed the consumer survey, 161 respondents met the study's criteria, having both an HIV and a self-reported mental health diagnosis. Of these 161, nine respondents completed the survey in Spanish. The characteristics of the 161 respondents are summarized in **Table 5**, below. As noted in the methodology section, survey respondents were somewhat older and were more likely to be white than the population of PLWHA and the mental health consumers in the SATGA. Half of respondents identified as gay or lesbian, one-fourth as straight, 9% as bisexual, and the remainder declined to answer. Two-thirds listed English as their primary language, 6% preferred Spanish, and 10% were comfortable with both languages. The majority had been diagnosed with HIV six or more years. The most common self-reported diagnoses were depression (77.6%), anxiety (59.0%), and bipolar disorder (37.9%); schizophrenia and post-traumatic stress disorder (PTSD) were each reported by less than 10% of respondents. Nearly two-thirds (63.4%) of respondents reported multiple mental health diagnoses. Strong correlations were found between depression and anxiety, bipolar and anxiety, and bipolar and schizophrenia. The only significant difference in diagnosis by demographic characteristics was that women and heterosexuals were more likely to report experiencing PTSD.

While the majority of respondents (67.1%) received their mental health services through the Ryan White system, 6% received some of their mental health services outside the system, 6% received all of their services outside of it, and 17% were not receiving mental health services. More than a third (37.3%) were worried about how the Affordable Care Act would impact their services. It should be noted that the survey was administered during a time when little was known about the effects of the Affordable Care Act on mental health services.

More than half (58%) of the respondents had a current prescription for medication for their mental illness, and 10% had been hospitalized for a mental health issue in the six months before the survey. These indicate that this sample had serious mental illness.

TABLE 5. CONSUMER RESPONDENT CHARACTERISTICS

	N*	Percent*		N*	Percent*
Gender			Age		
Male	113	70.2	18-24	5	3.1
Female	26	16.1	25-44	63	39.1
Transman	1	0.6	45-60	73	45.3
Transwoman	3	1.9	61+	4	2.5
Sexual Orientation			Language Preference		
Gay / Lesbian	82	50.9	English	107	66.5
Straight	41	25.5	Spanish	9	5.6
Bisexual	15	9.3	Bilingual	16	9.9
Race / Ethnicity			HIV Diagnosis		
Hispanic	73	45.3	Within Last Year	13	8.1
White	39	24.2	1-5 Years Ago	27	16.8
Black	26	16.1	6-10 Years Ago	42	26.1
Other	5	3.1	11+ Years Ago	60	37.3
Mental Health Diagnosis			Where MH Services Received		
Multiple	102	63.4	Ryan White System Only	108	67.1
Depression	125	77.6	Community / Private Only	10	6.2
Bipolar	61	37.9	RWP & Community / Private	10	6.2
Anxiety	95	59.0	Not Receiving Services	27	16.8
Schizophrenia	15	9.3			
Post-Traumatic Stress	7	4.3	Worried About ACA Impact		
Unknown	4	2.5	Yes	60	37.3
Refused to Disclose	4	2.5	No	46	28.6
			Don't Know	42	26.1
Hospitalized in Past 6 Months	16	9.9	Currently Prescribed Meds	94	58.4

* May not total 161 or 100% due to missing values, multiple responses, and/or rounding.

Findings

Knowledge and Use of Services

About two-thirds of those surveyed were aware that individual counseling and psychiatry services were available to them (67% and 63%, respectively), but only about half were aware of group counseling (53%) and only 43% were aware of support group availability. A minority of respondents reported needing services but not receiving them; this ranged from 44% reporting a need for individual counseling to 27% reporting a need for support groups. This is discussed more below. More than half of respondents reported that they had received individual counseling (56%) and psychiatry services (53%) and one-fourth reported attending group counseling (24%) and support groups (23%). Of those accessing services, their assessments of whether or not the

services met their needs were generally positive but left room for improvement. Individual counseling was rated highest, with 63% saying it met their needs, while support groups were rated the lowest, with only 51% rating them positively. See **Table 6**, below, for more detail.

TABLE 6. USE AND ASSESSMENT OF MENTAL HEALTH SERVICES

	N*	Percent*		N*	Percent*
Aware Services Available			Need for Services		
Individual Counseling	108	67.1	Individual Counseling	71	44.1
Psychiatry	103	64.0	Psychiatry	61	37.9
Group Counseling	86	53.4	Group Counseling	50	31.1
Support Groups	69	42.9	Support Groups	44	27.3
Services Received			Services Met Needs[1]		
Individual Counseling	90	55.9	Individual Counseling	57	63.3
Psychiatry	85	52.8	Psychiatry	51	60.0
Group Counseling	39	24.2	Group Counseling	24	61.5
Support Groups	37	23.0	Support Groups	19	51.4

* May not total 161 or 100% due to missing values, multiple responses, and/or rounding.
[1]For this variable, percent = number reporting service met needs / number reporting service received

Need for Services

Respondents were asked if there were services that they needed but did not receive. Responses were compared by respondent diagnosis using Chi-square analysis. In **Table 7**, below, an asterisk indicates that people with a particular diagnosis were significantly more likely to report need for the service than people without that diagnosis; two asterisks indicate an even larger difference. Among people with the most common diagnoses, i.e., depression, anxiety, and bipolar disorder, about half said they needed but did not receive individual counseling and psychiatry services. People with bipolar disorder and with multiple diagnoses reported the most need. People with multiple diagnoses were significantly more likely than those with single diagnoses to report needing but not receiving psychiatry, group counseling, and support groups. People with depression reported a need for individual counseling and support groups, while people with anxiety reported a need for psychiatric services. People with bipolar disorder reported not receiving the individual counseling, group counseling, and support groups that they needed. People with schizophrenia reported a need for group counseling, while people with PTSD reported a need for individual counseling and psychiatry services. **Table 7** also shows the number and percentage reporting a need by mental health diagnosis. Respondents who had been hospitalized for a mental health problem in the six months preceding the survey were not more likely to report a need for services, nor were people who had a current prescription for mental health illness. No other significant differences in the characteristics of clients reporting a need were found. See **Appendix E** for the detailed table and statistics from the consumer survey. As noted in the consumer survey limitations, consumers were asked if there were services that they needed but did not receive, but the survey did not explore whether or not respondents requested a service but did not receive it.

In the focus groups, consumers reported that they thought the Bexar County Ryan White mental health system was generally strong: *"Clients in San Antonio have access to a pretty good mental*

health system." However, they noted that psychiatry services were in short supply, and that there was little choice of doctor and some issues with continuity of care when agencies' psychiatrists change. One commented that support groups are not meeting clients' needs, *"but it is not for a lack of trying."*

TABLE 7. NEED FOR MENTAL HEALTH SERVICES BY RESPONDENT DIAGNOSIS

	Need: Individual Counseling		Need: Psychiatry		Need: Group Counseling		Need: Support Group	
	N	Percent	N	Percent	N	Percent	N	Percent
Overall	71	44.1	61	37.9	50	31.1	44	27.3
Diagnosis								
Multiple	51	50.0	48	47.1**	38	37.3*	37	36.3**
Depression	61	48.8*	52	41.6	43	34.4	40	32.0*
Anxiety	45	47.4	42	44.2*	31	32.6	29	30.5
Bipolar	29	47.5**	32	52.5	30	49.2**	25	41.0**
Schizophrenia	5	33.3	6	40.0	9	60.0*	7	46.7
PTSD	5	71.4*	6	85.7**	3	42.9	4	57.1

Note: percent = number of people with a need / number of people with diagnosis
*Responses from people with this diagnosis are significantly different than people without this diagnosis at the $p<0.05$ level.
**Responses from people with this diagnosis are significantly different people without this diagnosis at the $p<0.01$ level.

Barriers to Accessing Services and Medication

A set of possible barriers to care, based on the socio-ecological model, were presented to survey respondents. They were asked to rate these barriers on a scale of 1 to 5, where one indicated that it was not currently a barrier, and five indicated that it was a major one. In **Table 8**, below, average ratings and ratings by people reporting a need is presented. These scores are compared using the analysis of variance (ANOVA) statistical procedure. An asterisk indicates that people with a need rated the barrier as significantly more serious than people who did not report a need; two asterisks indicate an even larger difference. Rating barriers to care as more serious was correlated with reporting a need for services not met, confirming that these barriers make people less likely to request or receive the care they need.

At the individual level, being unsure what services were available, being unsure what was covered by insurance, and not feeling that services were needed were correlated with a need. At the interpersonal level, concern that one would be stigmatized for using mental health services emerged as a barrier to care, especially to attending support groups. At the institutional level, paperwork did not appear to be a significant barrier, while appointment times were a significant barrier only to psychiatric services. At the community level, transportation was rated as a significant barrier among people who were not accessing individual counseling, psychiatry, and group counseling services. Cost and lack of insurance coverage were rated as barriers by those with a need for individual counseling, psychiatry, and group counseling. **Table 8** below also shows the average scores assigned to these barriers among participants overall and among those reporting a need for services.

