Capacity Building Project: Serving the Mental Health and Substance Abuse Needs of HIV Infected Persons in Texas

Executive Summary

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July 1, 2010

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OVERVIEW

In 2009 the University of Texas at Austin School of Social Work was contracted by the Texas Department of State Health Services (DSHS) to conduct an evaluation study (*Capacity Building Project)* of the mental health and substance abuse services available across the state of Texas to those living with HIV/AIDS. The primary goal of the *Capacity Building* research project is to gain insight into the barriers and facilitators to accessing and linking HIV infected individuals in the state of Texas to essential mental health (MH) and substance abuse (SA) services. This project consisted of several components, including:

- an analysis of previous HIV jurisdictions' providers needs assessments;
- key informant interviews, focus groups and on-line surveys with regional Planning Council Chairs and Administrative Agents;
- focus groups with regional providers of MH and SA services;
- interviews with clients across Texas to further examine barriers and facilitators to accessing care;
- an online survey of case management staff directly responsible for the assessment and referral of clients into care; and
- an analysis of the resource directories across the state to determine accessibility and availability of services.

This executive summary will explain each step of the project, offer salient findings from each sub-study, and summarize recommendations for systems-level change. Complete reports from each component are part of the appendix. Each separate

report contains its own list of specific recommendations that can be further reviewed for additional details.

LITERATURE REVIEW

According to the Statewide Coordinated Statement of Need (Department of State Health Services (DSHS), 2008), in 2006, People Living With HIV/AIDS (PLWHA) in Texas totaled 60,571. The most common modes of exposure to HIV infection existed among men who have sex with men (MSM), Intravenous Drug Users (IDU), and heterosexual transmissions from sex. In Texas, MSM accounted for half of PLWHA, followed by 24% attributed to heterosexual sexual transmission and 17% to IDU. A large majority of infections among White males were MSM (78%). Hispanic male cases were also predominantly MSM (65%), with 18% being heterosexual and 12% IDU. While the majority of African American males infected in 2006 were classified as MSM (56%), nearly 21% of African American male cases were infected by heterosexual exposure, and 17% were IDU. Female cases across race/ethnicity were predominantly transmitted by heterosexual exposure.

There is a substantial body of scholarship showing substance abuse (SA) and mental health (MH) concerns among persons living with HIV/AIDS impacts their quality of life, diminishes medical adherence and leads to negative health outcomes (Brady, Gallagher, Berger, & Vega, 2002; Fallot & Heckman, 2005; Chen, Accortt, Westfall, Mugavero, Raper, Cloud et al., 2006; Cunningham, 2006; Myers, Wyatt, Loeb, Carmona, Warda, Longshore, et al., 2006; Dalmida, 2007; Israelski, Prentiss, Lubega, Balmas, Garcia, Muhammad, et al., 2007). In the U.S., approximately 26 million people suffer from a diagnosable mental health disorder in any given year

(NIMH, 2009). The Substance Abuse and Mental Health Services Administration (SAMH/SA) estimates that in 2006, 23.6 million people were in need of treatment for illicit drug or alcohol use problems (DSHS, 2009). A 2006 study of health care expenditures for HIV positive patients found that approximately 25% of HIV patients had SA and MH problems warranting outpatient visits for therapy (Chen, Accortt, Westfall, Mugavero, Raper, Cloud et al., 2006).

It is imperative that MH and SA issues are addressed effectively, as they can lead to negative health outcomes for PLWHA. Major mental health issues identified among PLWHA are major depression, generalized anxiety disorders, dysthymia, panic disorders, post-traumatic stress disorders, and substance use disorders (Brady, Gallagher, Berger, & Vega, 2002; Fallot & Heckman, 2005; Dalmida, 2007; Israelski, D. M., Prentiss, D. E., Lubega, S., Balmas, G., Garcia, P., Muhammad, M., et al., 2007). Particularly salient among women living with HIV are depression, PTSD, and substance use (Zierler, 1996; Axelrod, Myers, Durvasula, Wyatt, & Cheng, 1999; Kimerling, Calhoun, Forehand, Armistead, Morse, Morse, et al., 1999; Myers, Wyatt, Loeb, Carmona, Warda, Longshore, et al., 2006).

The co-occurrence of these issues can further impede adherence to antiretroviral regimens, as well as prevent clients from obtaining needed medical care. Research suggests that screening for MH health concerns and SA among HIV-positive patients followed by subsequent treatment is an important component to improving adherence to antiretroviral medications (Lucas, Gebo et al. 2002; Tucker, Burnam et al. 2003). In accordance with recommendations from the Health

Resources Services Administration (2004), there is a significant need for mental health and substance abuse services to be a key component of HIV care.

METHODS

This study used a variety of quantitative and qualitative research methods in order to achieve the overarching goals of the study. The research team consisted of two Ph.D. level staff, three Ph.D. students, three Masters level students, and one research associate. Each was trained by the PI on research methodological approaches and research protocol. Several members of the research team also completed research and statistical coursework in the UT-Austin. Each also completed ethics training and was expected to complete a certificate course on safety of human subjects. In order to meet the intended outcomes, the study was divided into several sub-studies. The methods for each sub-study are described below.

