Breaking Down Barriers: Access to HIV Testing and Treatment in

San Francisco

Among those affected by Mental Health and Substance Use Issues



**A needs assessment conducted for the HIV Prevention Planning Council**

By

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**“…the number one issue that prevented people from initiating [HIV] care or maintaining care was mental health and substance use.”**

-HIV/Mental Health Service Provider

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|  Introduction |

**T**

he HIV Prevention Planning Council (HPPC) and San Francisco Department of Health (SFDPH) HIV Prevention Services (HPS) engaged Harder+Company Community Research, an independent consulting firm, to conduct a community needs assessment to assess how mental health and substance use affect access to HIV testing and care among high risk populations in San Francisco, as prioritized by the HPPC in 2010. This needs assessment is intended to provide in-depth information to improve HIV prevention planning efforts with the aim of better meeting the HIV-related needs of those affected by mental health and substance use in San Francisco.

## National and Local Trends

Data from both the national and local level underscore the influence of mental health and substance use on people living with HIV and high risk HIV-negative people. As detailed below, these data and research demonstrate that mental health and substance use issues are prevalent among people living with HIV, and also impact HIV transmission and adherence.

National prevalence data from the HIV Cost and Services Utilization Study indicate that many people living with HIV are affected by mental health and/or substance use issues.[[1]](#footnote-1) Nearly half of this nationally representative sample of people living with HIV screened positive for mental health issues - most commonly mood disorders such as depression - and more than 12 percent were substance use dependent. According to the 2010 HIV Prevention Plan for San Francisco, nearly 30 percent of the unduplicated clients sampled living with HIV/AIDS used mental health treatment services, and 11 percent used substance use treatment services.[[2]](#footnote-2)

Not only are mental health and substance use issues prevalent among HIV infected individuals, but they are also factors associated with HIV risk behavior and adherence to treatment. The 2010 San Francisco HIV Prevention Plan outlines substance use and mental health as important cofactors that increase risk of HIV infection[[3]](#footnote-3). In particular, there is evidence that those with co-occurring mental health and substance use issues may have increased risk of HIV transmission. Additional research demonstrates that both mental health and substance use issues can impact adherence to HIV medications.[[4]](#footnote-4),[[5]](#footnote-5),[[6]](#footnote-6)

HIV-related health disparities are evident both nationally and in San Francisco.[[7]](#footnote-7),[[8]](#footnote-8) Given the overall population demographics for San Francisco, African Americans and Whites are disproportionately affected by HIV/AIDS. In terms of gender, men and transpeople – particularly transfemales – represent a greater proportion of people living with HIV/AIDS compared to corresponding percentages in the overall San Francisco population. Women of color - African American women in particular - are disproportionately affected by HIV/AIDS in San Francisco.

According to the epidemiologic data presented in the 2010 San Francisco HIV Prevention Plan, the primary mode of transmission for people living with HIV/AIDS was through men who have sex with men (MSM) sexual contact (71 percent), followed by injection drug use (20 percent). [[9]](#footnote-9) The 2010 San Francisco HIV Prevention Plan indentifies high HIV risk behavioral groups in San Francisco for priority intervention including MSMs, transfemales who have sex with males (TFSMs), and injection drug users (IDUs).

## National and Local Strategies to Address HIV-related needs

### National HIV/AIDS Prevention Strategy

Through the National HIV/AIDS Prevention Strategy, the Obama administration articulated a national plan to reduce new infections, reduce health disparities related to HIV, and improve health outcomes and access to care for people living with HIV/AIDS.[[10]](#footnote-10) Health care reform legislation, known as the *Affordable Care Act*, provides a national platform for improving HIV-related health outcomes and access to care. This legislation expands access to insurance coverage for people living with HIV, while the Ryan White HIV/AIDS Program and other specific programs offered at the State and Federal levels aim to meet the remaining gaps in coverage.[[11]](#footnote-11)

Of particular importance to this needs assessment, the National HIV/AIDS Prevention Strategy identifies specific action steps to improve services for people living with HIV that include providing support for co-occurring health conditions (e.g., mental illness and substance use issues), and for those with difficulty meeting basic needs (e.g., housing). The National HIV/AIDS Prevention Strategy further highlights the need to integrate HIV prevention and care efforts with social services to create comprehensive, community-based approaches to improving health outcomes for people living with HIV.

### San Francisco Service Integration

San Francisco’s health and social service system is currently in the process of undergoing an integration process to ensure the system is prepared for and has the capacity to serve San Franciscans that are expected to enter the system as a result of the *Affordable Care Act*. This integration is intended to increase overall coordination of services, improve client experience, and reduce health disparities.

An example of this is the current integration process between Community Behavioral Health Services (CBHS) and HIV Prevention Section (HPS). In September 2011, SFDPH received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of their grant program aligned with the Congressional Minority AIDS Initiative and the National HIV/AIDS Strategy. With this funding, Community Behavioral Health Services (CBHS) collaborated with the HIV Prevention Section (HPS) to establish the Minority AIDS Initiative – Targeted Capacity Expansion (MAI-TCE) program. MAI-TCE is a multi-sector collaboration involving multiple SFDPH departments. Within MAI-TCE, the role of SFDPH HPS is to provide a general approach to HIV to support CBHS and coordinate with Enhanced Comprehensive HIV Prevention Planning (ECHHPP) in a city-wide approach to achieve national HIV/AIDS prevention strategy goals.

Through MAI-TCE, SFDPH is integrating behavioral health services into HIV prevention and care services starting in October 2012. These efforts will be accomplished by incorporating positions for behavioral health specialists into specific HIV prevention and care service settings (e.g., HIV Centers of Excellence, City Clinic, Southeast Health Center Transitions Clinic) and through an intervention with MSMs to prevent binge drinking.

In addition, SFDPH has prioritized the implementation of Centers for Disease Control and Prevention (CDC) recommendations for routine testing.  SFDPH has undertaken a number of efforts in this front such as a) issuing a policy regarding routine testing; b) developing integrated guidelines for screenings for communicable diseases including HIV; and c) working closely with the SFDPH Primary Care Quality Improvement (CQI) Committee to develop CQI measures for routine testing. Alongside routine testing, SFDPH has established the Linkage Integration Navigation and Comprehensive Services Team (LINCS) to identify, locate, and connect those who have tested positive to HIV care services.

## What does this report add?

This needs assessment serves to provide an in-depth look at how to strengthen the existing efforts underway and to ensure that San Francisco’s service system is able to provide high-quality coordinated services for HIV positive and high-risk HIV negative people with mental health and substance use issues. Ultimately, SFDPH aims to create a health and service system where “Any Door is the Right Door” – in other words a system that connects people to comprehensive support that meets the breadth of their needs (e.g., mental health support services, HIV testing and treatment, social services), regardless of where they enter the system.

## Acknowledgements

This report was made possible by the time, expertise, and contributions of those affected by mental health and substance use issues who participated in focus groups, as well as the service providers who shared their input through phone interviews. We would also like to thank the HPPC Needs Assessment Advisory Committee, as well as individuals from the San Francisco Department of Public Health and the HIV Prevention Planning Council (HPPC), who provided input throughout the needs assessment.