In general, perception of the seriousness of barriers to care did not differ by respondents' characteristics. However, a few differences were found. People with multiple diagnoses considered inconvenient appointment times as a more significant barrier than those with single diagnoses. People with schizophrenia were significantly more likely than those with other diagnoses to rate not feeling ready for mental health services, concern about being judged for using services, and concern about the ability of the provider to meet their needs as barriers to care. People who had been recently hospitalized reported more concern about stigma. People currently prescribed medications for mental illness rated inconvenient pharmacy locations as less of a barrier than people without current prescriptions. Men and women did not rate barriers differently. People who are between the age of 45 and 60, those who have been diagnosed with HIV for longer than 11 years or more, and those who are white report feeling less concerned about being judged for using mental health services compared to other groups. See **Appendix E** for the detailed table and statistics from the consumer survey.

TABLE 8. SOCIO-ECOLOGICAL BARRIERS TO CARE AMONG CONSUMERS REPORTING A NEED FOR SERVICES

	Individual-Level Barriers				*Interpersonal-Level Barriers*	
	Unsure What Services are Available	Unsure What Insurance Covers	Do Not Feel Ready for Services	Do Not Feel That Services are Needed	Worried About Being Judged for Using Services	Worried about Cultural Competence of Provider
Overall	2.44	2.30	2.02	2.03	2.28	1.77
Need:						
Ind. Counsel.	2.84**	2.65*	2.36*	2.47**	2.50	2.05*
Psychiatry	2.75	2.75**	2.27	2.43*	2.69*	1.94
Grp. Counsel.	3.07**	2.60	2.26	2.43*	2.71*	2.05
Support Grp.	3.10**	2.58	2.33	2.45	2.95**	1.97
	Institutional-Level Barriers		*Community-Level Barriers*		*Policy-Level Barriers*	
	Too Much Paperwork Required	Inconvenient Appointment Times	Inconvenient Pharmacy Locations	Transportation Issues	Costs of Medications & Co-pays	Insurance Does Not Cover Medications
Overall	2.05	2.20	1.85	2.18	2.21	2.06
Need:						
Ind. Counsel.	2.20	2.39	2.24**	2.52*	2.55*	2.49**
Psychiatry	2.25	2.57*	2.04	2.69**	2.65*	2.39
Grp. Counsel.	2.26	2.44	2.07	2.73**	2.55	2.49*
Support Grp.	2.24	2.43	2.00	2.57	2.58	2.31

*Responses from people with this need are significantly different than people without this need at the $p<0.05$ level.
**Responses from people with this need are significantly different people without this need at the $p<0.01$ level.

In the focus groups, multiple participants discussed lack of knowledge of available services, particularly knowledge of services outside their usual agency. They also noted that some people are not clear on the distinction between a counselor and psychiatrist, leading to dissatisfaction with short psychiatric visits. Consumers discussed clients' responsibility to seek out services if they need them and noted that some clients simply do not want mental health services. One participant said that people often do not seek out services until they are "scared into care" by a crisis. They agreed that stigma was a significant factor, especially the double stigma of being HIV-positive and having a mental illness. They felt that there was a need for services and support groups tailored for straight men, who often feel out of place in services targeted to gay

men, especially as several consumers said that support groups often become "hook-up" sites, where people look for dates. They noted that, since the HIV community in San Antonio is small, information shared at support groups often does not feel confidential. Consumers discussed the importance of a provider who is culturally-competent, and felt that agencies did a good job addressing this need. They particularly noted the availability of family-centered services and bilingual counselors as strengths: *"Language is no longer a barrier. There are counselors who are bilingual and a translator is provided if you need it."* They did not mention paperwork or inconvenient appointment times as a barrier, but several commented that there were often long wait times between scheduling an appointment and the appointment date, as well as long wait times on the day of the appointment, particularly for psychiatry. Inconvenient pharmacy locations were not identified as a barrier in these groups, but one participant brought up transportation assistance as a need. Several commented that it was convenient to have medical and mental health services at the same location.

SURVEY OF CASE MANAGERS

Respondent Characteristics

Of the 26 case management surveys sent out, 13 were received. Although not all staff included their job title, surveys were received from directors of case management, case managers, and early intervention specialists. Their experience in the field was spread evenly, from three with less than a year of experience, to three with more than ten years of experience. Their demographic characteristics are summarized in **Table 9** below. Case managers are more likely to be women and to be Hispanic compared to the clients they serve.

TABLE 9. RYAN WHITE CASE MANAGER RESPONDENT CHARACTERISTICS					
	N	Percent		N	Percent
Race/Ethnicity			Age		
Hispanic	10	77	18-24	1	8
White	2	15	25-44	9	69
Black	0	0	45-60	3	23
Other	1	8	60+	0	0
Sex					
Male	4	31			
Female	9	69			

Findings

Need for Services

Case managers were asked which groups they felt were underrepresented in mental health services. The most common answers were women and transgendered people, adults aged 18-24 and 25-44, heterosexuals, Hispanics, and those who were diagnosed with HIV 1-5 years ago. This is fairly similar to service providers' perceptions, with the exception that case managers were more concerned about underrepresentation of women and young adults than service providers. The only area of disagreement was on the ethnicity of those underrepresented. Service providers identified Whites while case managers identified Hispanics. Like consumers, case managers thought, *"Resources are there for the most part."* They felt that many people do not seek services and are thus *"underserved mostly by personal choice of the individual."* They therefore estimated a rate of 33-50% for services needed but not being accessed, which is consistent with what clients reported. In particular, they felt that young adults do not want mental health treatment. They also felt that there were inadequate services for transgendered people who, though small in numbers, have very high HIV rates mental health needs.

Barriers to Accessing Services and Medication

Case managers were asked to rate a series of barriers to care on a scale of 1 to 5, where one indicated that they did not think it was a barrier to care for their clients and five indicated that they thought it was a serious barrier to care. Their responses are summarized in **Table 10** below. In the open-ended sections of the survey, clients' knowledge of services were discussed by several respondents. One also noted that they may not be clear on the purposes and benefits of mental health services, that many do not realize how their mental health impacts their HIV care, and that many do not know the distinction between psychiatry, individual and group counseling, and support groups. They also said that many people are not ready to address their mental health issues: *"From my experience, a client will access mental health services when they are ready and willing."* Like consumers, they noted that the stigma of mental health diagnoses is a barrier to care. They placed a great deal of importance on the cultural competence of providers and felt that more multi-cultural and multi-lingual providers were needed. Case managers felt strongly that mental health services should be made more convenient through a "one-stop shop" model, i.e. at the same location as medical and other services. They did not discuss lack of knowledge

about insurance coverage or lack of insurance, though consumers considered these significant barriers.

TABLE 10. RYAN WHITE CASE MANAGERS' PERCEPTIONS OF CLIENT BARRIERS TO CARE			
Individual-Level Barriers		***Institutional-Level Barriers***	
Lack of knowledge by clients of available services	3.54	Inconvenient times (not available after 5 pm or on Saturday)	2.92
Clients feel they are not ready or don't need services	4.21	***Community-Level Barriers***	
Interpersonal-Level Barriers		Inadequate transportation or inconvenient locations	2.77
Clients are concerned about the stigma attached to mental health services ("I'm not crazy")	3.93	***Policy-Level Barriers***	
Client concern with lack of qualified mental health professionals to meet their needs	3.08	Lack of systems to see clients based on their insurance coverage or lack of insurance coverage	3.36

SURVEY AND INTERVIEWS OF DIRECT SERVICE PROVIDERS

Respondent Characteristics

Ten mental health direct service providers who operate in the Ryan White system were surveyed. Their demographic characteristics are summarized in **Table 11** below. Six of the respondents are licensed professional counselors, two are licensed clinical social workers, one is a licensed chemical dependency counselor, and one is a psychiatric mental health nurse practitioner. Three had 6-10 years of experience in their fields and seven had more than ten years' experience. However, not all of this experience included working with people with HIV; three had worked with PLWHA for less than a year. Six are able to offer services in both English and Spanish. Compared to the people to whom they provide services, women, Hispanics, and heterosexuals are overrepresented among this sample of providers.

TABLE 11. RYAN WHITE PROVIDER RESPONDENT CHARACTERISTICS					
	N	Percent		N	Percent
Race/Ethnicity			Age		
Hispanic	8	80	18-24	0	0
White	1	10	25-44	5	50
Black	1	10	45-60	4	40
Other	1	10	60+	1	10
Sex			Sexual Orientation		
Male	5	50	Gay / Lesbian	1	10
Female	5	50	Straight	8	80
			Bisexual	1	10

Findings

Need for Services

Service providers were asked which groups they felt were underrepresented in mental health services. The most common answers were transgendered people, adults aged 25-44, heterosexuals, Whites, monolingual Spanish-speakers, and those who were diagnosed with HIV 1-5 years ago. In interviews, they discussed transgendered people and straight men as having a need for mental health services. Like case managers, they felt that services were available and that accessing them was a *"relatively easy process,"* especially when incorporated into clinics.

