



Mental Illness 101

Common Risk Factors

Providing Care

Treatment Resources

IMPACT OF MENTAL ILLNESS ON PEOPLE LIVING WITH HIV

“I was 17 years old and newly married when I found out that my husband had HIV and had infected me. A year later he was dead,” says “Luisa.” With the help of her social worker and comprehensive care team, Luisa has learned to manage her disease, as well as the depression and anxiety she feels. Because of the high-quality and culturally competent services she receives, Luisa is confident about her health and is retained in care. Nevertheless, it’s a continuous journey. Now 24, Luisa still feels isolated and lives in fear of her diagnosis being widely known. Other than her mother and new husband, nobody including her twin sister with whom she lives, knows about her health status. “My biggest concern has always been how to care for and protect my children,” says Luisa. Luisa’s concerns helped initiate a social support group at her clinic to help her and others know they’re not alone.

MENTAL ILLNESS AND THE RYAN WHITE HIV/AIDS PROGRAM

From the beginning, a primary focus of the Ryan White HIV/AIDS Program has been building a comprehensive approach to the health care needs of people living with HIV (PLWH). This is because HIV is often only one of many health problems suffered by the historically underserved populations who rely on this program. Many of these patients not only have nowhere else to turn for HIV care, they also have had difficulty accessing any kind of care. Unless all of their health care needs are addressed, the long term potential for successful treatment of HIV is severely compromised.

DID YOU KNOW?

- Incorporating mental health screening and care into HIV interventions can reduce the opportunity costs of care and improve treatment outcomes.¹
- The Affordable Care Act has designated depression screening for adults and behavioral assessments for children as preventive services available at no cost to patients.²



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➔ DIRECTOR'S NOTES

People living with HIV (PLWH) have higher rates of mental illness than the general public. Too often, mental health conditions go undiagnosed and untreated, which can create barriers to care and cause interruptions in HIV treatment.

While screening tools can go far in identifying mental health conditions and suicidality, social stigmas associated with seeking mental health treatment persist. Addressing such conditions, however, is critical to overall well-being and quality of life for PLWH.

Patients may not have support systems or feel comfortable disclosing anxiety disorders, depression, or other conditions to their network of family and friends. As such, support groups and creating safe, friendly spaces can go far in making patients feel at ease. So too can normalizing the screening process.

Some patients may be high-functioning but triggers of mental distress, such as anniversaries of a trauma, anniversary of one's HIV diagnosis, or recognition of new symptoms or progression of disease can spike a need for care services.

The Ryan White HIV/AIDS Program has been — and will continue to be — dedicated to addressing comprehensive care needs. That is why we are dedicating this edition of *HRSA CAREAction* to mental health. It is also why we released a recent [newsletter](#) on HIV-associated neurocognitive disorders, covered neuropsychiatric disorders in our recent [Guide for HIV/AIDS Clinical Care Guide](#), and included performance measures on mental health issues as part of preventive care and treatment. We understand that treating HIV means treating the entire person and that moving patients along the HIV Care Continuum requires that we help remove obstacles to care and treatment and support them along the way.

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Cover: University of North Carolina at Chapel Hill Infectious Disease Clinic Guide to Healing program staff member Ethel (left) provides support to clinic patient Tammy (right). Photograph taken for and permission granted to the Health Resources and Services Administration, HIV/AIDS Bureau.

Copies are available to be downloaded at www.hab.hrsa.gov.

This publication lists non-federal resources to provide additional information to consumers. The views and content in those resources have not been formally approved by the U.S. Department of Health and Human Services (HHS). Listing of the resources is not an endorsement by HHS or its components.

Therefore, throughout the 24 years and counting of the Ryan White HIV/AIDS Program, grantees and providers have worked to address *all* of their patients' health care needs, whether that is accomplished by providing care directly, creating linkage and referral relationships with specialists and other community-based service organizations, or helping clients enroll in insurance and benefits programs for which they are eligible, such as those made available through the Affordable Care Act (ACA). The result is that the Ryan White HIV/AIDS Program is better positioned than ever before to help PLWH access care for any comorbidity that they may encounter.