Needs Assessment Analysis

To determine the mental health and substance abuse service needs of PLWHA in Texas, a document analysis was conducted of the eight administrative agents' comprehensive HIV needs assessments. Key themes, patterns, similarities and differences among the administrative areas were identified and two coders and the PI to reached consensus on the findings.

Administrative Agent & Planning Council Chairs: Survey and Focus Group

This study was conducted in two phases. In phase I, a research staff member was trained by the PI to contact the nine Administrative Agents and the five planning council chairs of the planning areas across Texas. The participants were

asked to complete an on-line survey. After agreeing to participate, a follow-up email was sent to research participants with the link to the survey. No personal information was collected to ensure confidentiality of responses.

In Phase II, the Administrative Agents were asked to participate in a recorded teleconference key informant focus group. Participants were asked to complete an informed consent form. The PI, Co-I and a primary research staff member led the 90- minute recorded conference call.

Mental Health and Substance Abuse Provider Study

For the MH and SA provider study, three focus groups were conducted. At the direction of DSHS, the research team targeted recruitment to providers that predominantly served the MH and SA needs of PLWHA. Providers were directly recruited through email and phone communication. The SA group (N=8) was conducted with a group of service providers in the Dallas area. Due to lack of participation in the MH focus groups, two groups were scheduled in order to ensure an appropriate number of participants. Therefore, one group (n=4) was conducted with Houston area providers, and another (n=3) was conducted with Austin and Dallas area providers.

Client Interview Study

Based on DSHS recommendations, HIV-positive clients (n=90) from six key areas in Texas (Austin, Dallas, El Paso, Harlingen, Houston, and San Antonio) were recruited for participation in one-on-one interviews. Three of the sites were Ryan White clinic/medical care provider sites and the other three sites were AIDS Service Organizations (ASOs). The structured interviews focused on the clients' experiences

in seeking MH and SA services, including (a) whether clients felt their needs were met, (b) motivating factors that encouraged service utilization, (c) inhibiting factors that prevented service utilization, and (d) provider understanding of client needs.

Five members of the research team were trained to conduct these interviews, which were audio recorded and transcribed. Before participating in the interviews, clients were screened at local AIDS service organizations. Upon qualifying for the study, clients were informed of the study and signed consent forms. The interviewer also gathered demographic data on each participant for further analysis

Case Management Study

The case manager online survey was developed by the evaluation team and reviewed by members of the DSHS project committee. It was then sent to DSHS and disseminated to case managers who serve PLWHA. The survey instrument contained two sections. In section I, respondents were asked demographic information, such as age, race/ethnicity, gender, service areas, caseload, education, licenses held, and working years. Section II consisted of questions concerning respondents' perceived comfort level of assessment tools and their cultural competency in dealing with HIV infected clients, both in mental health and in substance abuse. The questionnaire also offered respondents an opportunity to express their written concerns that HIV infected clients face, and to comment on the service barriers, client's care and areas for system improvement. The final analysis was based on 113 case managers that had responded the survey.

Resource Directory Study

Research staff member was trained by the PI to contact 21 regions of the state and obtain community resource guides that they offer services to PLWHA. A full list of the areas that were contacted can be found in the full report summarizing the results of this study. Most of the areas contacted did have resource guides, mostly obtained through contact with their regional planning council. For those regions which did not have planning guides, web searches (using Google) guided the development of a resource list.

After contact information was entered into a resource matrix, four research assistants were trained on conducting quality management phone calls. In order to ensure that the data obtained was accurate and that all identified resources were active, research staff made telephone contact with each agency and asked them a series of questions about the depth and breadth of their MH and SA services. The resource matrix was then adjusted based on agency responses.

MAJOR FINDINGS

Administrative Agent& Planning Council: Survey and Key Informant Study

This study consisted of an on-line survey of the administrative agents (9) and planning council chairs (5), in addition these administrative agents participated in a telephone focus group and an online survey. Major findings cut across mental health and substance abuse, and further along assessment, referral, follow-up and treatment. Several themes were identified through this process.

1. **Client Readiness** and **Motivation** were seen as overarching barriers which must be addressed in order to ensure clients are able to access and stay in services. Additionally, training was mentioned frequently as a helpful solution.
2. **Mental Health and Substance Abuse are unique**, and must be addressed individually. For example, although stigma was mentioned as impacting both services, it appears to impede substance abuse service utilization more intensely. Additionally, availability of services and other barriers fit within this theme.
3. **AIDS Exceptionalism vs. Normalization** appears to be an issue that occurs within the system. Under this theme was the need for more networking, larger networks of providers, and providers that can specialize in working with clients who have MH and/or SA concerns in addition to their HIV concerns. This can also be viewed as an issue of specializing or streamlining.
4. **Rural areas** have specific concerns. Lacking a full array of services, culturally/linguistically appropriate services, and increased stigma seem to decrease utilization in these areas.
5. **Training and skill building** are primary tactics for addressing these problems, however these trainings must be offered in specific areas of need, and must also be flexible to meet the scheduling needs of participants. Within this are specific recommendations for training including assessment tools, ARIES procedures and motivational interviewing skills.