## Methods

The methods used for this needs assessment include a literature review of secondary data sources, and primary qualitative data collection through the use of interviews with service providers and focus groups with specific populations affected by mental health or co-occurring mental health and substance use issues. The evaluation team met with SFDPH staff and an Advisory Committee to ensure that the needs assessment design and methods reflected current HIV prevention priorities. Through a combination of secondary and primary data sources, this needs assessment aimed to address the following questions:

**Evaluation Questions**

1. **Are mental health and substance use issues barriers to testing and treatment for HIV positive and high risk HIV negative people?**
2. **What are the best practices in prevention and program delivery adherence for populations with mental health or co-occurring mental health and substance use issues?**
3. **How does access to mental health and substance use services affect linkages to care and treatment?**
* **Advisory Committee.** In accordance with the 2010 San Francisco HIV Prevention Plan, an Advisory Committee was convened to guide the needs assessment process to ensure that it was ethical and adhered to the values of the HPPC. This committee of six members was selected in coordination with the HPPC Steering Committee and SFDPH staff, providing a means for oversight and direction for the needs assessment. The committee provided input into the needs assessment process, protocol development, and reviewed the findings. Additional communications with Advisory Committee members between meetings was conducted by both phone and email, and the feedback of members unable to attend meetings was gathered through phone interviews.
* **Literature Review.** The needs assessment team gathered existing materials and publications to understand the scope of the issue and unmet needs as outlined in relevant literature.
* **Interviews.** Fifteen phone interviews were conducted with service providers including clinicians and case managers. Interviewees included a mix of those providing prevention services, services for HIV positive people, and/or mental health services for high risk HIV negative or HIV positive people. In addition, three providers from the Advisory Committee were interviewed, for a total of eighteen interviews. The interviews were open-ended, confidential and approximately 45 minutes in length. The interviews explored providers’ experiences with barriers, clients’ priority needs, best practices, and ways to improve service coordination. The completed interviews were transcribed and content analysis was conducted in order to identify key themes.
* **Focus Groups.**  The needs assessment team worked with service provider interviewees and Advisory Committee members to recruit HIV-positive and high risk HIV-negative focus group participants affected by mental health issues. Through these contacts, participants were recruited directly and with posted flyers. Recruitment flyers were also distributed electronically to a breadth of other service providers throughout San Francisco.

Potential participants were screened for eligibility using the following criteria: San Francisco residency, mental health diagnosis or seeking mental health services, high HIV risk populations (active IDU, TFSM, MSM), HIV status (negative, positive, unknown), and age (18 years or older for consent purposes).

Focus groups were held at locations convenient for the selected populations, and each focus group was facilitated by a trained staff member. Three focus groups in total were conducted with individuals affected by mental health issues: (1) HIV-negative or status unknown, high-risk behavioral risk populations (MSMs, TFSM, or IDUs) (n=2), (2) HIV-positive MSM and/or IDUs (n=8), and (3) HIV-positive women (open to TFSM) (n=11). Among the 21 focus group participants, about 43 percent (n=9) were White, 24 percent (n=5) were African American, and 19 percent (n=4) identified as Native American and White. One participant identified as “Other”, one participant identified as Latino, and one participant identified as Asian/Pacific Islander. Ages across participants ranged from 31 to 67 years old.

The purpose of the focus groups included, among other topics, identifying participants’ experiences with barriers to getting tested and seeking treatment, and ways to improve access to testing and treatment. Focus group data were analyzed using a content analysis approach, whereby common themes were identified and described.

## Limitations

As with any research effort, this needs assessment has limitations that should be identified when considering the findings and recommendations. The primary limitation to note in this assessment was a limited response to focus group recruitment efforts. Although the approach used for focus group recruitment of high behavioral risk populations had been successful in numerous other needs assessments and evaluations conducted by Harder+Company for the HPPC, the response to recruitment efforts in the current needs assessment was particularly low among HIV positive transfemales and IDUs. Due to the lack of eligible HIV positive transfemales and IDUs responding to recruitment efforts, a third focus group was conducted with an existing support group of HIV positive women (open to TFSM) with mental health issues. Individuals from this group provided the valuable perspective of those with a long-term history of mental illness that preceded their HIV diagnosis.

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|  Findings |

This section highlights the findings from this needs assessment including barriers to HIV testing and treatment, barriers to mental health referrals, clients’ unmet needs, and HIV prevention and engagement in services for populations affected by mental health and substance use issues. These findings emerged from an analysis of interview and focus group data collected for this needs assessment.

## Barriers to HIV Testing and Treatment

The 2010 San Francisco HIV Prevention Plan notes that alongside barriers that affect access to HIV-related services such as transportation, service hours, cultural sensitivity, and language; mental illness and substance use, as well as competing priorities such as meeting basic needs, are barriers to care for those with unmet needs in San Francisco.[[12]](#footnote-12) The National HIV/AIDS Prevention Strategy report also explains that for many vulnerable communities greatly impacted by HIV but with limited access to resources, other issues such as getting basic needs met (e.g., housing) may be more pressing than HIV testing and treatment.[[13]](#footnote-13)

This needs assessment explored how mental health and substance use issues affect access to HIV testing and treatment in San Francisco. During interviews, service providers were asked how mental health and substance use affected a client’s decision to seek HIV testing and HIV-related treatment. Providers were also asked whether any particular mental health diagnoses affected access to testing and treatment more than others. Focus group participants – all of whom were affected by mental health issues – were asked what prevented or delayed them from seeking HIV testing and/or treatment. They were further asked in which ways mental health and substance use issues affected their desire to seek HIV testing and/or treatment. The following sub-sections present both service provider and focus group participant perspectives on the barriers to HIV-related services experienced by those with mental health and substance use issues.

**Key Barriers to HIV Testing and Treatment**

* Clients’ competing priorities *(e.g., basic needs, mental health and substance use issues)*
* Lack of motivation and unwillingness *(e.g., depression, denial)*
* Inability to keep appointments
* Self-medication for mental health issues

### Service Provider Perspectives

According to service provider interviewees, mental health and substance use issues are in many ways barriers to HIV testing and treatment. Providers described several mental health and substance use related barriers that were common to accessing both HIV testing and treatment. These key barriers included: clients’ competing priorities, a lack of motivation and unwillingness (e.g., depression, denial), an inability to keep appointments, and self-medication for mental health issues. This sub-section begins with a description of provider perspectives on common mental health diagnoses and substances used that affect access to HIV testing and treatment among clients affected by mental health and substance use issues. This introduction is followed by an exploration of the key mental health and substance use related barriers that were common to both HIV testing and treatment, as well as a description of those that were specific to either testing or treatment, and the ways in which mental illness and substance abuse were not barriers in all cases. This sub-section of service provider perspectives closes with a discussion of other barriers to accessing services.

**Specific mental health diagnoses and substances used**. During interviews, service providers highlighted some of the mental health and substance use issues that most affected access to HIV testing and treatment among their clients. Those most frequently mentioned included: severe depression and the corresponding inertia, lack of personal care, and lack of motivation; schizophrenia; bipolar disorders; post traumatic stress disorders (including trauma related to sexual abuse and assault); dissociative disorders; severe anxiety disorders; and personality disorders. Providers also indicated that the substances used that most affected access to HIV testing and treatment were alcohol, methamphetamines, pain medications, heroin, and crack.

**Key barrier: Clients’ competing priorities**. Service providers identified competing priorities (e.g., meeting basic needs) as the most common barrier to HIV testing and treatment among those affected by mental health and substance use. Overall, service providers agreed that clients affected by mental health and substance use typically prioritized other needs over both HIV testing and treatment. Many providers explained that those affected by mental health and substance use issues were struggling to meet basic daily needs such as housing, and providing for substance use habits, and that these took precedence over HIV testing and treatment. One interviewee explained that clients with severe mental illness such as schizophrenia were generally “fighting for [basic], more primitive needs like housing, food, and shelter.” This interviewee added that many are “trying to achieve a sense of safety and stability in their lives” and for these clients, “this precludes the idea of ‘I need to see a doctor, I need to get tested.’” A few providers added that HIV testing and treatment were seen as agency defined priorities, rather than patient defined priorities. Providers described that for many, their mental health and substance use issues superseded any HIV-related concerns. In the words of one provider, “People with psychiatric issues are being infected with HIV and their primary issue is the psychiatric issue, not HIV.” Providers also explained that among those seeking support services, many did so initially for mental health and substance use support, rather than for services related to HIV. The following text box further highlights provider perspectives on competing needs in their own words.