Barriers to Accessing Services and Medication

Service providers were asked to rate a series of barriers to care on a scale of 1 to 5, where one indicated that they did not think it was a barrier to care for their clients and five indicated that they thought it was a serious barrier to care. Their responses are summarized in **Table 12** below. Like both consumers and case managers, they considered lack of knowledge of services and *"what therapy is and how it works"* as critical barriers to care, as well as lack of referrals from primary care physicians. Like clients and case managers, they spent a great deal of time discussing the role of stigma, saying mental health care *"needs to be talked about in public and normalized [through] talk."* They said that *"the system is good, the services are there,"* though they noted that there were long wait times for psychiatry appointments due to a low number of providers. The providers also pointed out that it is hard to access care outside normal business hours. They thought that providers needed additional education on how to serve people of different cultural backgrounds.

TABLE 12. RYAN WHITE SERVICE PROVIDERS' PERCEPTIONS OF CLIENT BARRIERS TO CARE

Individual-Level Barriers		***Institutional-Level Barriers***	
Lack of knowledge by clients of available services	4.00	Inconvenient times (not available after 5 pm or on Saturday)	2.89
Clients feel they are not ready or don't need services	4.11	***Community-Level Barriers***	
Interpersonal-Level Barriers		Inadequate transportation or inconvenient locations	3.63
Clients are concerned about the stigma attached to mental health services ("I'm not crazy")	4.56	***Policy-Level Barriers***	
Client concern with lack of qualified mental health professionals to meet their needs	2.67	Lack of systems to see clients based on their insurance coverage or lack of insurance coverage	3.56

COMMON THEMES

The input from consumers, service providers, and case managers is compared in terms of where areas of agreement and disagreement lie. The following discussion, based on both the quantitative and qualitative data received throughout the study, focuses primarily on the key areas of needs and barriers to care.

Need for Services

The demographic characteristics of all Ryan White clients and Ryan White clients who access mental health services are presented in **Table 13** below. Chi-square, a type of statistical test, was used to compare the proportions of different demographic groups. Compared to all Ryan White clients in the SATGA, among Ryan White mental health clients, women are overrepresented while men are underrepresented. The two groups are equivalent in terms of age distribution. Hispanics are overrepresented while Whites are underrepresented. The two groups are equivalent in terms of sexual orientation. People with recent HIV diagnoses, i.e. in the last 1-5 years, are overrepresented among mental health clients, probably due to higher levels of need. People with very recent diagnoses of less than one year, and people with longer times since diagnosis, such as six years or more, are evenly represented among mental health clients.

TABLE 13. DEMOGRAPHIC CHARACTERISTICS OF ALL RYAN WHITE CLIENTS COMPARED TO MENTAL HEALTH CLIENTS

All Ryan White Clients In the SATGA 2012			***Ryan White Mental Health Clients In the SATGA 2012***		
	N	Percent		N	Percent
Gender*			Gender*		
Male	2626	78.0	Male	588	73.2
Female	696	20.7	Female	200	24.9
Transman	0	0	Transman	0	0
Transwoman	44	1.31	Transwoman	15	1.9
Age			Age		
13-24	236	7.0	18-24	48	6.0
25-44	1447	43.0	25-44	373	46.5
45+	1561	46.4	45+	382	47.6
Race / Ethnicity**			Race / Ethnicity**		
Hispanic	2057	61.1	Hispanic	505	62.9
White	679	20.2	White	152	18.9
Black	586	17.4	Black	135	16.8
Other	144	1.3	Other	11	1.4
Sexual Orientation			Sexual Orientation		
Gay/Lesbian/Bisexual	2034	57.6	Gay/Lesbian/Bisexual	480	59.8
Straight	937	26.5	Straight	235	29.3
Unknown	561	15.9	Unknown	88	11.0
HIV Diagnosis*			HIV Diagnosis*		
Within Last Year	207	5.9	Within Last Year	62	7.6
1-5 Years Ago	1050	29.7	1-5 Years Ago	299	37.2
6-10 Years Ago	715	20.2	6-10 Years Ago	146	18.2
11+ Years Ago	1204	34.1	11+ Years Ago	292	36.4
Unknown	356	10.1	Unknown	4	0.04

* The difference between the two groups is significant at the p<0.05 level.
** The difference between the two groups is significant at the p<0.01 level.

Barriers to Accessing Services and Medication

The average scores that service providers, case managers, and clients assigned to various barriers were ranked to determine the barriers they considered most serious. **Table 14**, below, shows the barriers to care with the three highest scores. Lack of knowledge about available services was

ranked first by consumers and third by providers. Stigma was rated first providers, second by case managers, and third by consumers. All three groups in open-ended questioning also discussed these two barriers extensively. They also included lack of insurance coverage, though clients were more concerned about coverage for medications while providers identified coverage for office visits.

TABLE 14. RANKING OF BARRIERS TO MENTAL HEALTH CARE BY PROVIDERS, CASE MANAGERS, AND CLIENTS

Ranking	*Barrier Identified by Providers*	*Barrier Identified by Case Managers*	*Barrier Identified by Clients*
1	Clients are concerned about the stigma attached to mental health services ("I'm not crazy")	Clients feel they are not ready or don't need services	I am unsure of what services are available.
2	Clients feel they are not ready or don't need services	Clients are concerned about the stigma attached to mental health services ("I'm not crazy")	I am unsure where I can receive services based on my insurance coverage.
3	Lack of knowledge by clients of available services	Lack of knowledge by clients of available services	I am worried about others knowing that I need mental health services and judging me negatively.

Areas of Agreement

The input from consumers, service providers, and case managers revealed the following areas of agreement between the three groups:

- Clients and case managers noted high levels of unmet need, or specifically services needed, but not being accessed by clients, which corresponds to the 27-44% of consumers who reported a need for various services.
- Client knowledge, both of the purpose and methods of therapy and of the services available, was considered a major barrier by consumers, case managers, and service providers alike.
- All three groups rated coordination of services as fairly effective in the Ryan White system, but saw a disconnection with services outside the system. Consumers thought that agencies coordinated well, though they felt they could "cross-promote" each other's services more effectively. Case managers and service providers tended to refer within the system but not outside of it.
- Stigma was identified as a major issue by all groups of respondents. They noted that HIV, mental illness, and homosexuality all carry stigma, and that this is shaped by cultural factors and difficult to address.
- All three groups identified a shortage of psychiatric services and providers.
- All three groups noted unfamiliarity with existing mental health support groups in and outside of the Ryan White care system.

Areas of Disagreement

The input from consumers, service providers, and case managers revealed the following areas of disagreement between the three groups:

- The sufficiency of available services was rated differently by the different respondents. Clients were unsure what services were available. Case managers gave mixed responses, saying that *"services are there,"* but also stating that between a third and half of consumers were not getting the services they needed.
- Service providers and case managers perceived the "one-stop shop" model differently. Case managers rated it highly, seeing it as making it more convenient to clients. Service providers, on the other hand, commented that clients could be overwhelmed with so many people intervening in their lives, i.e., case managers, counselors, and providers, and often felt that having so many people at one location familiar with an individual consumer's case reduced confidentiality.
- Service providers and case managers tended to displace responsibility onto consumers if needs were not met; the consumers themselves cited more practical barriers. The providers and case managers rated feeling unready for services or feeling that services were not needed more highly than consumers did, whereas consumers' top concerns centered on insurance coverage, i.e., knowing what was covered and cost of copays for visits and medications.

RECOMMENDATIONS

Throughout this mental health study, similar issues arose in the focus groups, key informant interviews and consumer interviews. These are the "overarching themes" of this study and require: (1) thoughtful consideration, (2) short and long term planning, and (3) effective implementation of those plans.

The overarching themes are followed by the specific population and service category recommendations. These further inform the overarching themes.

Individual Level: Increase Clients' Knowledge of Services

Overarching Themes:

- Clients are not aware of services available.
- Clients don't understand the difference between requesting appropriate services and understanding functions and outcomes expected of the various types of intervention.
- Clients are unaware of the cost and of what services their insurance will cover.

Recommendations:

- Hold a mental health open house for consumers, highlighting support groups, counseling, and psychiatric services available in the local mental health service system, with ongoing educational presentations to the People's Caucus.
- Create a resource card for clients who have health insurance to use that provides steps on how to access individual health insurance benefits.

- Collaborate with the University of Texas Health Science Center's Interprofessional Collaboration class to produce educational materials on HIV & mental health that can be distributed at multiple sites accessed by HIV consumers.
- Maintain and update quarterly an inventory of support groups on HIV210.org.

Interpersonal Level: Reduce Stigma Associated with a Mental Health Diagnosis

Overarching Theme:

- Clients are worried about being judged negatively for using psychiatric services, group counseling and support groups.

Recommendation:

- Create a brochure or other materials that focus on normalizing mental health issues.

Institution Level: Increase and Identify the Options Available for Psychiatric Services

Overarching Themes:

- Clients noted having long wait times to get an appointment for psychiatric services.
- Clients noted having long wait times at the time of the appointment.
- Clients indicated a gap in continuity of care when a change in psychiatric staff occurred.