Mental Health and Substance Abuse Provider Study

The provider sub-study was conducted with three focus groups. Two focus groups requested input from Mental Health (n=8) providers in different areas of the state. The major findings from this include:

1. **Accessibility of services** was a major point in determining barriers to clients obtaining MH care and then remaining in care according to the MH provider focus group participants. Accessibility issues often related to systems, restrictive policies, and significant funding gaps. The lack of accessible services creates a barrier to clients, or loss of their "window of opportunity".
2. **Staff and provider capacity** was discussed beyond what has been outlined above related to the severe lack of qualified MH providers and psychiatrists. Lack of mental health professionals creates long waiting lists for services which present a significant barrier to clients accessing services. They also pointed out that not enough providers are willing to work with uninsured clients or those with just Medicare or Medicaid funding.
3. **Client barriers and challenges** included transportation, long waits, cost of prescription medications, eligibility confusion and a lack of Spanish speaking staff. The clients' own untreated mental health problems can make it highly unlikely that the client will access services.
4. **Continuum and continuity of care issues** were clearly linked to the lack of services, limited service types and the lack of qualified providers. They noted

a lack of emergency-based crisis services at one end of the continuum and the lack of counseling for basic depression and anxiety issues.

Another focus group was conducted with substance abuse providers (n=11) from the Dallas area of the state who focus their efforts on substance abuse treatment. Several themes emerged from this sub-study as well, including:

1. **Continuum of Care and Continuity of Care Issues** were inter-related throughout the provider focus group responses to the questions posed. Focus group participants repeatedly discussed the need for the development of a full continuum of treatment services (detoxification services through after-care) at the local level, which would allow for more continuity in the care of SA. This would also reduce the number of people who have "fallen out of care" due to services not being accessible.
2. **Accessibility related to Systems and Policies** was a recurrent theme of the focus group responses related to the challenges faced by clients as well as providers in obtaining SA services for PLWHA. Providers noted that this issue coupled with the lack of treatment services and resources located in the client's area posed major roadblocks for PLWHA.
3. **Skills and Training of Providers** were topics discussed in reference to the focus group questions centering on SA knowledge, training, and client referrals and follow-up. Focus group participants noted that issues of co-morbidity and multiply diagnosed clients were often overwhelming for providers and clients. Some participants noted there were many training opportunities in their communities, while rural providers indicated they

were not notified of trainings related to HIV, SA, and MH issues. There was consensus among focus group participants indicating they had sufficient training in SA treatment.

4. **Client Issues and Readiness** discussion points related to clients getting the care they needed. In response to the focus group question, "What are some of the challenges you see clients face in making behavioral changes around their SA issues?" participants talked about their clients having a "greater sense of hopelessness." They also discussed the fact that they thought this target population has more legal problems and less family support and less extended family than non HIV-infected clients.

Client Interview Study

For the client interviews, six Texas cities (Austin, Dallas, El Paso, Harlingen, Houston and San Antonio) were selected and 90 clients were interviewed about their experiences seeking and being treated for their mental health and substance use disorders.

For their mental health needs, several themes emerged including:

1. Most clients are referred through their **HIV physician.**
2. Many cited **waiting periods** as one barrier to seeking treatment, as well as having to see multiple providers in order to receive care.
3. Accessing services is easier for clients who receive their primary medical care from a **"one stop" agency**, or an integrated care provider.

4. The **client-provider relationship** was one of the most important components to continuing therapy.
5. **Lack of availability** was the most common barrier discussed, including waiting lists, short appointment times and non-HIV trained clinical options.
6. Clients seem to be primarily motivated by **rapport** with their provider, **effective therapeutic techniques** and internal **motivation**.

For their substance abuse service needs, several themes emerged including:

1. The pathway into substance abuse treatment is distinctly **different** from mental health services.
2. Having **only one statewide SA inpatient provider** specifically serving people with HIV/AIDS is a barrier for some seeking treatment.
3. **Client readiness** was the most salient facilitator to continued SA treatment.
4. Many clients **do not abstain from all use of substances**, although many use drugs they consider less dangerous (i.e., quitting cocaine but continuing to smoke marijuana). This indicates that risk reduction and harm reduction are potentially effective ways for clients to improve health outcomes and quality of life.
5. Client rapport with providers and their providers' knowledge about their personal circumstances encouraged continued treatment.