**In Their Own Words: Competing Needs**

Service providers indicated that many clients affected by mental health and substance use faced competing needs related to daily survival that were barriers to accessing HIV testing and care.

*“The client is so far away - from living in their own world - and is concerned simply about survival rather than care or testing. So many people with terrible mental health disorders are simply trying to survive each day.”*

*“People are very disorganized and in crisis mode all the time, and so anything having to do with primary care, including HIV testing, it is just not a priority.”*

For those affected by substance use issues in particular, another competing priority was meeting their substance use needs, which often trumped all other needs, including accessing HIV-related services.

*“Finding drugs, finding a place to sleep, dealing with their competing priorities in their mind, just managing to get through the day might be a hard enough task without adding getting an HIV test to that.”*

 *“If you are a person who is addicted, everything goes by the wayside from relationships to housing [to] caring about physical health.”*

**Key Barrier: Lack of motivation and unwillingness**. In addition to competing needs, interviewees discussed a lack of motivation and unwillingness to seek HIV testing or treatment (e.g., depression, denial). Several of these responses specific to those suffering from depression are highlighted in the text box below. While those with mood disorders such as severe depression may experience inertia around self-care and seeking services, this does not necessarily mean they stop risk-related behavior as well. An interviewee explained that while they may be “holed up in an apartment” as a result of their mental illness, they may still be inviting sexual partners over, while not leaving the confines of their living space.

**In Their Own Words: Lack of Motivation and Depression**

Providers described a lack of motivation – particularly among those with depression – as a barrier to both HIV testing and treatment.

*“When I think about mood disorders, I think it’s absolutely a barrier, particularly with depression where people get less motivated…”*

 *“If you are not able to provide for yourself, if you are debilitated by depression or bipolar or whatever the disorder is…it’s going to have an effect on all your ability to access HIV testing. I imagine if [you are] depressed [and] you don’t want to live anyway, the idea of getting an HIV test – I can’t imagine it would show up as an important activity.”*

*“People are beset by depression, by psychosis, by trauma, by trauma reenactment, many of which involve drug use. The idea of going in and getting [tested] and opening oneself up to another piece of information that could be potentially devastating...”*

*“The mental health issue we encounter is depression and that affects all aspects of their life including access to care.”*

Denial was noted to be of particular importance among those not receiving treatment for their mental health and substance use issues. As one interviewee described,

**“When clients are out of care, or not getting treated for either substance use or mental health issues, they can stay in denial about their need for care, and don’t access treatments. I want to underscore the point of untreated mental health and substance use really do increase the spreading of HIV.”**

**Key Barrier: Inability to keep appointments**. Providers also indicated that a barrier to both HIV testing and treatment among those affected by mental health and substance use was an inability to maintain appointments. An interviewee described the difficulty clients have maintaining appointments when faced with mental health issues:

**“I saw a lot [of issues] that pose a barrier to care – paranoid schizophrenia, bipolar disorder, which went along with methamphetamine use – these were people being too unstable in their moods to maintain appointments.”**

**Key Barrier: Self-medication for mental health issues**. A few providers also indicated that self-medication to assist in dealing with mental health issues was a barrier to both HIV testing and treatment.

**“Quite frequently clients with severe mental health disorders try to medicate themselves with speed or crack or heroin and in doing so get further away from accessing [HIV] testing or treatment. Mental health problems lead to further substance abuse and exacerbates it, pushing away the client, further and further away from care.”**

**“We found out that people with undiagnosed bipolar or schizophrenia were using drugs or alcohol and they were self medicating – that is a big barrier [to HIV testing and treatment]. There are a lot of people on the street that may have been diagnosed and may be prescribed medications but [they were] not able, [did] not adhere to medications, so they go back to self medicating.”**

**Barriers specific to HIV *testing***. Additional barriers related to mental health and substance use that surfaced during interviews in regards to HIV *testing* specifically included: anxiety and fear; and difficulties with thought processes (e.g., decision-making, understanding information and risk, and retaining information). Several service providers described anxiety and fear around testing – both the testing process and receiving the testing results - that resulted from their clients’ mental health or substance use issues. Some connected the anxiety and fear to specific issues such as depression, paranoia, or co-occurring mental health and substance use. In the words of one provider describing mental health related paranoia as a barrier to testing:

**Barriers to Specific to HIV *Testing***

* Anxiety and fear
* Difficulties with thought processes *(e.g., decision-making, understanding information and risk, and memory/recall)*

**“For people with mental health issues who don’t get treatment for mental health, there’s a lot of paranoia around having labs or any of that. Unless people are stabilized around psychiatric issues they may not agree to be tested [for HIV] or receive medical services.”**

Another common theme among barriers to HIV *testing* discussed by several providers was impaired thought processes resulting from mental health and substance use issues. These included difficulties with decision-making, and understanding information and risk, as well as challenges with memory and recall. As one provider explained, mental health issues can “have an impact on your ability to make good judgments and think through whether something is the right thing to do or not – [for example to] get tested or engage in risky behavior.” Other interviewees highlighted how those affected by mental illness may have difficulty processing information and understanding risk. For example, one interviewee said: “I think about thought disorders where people just are questionably able to assimilate the information to assess their risk or understand what HIV is.” Another provider noted that for substance use, the barriers are “more around memory and perceived risks and behaviors.”

Difficulties with memory and recall stemming from mental health and/or substance use may present additional challenges to providers in ascertaining HIV risk and using limited resources effectively. Several interviewees explained their experiences with patients who were not able to remember their behaviors reliably to assess risk and in other cases were not able to remember having tested positive in the past. In the words of one provider, “I’ve had a few cases in my time where someone had some serious behavioral health issues, tested positive, and then never came back for the confirmatory or kept testing and kept testing positive – didn’t remember having tested positive…” Another interviewee emphasized that a lack of coordination across services was also a factor affecting whether providers were able to identify patients who have already tested positive.

**Barriers specific to *treatment***. As with testing, providers discussed additional barriers related to mental health and substance use that were specific to HIV *treatment* and care; these were most commonly: intermittent treatment (including difficulty with adherence to medication) and stigma. Several providers described intermittent care among those affected by mental health and substance use as a barrier to HIV treatment. This intermittent treatment presented challenges for follow-up, medication adherence, and overall HIV-related care. One provider described how “incarceration and homelessness” among many clients with mental health and substance use issues resulted in people being “in and out of care.” Given that clients are away from treatment and care for extended periods, this provider concluded that “so again, it’s like you can’t do primary care.” More specifically, some interviewees described the direct effects of mental health and substance use on medication adherence as a barrier to HIV treatment. From the perspective of one interviewee, “If I can’t get out of bed to get meds, and my depression worsens and worsens. I’m probably not taking [my] HIV meds.”

**Barriers to Specific to HIV *Treatment***

* Intermittent treatment *(including difficulty with adherence to medication)*
* Stigma

According to service providers interviewed, another barrier to HIV care was the stigma associated with mental illness, substance abuse, and HIV, or any combination thereof. Along with this stigma, several providers described that some patients felt judged by those providing services, while others maintained an overall distrust of institutions, including those providing services. As one provider explained,

 **“I think [those affected by mental health and substance use issues] just feel stigmatized by systems and we represent one of those systems.”**

The following text box provides further examples of how service providers described the role of stigma as a barrier to HIV treatment among those affected by mental health and substance use issues.

**In Their Own Words: Stigma**

Many service providers discussed stigma around mental health, substance use, and HIV as a barrier to care, with some noting that clients felt judged by providers, while others had an overall distrust of institutions.