Recommendations:

- Support the Mental Health Consortium's recommendation of a pipeline for new mid-level psychiatric practitioners.
- To help reduce gaps in providing mental health services, recommend to Bexar County the inclusion of provisions in contracts with Ryan White providers that require the development of policies addressing the agency's transition plan when mental health staffing changes.
- Encourage primary care physicians to refer to mental health services in and outside of the Ryan White care system.
- Request that Ryan White-funded agencies explore the option of service hours outside of normal business hours.

Community Level: Promote the Coordination of Mental Health Services Between Ryan White Providers and the General Community

Overarching Themes:

- In regards to medication barriers, it was noted that pharmacy locations can be inconvenient.

- Although it was indicated that coordination of services in the Ryan White system is strong, there appears to be a gap in coordination of services between Ryan White services and the general mental health community.

Recommendations:

- Educate case managers on non-Ryan White affiliated mental health professionals in the community.
- Hold a Mental Health Summit to allow non-Ryan White providers to learn about the Ryan White system and allow Ryan White and Non-Ryan White providers to learn about the services/resources that the other provides.
- Investigate the option of mail order pharmacies for easier access to medications.

Policy Level: Ensure Adequate Funding for Mental Health Services Not Covered By Health Insurance Programs

Overarching Theme:

- Clients noted long wait times to access psychiatric services and long waits at the provider's office because Provider is often double or triple booked.

Recommendation:

- Increase Ryan White funding for Health Insurance Premiums & Cost-Sharing Assistance and for Local AIDS Pharmaceutical Assistance to help cover mental health medical costs incurred by consumers.

A recommendation that addresses all levels of the socio-ecological based model is that of continued advocacy. This study recommends advocating and supporting the initiatives recommended by the Mental Health Consortium, Mental Health Task Force, and any other organizations, programs, and initiatives that improve access to and reduce the stigma associated with mental health services.

CONCLUSION

The preceding is a socio-ecological based study of the mental health continuum in the San Antonio Transitional Grant Area as it relates specifically to the HIV community. The study looked at the various levels of influence on health outcomes and behaviors to include the individual, interpersonal, organizations and social institutions, community, and policy levels and made recommendations specific to those levels. The study was generated to look at mental health services and needs in the San Antonio because of higher mental health rates in the HIV population than that of the general population. Poor mental health has been associated in the HIV population with lower rates of receiving antiretroviral medications, poor medication adherence, and higher risk behaviors leading to possible transmission of HIV to others.

The study reported on the estimated mental health rates for both the general population and HIV infected individuals and noted the higher rates of poor mental health that is often found in the HIV infected community, as well as possible effects of poor mental health. In order to gain a perspective of the current state of the mental health continuum, the study also looked at current resources in the Ryan White care system and general community.

Information for the study was obtained from various entities with the key concepts focusing on needs for services, as well as barriers to accessing mental health care and medication. In order to gather the most comprehensive data possible during the time frame, surveys were conducted with case managers and mental health providers in the Ryan White care system as well as consumers who had a self-reported HIV and mental health diagnosis through surveys and two focus groups. Ten mental health provider surveys, 13 case manager surveys, 10 focus group participants, and 161 consumer-based surveys were used to tabulate the information contained in this study.

The study provided qualitative and quantitative results of the data gathered from the different groups and included both strengths and findings. In some areas, the groups had varied opinions of barriers to mental health and the current state of mental health services, but several common themes also emerged across the groups. Clients and case managers noted high levels of unmet need, or specifically services needed, but not being accessed by clients. All three groups agreed that client knowledge of the purpose of methods of mental health care therapy and counseling services available was a major barrier; that there is a fairly effective coordination of services in the Ryan White care system, except for the disconnection with outside services; and that there is a shortage of psychiatry services and providers. Furthermore, all three groups agreed that stigma associated with HIV, compounded by a need for mental health services, remains a major issue.

The study helped to identify several factors for needs and barriers to service. Several recommendations were presented in the study to improve the current Ryan White mental health care system in order to provide a high quality of care. These recommendations include advocacy for initiatives and programs that improve access for mental health services, increased client knowledge regarding mental health services, reduction of stigma associated with mental health services, increased number of psychiatric practitioners to reduce long wait times for clients, and collaboration with other mental health providers.

The Planning Council will assemble a workgroup to develop strategies addressing each recommendation with the goal of strengthening the mental health continuum and ensuring the availability of quality services to all those requiring them in the HIV community.

APPENDIX A: MENTAL HEALTH PROVIDER SURVEY INSTRUMENT

Mental Health Service Providers – Key Informant Questions, Survey

1. Provider demographics.
   Gender: Male Female Transgender
   Age: 18-24 25-44 45-60 60+
   Sexuality: Gay/lesbian Straight Bisexual
   Race/Ethnicity: Hispanic Caucasian African-American Other _____
   Able to conduct services in: English Spanish Other _____

2. What professional associations do you belong to (e.g., NAMI, NASW)?

3. What type of credentialing do you have?
   - ☐ LPC (includes LPC-I)
   - ☐ LCSW
   - ☐ LMSW (under supervision)
   - ☐ LMFT
   - ☐ Psychologist
   - ☐ Psychiatrist
   - ☐ Psychiatric nurse
   - ☐ Psychotherapist
   - ☐ Other _____

4. How long have you been a mental health professional?
   - ☐ Less than 1 year
   - ☐ 1-2 years
   - ☐ 3-5 years
   - ☐ 6-10 years
   - ☐ More than 10 years

5. How long have you provided mental health services to people with HIV?
   - ☐ Less than 1 year
   - ☐ 1-2 years
   - ☐ 3-5 years
   - ☐ 6-10 years
   - ☐ More than 10 years

6. What type of insurance/payment coverage does your agency accept for mental health services?
   - ☐ Ryan White
   - ☐ Medicaid
   - ☐ Medicare
   - ☐ Care Link
   - ☐ Private Insurance

7. In your opinion, what characteristics does the average mental health client at your agency possess?

Gender: ☐ Male ☐Female ☐Transgender
Age: ☐ under 18 ☐18-24 ☐25-44 ☐45-60 ☐ 60+
Sexuality: ☐ Gay/lesbian ☐ Straight ☐ Bisexual
Race/Ethnicity: Hispanic Caucasian African-American Other _____
Language Preferred: ☐ English ☐ Bilingual ☐Monolingual Spanish
Diagnosis: ☐ within last year ☐ 1-5 years ago ☐ 6-10 years ago ☐10+ ago

8. In your clinic, who do you perceive as having the least representation with regards to mental health services?
Gender: ☐ Male ☐Female ☐Transgender
Age: ☐ under 18 ☐18-24 ☐25-44 ☐45-60 ☐ 60+
Sexuality: ☐ Gay/lesbian ☐ Straight ☐ Bisexual
Race/Ethnicity: Hispanic Caucasian African-American Other _____
Language Preferred: ☐ English ☐ Bilingual ☐Monolingual Spanish
Diagnosis: ☐ within last year ☐ 1-5 years ago ☐ 5-10 years ago ☐10+ ago

9. Why do you perceive that this population (as noted in question 8) is not represented in receiving mental health services?

10. What do you perceive are some assets/strengths of mental health care offered to HIV+ individuals living in San Antonio?

11. What (if any) do you perceive as challenges regarding the current status of mental health professionals **in San Antonio** in working with HIV+ clients? Please rate on a scale of 1-5 (**1 not being a factor, 5 being a major factor).**

Lack of mental health professionals:	1	2	3	4	5
With knowledge/experience with HIV					
Familiar with and experiences in working with issues of sexual orientation					
Comfortable to openly discuss sexual issues					
Who share a similar culture with the clients to be served					
Who speak Spanish					
Other:					
Other:					

12. What do you think can be done to change our mental health service system to be more responsive to clients' needs?

13. Besides the current status of mental health professionals, what (if any) do you perceive as challenges HIV+ individuals face when accessing/trying to access mental health services in San Antonio? Please rate on a scale of 1-5 (**1 not being a factor, 5 being a major factor**).

	1	2	3	4	5
Lack of knowledge by clients of available services					
Lack of systems able to see clients based on their insurance coverage (i.e.- Care Link, Medicaid, Medicare) or lack of insurance coverage					
Clients feel they are not ready or don't need services					
Clients are concerned about the stigma attached to mental health services ("I'm not crazy")					
Inadequate transportation or inconvenient locations					
Inconvenient times (not available after 5pm or on Saturday)					
Client concern with lack of qualified mental health professionals to meet their needs					
Child care					
Other:					
Other:					

14. What do you feel if anything can be done, to help encourage these clients to participate in mental health services?

15. What is your perception of the retention rate of mental health services by HIV clients?

	0-5%	6-10%	11-15%	16-20%	21-25%	25% +
Clients referred, but never schedule an initial appointment						
Clients who schedule an initial appointment, but do not show						
Clients who have an initial appointment, but do not return for a follow-up visit						
Clients who have completed at least two visits, but drop out before 5 sessions (without completing their treatment plan)						

16. What percentages of your clients tend to schedule visits around certain types of crisis?

	0-5%	6-10%	11-15%	16-20%	21-25%	25% +
Child Protective Services						
Legal						
Disability						
Domestic Violence						
Suicide						
Alcoholism/Substance Abuse						
Other:						

17. Do you currently refer clients out to other mental health programs within the community?

☐ Yes ☐ No

If yes, who do you commonly refer to?