Case Manager Study

The Case Manager on-line survey highlights several important themes which helped to verify findings from other segments of the HIV provider community. The major findings for mental health treatment include:

1. The majority of case managers report using a tool to assess for mental health (78%) and substance abuse (81%) and most feel comfortable using the tool.
2. The majority of clients seem to be screened for mental health concerns only annually or semi-annually (53%) with a similar finding for substance abuse (56%).
3. Most (73%) feel their agency adequately assesses and refers for mental health treatments.
4. Results showed client refusal rate was below 50%. However, more than half (65%) of respondents estimated fewer than 50% of their referred clients follow through on MH referrals. In addition, a significant majority (89%) of respondents estimated the percent of PLWHA dropping out of treatment was below 50%.
5. Respondents were asked to estimate the percentage of client refusal, follow through, and drop out for SA referral. Table 25 shows that 73% of respondents reported that between 21-79% of referred clients refuse the referral. However, 81% of respondent's estimate that of those who accept the referral under 50% referred clients follow through. In addition, 80% of respondents report that the treatment drop out rate for PLWHA was estimated below 50%.
5. When asked how frequently clients follow-through with referrals, case managers estimated that a majority do not follow through with mental health

referrals (50%) and a higher rate do not follow through for substance abuse (60%).

6. Depression, anxiety and bipolar disorder were the most frequently reported mental health concerns.
7. Transportation, financial support and client readiness were the most reported barriers to seeking mental health treatment.
8. Housing needs, limited community resources and a lack of family support are barriers to seeking substance abuse treatment.

Resource Directory Study

Several major findings emerged from the resource directory analysis, indicating a need for improvement in the way that services are made known to clients. These include:

1. Services are concentrated in large urban areas, making it more difficult for rural residents to seek help for mental health and substance abuse needs.
2. Outpatient services are most common, followed by support groups. Very few inpatient services exist, with only one provider specializing in HIV positive client care.
3. Crisis and housing services are very rare, with almost no specialization in HIV.
4. Payment options are limited and most agencies do not offer comprehensive options (i.e., do not accept Medicare/Medicaid).

5. Self-pay is the most common option for payment, which is difficult for many clients in this population.
6. Most agencies do not offer evening hours which may be a barrier to clients who are working.
7. The directories often have errors or include information on providers who do not actually offer services listed. This suggests a need for a comprehensive centralized directory which is regularly updated (perhaps available online with print options).

MAJOR THEMES

Several themes emerged from the summation of the multi-study capacity building project. This section of the report discusses insights that will lead to further recommendations and conclusions. Each study provided a different perspective based on the skills, knowledge, experience and expertise of the group answering questions related to meeting the substance abuse and mental health needs of individuals infected with HIV/AIDS in the state of Texas. Noting the similarities and contradictions can provide a deeper level of understanding that can lead to more successful program planning and better outcomes.

The following themes emerged in all the components of the project and merit inclusion in this discussion section.

Stigma

HIV/AIDS related stigma is not a new concept and much has been written about this. When coupled with stigma related to mental illness, addiction, and other discriminatory practices (i.e. racism, ageism, sexism), it becomes a formidable barrier to obtaining needed services. The experience of being or feeling stigmatized is quite potent with the target population and ranges from issues pertaining to organizations, provider groups, to individuals with whom clients come in contact.

The AA report indicates stigma and client motivation were key barriers to MH utilization. This survey also noted that decreasing stigma was one way to change the barriers to MH care. Members of the MH group also pointed out that stigma prevents some clients with HIV/AIDS from accessing a provider for MH services if the provider is identified as part of a "gay organization," that is, "only gay people go to that agency." Stigma was also noted by the SA group and in the CM survey as a factor in clients not utilizing SA services utilization.

While clients may have expressed stigma differently, they did describe experiences such as not feeling comfortable talking about their HIV status or sexual orientation in treatment groups. Clients indicated they did not want to access services if they felt judged or discriminated against.

Assessment Tools and Assessment Skills

The evaluation results indicated the importance of programs and case managers having standardized assessment tools for both mental health and substance abuse. This was a recurrent theme when suggestions for removing

barriers were offered by this group. Upon examination of the information relayed by the key informant and administrative agent groups, it appeared that there was a strong belief that the lack of MH/SA service utilization (and consequently, the return of unspent funds) was closely related to the case management staff's ability to assess the need for these services and/or provide appropriate follow-up.

This group also stressed the importance of assessment skills and training for case managers so that they could make appropriate SA and MH referrals. AA's and key informants stressed both these issues in their survey and focus group; however, the case manager survey offered another perspective.

Case Managers noted that they have standardized MH and SA assessment tools and that they appreciate having access to them. The majority of the CMs were comfortable with both their MH and SA assessment tools. CMs saw themselves as skilled and knowledgeable (medium to high—90%) in assessing and referring clients with HIV/AIDS for MH and SA. The client interviews information did not render any information related to CM, MH, and SA assessment skills.

The provider focus groups did not yield any substantial information related to the lack of standardized assessment tools for MH/SA as a barrier to clients accessing services and following up on referrals or as a reason why Ryan White MHSA funds were returned to the state unspent. They did suggest that DSHS (Substance Abuse and Mental Illness Symptoms Screener) SAMISS tool should be reviewed and reevaluated and that case managers using the standardized screening/assessment tool sometimes did not know how to interpret the information provided by clients.