 *“Without an easily accessible support group, living with HIV is stigmatizing, having a mental health issue is stigmatizing, substance use or dependence is stigmatizing… When one feels stigmatized one feels undeserving of care.”*

*“A lot of drug users have had really negative experiences with medical providers – feeling judged.”*

 *“Medical care is very stigmatizing; and they already feel stigmatized. Why would they come closer to providers who may not understand their life and their lifestyle?”*

 *“When you’ve been hospitalized repeatedly because of mental health reasons, incarcerated repeatedly, a clinic conjures up that same institution.”*

**Not always a barrier**. While mental health and substance use issues were commonly described as barriers to HIV testing and treatment among service providers, they were not considered to be a barrier in all cases. Several providers noted that the relationship between mental health, substance use, and access to HIV services depends on both the population and the mental health or substance use issue. For example, those affected by an obsessive compulsive disorder may seek additional testing in the absence of risk as a manifestation of their mental illness. As noted by one provider, “there is a group of folks who are also more likely to be hyper-hyper vigilant,” explaining further that those who have an obsessive compulsive disorder may attempt “to have screening done regardless of [the] risk present.” This holds true for those who have substance use issues as they relate to HIV treatment as well: while there is evidence that the daily activities of some users’ are disrupted to the point that they are unable to maintain HIV medication routines, there is also evidence that other users are able to adhere to antiretroviral routines.[[14]](#footnote-14) As one interviewee shared,

**“It’s a continuum…with certain substances, there is a lack of attention to personal health, personal care, [for] others, it is a hyperconscious concept.”**

**Additional barriers to accessing services**. Other barriers faced by those with mental health and substance use issues emerged as themes from interviews with service providers. These barriers included a lack of culturally competent care (e.g., language barriers), as well as a lack of client-centered care (e.g., difficulty accessing services due to hours or location of services, restrictive policies for those using or exhibiting behavioral issues related to their mental health or substance use issues).

**Other Barriers to Accessing Services**

* Lack of culturally competent care *(e.g., language barriers)*
* Lack of client-centered care *(e.g., difficulty accessing services due to hours or location of services, restrictive policies for those using or exhibiting behavioral issues related to mental health or substance use issues)*

While noting that agency capacity for cultural competency has been improving, several providers indicated that improvements in providing culturally competent care could improve access to services, especially to “those with co-occurring disorders who may be homeless or unstably housed.” Several mentioned specific linguistic and ethnic groups in discussing the need for improved culturally competent care, while also emphasizing the need for broader capacity building in general. For example, one provider noted, “We need more...language capacity in San Francisco,” particularly within mental health and substance use services.” Another interviewee added that providers themselves may be barriers to care, explaining that “[impatience] and lack of expanded knowledge beyond your own arena [as a provider] become barriers to other people.”

Several providers also noted a lack of client-centered services as a barrier, specifically in regards to restrictive policies that may be in place for those using or exhibiting behavioral issues related to mental health and/or substance use issues, as well as difficulties clients may have accessing services due to the hours or location of services. Even though a harm reduction approach is used throughout San Francisco, interviewees indicated that this approach is not always applied when someone is in a “chaotic state” due to mental illness or substance use. As a provider explained, it is “difficult for them to attend sessions in a strict outpatient model like most facilities operate.” The hours and location of services were also identified as barriers. One interviewee shared that for a “substance using mental health person, their cognizance of time is very different…if we really want to respond, then we have to be able to look at [that], [and] also it’s about [the] venue.” Another interviewee described how hours of service were typically “a barrier to someone who [is] affected by alcoholism or drugs or depression, and doesn’t get out of bed until 12.” While many interviewees noted mental health and substance use related issues were the primary barriers to testing and treatment, this interviewee reframed these barriers as an issue of provider responsiveness, “I think that the number one barrier for both [HIV testing and treatment] is that services are not client-centered.”

### Focus Group Participant Perspectives

As was found in the interviews with service providers, a number of participants across focus groups agreed that mental health affects an individual’s desire to get HIV testing. One participant explained that individuals living with mental health issues are not likely to get tested or treatment because of an “*I don’t give a damn attitude*.” Many participants also explained that those affected by mental health or substance use issues may not get HIV testing or treatment because they typically do not remember to see a medical provider or simply do not want to see any more doctors. Similar to what interviewees noted, one focus group participant explained that individuals suffering from depression *“don’t want to get out of bed”* and will often not get tested because they *“don’t want to deal with [HIV].”* Similarly, other participants agreed that having a mental diagnosis affects whether an individual adheres to treatment because *“you can’t even get out of the house.”* Focus group participants also named several other barriers to getting tested for HIV including fear and denial, and HIV stigma. Focus group participants agreed that cost was not a barrier to HIV testing and that information about testing sites in San Francisco was readily available and thus not considered a barrier to testing. One participant commented, “It’s easy to find it. You don’t even have to have access to the internet. You can walk out and stand on the sidewalk and someone can get you where you need to go [for HIV testing].”

Participants in the focus group with HIV-positive women were asked whether linkage to mental health services helps facilitate easier access to HIV testing and treatment. About a third of the women agreed, based on their experience, that utilization of mental health services provided easier access to HIV testing and treatment. At the same time, others noted that having a mental health diagnosis has not had any effect on whether or not they seek HIV-related services. While cost was not considered a barrier to *testing*, participants in the focus group with HIV-positive women discussed cost and lack of insurance as primary barriers to receiving HIV-related *treatment*. One participant voiced her frustration in dealing with county health departments in obtaining health insurance and benefits that would allow her to receive the care she needs. Another participant shared that while in jail, she was denied access to her HIV medications. Lastly, other participants noted that a lack of information or awareness of resources was a barrier to getting HIV treatment. One participant who needed HIV care but didn’t know where to go shared, “They told me I was positive. I really didn’t know what to do. I didn’t know where to go. I didn’t know what the first step to take was.”

**Barriers Specific to *Treatment:***

 **Focus Group Additions**

* Lack of information and awareness of HIV treatment related resources

## Barriers to Mental Health Referrals

### Focus Group Participant Perspectives

The two focus groups with HIV positive participants provided different perspectives on referrals to mental health services. Many of the participants in the focus group for HIV positive MSM were recruited through their HIV service providers and indicated that they accessed HIV-related services first, and were then given mental health referrals. In contrast, the focus group with HIV-positive women was conducted with an existing support group from a site that provided both mental health and HIV support services directly. Many of these women had a long history of severe mental health issues that preceded their HIV diagnosis: bipolar manic depression, post-traumatic stress disorder, anxiety, depression, and schizophrenia.

**Key Barrier to Mental Health Referrals**

* Extensive waitlists

A common theme among the HIV positive MSM focus group participants was the challenge of being referred off-site for mental health services and the long waiting periods to receive those services. One person explained, “Mental health issues [are] usually [urgent] and require immediate action.” Despite this, participants described difficulties getting their first appointment, particularly when receiving a referral, as well as experiencing long waiting lists for mental health services. Some focus group participants also stated that a lack of insurance and lack of mental health beds in San Francisco made it difficult to access much needed services.

## Clients’ Unmet Needs

According to 2007 data recently published from a national surveillance study, [[15]](#footnote-15) the most common ancillary service needs among adults receiving HIV-related medical care were HIV case management, mental health counseling, access to dental services, social services, and transportation assistance. The need for mental health counseling was the second most frequently reported *service need* among these adults, affecting a third of respondents (33 percent). The greatest *unmet need*[[16]](#footnote-16)among respondents was for assistance finding shelter or housing (26 percent), as indicated by the percentage of persons who reported a need for ancillary services but had not yet received them.