If not, why not?

18. Do you currently refer clients out to any other services (including substance abuse services) within the community?

☐ Yes ☐ No

If yes, who do you commonly refer to?

If not, why not?

19. Do you feel that the current support groups in San Antonio are meeting the needs of your clients?

20. Do you refer to support groups in the community? If so, which ones?

21. What type of support groups have your clients asked for in the community, or do you feel are necessary?

22. Do you foresee the Affordable Care Act (as it currently stands) affecting the services you are able to provide?

☐ Yes ☐ No ☐ I don't know

If so, how?

23. If you could wave you a magic wand, what changes would you like to see in mental health care in San Antonio over the next three years?

24. We are looking to engage clients with a mental health diagnosis in learning about how they perceive mental health services within the community. How would you suggest that we go about recruiting clients?

APPENDIX B: CONSUMER ADVOCATES' FOCUS GROUP INSTRUMENT

Consumer Advocates Focus Group Questions

1. How long have you been HIV positive and living in San Antonio?
2. How long have you been an active advocate for the HIV community in San Antonio?
3. Membership in HIV community groups (Planning Council, QM Committee, Task Force, etc)
4. What do you perceive as some of the assets/strengths of mental health care offered to HIV+ individuals living in San Antonio?
5. Which communities or groups do you feel are currently under-served by the existing mental health infrastructure? Why is this the case?
6. What do you perceive as challenges HIV+ individuals face when accessing/trying to access mental health services in San Antonio with the existing Mental Health providers?
7. Besides the current status of mental health professionals, what (if any) do you perceive as challenges HIV+ individuals face when accessing/trying to access mental health services in San Antonio?
8. What do you feel can be done (if anything) to improve mental health services in San Antonio?
9. What do you feel can be done (if anything) to encourage clients to participate in mental health services?
10. Do you feel that the current support groups in San Antonio are meeting the needs of HIV+ clients? If not, what type of support groups do you recommend or what do you feel could be done to encourage clients to participate in support groups?
11. How might we go about accessing these communities/groups to better serve their specific needs?
12. What specific services/infrastructure /training would be needed?
13. We are looking to encourage clients with a mental health diagnosis in learning about how they perceive mental health services in the community. How would you suggest that we go about recruiting clients?

APPENDIX C: CASE MANAGER SURVEY INSTRUMENT

Case Managers/Other Professionals Survey

1. Personal demographics:

Gender:

☐ Male ☐ Female ☐ Transman ☐ Transwoman

Age:

☐ 18-24 ☐ 25-44 ☐ 45-60 ☐ 61+

Race/Ethnicity:

☐ Hispanic ☐ Caucasian ☐ African-American ☐ Other

2. What is your job title?

3. How long have you worked in the HIV field?
   - ☐ Less than 1 year
   - ☐ 1-2 years
   - ☐ 3-5 years
   - ☐ 6-10 years
   - ☐ More than 10 years

4. In your experience, what are the characteristics of the potential client group LEAST served by the existing mental health system in your community?

Gender:

☐ Male ☐ Female ☐ Transman ☐ Transwoman

Age:

☐ under 18 ☐ 18-24 ☐ 25-40 ☐ 45-60 ☐ 60+

Sexual preference:

☐ Gay/lesbian ☐ Straight ☐ Bisexual

Race/Ethnicity:

☐ Hispanic ☐ Caucasian ☐ African-American ☐ Other

Diagnosis:

☐ within last year ☐ 1-5 years ago ☐ 5-10 years ago ☐ 10+ ago

5. What in your experience leads you to believe that this group is underserved? Please describe.

6. In your opinion, what percentage of clients who could benefit from mental health services are NOT currently enrolled in services?

☐ 0-10% ☐ 11%-20% ☐ 21%-30%
☐ 31%-40% ☐ 41%-50% ☐ 51% +

7. What do you perceive are some of the assets/strengths of mental health care offered to HIV+ individuals living in San Antonio?

8. Please rate on a scale of 1-5 (‘**1’indicating this is not currently a problem, ‘5’ indicating this is a major problem**). Please also indicate any other difficulties not listed on the table.

	1	2	3	4	5
Lack of knowledge by clients of available services	☐	☐	☐	☐	☐
Lack of systems able to see clients based on their insurance coverage (i.e.- Care Link, Medicaid, Medicare) or lack of insurance coverage	☐	☐	☐	☐	☐
Clients feel they are not ready or don't need services	☐	☐	☐	☐	☐
Clients are concerned about the stigma attached to mental health services ("I'm not crazy")	☐	☐	☐	☐	☐
Inadequate transportation or inconvenient locations	☐	☐	☐	☐	☐
Inconvenient times (not available after 5pm or on Saturday)	☐	☐	☐	☐	☐
Client concern with lack of qualified mental health professionals to meet their needs	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

9. What do you feel (if anything) can be done to help encourage clients to participate in mental health services?

10. Do you currently refer out to other *mental health* programs within the community (outside the RW system?
    ☐ Yes ☐ No

    If yes, who do you commonly refer to?

    If no, why not?

11. Do you currently refer clients out to any other services (including substance abuse services) within the community?
    ☐ Yes ☐ No

    If yes, who do you commonly refer to?
    If no, why not?

12. In what ways are the existing support groups in San Antonio meeting the needs of your clients?

13. In what ways are the existing support groups in San Antonio NOT meeting the needs of your clients?

14. Do you refer to support groups within the community?
    ☐ Yes ☐ No

    If yes, please list the support groups you refer to:

15. What type of support groups have your clients requested in the community?

16. In your experience is there a real need for these type of support groups?
☐ Yes ☐ No

Why or why not?

17. We are looking to engage clients with a mental health diagnosis in learning about how they perceive mental health services within the community. How would you suggest that we go about recruiting clients?

18. What from your experience tells you this would be a good recruitment strategy?

19. Do you foresee the Affordable Care Act (as it currently stands) affecting the availability of Mental Health services you are referring clients to?
☐ Yes ☐ No ☐ I don't know

Please explain:

20. Other comments regarding mental health care for HIV+ clients:

APPENDIX D: HIV/AIDS CONSUMER SURVEY INSTRUMENT

MENTAL HEALTH SURVEY

This year, the San Antonio Area HIV Health Services Planning Council is conducting a survey on mental health services. The goal of this survey is to learn what services you are aware of in the Ryan White care system and learn if there is anything keeping you from getting your needs met. Your answers will help to improve future services and your access to them.

Because you have first-hand experience of mental health services, and are able to provide input on any barriers you have in trying to obtain these services, your participation is important.

Your information will be kept confidential. Your name is not required on this survey, and only the numbers and answers from the survey responses will be gathered to determine results.

We thank you in advance for your participation and your assistance in improving mental health services for Ryan White clients.

HIV/AIDS Consumer Survey (English)

1. Are you HIV positive?
☐ Yes ☐ No

2. Have you ever received a mental health diagnosis?
☐ Yes ☐ No

3. What diagnosis have you been given by a mental health professional (check all that apply)?
☐ Depression ☐ Bi-polar Disorder ☐ Anxiety/Panic Disorder ☐ Schizophrenia
☐ Other _____ ☐ I don't know ☐ I don't wish to disclose

4. In the last six months have you been hospitalized for mental health reasons?
☐ Yes ☐ No

5. Where do you receive your mental health services?
☐ Ryan White System only (FFACTS, Centro Med, AARC)
☐ Community/private organizations only
☐ A combination of the Ryan White System and other community/private organizations
☐ I am not receiving services at this time.

6. In the last 12 months, did you ***know*** about the following services being offered through Ryan White?
   - Individual mental health counseling (talk therapy) ☐ Yes ☐ No
   - Psychiatry Services (staff who could prescribe you medication) ☐ Yes ☐ No
   - Group Counseling (led by a staff member) ☐ Yes ☐ No
   - Support Group (not led by a staff member) ☐ Yes ☐ No

7. In the last 12 months, did you ***need*** any of these services, but ***didn't use them***?
   - Individual mental health counseling (talk therapy) ☐ Yes ☐ No
   - Psychiatry Services (staff who could prescribe you medication) ☐ Yes ☐ No
   - Group Counseling (led by a staff member) ☐ Yes ☐ No
   - Support Group (not led by a staff member) ☐ Yes ☐ No

8. In the last 12 months:

	Did you ***receive*** this service?		*If you received the service*, did it meet your needs?	
	Y	N	Y	N
Individual mental health counseling (talk therapy)				
Psychiatry Services (staff who could prescribe you medication)				
Group Counseling (led by a staff member)				
Support Group (not led by a staff member)				

9. If a service you received didn't meet your needs (a "No" in the last box of question 8), please explain why it didn't meet your needs.

10. What (if any) challenges have you faced or are you facing when accessing/trying to access mental health services in San Antonio?