Training

One of the most important training issues surfaced in the MH and SA provider focus groups. Providers, particularly the MH providers, noted the importance of training HIV/AIDS medical providers in the appropriate use of psychotropic medications. They discussed a great deal of reluctance amongst HIV/AIDS physicians in prescribing medications for patients experiencing MH symptoms other than depression. Part of this reluctance was directly related to the need for these physicians to obtain more training from psychiatrists, since it was also clearly noted that there was a scarcity of psychiatrists in general throughout the state. It is important to note that this scarcity is greater when we examine the rural areas of the state and the fact that there are a limited number of psychiatrists willing to work with this particular target population with its lack of funding and the complexity of needs. Increasing primary care providers' comfort and knowledge related to the prescribing of these MH medications is essential.

The outcome of this type of training for HIV/AIDS primary care providers may be seen through further analysis of the client interviews data. It was noted that a number of clients who obtained MH services received their psychotropic medication prescriptions from their HIV/AIDS primary care providers. This appeared to be a factor in not only increasing the clients' sense of MH wellness (getting the help they needed), but also, a possible factor in them following up with their MH counseling referrals.

It is also important to note that a high number of clients obtaining services reported being "told to go to counseling and treatment" directly by their primary care physician. A referral from the primary care physician seemed to be valued above those from other sources. If this is true, primary care providers will also need continued training in assessing the MH/SA needs of their patients in order to be effective referral sources and advocates.

There is a need for more training related to both MH and SA dual-diagnosis. Issues related to the co-morbidity of MH and SA in clients with HIV/AIDS is well documented in the literature, and as noted in the study, accounts for many of the challenges and barriers clients and providers experience in obtaining needed services. Assessing both the MH and SA issues of clients creates challenges related to referrals, follow-up and obtaining the most appropriate services for this population.

While the majority of case managers surveyed indicated confidence and comfort in their level of cultural competence in the area of Gay, Lesbian, Bisexual and Transgender (GLBT) issues, additional training related to these specific groups and sexual orientation was cited by others surveyed, as an important area for further training. Aside from increasing understanding and knowledge helpful in the development of various levels of program and service planning, a byproduct of this training may be an increase in rapport and trust between clients and providers, which was cited as an important tool (by both clients and case managers) for retaining clients in treatment.

In addition to specific training related to dual-diagnosis, and GLBT issues, another reoccurring training theme centered on trauma and post-traumatic stress disorder (PTSD). The research and literature on PTSD continue to develop and deepen the understanding about the broad implications of the experiences of trauma on the target populations served through Ryan White funded programs. Training in this area will also make for better assessments and referrals for MHSA concerns.

Client Issues and Readiness

The area of client motivation and readiness had a great deal of variation throughout the different survey components and bares closer review. The sense of hopelessness noted earlier as a factor in PLWHA dealing with challenges of HIV, MH/SA concerns, and the many structural barriers that exist, all influence client motivation and readiness.

The MH focus group providers noted transportation, financial support and client denial and unwillingness as the top three barriers of PLWHA for obtaining MH assistance. They also indicated that transportation and financial resources would improve the case managers' ability to get PLWHA the MH help they needed. Members of the SA focus groups indicated that client willingness to get assistance, financial resources (specifically for housing), and family/social support systems were the top 3 barriers to PLWHA obtaining assistance.

The key informant interviews and administrative agents indicated that the primary barriers to the treatment of mental health problems were a weak provider

network, as well as client challenges such as motivation. In relation to SA barriers, they noted that the top barrier to the success of SA services was client related challenges, like readiness, ability to follow-though, and unstable lifestyles.

Case managers stated that referral, follow up and client retention in MH services was related closely to the following factors: case manager involvement (encouragement, follow-up), good rapport with staff and good relationships with MH providers and counselors.

It is important to note transportation was a key barrier to MHSA treatment in all groups except the client sample. Clients' focused primarily on their relationship with the MH/SA providers, case managers and clinic staff as being fundamental to obtaining MHSA services. While the researchers note that transportation is important to service access, clients rarely spoke about transportation problems as a barrier to retention.

Clients indicated that what motivated them to continue seeking services were: (a) rapport with provider (b) effective therapeutic techniques and models, and (c) internal drive to get well. Specifically when discussing the relationship with their providers, clients mentioned the importance of trust, being listened to, and having someone who, "acts like they care." This relationship factor was noted as more important than their MHSA providers' understanding of HIV or GLBT issues. When discussing internal factors, clients said they wanted to understand themselves better and develop coping strategies to function better. They also noted that what prevented them from following –up on services were problems with the therapeutic relationship.

There were several factors that played a role in clients' decisions to maintain SA treatment services. First, there was an emphasis on their personal decision to change and readiness to receive services. There was also the important aspect of separating the substance abuser from the drug addiction/using environment in order to get stabilized. Similarly, clients were less likely to want to continue SA services if they felt their providers were overly pushy or confrontational. Clients indicated that they did not want to be forced or shamed into treatment or told what to do, where to go, or when. At the same time, the majority of clients who had received SA treatment were connected to programs that required their mandatory participation.