### Service Provider Perspectives

**Key Unmet Needs**

* Housing
* Funding and resources for support services
* Treatment for mental health and substance use issues
* Coordinated care and service integration
* Employment related services

Service providers offered their perspectives on unmet needs affecting the clients with mental health and substance use issues that they served. This section highlights the most common themes that surfaced from provider interviews related to unmet needs, including housing, funding and resources for support services, treatment for mental health and substance use issues, coordinated care and service integration, and employment related services. In addition, a few providers discussed the need for patient escorts (e.g., walking patients to referral sites), peer navigators (e.g., assisting clients to navigate system of care, serving as a role model who helps clients access needed care), non-judgmental and culturally competent care (described earlier in this report as a barrier), outreach, and training for medical providers to work more effectively with mental health patients. While some providers noted technological needs among clients (e.g., cell phones and text appointment/ medication reminders), another provider cautioned that “we have to be really mindful of not making classist assumptions” when assuming access to social media as an outreach strategy. Individual interviewees also mentioned the need for health literacy and conversations around sexual health, among others.

**Key Unmet Need: Housing.** Service provider interviewees were asked to identify the most important unmet needs among their clients’ with mental health and substance use issues. By far the most common theme across interviewees was the need for housing, with nearly all interviewees underlining the importance and need for housing. In addition some interviewees also highlighted other basic needs such as food and clothing.

**In Their Own Words: Housing**

By far the greatest unmet need among clients affected by mental health and substance use issues, as identified by service providers, was the need for housing.

 *“Housing, everything starts with housing. If people are not housed, it is hard to be stable.”*

*“Housing. I think if you could get a large number of people safely and securely housed you’d really impact health outcomes.”*

*“If a person doesn’t have a place to live, they don’t have food coming in routinely and it is hard for them to focus on anything else.”*

*“The biggest thing is housing. [It is] too hard to address. Housing is a big issue…and mental health services. I think we do a better job in San Francisco, but I think behavioral health services is under-resourced.”*

**Key Unmet Need: Funding and resources for support services.** In terms of funding and resource needs, providers specified need in the following areas: funding for mental health and substance use support services, funding for other support services (e.g. HIV-related), and funding to support the transportation needs of clients to reach appointments. One provider indicted that as resources decline, mental health and substance use resources are the first to be cut. In describing the “one-stop shop” concept of the Centers of Excellence for HIV, this provider explained that the “concept included everything housed in one place: case management, psychiatry, behavioral [health], mental health – all there” but when less money was available, mental health services were scaled back and that “[despite the] best intentions, [mental health] is what goes first.” So that while there still may be psychiatry, other services such as therapists, group interventions, and outpatient mental health are frequently defunded. Another provider indicated a lack of funding to replace mental health service positions once vacated. In terms of transportation, especially among those with severe mental health issues who may be dependent on Social Security or disability, “[they] have to have money for transportation.”

**In Their Own Words: Lack of Funding and Resources for Support Services**

According to several interviewees, declines in funding presented barriers to accessing needed HIV and behavioral health related care.

*“I worry. Mental health and substance use will have a harder time [receiving] funding, people will fall out of care, people’s viral loads will go through the roof, [and there will be a] higher [infection] rate.”*

Several providers indicated a lack of funding for mental health services, but more specifically a lack of capacity at their organization for mental health services.

 *“Mental health services are being cut around the city [and] we have an increase in people showing up for urgent care in mental health crisis and we aren’t even equipped to provide the services they are presenting with…’”*

*“Within our clinic we have one psychiatrist, that’s it. If they miss their appointment they have to wait a couple months.”*

**Key Unmet Need: Treatment for mental health and substance use issues.** Another commonly discussed unmet need among those affected by mental health and substance use issues was the need for treatment. In discussing treatment for mental health and substance use issues, providers highlighted needs related to getting diagnosed, accessing medication, adherence, medical detox, and shorter wait lists for care. Several providers agreed that diagnoses and stabilizing mental health issues through treatment were among the most pressing and immediate needs facing clients with mental health and substance use issues: “there is so much to address, the most immediate would be diagnoses and being treated [for the mental health and substance use issues].” Others noted that mental health issues must be treated before other issues can be addressed. As one interviewee shared,

**“I also think that if we, the community helpers, are not reflecting on and providing therapy on [post traumatic stress disorder] then anything we do will be simply a band-aid.”**

Providers described how addressing unmet mental health treatment needs facilitates access to HIV testing and treatment. For those with severe mental illness, there is a need to stabilize them psychiatrically before they are able to consent to HIV testing. In the words of one provider, “fast access to mental health care helps get [patients to] testing more quickly and get them into primary care.” While some are able to get prescriptions for medications –both mental health, substance use, and HIV-related -that they can afford, they may not be able to access side effect medications. One interviewee described how injection drug users with hepatitis C were unable to access medication to help with the side-effects of interferon, and stopped using interferon due to its side-effects. This interviewee explained, “that level of access to medication [to help with medication side-effects] is an unmet need. There is some trying to adhere to things they can’t adhere to.” Another provider expressed a need for increased access to medical detox and longer stays for those affected by mental health issues. In terms of shorter waitlists, the need for mental health services among those suffering from severe mental illness is urgent, and as one provider explained, “I want to say we have an appointment for you today and will assign you a therapist tomorrow.”

**Key Unmet Need: Coordinated care and service integration.** Although there was acknowledgment that organizations were improving their care coordination, a common theme that surfaced among interviewees was the continued need to increase care coordination and an integration of services. This included coordinating across mental health, substance use, HIV, and social service agencies, because as one provider highlighted, “at the end of the day you are one team” and that “clients respond better when with a team of people and that team is working for their good.” Through an integrated services approach, organizations are challenged to imagine possibilities that foster smoother utilization from a clients’ perspective. As described by an interviewee, one method for improved coordination involves case managers who work closely with clients, coordinating and ensuring access to a range of services across multiple providers and care settings.  This provider stated:

 **“…really re-envisioning what a case manager or outreach worker is, so it is not tied to the agency but is tied to the person, so this partner in health works with the individual regardless of who their primary care is, so there is some consistency.”**

**Key Unmet Need: Employment related services.** Some providers also described a need for job training and employment services among clients affected by mental health and substance use issues. Not only does the employment provide a means of financial support, but also a “kind of meaningful purpose.”

### Focus Group Participant Perspectives

Conversations with focus group participants highlighted critical unmet needs among those affected by mental health and substance use issues. In terms of non-HIV needs, many participants mentioned stable housing, with a few indicating food or counseling. According to focus group participants, the most important HIV prevention need among those affected by mental health or substance use issues living in San Francisco is HIV testing. Participants discussed the importance of universal or routine testing where everyone who walks in the door of a clinic or hospital is offered an HIV test.

**Key Unmet Needs:**

**Focus group additions**

* Routine HIV testing
* Groups or workshops with resources for people living with HIV

In addition, several participants across focus groups identified the need for groups or workshops that support people living with HIV and provide information about HIV, resources, and how to access resources (e.g., Shanti LIFE, PLUS program). Several participants in the focus group with HIV-positive women agreed that patients should be asked about HIV during every annual health care visit. As part of updating a patient’s medical information every year, several participants thought that providers should regularly ask their patients about their HIV status and whether they would like to get an HIV test. Individual focus group participants identified other HIV-related needs including free needle exchange, free condoms, adherence support, pre-exposure prophylaxis (PreP), and prevention with positive programs to address transmission risk.

## HIV Prevention and Engagement in Services

This section presents service provider perspectives on HIV prevention efforts and program delivery adherence for populations with mental health and substance use issues. According to interviews with service providers, the most commonly recommended HIV prevention strategy included case management, followed by group interventions and basic HIV education efforts, as detailed below. This finding resonates with data presented earlier in this report that the most commonly reported ancillary service need in a national sample of people receiving care for HIV infection was for HIV case management, as reported by over 40 percent of participants.[[17]](#footnote-17) In terms of program delivery adherence, the most common suggestions for supporting engagement in services among those affected by mental health and substance use included: offering incentives to meet clients’ basic needs (e.g., food, shelter, and transportation), incorporating harm reduction approaches so that clients may continue participation even when expressing disruptive behaviors related to their mental health or substance use, building relationships and trust, conducting outreach, and fostering a safe and welcoming space.