Mental Illness 101

Perhaps no comorbidity is more frequent or challenging than mental illness. In general, mental disorders — encompassing a broad range of conditions that include mood, anxiety, and other disorders — are extremely common in the United States. It is estimated that 1 in 4 adult Americans suffer from a diagnosable mental illness during a given year.^{3,4}

A very high proportion of mental illnesses go undiagnosed or unaddressed; some estimates put the percentage as high as 50%.⁵ Rates of serious psychological distress are much higher among people living in poverty than in the general population.⁶ In addition, African-Americans are more likely to be living with serious psychological distress than non-Hispanic whites and have poorer access to mental health care services.^{7,8} The similarities between mental illness and HIV do not stop there. Mental illness carries enormous stigma and remains one of the most challenging barriers to care.

Having a mental disorder is also associated with increased risk for socio-economic and health problems — including HIV. "Mental illness can become an HIV risk factor for people who are emotionally [unstable] and may not be making good decisions for themselves or are in survival mode and just trying to do what they can to get by," explains Jill Egizio, a licensed clinical social worker at the University of Illinois, College of Medicine's Heart of Illinois HIV/AIDS Center in Peoria, IL.

➔ **TABLE 1. COMMON RISK FACTORS FOR MENTAL ILLNESS⁹**

Individual Attributes	<ul style="list-style-type: none"> • Low self-esteem • Cognitive/emotional immaturity • Difficulties in communicating • Medical illness/substance abuse
Social Circumstances	<ul style="list-style-type: none"> • Loneliness, bereavement • Neglect, family conflict • Exposure to violence/abuse • Low income and poverty • Difficulties or failure at school • Work stress, unemployment
Environmental Factors	<ul style="list-style-type: none"> • Poor access to basic services • Injustice and discrimination • Social and gender inequalities • Exposure to war or disaster

MENTAL ILLNESS AMONG PLWH

The same mental disorders that occur in the general population occur among PLWH, but at almost twice the rate, affecting nearly one in every two HIV-positive individuals.¹⁰ This is an astounding burden of disease among individuals already at disproportionate risk for a host of health and socioeconomic problems. For example:

- General anxiety disorders are estimated to occur in approximately 16% of PLWH, compared with 2.1% of the general population.¹¹
- An estimated 20% to 40% of PLWH will suffer from depression during their lifetime, more than twice the rate of the general population.¹²
- PLWH suffer from HIV-Associated Dementia (HAD) at higher rates than the general population.¹³ HIV is a neurotropic virus that directly invades the brain shortly after infection. Both HIV and medications to treat it can affect brain function and cause changes in mood, behavior, and cognitive ability.

The HIV diagnosis itself may cause significant emotional trauma and distress. For some PLWH, even suicide may be considered due to feelings of helplessness, fear of pain, disability, and stigma.¹⁴ “There’s no way that you can get a diagnosis like HIV and not need ongoing mental health

support,” says one young adult patient at a Ryan White HIV/AIDS Program clinic in California. “It’s an absolutely devastating diagnosis, and every day you have to take a pill is a reminder of that.”

In addition to an HIV diagnosis, there are a number of factors that, when present, can further increase risk for mental illness in PLWH. In many cases — substance abuse and stigma are but two examples — these risk factors also pose significant barriers to accessing HIV primary care.

Trauma and Abuse

American women with HIV are twice as likely to have been the victim of intimate partner violence and five times more likely to have post-traumatic stress disorder (PTSD) compared to national samples of American women.^{15,16} In addition, approximately 2 out of 5 HIV-positive women reported childhood sexual abuse (39%) and childhood physical abuse (42%), rates twice as high as the national average.¹⁷

Similar patterns are evident among men and at-risk youth. For example, American men with HIV are also five times as likely to have experienced a sexual assault compared to national averages for men overall.^{18,19} In addition, men who have sex with men (MSM) and at-risk