Integrated Care

Factors related to integrated care include integrated MHSA models of treatment, the utilization of multi-disciplinary teams, and service provision within the context of medical care. The information received from client interviews noted that a number of clients who reported getting SA treatment services and significantly changing their drug and addiction behaviors also indicated that they still used drugs/alcohol, but to a lesser degree or they used different substances. For example, a few clients indicated they no longer used crack/cocaine but still smoked marijuana. It appears that a number of clients moved from very harmful risk behaviors to less risky behavior as part of the process of dealing with addiction. This information has also been noted in the literature and through reports from case managers and other providers. It is in fact an argument for developing multiple

services philosophies so that harm reduction and risk reduction as it relates to health, SA and MH is incorporated in the overall care and successful treatment models for working with PLWHA.

Information from clients also indicated a desire for interactive sessions with MH providers. Participants valued therapeutic techniques and styles that allowed for conversation and feedback. They discussed the importance of empowerment, having clear goals, and "active counselor input"—in other words, a counselor who offers advice and talks through options without being, "pushy."

Clients who said their providers met their needs also commented on provider availability and feeling like there was an "open door." Clients noted that accessing MH services was easier when they received services at 'one-stop-shopping' agencies—HIV/AIDS Ryan White medical providers that offered MH psychiatric and counseling services on-site and in conjunction with medical care as opposed to referring clients offsite. There was a similar suggestion by one of the SA focus group providers who indicated a need for making SA treatment services a part of routine HIV medical care: "after all SA is a medical issue."

A number of clients noted a desire to be part of a support group or a history of support group involvement at a local ASO or at their medical provider's clinic, and many of these clients had moved from working with a support group leader to moving on to seeing a counselor/ therapist at their clinic to becoming involved in an HIV/SA focused group where they had first attended an HIV support group. These were often the same clients who reported that it was their primary care physician who advised them to get MH or SA services and their case manager who assisted

them. It appears that having direct referrals from physicians (along with case manager follow-up), services co-located with access to a multi-disciplinary team of medical providers and various credentialed or non-credentialed providers, may establish a more conducive environment for the provision of MHSA services and clients' retention in these types of services.

Resources and Networking

The need for more SA treatment options and mental health services throughout the state, and the emphasis placed on the value of networking by all those surveyed, clearly points to the tremendous impact this has on clients obtaining SA and MH services. This lack of resources often results in long waiting periods to get services, challenging eligibility applications, lost opportunities due to distance and lag time, lack of translation and interpretation services, no continuum of care, and transportation and housing needs going unmet. Time is also a resource and is itself a constraint to effective networking and follow-up.

The key informant interviews clearly pointed to a key barrier of substance abuse utilization being the lack of coordination between providers and the lack of funding for residential treatment. The lack of resources and treatment options also includes the need for more harm reduction/risk reduction programming, opiod replacement therapy, an overloaded LMHA system, lack of providers in rural areas, and not enough psycho-educational support groups. They also noted that provider networking and the referral relationships among the providers made referring for SA problems easier. As the resource directory study indicated, there is a lack of

providers throughout the state, and also a need for more updated and accurate lists of available providers for clients.

SA focus group participants repeatedly discussed the need for the development of a full continuum of treatment services (detoxification services through after-care) at the local level, which would allow for more continuity in the care of the disease of SA. This would also reduce the number of people who have fallen out of care due to services not being accessible.

The MH focus group providers noted that resources were limited and that there are not enough providers who are willing to work with uninsured clients or those with only Medicare or Medicaid funding. Some programs, such as the statewide DSHS Local Mental Health Authorities (LMHAs) and the DSHS sponsored North Star program (in north Texas), are restricted to serving clients within a narrow spectrum of mental health diagnoses, and they do not provide counseling services. This group also noted that a major resource problem for clients getting the MH services they need is the fact that there are not enough resources that can help pay for psychotropic medications that are prescribed for them once they seek help.

The case manager survey noted that the top three factors to improve their ability to get clients with HIV/AIDS help with substance abuse were the need for substance abuse facilities/programs, more funding for services and more resources for clients (i.e., housing, transportation). Overall, these factors reflect that there is a pressing need for more services and resources that can serve PLWHA with SA issues.

SYSTEM CONSTRAINTS

In order to fully understand the ability for each member of the MHSA system to provide effective services for people living with HIV/AIDS, one cannot overlook the system constraints which impact the ability for system-wide change. Below are several constraints that were themes identified throughout the overall study. Components of each can be found throughout the sub-studies.