**HIV Prevention Strategies**

* Case management
* Group interventions or workshops
* Basic HIV education

### HIV Prevention for Populations with Mental Health and Substance Use Issues

Service providers were asked to recommend HIV prevention activities that could be effective for populations with mental health or co-occurring mental health and substance use issues. Case management, group interventions, and HIV education were the most commonly cited strategies. Interviewees specified that case management ensures that clients are connected to primary care, HIV treatment, mental health and substance use treatment, housing, and food. Case management helps stabilize clients and as one provider stated, “[case management] makes a difference in patient outcomes and whether or not [they] remain in or out-of-care for HIV.”

A number of interviewees agreed that group interventions and workshops were also effective in delivering prevention messages for people dealing with mental health and/or substance use issues. One provider suggested that participation in groups and workshops decreases social isolation among clients, explaining, “We know folks with mental illness or substance use experience social isolation.” Group interventions also provide clients an opportunity to talk openly about their experiences and needs among peers in a comfortable and confidential environment. Interviewees shared,

**“It is very important to have group interventions…for them to actually work on changing behavior pattern…they need to have community or group meetings. They can talk with staff, but they can talk about issues with other people like them. They come back again and again.”**

**“It’s really talking about stuff and putting it out there and in a space where people can be honest and open. That’s really powerful.”**

Some providers noted that effective prevention activities for people with mental health and substance use issues include basic HIV education and safer sex awareness. One interviewee explained, “We shouldn’t assume that [people are able to use condoms and sero-sort their partners]. I think [providers] should talk to [clients] about safer sex…and condoms.” Interviewees agreed that basic HIV 101 education for clients should include information about HIV transmission and safer sex practices, and provide access to “tools of safe sex” such as condoms and dental dams.

Interviewees mentioned other prevention strategies that could be effective such as individual interventions (e.g., one-on-one counseling), routine HIV testing, and continuing syringe access. With regards to syringe access, one interviewee emphasized, “We know [it] works, it’s cheap, and it’s effective.” One provider also mentioned long-term/residential behavioral treatment programs as a successful intervention. Residential programs provide stable housing and treatment, as well as linkages to HIV testing, care, and other resources. According to the interviewee, clients in such programs are “getting used to making appointments and [going] to medical appointments” and “have come out with successes.”

In addition to provider perspectives, focus group participants provided suggestions for engaging people with mental health and/or substance use issues in HIV testing and prevention, as highlighted in the following text box.

**Focus Group Participant Suggestions for Effective Engagement**

Focus group participants offered suggestions for effective ways to engage those with mental health and substance use issues around HIV testing and treatment. These included:

* Outreach and provider follow-up (e.g., by case manager or mental health provider),
* Increase services in underserved neighborhoods (e.g., Bayview, Tenderloin),
* Conduct citywide health fairs and testing days,
* Connect substance use programs to HIV testing sites and have substance use programs refer clients for HIV testing,
* Implement creative and alternative ways of meeting with clients informally to encourage increased participation and engagement (e.g., in-person meetings, coffee hour/chat with clients),
* Expand testing sites to include hospitals and shelters/ensure universal and free testing,
* Provide case management services,
* Partner with community venues to do outreach (e.g., night clubs, churches),
* Develop one-stop shops where clients can address health care related needs in one place (e.g., Centers of Excellence),
* Partner with the criminal justice system,
* Implement incentives as a way to encourage people to get tested and care,
* Provide mobile testing vans,
* Improve communication between providers,
* Increase awareness through HIV 101 basic education.

### Program Delivery Adherence

Service providers were asked to describe how organizations could better support those with mental health and substance use issues to maintain participation in programs and/or resources. Many interviewees discussed incentives as an effective strategy for maintaining participation among clients. In order for clients to maintain participation in services, programs need to “offer something [clients] need” such as food, transportation, and shelter. One respondent commented that food, in particular, was an “effective draw.” With regards to transportation, one provider recommended, “[Clients] lack resources for transportation…so increasing the transportation voucher budget, taxi budget…all those things that help clients get here [and] improve people’s follow-through…”

**Engagement Strategies**

* Incentives that clients need
* Harm reduction approaches
* Building relationships
* Conducting outreach
* Fostering a safe and welcoming space

Providers also spoke extensively about the value of harm reduction practices in keeping clients engaged in services. For many clients, disruptive and loud behavior may be due to mental health or substance use issues. Providers suggested that agencies consider ways to deal with their behavior aside from expelling them from the site. One interviewee suggested, “When a person who is high comes into the clinic, or a person’s mental health disorder manifests in loud behavior, do you kick them out? If our purpose is to maintain people in care, we can’t kick them out.” Instead of turning away clients in need, a few interviewees agreed that agencies should provide opportunities for people who are not ready or not fully capable of engaging in services. For example, informal support groups, social activities, or outings can be offered as alternatives, as one provider stated, “Until they are ready…there should be other opportunities afforded to them.” Another provider added, “Consider the threshold, lower the threshold, find ways to be more available to patients when they come in [in a certain state], and focus on building the relationship.”

A number of other providers agreed that building relationships with clients was key. One interviewee explained, “It really is about building trust. They don’t trust [easily] and will put up all sorts of obstacles.” Relationships and trust are the “touch stone for getting people in [and] closer to care.” Another provider who described the process used for developing relationships with new clients and gaining their trust, explained:

**“What we would do is start to build a relationship with them. We get a lot of what I call sidewalk therapy –people too paranoid or agitated to come inside, we would stand outside with them and talk with them. Sometimes, this would go on for several months until finally the person would trust us enough to go inside, and sit inside our office for a few months before they felt safe enough to have the door closed.”**

A few respondents mentioned outreach to those lost-in-care or intermittent care seekers. Outreach workers are able to “find folks who are out there and bringing them back into care.” One interviewee noted a current SFDPH effort – Linkage Integration Navigation and Comprehensive Services (LINCS) Team – administered through HIV Prevention Section. LINCS is a safety net aimed at tracking down people who are lost to care or are sporadically linked to care. The team works closely with medical providers and community-based testing teams and focuses on linkage to HIV care. Such programs, providers agreed, would be helpful in supporting the retention of clients in care.

Finally, a few interviewees discussed the importance of having a safe and welcoming space for clients. One provider noted, “What happens with people who have mental health disorders and drug or alcohol issues, [is that] people don’t listen to them, they don’t look at them.” On the contrary, at this interviewee’s organization, clients were welcomed into a respectful and safe space that they keep coming back to. This interviewee stated,

**“We treat people with respect. We treat people with dignity. And they feel that they are treated with dignity and they feel seen and heard and validated. And then they feel like they want to connect with us more.”**

Interviewees provided other suggestions related to creating a safe and welcoming space for clients such as establishing a Patient Advisory Group whose role would be to identify what is working and not working at the agency and to come up with ideas about “how to support clients that are having difficulty’; ensuring culturally-inclusive staff and linguistically accessible services; and considering whether the presence of security staff as barrier to access for clients.

## Summary of Key Findings

Findings presented in this needs assessment demonstrate that in many ways those affected by mental health and substance use issues face barriers to accessing HIV testing and treatment. The most common barrier to both HIV testing and treatment was competing priorities related to daily survival. Other common mental health and substance use related barriers to HIV testing and treatment were depression and a lack of motivation or willingness (e.g. depression, denial), an inability to keep appointments, and self-medication for mental health issues. Specific to HIV *testing*, additional barriers related to mental health and substance use included anxiety/fear and difficulties with thought processes (e.g., decision-making, understanding information and risk, and retaining information). *Treatment* specific barriers related to mental health and substance use included intermittent treatment (including difficulty with adherence) and stigma. Other common barriers to accessing services included a lack of culturally competent care (e.g., language barriers) and a lack of client-centered care (e.g., difficulty accessing services due to hours or location of services, restrictive policies for those using or exhibiting behavioral issues). In addition to these themes, some HIV positive focus group participants shared a desire for more information and raised awareness of resources. Focus group participants also noted extensive waitlists as a barrier for mental health referrals.