➔ **TABLE 2. MENTAL DISORDERS AMONG PLWH**

DISORDER	DEFINITION
<i>Mood Disorders</i> ²⁰	
Major depression	Characterized by a combination of symptoms that interfere with a person’s ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Some people may experience only a single episode within their lifetime, but more often a person may have multiple episodes. Low mood may be associated with suicidal thinking, plans, or action.
Dysthymia	Characterized by long-term (two years or longer) symptoms that may not be severe enough to disable a person but can prevent normal functioning or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.
Bipolar disorder	Also called manic-depressive illness, characterized by cycling mood changes — from extreme highs (i.e., mania) to extreme lows (i.e., depression with or without suicidality) — often with periods of normal mood in between.
<i>Anxiety Disorders</i> ²¹	
Generalized anxiety disorder	Characterized by chronic anxiety, exaggerated worry, and tension accompanied by a variety of physical symptoms. Symptoms may get better or worse at different times, and often are worse during times of stress.
Panic disorder	Characterized by sudden and repeated attacks of fear that last for several minutes or longer. A person may also have a strong physical reaction during a panic attack, including a pounding or racing heart, sweating, breathing problems, weakness or dizziness, feeling hot or a cold chill, tingly or numb hands, chest pain, or stomach pain.
Post-traumatic stress disorder (PTSD)	PTSD develops after a terrifying ordeal that involved physical harm or the threat of physical harm. PTSD may cause a variety of symptoms that involve re-experiencing the original trauma (in the form of flashbacks, bad dreams, and frightening thoughts), avoidance symptoms, and hyperarousal symptoms. Sometimes people have very serious symptoms that go away after a few weeks. This is called acute stress disorder, or ASD. When symptoms last more than few weeks and become an ongoing problem, they might be PTSD.
<i>Other</i> ²²⁻²⁷	
Adjustment disorders	A group of symptoms, such as stress, feeling sad or hopeless, and physical symptoms that can occur after a stressful life event (including diagnosis of illness); symptoms are often severe enough to affect work or social life.
HIV-associated neurocognitive disorders (HAND)	Describes a spectrum ranging from mild, asymptomatic neurologic impairment to severe, HIV-associated dementia (HAD). Symptoms of HAND include behavioral changes; difficulties with decision-making, problem solving, concentration, learning, language, and memory; loss of coordination; weakness; and tremors.
Insomnia	Most often, insomnia is defined by the presence of an individual’s report of difficulty with sleep. Thus, the presence of a long sleep latency, frequent nocturnal awakenings, or prolonged periods of wakefulness during the sleep period or even frequent transient arousals are taken as evidence of insomnia.
Substance use disorder	Abuse or physical or psychological dependence on any substance that is ingested to produce euphoria (“high”), alter one’s senses, or otherwise affect functioning.

youth who have experienced childhood abuse were more likely to engage in risky sexual behavior and be HIV-positive later in life.^{28,29}

Substance Abuse

Substance abuse is associated with increased risk for HIV and of a mental disorder. In 2012, more than 8.4 million Americans reported having co-occurring mental health and substance use disorders.³⁰ Mental disorders can sometimes lead to alcohol or drug use, as some people with a mental health condition may misuse these substances as a form of self-medication.³¹ “With our patients with mental disorders, we see everything from benzodiazepine addiction, to alcoholism and misuse of opiates and stimulants,” says Dr. Lynn Taylor, assistant professor of medicine, Division of Infectious Diseases at Brown University, and attending physician at the Ryan White HIV/AIDS Program-funded Miriam Hospital in Providence, RI.

Gender Stereotypes

Even gender can play a role in whether PLWH seek mental health treatment. Studies have shown that men may be less likely to seek treatment for depression, due to a perception that doing so would go against gender norm of “toughness” and autonomy.³² Some public health professionals, however, have been successful in reframing this gender norm to portray seeking help as an act of toughness and taking control of one’s life.³³

Stigma

Stigma causes suffering and keeps people from accessing care and services, and from staying in care over time. “It’s incredible how drastically there have been scientific advances [in treating PLWH], but we haven’t come as far in terms of stigma,” observes Dr. Taylor. “It’s [still] just so frequent to hear patients come into the hospital saying that no one can know what’s going on, no family or friends can know that they’re in the hospital ... there’s still an everyday struggle, an everyday burden.”

Stigma is an all too familiar foe of PLWH. In addition to HIV stigma, many PLWH have encountered stigma related to sexual orientation, race, gender, and other issues. They may not seek care for a mental disorder out of concern about encountering yet a new form of stigma.

Stigma is often discussed in the context of public stigma — stigma directed by society at an individual or

population. Stigma can also originate with close family and friends, which can be even more damaging than broader societal stigma because it can destroy the support network that would otherwise be a valuable aid in the sufferer’s recovery. Self-stigma can also be extraordinarily damaging.³⁴ People who experience internalized prejudice feel ashamed of themselves.