Please rank on a scale of 1-5 *('1' indicating this is not currently an issue, '5' indicating this is a major issue)*. Please also indicate any other difficulties not listed on the table.

	1	2	3	4	5
I am unsure of what services are available.					
I am unsure where I can receive services based on my insurance coverage.					
I don't feel that I am ready for services.					
I don't feel that I need services.					
I am worried about others knowing that I need mental health services and judging me negatively.					
It is hard for me to get there with the transportation I have available to me.					
The times services are offered aren't convenient for me.					
I don't feel that the mental health staff are qualified to meet my needs (don't speak my language, aren't like me, don't have knowledge of the issues I face.					
There is too much "red tape" and paperwork to get the service.					
Other:					
Other:					

11. Are you currently being prescribed medication for mental health reasons?

☐ Yes ☐ No

If yes, what (if any) challenges have you faced or are you facing when trying to access your medications?

Please rank on a scale of 1-5 *('1' indicating this is not currently an issue, '5' indicating this is a major issue)*. Please also indicate any other difficulties not listed on the table.

	1	2	3	4	5
Cost of medication or co-pays that I have to pay out of pocket					
My insurance won't cover all my medications and so I have to pay full price on some/all					
The pharmacy I have to use is not convenient					
Other:					
Other:					

12. Are you concerned about the changes to your mental health care services once the Affordable Care Act (Obama Care) is in place?
☐ Yes ☐ No ☐ I don't know about the changes

13. Do you feel that the current support groups in San Antonio are meeting your needs or the needs of your peers?
☐ Yes ☐ No ☐ I don't know about the support groups offered

Why or why not?

14. If you have attended support group(s) in the last 12 months, what types of groups do you/did you attend? For how long?

15. What (if any) types of support groups would you like to see offered?

16. What do you think are some of the strengths of mental health care provided to HIV+ clients in San Antonio?

17. What could we do better?

18. Please pick the categories which best describe you.
Gender: ☐ Male ☐Female ☐ Transwoman ☐ Transman ☐ Other
Age: ☐ 18-24 ☐ 25-44 ☐ 45-60 ☐ 61+
Sexuality: ☐ Gay/lesbian ☐ Straight ☐ Bisexual
Race/Ethnicity: ☐ Hispanic ☐ Caucasian ☐ African-American ☐ Other
Language Preferred: ☐ English ☐ Bilingual ☐ Monolingual Spanish
HIV Diagnosis: ☐ Within the last year ☐ 1-5 years ago ☐6-10 years ago ☐ 11+ years ago

EVALUACIÓN DE SALUD MENTAL
PREGUNTAS DEL CONSUMIDOR

Este año, el Ayuntamiento de San Antonio Area de Planificación Servicios de Salud VIH está llevando a cabo dos estudios - el primero para la salud mental y más tarde este año, uno en abuso de sustancias. El objetivo de estos estudios es ayudar a determinar el estado actual de los servicios para los clientes en el sistema de atención de Ryan White, así como los obstáculos que puedan afectar a los clientes que reciben servicios para las sugerencias se pueden hacer para ayudar a mejorar el sistema.

Su papel en este estudio de la salud mental es fundamental, sobre todo porque se puede experimentar de primera mano los servicios de salud mental que se ofrecen y son capaces de dar su opinión sobre las barreras que tienen al tratar de obtener estos servicios.

Le agradecemos de antemano por su participación y su colaboración en la mejora de los servicios de salud mental para los clientes de Ryan White.

Evaluación de salud mental
Preguntas del consumidor

1. ¿Eres VIH positivo?
   Sí No

2. ¿Ha recibido un diagnóstico de salud mental?
   Sí No

3. ¿Qué diagnóstico ha dado un profesional de salud mental (marque todas las que apliquen)?
   depresión trastorno bipolar ansiedad/pánico trastorno esquizofrenia
   otros _____ no sé que no quiero revelar

4. ¿En los últimos seis meses han sido hospitalizados por razones de salud mental?
   Sí No

5. ¿Donde recibe sus servicios de salud mental?
   Ryan White sistema solamente (FFACTS, Centro Med, AARC)
   Organizaciones comunidad / privado sólo
   Una combinación del sistema de Ryan White y otras organizaciones de la comunidad / privado
   No estoy recibiendo servicios en este momento.

6. En los últimos 12 meses, ¿usted ***sabe*** acerca de los siguientes servicios que se ofrecen a través de Ryan White?
   - Consejería de salud mental individual (psicoterapia) Sí No
   - Servicios de Psiquiatría (personal que podría prescribirle medicamentos) Sí No
   - Terapia de grupo (dirigido por un miembro del personal) Sí No
   - Grupo de apoyo (no dirigido por un miembro del personal) Sí No

7. En los últimos 12 meses, ¿usted ***necesitaba*** alguno de estos servicios, pero ***no los usó***?
   - Consejería de salud mental individual (psicoterapia) Sí No
   - Servicios de Psiquiatría (personal que podría prescribirle medicamentos) Sí No
   - Terapia de grupo (dirigido por un miembro del personal) Sí No
   - Grupo de apoyo (no dirigido por un miembro del personal) Sí No

8. En los últimos 12 meses:

	¿Ha ***recibido*** este servicio?		*Si usted recibió el servicio*, ¿conocieron sus necesidades?	
	Sí	No	Sí	No
Consejería de salud mental individual (psicoterapia)				
Servicios de Psiquiatría (personal que podría prescribirle medicamentos)				
Terapia de grupo (dirigido por un miembro del personal)				
Grupo de apoyo (no dirigido por un miembro del personal)				

9. Si un servicio que usted recibió no cumplía con sus necesidades (un "No" en el último cuadro de la pregunta 8), explique por qué no se ajusta a sus necesidades.

10. ¿Lo que (en su caso) los desafíos que han enfrentado o se le enfrenta al acceder / tratando de acceder a los servicios de salud mental en San Antonio?

Por favor clasifique en una escala de 1 a 5 (donde '1' indica que esto no es actualmente un problema y '5' indica que este es un problema importante). Indique también cualquier otra dificultad que no figura en la tabla.

	1	2	3	4	5
No estoy seguro de qué servicios están disponibles.					
No estoy seguro donde puedo recibir servicios basados en la cobertura de mi seguro.					
No me siento que estoy listo para servicios.					
No me siento que necesito servicios.					
Estoy preocupado por los demás sabiendo que necesito servicios de salud mental y para mí juzgar negativamente.					
Es difícil para mí llegar con el transporte que tengo a mi disposición.					
Los tiempos de servicios que se ofrecen no son convenientes para mí.					
No siento que el personal de salud mental están capacitados para cumplir con mis necesidades (no hablan mi idioma, no son como yo, no tiene conocimiento de los problemas que enfrento).					
Hay mucho "papeleo" para obtener el servicio.					
Otros:					
Otros:					

11. ¿Actualmente se recetan medicamentos por razones de salud mental? Sí No

En caso afirmativo, ¿cuál (si alguna) los desafíos que ha enfrentado o se le enfrenta al tratar de acceder a los medicamentos?

Por favor clasifique en una escala de 1 a 5 (donde ‘1’ indica que esto no es actualmente un problema y '5' indica que este es un problema importante). Indique también cualquier otra dificultad que no figura en la tabla.

	1	2	3	4	5
El costo de la medicaciones o co-pagos que tengo que pagar de mi bolsillo					
Mi seguro no cubre todos los medicamentos y así tengo que pagar el precio completo en alguna / todas las					
La farmacia que tengo que usar no es conveniente					
Otros:					
Otros:					

12. ¿Está preocupado por los cambios en los servicios de atención de la salud mental una vez que La Ley del Cuidado de Salud (“Obamacare”) está en su lugar?

    Sí No que no sé acerca de los cambios

13. ¿Cree usted que los grupos de apoyo actuales en San Antonio están cumpliendo con sus necesidades o las de sus compañeros?

    Sí No que no sé acerca de los grupos de apoyo ofrecidos

    ¿Por qué o por qué no?

14. ¿Si ha asistido a grupos de apoyo en los últimos 12 meses, qué tipos de grupos asistió? ¿Por cuánto tiempo?

15. ¿Lo que (eventualmente) tipos de grupos de apoyo le gustaría ver ofrecido?

16. ¿Qué crees que son algunas de las fortalezas de atención de salud mental proporcionada a clientes VIH+ en San Antonio?

17. ¿Qué podríamos hacer mejor?