According to interviewees, the most common unmet needs among those affected by mental health and substance use issues were basic needs such as housing, funding and resources for support services (e.g., funding for mental health and substance use support services, funding for services in general, and funding to support the transportation needs of clients to reach appointments), treatment for mental health and substance use issues, care coordination and integration of services, and employment related services (e.g., job training). Providers also shared a need for patient escorts, peer navigators, non-judgmental and culturally competent care, outreach, and training for medical providers to work more effectively with mental health patients. Focus group participants also described the need for stable housing, and were also probed directly about HIV prevention needs. According to these participants, the most important HIV prevention need among those affected by mental health and substance use was routine HIV testing. Participants also acknowledged the need for groups or workshops to support people living with HIV and providing HIV-related information and resources.

In addition, service providers provided input on HIV prevention and program delivery adherence among those affected by mental health and substance use. The most commonly recommended HIV prevention strategy for populations with mental health and substance use issues was case management, followed by group interventions and basic HIV education efforts. To support engagement in programs and services, providers discussed offering incentives that helped clients meet their basic needs (e.g., food, shelter, and transportation), incorporating harm reduction approaches that allowed clients to continue participation even with disruptive behavior related to mental health or substance use issues, building relationships, conducting outreach, and fostering a safe and welcoming space.

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|  Promising Practices for Strengthening the System |

The following recommendations, based on findings from the interviews and focus groups, are focused on strategies or best practices for strengthening the current system to better serve people living with HIV and/or at high risk for HIV facing mental health and substance use issues. One interviewee cautioned that “these are complicated problems, and there’s not an easy solution. We have to be really careful of coming up with ideas that sound good but really miss the needs of clients who are suffering terribly and alone.”

* **Increase stable housing opportunities for people with mental illness and/or substance use issues.** Both interviewees and focus group participants highlighted the importance of stable housing for people affected by mental illness and/or substance use issues. One provider emphasized,

**“Three words: housing, housing, housing. People need access to affordable housing. That is the number one issue. It is hard to stay connected to medical care, mental health, and other kinds of treatment when in living in the street, bouncing in and out of shelters. I think housing is really, really important.”**

Providers also suggested a need for sober living situations so that the environment supports the lifestyle change a client is trying to make, as well as harm reduction approaches so that clients don’t lose their housing if the substance use or mental health behavior persists.

**In Their Own Words: HIV Prevention through Housing**

According to service providers, HIV prevention efforts will be furthered by addressing the need for stable housing among those affected by mental health and substance use issues:

*“Access to a stable living environment has a huge impact [on] adherence to medication or initiation of medication…Being less stable has an impact overall regarding whether someone will get an HIV test. Is an HIV test the most important priority of someone on the street or is it getting a roof over their head for the night or food in their stomach?”*

 *“Making sure to get people’s primary needs met first – food, clothing, shelter- things like that…then we can get them more stabilized in their health care and their sexual health overall.”*

*“Yes, the city wants to see many people tested who are at risk. But if that’s not the person’s priority, then they need to be able to address what that person’s priority is in that moment.”*

* **Ensure that resources and referrals are in place for successful linkage to HIV testing and treatment.** As described below, interviewees shared a number of recommendations related to making the process of connecting to services easier and making sure that referrals are successful.
	+ **Peer navigators.** Many interviewees agreed that for individuals affected by mental health or substance use issues, keeping any type of appointment can be challenging. Some providers recommended that peer navigators or peer escorts have been helpful in ensuring that clients make it to their appointments. Peer navigators can “bring people in for medical care for HIV testing” and by sharing their own experiences, show “that it is possible to get the care [one] needs and be treated with respect.” Even if a client successfully arrives at an agency for an appointment, one interviewee shared that peer navigators can make certain that the client remains and is actually seen by a provider. This interviewee stated,

**“You need [peer navigators] to escort clients to referrals and be able to sit there until they are able to do it themselves. They can ask the questions and advocate for them…a lot of times [clients] aren’t going to make it, they won’t go, they’re not feeling good or they’re going through detox, or swearing at medical staff, they may get thrown out. But if escorted, the peer advocate can speak on their behalf. They can mediate and its’ helpful.”**

* + **Opportunities for Access.** In some cases, even though a client makes it into the door of a service agency, access may still be prohibited particularly if a client’s mental health or substance use manifests in disruptive behavior. Providers shared the need for services that were accessible to those in crisis and those manifesting disruptive behaviors resulting from their mental illness or substance use. One provider explained, “In some agencies, if someone starts yelling in the waiting room, they kick them out. They might be yelling because that’s the result of their mental health issue… [Agencies] don’t have policies that support people like that.” While a couple interviewees voiced the need for calm and secure environments, others explained that restrictive policies were barriers to those suffering from mental illness and substance abuse. To address this issue, some interviewees suggested that agencies “be more open, less rigid” and take a harm reduction approach by accommodating clients “where they’re at.” One provider added that programs need to adjust so that they are “more user friendly” and accessible for individuals with mental health or substance use issues.
	+ **Location and hours of services.** Providers emphasized that for people affected by mental health and/or substance use issues, the location and hours of service makes a difference in whether or not they are linked to testing or care. Interviewees suggested that services should be available after-hours, weekends, and evenings. One interviewee advocated for agencies funded to provide HIV testing to offer testing at least one night a week after-hours. Other providers also mentioned the need for drop-in services, especially for people with mental health or substance use issues, who are likely to have a hard time keeping appointments:

**“Some clients with serious behavioral health problems need drop-in hours. It’s hard to keep appointments.”**

**“They don’t do really well with appointments. If we want to keep them in treatment, if we want to keep them engaged in care, we need to figure out a way so that there is more [flexibility] with [service] hours…they're going to show up whenever they’re going to show up.”**

* + **Transportation support.**  Another theme that emerged throughout this needs assessment was the need for additional transportation support such as transportation vouchers. Alongside literature identifying transportation needs as a barrier to HIV testing and treatment, interviewees described transportation assistance as an unmet need among clients affected by mental health and substance use issues, and as a factor affecting clients' ability to utilize services.
	+ **HIV screens during mental health intake and assessment.** When entering services for mental health, substance use, or HIV, intake and assessment are often conducted to gather information about clients’ immediate and long-term needs as well as information about clients’ personal histories and background. Interviewees suggested that during intake, behavioral health and medical providers should routinely ask about HIV and sexual health. Doing so, providers noted, would help identify clients’ HIV testing and care needs if any. Inquiring clients about HIV in mental health settings is not standard practice and is “not happening across the board” as one interviewee pointed out. Another provider noted that “people rarely get asked about an HIV test” suggesting the need for providers to “empower [their clients] to bring up [HIV] and follow through with actions that support lower risk behavior.” One mental health provider offered a different perspective noting that mental health clinicians were assessing clients’ need for HIV testing and care. This provider asserted that mental health providers were “linking people to testing and primary care” and that linkage in mental health settings “happens all the time.”

Interviewees also discussed how assessments can serve as a tool for identifying clients’ HIV testing and care needs in both mental health and substance use service settings. One provider suggested that assessments, as with intake forms, can be standardized to include questions regarding HIV testing and care. A checklist of pertinent questions such as the following might help facilitate discussions with clients around their HIV testing and care needs: *When was your last HIV test? If living with HIV, when was your last visit to your doctor? Are you currently taking HIV medications? Where else are you receiving services?* Standard questions at intake and assessment could help determine how best to link clients to HIV resources.