Lack of Support from Family and Friends

The absence of a close support network can impair mental health and general well-being. Stigma is not the only factor that can make family and friends unable or unwilling to care for their HIV-positive loved one; PLWH and their families may be alienated from one another for reasons unrelated to HIV. Whatever the reason, the lack of a close community can be an indicator of increased risk for mental disorders.³⁵

Financial Instability

Poverty undeniably influences both physical and mental health. From 2005 to 2010, the prevalence of depression among adults 45 to 64 years of age was almost five times as high for those below the poverty level (24%) compared to those at 400% or more of the Federal Poverty Level (5%).³⁶ In 2012, the percentage of adults with any mental illness in the past year was higher among unemployed adults (25.5%) than among those who were employed either part time (19.8%) or full time (15.2%).³⁷

Relatedly, housing instability has been a chronic problem in the fight against HIV. Dr. Taylor adds: “We say housing is health.” People who do not have a permanent place to live or who are homeless have higher rates of chronic diseases — including mental health conditions — than the general population does.³⁸

Entering/Leaving Criminal Justice System

Each year, an estimated 1 in 7 PLWH pass through a correctional facility.³⁹ The prevalence of mental disorders that complicate care and contribute to social marginalization are high among people in corrections. The U.S. Department of Justice estimates that roughly 50% of inmates in prisons and jails have a mental disorder.⁴⁰ In addition, estimates of use of illicit substances among incarcerated individuals prior to their entering corrections range from 50 to 70%.⁴¹

LINKAGES TO MENTAL HEALTH SERVICES IN JAIL SETTINGS

The Special Projects of National Significance (SPNS) Program's Enhancing Linkages to HIV Primary Care and Services in Jail Settings (EnhanceLink) Initiative studied innovative methods for linking PLWH who will soon be or have been recently released from jail settings into HIV care and services. While many EnhanceLink study participants had histories of depression, suicidal ideation and attempts, and other kinds of emotional distress, only a few participants had a prior formal mental health diagnosis. This is despite the fact that 54% presented with an Addiction Severity Index (ASI) mental health score of .22 or greater, indicative of severe psychiatric illness.⁴² To link patients to much-needed mental health services upon exiting the jail setting, many EnhanceLink grantees provided active referrals to a community partner with counseling services and emphasized the benefits of joining support groups.

Learn more about how to implement the findings and best practices from the EnhanceLink Initiative by visiting the Integrating HIV Innovative Practices (IHIP) Jails Linkages training toolkit on the Health Resources and Services Administration's (HRSA's) TARGET Center: <https://careacttarget.org/ihip/jails>.

IMPROVING MENTAL HEALTH CARE FOR PLWH

There are indications that the need for mental health care is expanding among PLWH, and some experts are attributing the increase at least in part to the fact that PLWHs are living much longer lives than they once were. Many steps have been taken within the Health Resources and Services Administration (HRSA) and within the HIV/AIDS Bureau (HAB) to improve access to mental health services for PLWH.

Treatment Resources

Section 8 of HAB's 2014 Guide for *HIV/AIDS Clinical Care* (www.hab.hrsa.gov/deliverhivaidscares/2014guide.pdf) defines and provides clinical information about several

mental disorders most common among PLWH. These disorders include mood and anxiety disorders, as well as insomnia, suicide risk, and HIV-associated neurocognitive disorders. The guide notes that "HIV is a neurotropic virus that directly invades the brain shortly after infection" and may cause cognitive, behavioral, and motor difficulties.⁴³ Read more about neurocognitive disorders in the July 2014 issue of *HRSA CAREAction* at hab.hrsa.gov/deliverhivaidscares/hrsacareactionnewsletter.pdf.

In addition, comprehensive Health and Human Services (HHS) guidelines on the use of antiretroviral agents in HIV-1-infected adults and adolescents are available at <http://aidsinfo.nih.gov/guidelines>.

Mental Health Screening and Diagnosis

Incorporating mental health screening and care into HIV interventions can improve overall treatment outcomes.⁴⁴ At the College of Medicine's Heart of Illinois HIV/AIDS Center, the nursing assessment includes mental health and substance abuse screening at each patient's first visit. "Our gold standard would be that every patient meets with a mental health counselor to make that connection, to even provide a kind of overview of the services and do some myth-busting about counseling," says Dr. Egizio. "There are a lot of people that shy away from that because they don't want to be labeled crazy or have people think that they can't handle their problems. Sometimes the face-to-face meeting can help soften that a bit."