18. Por favor elegir las categorías que mejor te describen.

Género: masculino femenino transexual otros
Edad: 18-24 25-44 45-60 61 +
Sexualidad: Homosexual/lesbiana heterosexual bisexuales
Raza/origen étnico: hispano caucásico afroamericano otros
Idioma preferido: Español Ingles Bilingue
Diagnóstico de VIH: en el último año 1-5 años 6-10 años 11 + hace años

APPENDIX E: DETAILED RESULTS OF CONSUMER SURVEY

DESCRIPTIVE STATISTICS

Respondent Characteristics

Variable	N*	Percent*	Variable	N*	Percent*
Gender			Age		
Male	113	70.2	18-24	5	3.1
Female	26	16.1	25-44	97	39.1
Transman	1	0.6	45-60	73	45.3
Transwoman	3	1.9	61+	4	2.5
Sexual Orientation			Language Preference		
Gay / Lesbian	82	50.9	English	107	66.5
Straight	41	25.5	Spanish	9	5.6
Bisexual	15	9.3	Bilingual	16	9.9
Race / Ethnicity			HIV Diagnosis		
Hispanic	73	45.3	Within Last Year	13	8.1
White	39	24.2	1-5 Years Ago	27	16.8
Black	26	16.1	6-10 Years Ago	42	26.1
Other	5	3.1	11+ Years Ago	60	37.3
Mental Health Diagnosis			Where MH Services Received		
Multiple	102	63.4	Ryan White System Only	108	67.1
Depression	125	77.6	Community / Private Only	10	6.2
Bipolar	61	37.9	RW & Community / Private	10	6.2
Anxiety	95	59.0	Not Receiving Services	27	16.8
Schizophrenia	15	9.3	Worried About Impact of ACA		
Post-Traumatic Stress	7	4.3	Yes	60	37.3
Unknown	4	2.5	No	46	28.6
Refused to Disclose	4	2.5	Don't Know	42	26.1
Hospitalized in Past 6 Months	16	9.9	Currently Prescribed Meds	94	58.4

*** May not total 161 or 100% due to missing values, multiple responses, and/or rounding.**

Correlative Statistics

Representativeness of Sample Population

The survey sample is representative of both Ryan White program (RWP) mental health clients and people living with HIV/AIDS (PLWHA) in the four-county San Antonio region in terms of gender. The sample is representative of RWP mental health clients in terms of age, though it skewed slightly older than the PLWHA population because people under 18 were not sampled. The sample is not representative of either population in terms of ethnicity. This is because the population of mental health clients and the population of PLWHA are very different, with Hispanics underrepresented compared to PLWHA and blacks overrepresented. Assuming that mental health needs are the same across racial/ethnic groups, this suggests that Hispanics may need additional outreach in terms of mental health services.

CHARACTERISTICS OF SAMPLE AND POPULATION

Respondents			Ryan White Mental Health Clients In the SATGA 2012			People Living with HIV/AIDS In the SATGA 2012		
Variable	N*	Percent*	Variable	N	Percent*	Variable	N	Percent
Gender			Gender p=0.09			Gender p=0.38		
Male	113	70.2	Male	588	73.2	Male	4,433	84.05
Female	26	16.1	Female	200	24.9	Female	841	15.95
Transman	1	0.6	Transman	0	0	Transman	x	X
Transwoman	3	1.9	Transwoman	15	1.9	Transwoman	x	X
Age			Age p=0.07			Age p<0.01		
18-24	5	3.1	18-24	48	6.0	13-24	292*	5.54
25-44	97	39.1	25-44	373	46.5	25-44	2,259	42.83
45-60	73	45.3	45+	382	47.6	45+	2,706	51.31
61+	4	2.5						
Race /Ethnicity			Race / Ethnicity p<0.05			Race / Ethnicity P<0.01		
Hispanic	73	45.3	Hispanic	505	18.9	Hispanic	3,044	57.7
White	39	24.2	White	152	16.8	White	1,231	23.3
Black	26	16.1	Black	135	62.9	Black	799	15.2
Other	5	3.1	Other	11	1.4	Other	38	0.7

*** May not total 161 or 100% due to missing values, multiple responses, and/or rounding.**

Multiple Mental Health Diagnoses

Respondents were asked to self-report their diagnoses and could select all that applied. The most common diagnoses were depression (77.6%), anxiety (59.0%), and bipolar disorder (37.9%); other diagnoses were reported by less than 10% of respondents. Nearly two-thirds (63.4%) of respondents reported multiple mental health diagnoses. Significant correlations were found between depression and anxiety (p=0.005), bipolar and anxiety (p=0.048), and bipolar and schizophrenia (p=0.003). This suggests that if a client presents with one of these diagnoses, they may need to be screened for the correlated diagnosis.

CORRELATION BETWEEN MENTAL HEALTH DIAGNOSES

Diagnosis	Anxiety		Bipolar		Schizophrenia		PTSD	
	N	Correlation P-value	N	Correlation P-value	N	Correlation P-value	N	Correlation P-value
Depression	81	0.220 0.005	51	0.112 0.158	13	0.069 0.381	7	0.114 0.148
Anxiety			42	0.158 0.048	10	0.050 0.529	3	-0.070 0.378
Bipolar					11	0.234 0.003	4	0.085 0.286
Schizophrenia							2	0.141 0.074

Use and Assessment of Services

About two-thirds of those surveyed were aware that individual counseling and psychiatry services were available to them, but only about half were aware of group counseling and only 43% were aware of support group availability. A minority of respondents reported needing services but not receiving them; this ranged from 44% reporting a need for individual counseling and 27% reporting a need for support groups. This is discussed more below. More than half of respondents reported that they had received individual counseling and psychiatry services and one-fourth reported attending group counseling and support groups. Of those accessing services, their assessment of whether or not the services met their needs were generally positive but leave room for improvement. Individual counseling was rated highest, with 63% saying it met their needs, while support groups were rated the lowest, with only 51% rating them positively.

USE AND ASSESSMENT OF MENTAL HEALTH SERVICES

Variable	N*	Percent*	Variable	N*	Percent*
Aware Services Available			Need for Services		
Individual Counseling	108	67.1	Individual Counseling	71	44.1
Psychiatry	103	64.0	Psychiatry	61	37.9
Group Counseling	86	53.4	Group Counseling	50	31.1
Support Groups	69	42.9	Support Groups	44	27.3
Services Received			Services Met Needs[1]		
Individual Counseling	90	55.9	Individual Counseling	57	63.3
Psychiatry	85	52.8	Psychiatry	51	60.0
Group Counseling	39	24.2	Group Counseling	24	61.5
Support Groups	37	23.0	Support Groups	19	51.4

*** May not total 161 or 100% due to missing values, multiple responses, and/or rounding.**
[1]For this variable, percent = number reporting services met needs / number reporting services revcieved

Need for Services

Respondents were asked if there were services that they needed but did not receive. Responses were compared by respondent characteristics using chi-square analysis.

Among people with the most common diagnoses, i.e., depression, anxiety, and bipolar disorder, about half of respondents said they needed but did not receive individual counseling and psychiatry services. People with bipolar disorder and with multiple diagnoses reported the most need. People with multiple diagnoses were significantly more likely to report needing but not receiving psychiatry, group counseling, and support groups. People with depression reported a need for individual counseling and support groups, while people with anxiety reported a need for psychiatric services. People with bipolar disorder reported not receiving the individual counseling, group counseling, and support groups that they needed. People with schizophrenia reported a need for group counseling, while people with PTSD reported a need for individual counseling and psychiatry services.

Respondents who had been hospitalized for a mental health issue in the six months preceding the survey were not more likely to report a need for services, nor were people who had a current prescription for mental health medication.

NEED FOR SERVICES BY RESPONDENT CHARACTERISTICS

	Need: Individual Counseling		Need: Psychiatry		Need: Group Counseling		Need: Support Group	
	N	Percent	N	Percent	N	Percent	N	Percent
Overall	71	44.1	61	37.9	50	31.1	44	27.3
Diagnosis								
Multiple	51	50.0	48	47.1**	38	37.3*	37	36.3**
Depression	61	48.8*	52	41.6	43	34.4	40	32.0*
Anxiety	45	47.4	42	44.2*	31	32.6	29	30.5
Bipolar	29	47.5**	32	52.5	30	49.2**	25	41.0**
Schizophrenia	5	33.3	6	40.0	9	60.0*	7	46.7
PTSD	5	71.4*	6	85.7**	3	42.9	4	57.1
Hospitalized in Last 6 Months for MH Issue	7	43.8	6	37.5	8	50.0	6	37.5
Yes	64	44.1	55	37.9	42	29.0	38	26.2
No								
Currently Prescribed MH Medication								
Yes	41	43.6	42	44.7	34	36.2	26	27.7
No	30	45.5	19	28.8	16	24.2	18	27.3
Sex[1]								
Men	49	43.4	42	37.2	37	32.7	32	28.3
Women	11	42.3	11	42.3	6	23.1	6	23.1
Age								
18-24	4	80.0	4	80.0*	4	80.0*	4	80.0**
25-44	28	44.4	20	31.7	20	31.7	18	28.6
45-60	32	43.8	30	41.1	23	31.5	19	26.0
61+	1	25.0	2	50.0	0	0	1	25.0
Sexual Orientation								
Gay / Lesbian	35	42.7	29	35.4	24	29.3	22	26.8
Straight	15	36.6	14	34.1	10	24.4	11	26.8
Bisexual	10	66.7	10	66.7*	9	60.0*	6	40.0
Race / Ethnicity								
Hispanic	34	46.6	27	40.0	28	38.4	25	34.2
White	11	28.2*	15	38.5	6	15.4*	4	10.3**
Black	14	53.8	12	46.2	10	38.5	11	42.3
Other	3	60.0	2	40.0	1	20.0	1	20.0
HIV Diagnosis								
Within Last Yr.	8	61.5	5	38.5	5	38.5	3	23.1
1-5 Years Ago	14	51.9	13	48.1	9	33.3	7	25.9
6-10 Years Ago	16	38.1	13	31.0	13	31.0	14	33.3
11+ Years Ago	23	38.3	24	40.0	17	28.3	16	26.7

Note: percent = number of people with a need / number of people with characteristic

***Responses from people with this characteristic are significantly different than people without this characteristic at the p<0.05 level.**

****Responses from people with this characteristic are significantly different people without this characteristic at the p<0.01 level.**

Barriers to Accessing Services and Medication

Respondents were asked to rate a series of barriers to receiving services on a scale of 1 to 5, where one indicated that it was not currently an issue, and five indicated that it was a major issue. The table below presents average scores assigned to the barriers by different groups of respondents. Scores are compared by respondent characteristic using ANOVA. The barriers are presented to show how they correlate with the Socio-Ecological Model.