* + **Referrals.** A number of respondents highlighted the value of a “warm hand-off” when referring clients for additional services, including HIV testing and care. One provider commented, “A warm hand-off is the best linkage. When that is not possible, I call and say, ‘I have someone who needs to get tested. Can I send them over? Is there someone who can provide testing?” Providers expressed that a warm-hand off is ideal because the referral is conducted in person and guarantees that clients are connected to the services they need. Follow-through is ensured and the providers involved are able to communicate and share information immediately. While ideal, a warm hand-off is not always feasible. In this instance, interviewees suggested that relationship building between providers and learning about the services available are important. One respondent articulated,

**“A referral is a recommendation. I don’t make recommendations based on a resource guide. I make recommendations based on what I understand about an [agency’s] philosophy and [way] of treating clients…I don’t refer people to a service [with whom] I have not talked to.”**

* **Link individuals to HIV testing and care through outreach and community-building.** Interviewees spoke extensively about the need for outreach and activities that support community-building as a way to bring people into care.
	+ **Outreach Workers.** Several providers identified outreach as an integral part of linking individuals with mental health and/or substance use issues to HIV testing and care. Interviewees discussed the role that outreach workers can play in bringing individuals into primary care and subsequently HIV testing. Connecting individuals to primary care, providers stated, “is an important step in getting people tested for HIV.”

Peer outreach, in particular, was emphasized by providers and focus group participants as a useful tool for getting people into testing and care. Peers who have had a positive experience with services, for example, “can act as a magnet,” to inform others that a safe space and community exists, and “bring in others” into care. One provider stated, “They are community members, they bring a friend, they bring in a family member…We have really encouraged folks to bring in their [HIV-]negative peers or even their status unknown peers. It’s been very successful.” Peer outreach has been effective at one interviewee’s agency because “people need to be able to talk with [others] who have gone through similar situations and can provide that kind of lived-in experience.”

One provider suggested Project Homeless Connect, organized by SFDPH, as a promising model for outreach to people living with and/or at-risk for HIV dealing with mental health issues. Project Homeless Connect provides a single location where primary care and social service providers collaborate to serve the homeless of San Francisco. The interviewee suggested that a large-scale, comprehensive outreach and engagement event similar to Project Homeless Connect could be a “really good way to promote wellness and [provide] access to services,” noting that people are likely to be more open to broad messages of overall health and wellness, rather than specific messages around HIV or mental health.

Some providers also discussed social interventions as an effective strategy for getting people into services. Social activities and social events, for example, can be implemented as a form of outreach. One provider suggested, “Engage folks on a social level…We got people in the door…That meant the use of food, potlucks, games, and peer facilitators.”

* + **HIV Testing and Care through Community Building.**Community-building or creating spaces where people feel a sense of community were highlighted by several interviewees as important strategies for linkage to HIV testing and care. One HIV prevention agency uses social media to advertise community events where HIV testing is provided. However, the event is billed as a *community event* rather than an *HIV testing* event, bringing together a broader cross-section of the community. Such events have been successful in gathering community members and people from “different walks of life.” A provider from this agency discussed the importance of community events as part of their HIV testing outreach, stating,

**“These efforts are successful because they lead to having a positive sense of community…These events increase the positive feeling that people have towards [our] agency, which increases trust and leads to higher levels of testing being followed up on.”**

Another provider spoke about social interventions as vehicles, not only for outreach as mentioned previously, but also for building community. He explained, “Underlying all our group [activities] is the idea that we are creating an ongoing community with [clients], peers, and staff…In our group interventions, we actually try to meet and create that community on the spot.” Individuals undergoing treatment or considering treatment, one interviewee reiterated, “need to feel [that] there is a community for them that will support them while they engage in care.”

Lastly, community-building activities and events are also important in addressing stigma around HIV, mental health, and substance use by encouraging discourse and information-sharing. One provider explained that during such activities and events, program staff engages community members and potential clients, increasing their awareness of issues related to HIV, mental health, and substance use, and pointing them towards helpful resources. Former and current clients also have the opportunity to share their experience as consumers, “talking about the services they received and how helpful they were.”

* **Increase service coordination and communication between providers.** Linkages to HIV testing and care can also be facilitated through service coordination and better communication between providers as suggested by interviewees. Interviewees explained that establishing relationships between different agencies and service providers can help improve service coordination and facilitate linkages to care. One provider stated,

**“It’s about collaboration and making it seamless for clients through partnerships with other agencies. We are a small city rich with services. There’s a lot out there and its’ about helping people get to it.”**

Having a strong relationship or partnership allows for ease of communication between providers which is necessary for successful and efficient referrals. One interviewee referred to “having cross-pollination between agencies” where resource information and client data flow easily between mental health, substance use, and HIV testing and care settings. Data sharing, one provider pointed out, would enable providers to access client/patient information so they can track whether a referral was successful or whether an appointment was missed. Case consultations and conferences were also mentioned by interviewees as ways to facilitate of better communication and information-sharing between providers so that they can coordinate services for common clients.

One provider spoke about the need to forge relationships with testing sites specifically in order to improve exchange of information between the referral and testing site. Citing the importance of communication between providers to ensure that clients are linked to care appropriately, this provider commented, “If someone leaves my [organization] to get tested and then finds out they are positive, there should be feedback back to me, so that the client is not twisting in the wind.”

* **Increase cross-training to improve provider capacity to serve clients affected by mental health and substance use issues.** Many service provider interviewees noted the need for ongoing training for providers around mental health, substance use, and HIV to ensure competency and understanding of client needs.
	+ **Cross-training between HIV and mental health/substance use providers.**Several interviewees suggested that cross-training between mental health, substance use, and HIV providers would be useful in ensuring that clients are connected to appropriate services. As mentioned above, respondents suggested that mental health and substance use providers should be trained on topics and issues related to HIV, testing, and care so that they have the skills and knowledge to facilitate linkage. One provider commented, “If I have a client who I know is HIV-positive and I work at a mental health clinic, I have as much responsibility as an HIV agency to get them connected [to HIV care].” Cross-training between mental health, substance use, and HIV providers ensures that “Any Door is the Right Door” and that the multiple health needs of clients can be addressed.
	+ **Training for HIV providers.** With regards to mental health, HIV providers should have a strong understanding of how different mental health disorders, such as depression, anxiety, and personality disorders, are manifested in client behavior in order to better support clients in crisis, as well as assess their clients’ ability to follow-up on referrals and adhere to treatment and care. Trainings should impart providers with skills and techniques for engaging people affected by mental health issues. One interviewee suggested the need to understand “what people may or may not be capable of” based on their mental health diagnosis. A client with severe depression, for example, may have a difficulty motivating to make an early morning appointment. With training, providers can build understanding of the limitations faced by people living with mental illness or substance use and better determine appropriate services. One provider explained, “If [clients] are super chaotic in the morning and using in the morning, don’t schedule [appointments] in the morning. Talk to them about the best time.”
	+ **Training for mental health and substance use providers.** Interviewees also discussed the need for mental health and substance use providers specifically, to be trained on how and when to raise the subject of HIV, risk, and sexual health with their clients. Additionally, mental health and substance use providers should be aware of HIV testing options and resources for HIV care. One interviewee who agreed that ongoing orientation around HIV testing and care resources would be helpful commented, “I’m not sure how much of that is happening.” Another interviewee suggested that providers should not only learn about the different resources available, but also whether or not particular resources would be appropriate for and welcoming towards individuals dealing with mental health and/or substance use issues. On the other hand, one mental health provider interviewed indicated that the efforts suggested above were actually occurring in mental health service sites – that mental health providers “already include a focus on HIV prevention” when meeting with their clients and that they were knowledgeable about HIV testing, prevention, and resources. However, the interviewee agreed that cross-training between HIV and behavioral health providers would be helpful to ensure that HIV providers are well-aware of the HIV services occurring at mental health and substance use programs.

Interviewees highlighted other topics for provider trainings which they thought would be helpful such as providing services in a non-judgmental manner and building trust with clients. One respondent suggested that training on how to better serve LGBT, transgender, and the homeless is “an absolute must.”



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