At the Inova Juniper Program (IJP), a full-service HIV care provider with multiple sites in Northern Virginia, all new patients meet with a clinical social worker for a comprehensive psychosocial assessment that includes a dementia/depression screen. "We do that to see where they are at and what their needs are. Everyone walking in the door, we offer services to," says Cathy Bottrell, one of IJP's clinical managers. Each site has a mental health therapist who is dually trained to provide substance abuse counseling.

"Everyone gets that first initial part of the service, and we do have a lot of patients who receive mental health services on an ongoing basis," explains Bottrell. "Many times, it might just be if they are newly diagnosed, just to help them get through that process or even just talking with them in regards to adherence. We deal with a lot of anxiety, a lot of adjustment disorder, some patients have panic attacks. I think we really do see that HIV impacts patients' mental health."

IJP's comprehensive approach to mental health includes touching base with patients who have previously opted out of mental health services. "Every year, we check in with patients and offer services again. Because things change, so it can't be a one-time thing. We are there if they need it at any point."

Mental disorders are diagnosed based on the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5)*, available at www.dsm5.org/Pages/Default.aspx. However, diagnosing a mental illness is complex, and in PLWH, the process is complicated by HIV symptoms and side effects of HIV medications, which can often mirror those of common mental illnesses such as depression. These may include pervasive fatigue, loss of appetite, weight loss, confusion, nightmares, and nervousness.⁴⁵ In order to assess whether symptoms are depression-related, providers should ask their patients if they have experienced a loss of interest in activities that used to be pleasurable, as this is more likely caused by depression.⁴⁶ Note: HRSA's *Guide for HIV/AIDS Clinical Care* referenced above also offers screening guidelines that employ the SOAP (subjective, objective, assessment, plan) methodology.⁴⁷ The HHS Treatment Guidelines, also referenced previously, provide critical information about the impact of mental health on treatment.

Performance Measures

Underscoring HRSA's commitment to mental health care are new HRSA/HAB performance measures recommending that Ryan White HIV/AIDS Program providers screen all adolescent and adult patients for depression and develop a follow-up treatment plan if a patient's screen is positive.⁴⁸ This follow-up plan should include one or more of the following:

- Additional evaluation for depression
- Suicide risk assessment
- Referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, and other interventions or follow-up for the diagnosis or treatment of depression.⁴⁹

As part of preventive care and screening for PLWH, HAB performance measures require the use of a normalized and validated depression screening tool developed for the patient population in which it is being utilized. According to those performance measures, examples of available depression screening tools include but are not limited to the following:⁵⁰

Adolescent Screening Tools (patients 12 to 17 years of age)

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Beck Depression Inventory-Primary Care Version (BDI-PC)
- Mood Feeling Questionnaire, Center for Epidemiologic Studies Depression Scale (CES-D)
- PRIME MD-PHQ2

Adult Screening Tools (patients 18 years of age and older)

- Patient Health Questionnaire (PHQ9)
- Beck Depression Inventory (BDI or BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Depression Scale (DEPS)
- Duke Anxiety-Depression Scale (DADS)
- Geriatric Depression Scale (SDS)
- Cornell Scale Screening
- PRIME MD-PHQ2.

Visit the Substance Abuse and Mental Health Services Administration (SAMHSA)-HRSA Center for Integrated Solutions for more information about these and other depression screening tools: www.integration.samhsa.gov/clinical-practice/screening-tools.

While regular mental health screening is required as a HAB performance measure, clients may also benefit from toxicology screening. Many Ryan White HIV/AIDS Program providers also stress these benefits. In screening for substance abuse, clients may not wish to admit to the use of illegal or other substances that can interfere with their care. Supports and treatment may be accessible through the physician or comprehensive care team to provide substance abuse treatment, early substance abuse interventions, supports such as 12-Step programs, or peer support counselors with the clinic. A positive toxicology screen provides an opportunity for further assessment and support.

"Many people only think of toxicology screenings as punitive," says Dr. Timothy Flanigan, also of Miriam Hospital, but it is part of routine care for his team. "You can't expect patients who have anxiety disorders or depression and are intermittently using cocaine to admit that to you. It's important to prompt the discussion based on a positive toxicology screen," he explains. "Likewise, if they had used cocaine in the past and their toxicology

screens are negative, that's a good reason to encourage them and give them positive reinforcement."