While none of the barriers were rated very strongly, some trends did emerge. Rating barriers to care as more serious was correlated with reporting a need for services, confirming that these barriers make people less likely to receive the care they need. At the individual level, being unsure what service were available, being unsure what was covered by insurance, and not feeling that services were needed were correlated with a need. At the interpersonal level, concern that one would be judged for using mental health services emerged as a barrier to care, especially to attending support groups. At the institutional level, paperwork did not appear to be a significant barrier, and appointment times were a significant barrier only to psychiatric services.

At the community level, transportation was rated as a significant barrier among people not accessing individual counseling, psychiatry, and group counseling services. Cost and lack of insurance coverage were rated as barriers by those with a need for individual counseling, psychiatry, and group counseling.

In general, perception of the seriousness of barriers to care did not differ by respondent characteristics. However, a few differences were found. People with multiple diagnoses considered inconvenient appointment times as a greater barrier. People with schizophrenia were significantly more likely than those with other diagnoses to rate not feeling ready for mental health services, worry about being judged for using services, and concern about the ability of the provider to meet their needs as barriers to care. People who had been recently hospitalized reported more concern about stigma. A positive trend was the people currently prescribed medications rated inconvenient pharmacy locations as less of a barrier than people without current prescriptions. Men and women did not rate barriers differently. People who are older (45-60 years), those who have been diagnosed with HIV for longer (11 years or more), and those who are white report feeling less concerned about being judged for using mental health services compared to other groups.

INDIVIDUAL AND INTERPERSONAL BARRIERS TO CARE BY RESPONDENT CHARACTERISTICS

	Individual-Level Barriers				*Interpersonal-Level Barriers*	
	Unsure What Services are Available	Unsure What Insurance Covers	Do Not Feel Ready for Services	Do Not Feel That Services are Needed	Worried About Being Judged for Using Services	Worried about Cultural Competence of Provider
Overall	2.44	2.30	2.02	2.03	2.28	1.77
Need						
Ind. Counseling	2.84**	2.65*	2.36*	2.47**	2.50	2.05*
Psychiatry	2.75	2.75**	2.27	2.43*	2.69*	1.94
Grp. Counseling	3.07**	2.60	2.26	2.43*	2.71*	2.05
Support Grp.	3.10**	2.58	2.33	2.45	2.95**	1.97
Diagnosis						
Multiple	2.53	2.36	2.18	2.21*	2.40	1.77
Depression	2.50	2.32	2.08	2.10	2.33	1.76
Anxiety	2.39	2.32	2.07	2.18	2.23	1.72
Bipolar	2.63	2.39	2.30	2.23	2.47	1.94
Schizophrenia	2.45	2.36	3.09**	2.89	3.91**	2.55*
PTSD	2.40	3.00	2.60	2.50	3.00	1.20
Hospitalized in Last 6 Months for MH Issue						
Yes	2.36	2.36	2.62	2.27	3.15*	2.17
No	2.44	2.29	2.00	2.02	2.18	1.73
Currently Prescribed MH Medication						
Yes	2.43	2.31	2.02	2.13	2.31	1.78
No	2.42	2.27	2.13	1.86	2.20	1.71
Sex[1]						
Men	2.42	2.25	2.04	2.06	2.35	1.81
Women	2.60	2.50	1.95	2.00	1.90	1.60
Age						
18-24	2.40	2.50	1.75	1.75	3.60	1.80
25-44	2.58	2.38	2.22	2.17	2.57	1.98
45-60	2.40	2.24	1.90	1.91	1.98*	1.65
61+	1.75	2.00	2.00	2.33	1.50	1.00
Sexual Orientation						
Gay / Lesbian	2.28	2.15	1.82	1.92	2.14	1.80
Straight	2.58	2.47	2.23	2.00	2.40	1.54
Bisexual	2.82	3.20	2.80	2.88	2.80	2.10
Race / Ethnicity						
Hispanic	2.38	2.17	2.11	2.08	2.41	1.68
White	2.33	2.08	1.62	1.70	1.77*	1.58
Black	2.30	2.53	2.05	1.83	2.43	1.80
Other	3.20	3.60	2.60	3.00	2.60	2.50
HIV Diagnosis						
Within Last Yr.	2.36	1.89	1.91	1.60	2.40	1.09
1-5 Years Ago	2.15	2.32	1.96	2.00	2.62	2.12
6-10 Years Ago	2.78	2.40	2.33	2.19	2.41	1.71
11+ Years Ago	2.23	2.21	1.78	1.81	1.88*	1.65

[1]**Transgendered people are excluded due to low numbers (n=4)**

***Responses from people with this characteristic are significantly different than people without this characteristic at the p<0.05 level.**

****Responses from people with this characteristic are significantly different people without this characteristic at the p<0.01 level.**

INSTITUTIONAL, COMMUNITY-LEVEL, AND POLICY-LEVEL BARRIERS TO CARE BY RESPONDENT CHARACTERISTICS

	Institutional-Level Barriers		*Community-Level Barriers*		*Policy-Level Barriers*	
	Too Much Paperwork Required	Inconvenient Appointment Times	Inconvenient Pharmacy Locations	Transportation Issues	Costs of Medications & Co-pays	Insurance Does Not Cover Medications
Overall	2.05	2.20	1.85	2.18	2.21	2.06
Need						
Ind. Counseling	2.20	2.39	2.24**	2.52*	2.55*	2.49**
Psychiatry	2.25	2.57*	2.04	2.69**	2.65*	2.39
Grp. Counseling	2.26	2.44	2.07	2.73**	2.55	2.49*
Support Grp.	2.24	2.43	2.00	2.57	2.58	2.31
Diagnosis						
Multiple	2.10	2.40*	1.86	2.36	2.15	2.06
Depression	2.07	2.32	1.95	2.25	2.16	2.08
Anxiety	2.09	2.35	1.90	2.34	2.16	2.06
Bipolar	2.23	2.29	1.90	2.50	2.32	2.25
Schizophrenia	2.10	2.90	1.18	2.80	2.18	2.55
PTSD	2.20	2.40	1.80	3.80*	3.00	3.20
Hospitalized in Last 6 Months for MH Issue						
Yes	2.33	2.15	1.83	2.15	2.08	1.77
No	2.01	2.20	1.85	2.19	2.22	2.09
Currently Prescribed MH Medication						
Yes	2.11	2.22	1.71*	2.29	2.02	1.89
No	1.91	2.15	2.04*	1.96	2.57	2.39
Sex[1]						
Men	2.04	2.24	1.92	2.13	2.22	2.11
Women	2.05	1.95	1.45	2.50	2.05	1.80
Age						
18-24	1.60	1.80	1.75	2.20	2.00	2.25
25-44	2.39*	2.15	1.98*	2.18	2.40	2.21
45-60	1.73*	2.28	1.79	2.14	2.06	1.90
61+	2.00	2.25	1.25	2.00	1.50	1.50
Sexual Orientation						
Gay / Lesbian	2.04	1.99	2.03*	1.93	2.33	2.20
Straight	1.89	2.30	1.46	2.43	1.95	1.57*
Bisexual	2.45	2.80	1.83	3.30*	2.63	3.25**
Race / Ethnicity						
Hispanic	2.08	2.13	1.78	2.33	2.03	1.95
White	1.86	2.12	1.77	1.77	2.39	2.13
Black	1.85	2.00	1.65	1.90	2.62	2.14
Other	2.50	2.50	3.00	3.00	2.40	2.60
HIV Diagnosis						
Within Last Yr.	1.36	1.50	1.00*	1.70	1.82	1.64
1-5 Years Ago	2.60*	2.32	2.54**	2.38	2.23	2.19
6-10 Years Ago	2.09	1.79	1.72	1.97	2.43	2.14
11+ Years Ago	1.81	2.28	1.62	2.15	2.11	1.98

[1]**Transpeople are excluded due to low numbers (n=4)**

***Responses from people with this characteristic are significantly different than people without this characteristic at the p<0.05 level.**

****Responses from people with this characteristic are significantly different people without this characteristic at the p<0.01 level.**