1. Limited continuum of care:
    a. Lack of DSHS MH/SA treatment programs and options. DSHS MH/SA Local Mental Health Authority (LMHA's) community mental health services are overloaded and deal primarily with the severe and persistently mentally ill (SPMI)
    b. Lack of funding to more fully develop an MH/SA system of care throughout the state.
2. Lack of trained credentialed MH providers, including psychiatrists, throughout the state.
3. Ryan White requirements that require clients to be registered case managed clients before being seen by an MH or SA services provider.
4. Lack of funding for psychotropic medications, prescriptions related to MH conditions which cannot be filled due to lack of healthcare funding and the financial constraints of clients and programs.
5. Budgeting systems related to Ryan White funding which require budget decisions made in advance and prevent adjustments based on changing client needs. Indications are that budgeting systems need to be

more "nimble" so that changes can be made easily during the budget year, such as increasing the projection for monies needed for MH services.

RECOMMENDATIONS

The following section outlines overarching recommendations that were found through this evaluation study. In order to further offer guidance for improving the MH/SA system of care, recommendations are then broken into several key sections reflecting both general system recommendations and those which apply to specific structures within the system.

Key System Recommendations

1. It is valuable to adopt integrated approaches that do not separate SA and MH services.
2. Develop multiple entry points to services. MH/SA and HIV services should be available when clients are ready to participate.
3. Develop an ongoing dynamic mechanism, which is both formal and informal, for knowing what is important to clients and what their experiences with providers and services are.
4. Involve clients in planning services and deciphering services in a way that is easy to understand.
5. Increase the quality and capacity of key components of the Ryan White program to support access to MHSA services. Specifically, additional

supports for case management services and training of medical providers. Training on assessment and follow-up as well as a clearly detailed plan for these processes may alleviate confusion across components of the system.

Specific Recommendations

Department of State Health Service Recommendations

1. Integrate services when possible and examine ways to require Ryan White providers to provide primary care medical services that include medical and support case manager, nurse practitioners, and counselors who can do MHSA treatment.
2. Continue to utilize and require a statewide culturally and linguistically appropriate standardized MHSA assessment tool, at more frequently required intervals, for all DSHS Ryan White funded providers and provide ongoing training on the use of this tool.
3. Make significant achievements to increase the number of SA treatment services in already existing DSHS funded SA programs. This may also involve working with AAs on the feasibility of purchasing private MH and SA beds, and services through for profit private mental health organizations.
4. Continue to work with the DSHS MH/SA division to advocate for improvements in the LMHA systems throughout the state, to include joint efforts on legislative education.
5. Develop recommendations and requirements that allow for increased standardization of necessary documentation for eligibility to services throughout the state.

6. Work to initiate strategies that will assist PLWHA to obtain financial support for psychotropic medications. Examine alternatives such as expanding the ADAP program, special agreements with drug manufacturers, setting aside funds that can be justified as tools to medical adherence.
7. Expand supported housing funds and mechanisms related to Ryan White and HOPWA funding to improve housing options and enhance the success of clients.
8. Develop specialized training for Ryan White HIV health care providers (including psychiatrists) and increase their knowledge about MH medications and diagnosis.
9. Develop partnerships with professional organizations and training organizations (AIDS Education and Training Centers, Addiction Technology and Transfer Centers, The Texas HIV Connection, etc.) to develop a statewide recruitment strategy targeted at MH and SA professionals in order to increase the number of providers who can work with PLWHA. Consider incentivizing methods which may increase the number of MHSA providers who are willing, skilled and trained to work with the target population.
10. Consider the efficacy of harm reduction models that improve health outcomes and lower transmission risks, while also minimizing shame.
11. Provide specific recommendations to the AAs and providers on the use of MH treatment modalities that are most successful with the target population,
12. Study and develop recommendations related to the use of alternative MHSA providers who can support and improve client outcomes where there is a

scarcity of MHSA credentialed providers and services. This may include recovery coaches, the use of certified Promotoras/Community Health Workers, support group leaders, psychiatric nurses, student interns, etc.

13. In conjunction with key stake holders, specifically examine "lag-time" issues which deter clients from accessing SA and MH care in order to develop new solutions at the state and regional levels.
14. Review Federal Office of Minority Health Culturally and Linguistically Competent (CLAS) standards with contractors, which speak to mandated interpreter services for Limited English Speaking (LES) clients and consider establishing these requirements.
15. Support increased training around dual diagnosis issues.
16. Consider increasing budget flexibility for programs successfully utilizing their Ryan White MH/SA funding within the context of the Federal rules.
17. Encourage stronger partnerships and collaborations between the LMHA and the AA's.
18. Provide more networking opportunities and combined training opportunities for direct services providers funded throughout the state, for rural areas consider the development of an on-line curriculum.

Administrative Agent and Planning Council Recommendations –

1. Continue to develop and build more "one stop shopping" services/program which diminish barriers and allow clients to obtain some mental health and

substance abuse treatment services where they get their medical care and include psycho-educational groups and SA groups.