A Comprehensive Approach

Case managers, psychologists, therapists, psychiatrists, and general medical providers may all contribute to mental health care for PLWH. Some clinics may have the staff resources to address most of the mental health needs of their clients. Others may not. Referral networks are critical for filling the gap.

At Miriam Hospital, patients benefit from excellent medical care and Ryan White-funded case managers as well as counselors on site that can be used for an intervention, but they also make referrals to substance abuse treatment, as well as 12-Step programs, in the local area. Common mental disorders such as depression and anxiety are treated by Miriam Hospital's primary care providers and for more complex psychiatric needs, a psychiatrist is brought in to provide care. "We don't really have a full-service, one-stop clinic," says Dr. Flanigan, "but we do have a one-stop-shop philosophy."

IJP in Northern Virginia is able to link patients to services very quickly. "A lot of times, what will happen, which is key to the multidisciplinary team, is that a patient will be seeing their provider and they will talk about their mental health needs and the provider can link them to in-house services right away. They can even check with the social worker immediately and if they have an opening, they can talk about it that day," says Bottrell.

ACA Mental Health Care Expansion

The Affordable Care Act (ACA) expands mental health and substance use disorder coverage for an estimated 62 million Americans.⁵¹ Through the ACA, health insurance plans available through insurance marketplaces are required to cover mental health and substance use disorder services as an essential health benefit. The Mental Health Parity and Addiction Equity Act has also required insurance plans to include coverage for mental health and substance use conditions that compares to coverage provided for medical and surgical procedures. Depression screening for adults and behavioral assessments for children are included in preventive care services and are covered at no cost to the patient. In addition, the ACA has ensured that most insurance companies cannot deny or charge you more for coverage due to pre-existing mental illnesses. More information about the federal government's efforts to improve mental health can be found on www.mentalhealth.gov.

Talking about your mental health concerns and having anxiety and depression is a difficult thing to talk with a stranger about ... [but] over time, patients build a trusting relationship with their providers ... [and] when they are finally ready, they don't have to go somewhere else. It's all right here. That's the impact of a one-stop shop."

— Cathy Bottrell, Clinical Manager,
Inova Juniper Program, Northern Virginia

MEETING A PROFOUND NEED

With so many PLWH experiencing some sort of mental disorder today, there is a profound need for the kind of comprehensive support and care that Ryan White HIV/AIDS Program providers offer. Many patients face multiple risk factors that can compromise their mental health and make it more difficult for them to receive the HIV care they must have to lead healthier lives. What's more, dual stigma surrounding HIV and mental illness continues to be one of the biggest barriers, compounding suffering and increasing the sense of isolation that many PLWH may feel.

The response to this tremendous need starts with increased screening for mental disorders, and HAB performance measures and tools are designed to facilitate this process and encourage follow-up care. Indeed, comprehensive care that includes mental health is a critical part of the Ryan White HIV/AIDS Program, whether that care is provided on site or through referrals.

Mental health can provide tremendous benefits to overall health. For PLWH, these benefits may be even more pronounced, as care has been shown to reduce HIV risk behavior and increase engagement in care.⁵²⁻⁵⁴ Thus, improving mental health for PLWH can do more than improve quality of life. It helps build a long life, too.

➔ ONLINE RESOURCES

National Institute of Mental Health

www.nimh.nih.gov

AIDS.gov, Mental Health

<http://aids.gov/hiv-aids-basics/staying-healthy-with-hiv-aids/taking-care-of-yourself/mental-health/>

Department of Health and Human Services, MentalHealth.gov

www.mentalhealth.gov

SAMHSA-HRSA Center for Integrated Solutions, Screening Tools

www.integration.samhsa.gov/clinical-practice/screening-tools

American Psychological Association, HIV Office for Psychology Education (HOPE) Program

www.apa.org/pi/aids/programs/hope/index.aspx

Agency for Healthcare Research and Quality (AHRQ); The Academy for Integrating Behavioral Health and Primary Care

<http://integrationacademy.ahrq.gov/evaluationtools>

U.S. Department of Veterans Affairs , HIV/AIDS

www.hiv.va.gov/index.asp

Housing Opportunities for Persons with AIDS (HOPWA)

www.hudexchange.info/hopwa

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