2. Develop trainings at the local level around SA addiction, GLBT issues, SA assessment tool, and working with clients with dual diagnosis. Include invitations to local non Ryan White providers to attend.
3. Create a system of announcing trainings that increases accessibility to trainings for all providers in both rural and urban areas.
4. Specifically examine regional "lag-time" issues which deter clients from accessing MH and SA care in order to develop new solutions.
5. Increase emphasis on supervision of case managers within the context of each organization's/contractor's structure in order to improve quality and retention.
6. Create multiple contracts with MH providers so that PLWHA have an opportunity to utilize a provider of their choosing in their community, or that are located at agencies that can provide easier access to interpreters.
7. Offer appropriate incentives to MHSA providers successfully serving the target population.
8. Encourage and provide leadership for the development of structured high level productive networking between all regional SA and LMHA providers and Ryan White providers.
9. Strengthen the central mission and develop stronger networking linkages and better informed collaborations between contractors so that there is less agency competitiveness.

10. Continue to support ongoing resources for client transportation and child care for clients receiving SA services or moving towards these services.
11. Simplify eligibility for case management services, and create multiple entry point into services for PLWHA. This may require better reporting mechanisms, but may lessen waiting time and "red tape" for clients, thus increasing retention and reducing barriers to services.
12. Develop more flexible budgeting and funding mechanisms so that MH providers can increase funding requests mid year or alter goals based on client trends.
13. Work with local case management agencies to develop policies and procedures for closing cases in the CM system, so that CMs can focus more on high acuity and high need clients with MH and SA issues.

HIV Specific Agencies –

1. Utilize thoughtful and purposeful strategies that welcome clients, increase nonjudgmental behavior, and help in creating an accepting atmosphere, which may decrease feelings related to stigma.
2. Continue to develop mechanisms to share expertise, experience and knowledge related to SA and working with multiply diagnosed clients with referring partners.

3. Use clinical case managers to provide basic MH support related to strengthening coping strategies and problem solving skills of PLWHA waiting to obtain MHSA services.
4. Advocate with DSHS and AAs to increase marketing to MHSA providers in different communities and build the provider base.
5. Develop strategies for closing CM clients and utilizing an effective acuity tool so that caseloads are smaller and more focused.
6. Continue to partner with other disciplines and providers to support effective referrals and follow-up.
7. Train and encourage primary medical providers to effectively assess and refer clients to MHSA services.
8. Create more opportunities for clients to become involved in groups. This can be effective for serving clients' needs and can utilize skilled paraprofessionals.
9. Develop flexible hours so that clients and families with transportation or work schedule limitations can fully participate in obtaining needed services.

MH/SA and Case Management Service Providers

1. Utilize counseling models and techniques that provide clients with information, concrete goals, and tangible skills and coping strategies. Therapeutic models which are relationship-based and interactive may prove most successful with the target populations.

2. Educate clients on the roles of various professional roles so they understand what to expect from different types of providers (i.e. case managers, counselors, therapists, and psychiatrists).
3. Create more ongoing psycho-educational and support group services at primary care clinics and AIDS services organizations (ASO's) and encourage clients to become involved. These types of services can encourage later entry into more formal SAMH treatment services and effectively mitigate concerns with waitlists.
4. Research and develop a formalized referral system to benefit the target population.
5. Ensure that resources in your area are regularly updated and that clients have as much choice as possible in determining which provider will most effectively meet their needs.
6. Continue to build MHSA assessment skills and cultural and linguistic competency.
7. Actively participate in trainings, consultations and supervision opportunities provided by state, city and local providers.
8. Consider the use of harm reduction behavioral change strategies which support client behavior change.
9. Actively advocate for the services needed by PLWHAs.

AREAS OF FURTHER RESEARCH

Although this study offers a fairly comprehensive view of the HIV system of care

which surrounds those seeking MH and SA services, there are several areas in which the research team believes further investigation is warranted. These areas include:

1. Further examination of rural areas within the state. Although this study included (to the extent that was feasible) a sampling of rural providers and clients, this resource intensive high need area would benefit from further inquiry.
2. Case management staff are at the front-line for most clients seeking any services, be it MH, SA or other Ryan White services. Further research focusing on the case manager population may result in new findings appropriate for increasing this group's capacity.
3. Integrating groups from the various study components may provide more creative ideas and methods for working on the primary questions and needs. This study focused on each component of the system individually.
4. Further examination of the role of the case manager supervisor and organizational structures at the HIV organization level may yield better outcomes related to MHSA assessments, referrals, follow-ups, and the overall quality of services.
5. Further study with the specific regions that consistently spend MHSA funds, in order to identify best practices in funds monitoring.
6. Examine the Texas ADAP program and other similar large statewide programs that serve the target population successfully and determine if there are additional successes that can be built upon in developing a better MHSA referral and care system for PLWHA.

CONCLUSION

There is a significant and growing need for mental health and substance abuse services among people living with HIV and AIDS in Texas. This study was conducted to identify success factors and barriers that influence the ability of clients to seek, begin and complete needed treatment. In many ways, the state of Texas has created a highly effective system to support a growing number of individuals in need. The above recommendations reflect the input of DSHS, Administrative Agents, Case Managers and clients who work within this system on a daily basis.