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HIV/AIDS and Mental Health:

Final Report of the 7th International Policy Dialogue

International Affairs Directorate, Health Canada

January 30th – February 1st, 2012

Canada

Ottawa, Canada

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Également disponible en français sous le titre :
Le VIH/sida et la santé mentale : Rapport final du 7^e Dialogue international sur les politiques

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This publication can be made available in alternative formats upon request.

Publication date: July 2013

Cat.: H22-4/4-2013-2E-PDF
ISBN: 978-1-100-19175-1
Pub.: 130041

Canada

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Key themes emerging from the Dialogue

- HIV, mental health and substance abuse are linked in complex ways. Mental health and substance abuse can be a risk factor for HIV and can also be compounded by HIV. Furthermore, either can also arise as a result of HIV.

- The rates of co-morbidity among HIV, mental health and substance abuse are very high: studies commonly find rates of depression, anxiety or suicidal thoughts anywhere from 35% to 80% in people living with HIV.

- Stigma can be devastating and can increase both the risk of, as well as poor outcomes from HIV, mental health, and/or substance abuse.

- Poor mental health leads to poor HIV outcomes, from increased risk of infection, to reduced testing/ diagnosis, poor treatment adherence, greater transmission, and increased morbidity and mortality - but “studies consistently show that treating depression leads to reduced viral load.”

- Participants identified funding barriers to HIV and mental health services: funders are not always interested in supporting these issues and many high prevalence countries do not acknowledge mental health as an issue.

- Participants emphasized the need to demonstrate the value of investing in proven, simple, cost-effective depression interventions which improve all HIV outcomes.

- Participants also found deep fragmentation among policy, programs, services and research and noted that successful models of integrated care and policy must be disseminated and scaled-up.

- Through partnerships within the various sectors of HIV and mental health, shared programs can be designed; strategies can be developed; and organizations can learn from one another’s experiences.

Executive Summary

Background

The 7th International Policy Dialogue on HIV/AIDS and Mental Health brought together experts in the field from governments, international agencies and civil society around the world. Over three days of plenary presentations, dialogue and "Knowledge Café" breakout sessions, participants discussed a wide range of research and experiences. The challenges, ideas and solutions summarized here all emerged through the Dialogue; the data and quotations included are drawn from participants' presentations and discussions.

The Dialogue revealed the diversity of people, health challenges, needs and perspectives which are encompassed in the intersection of HIV/AIDS and mental health. Mental health, HIV, substance abuse and stigma interact in many ways. Mental health and substance abuse both negatively impact HIV outcomes. The co-occurrence of mental health and substance abuse increases a person's risk for HIV nearly 12 times more than those without (Hoff et al., 1997). A triple diagnosis impairs a person's well-being and quality of life significantly. There is a "triple stigmatization" associated with having HIV, a psychiatric illness and a substance use disorder. Stigma results in the extreme marginalization of this population and further reduces self-esteem, often precipitating self-destructive behaviours and potentially delaying or undermining treatment[1].

What are the key needs?

A significant body of evidence shows that mental health issues are far more common among people living with HIV/AIDS than in general populations, and conversely, HIV is more common among people with poor mental health. In many jurisdictions, mental health problems are not adequately acknowledged or treated, and available data is highly varied and may underestimate the prevalence of mental health problems.

Participants shared research and statistics on people living HIV/AIDS and various mental illnesses. Participants suggested rates of depression among people living with HIV ranging from 35% to 60% or even higher. Similar results were found in anxiety studies. The few studies of post-natal depression in HIV reported rates of over 40%. Participants cited studies on suicide that were of deep concern; one, for example, found that within 5-7 days prior to the interviews, almost 30% of the (HIV positive) participants had considered taking their own lives. Trauma seems to be less explicitly documented and addressed as a distinct issue, but was nonetheless integrally woven through the discourse: participants highlighted trauma - conflict, violence, rape, child abuse – as a major factor in both the physical and mental health of people living with HIV.

Poor mental health has a negative impact on all HIV-related outcomes, from risk of HIV infection to increases in both morbidity and mortality. Furthermore, with HIV, poor adherence can have unique and detrimental consequences compared to other chronic illnesses. However, extensive research consistently shows that treating depression (only depression or does this applies to other illnesses as

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[1] American Psychological Association, 2013, http://www.apa.org/pi/aids/programs/bssv/integration.aspx

well?) improves HIV outcomes.

Despite clear links between poor mental health and higher-risk sexual behaviour, abuse, violence and exploitation, HIV service providers know little about how to provide HIV services to those with severe mental illness, while mental health care providers may overlook the sexuality aspect of the individual with mental health illness. .

What are the barriers to meeting needs?

> "How do you get your country to move on a problem it won't even admit exists?"

Participants have found that there is little support for mental health services in many countries with high prevalence of HIV. Cases of mental health problems thus remain undiagnosed and undocumented. They see little funding for mental health within national and multilateral HIV programs, and even less pressure for such funding to be found: mental health is simply not seen as either a need or a priority. At the grassroots level, people already burdened with the stigma of HIV are reluctant to draw even greater stigma upon themselves by advocating for mental health services.

Stigma continues to wield overwhelming and pervasive influence on policy and services – stigma is exacerbated when addressing both HIV and mental health issues – or even more so with HIV *and* mental health *and* substance abuse. Research has found, and participants could not emphasize enough, that stigma plays an important role in health outcomes. Stigma can lead to HIV acquisition and transmission and to mental health issues, and then exacerbate the burden of poor physical and mental health, and hinder its treatment, in a myriad of ways. As one participant noted, "People are very reluctant to come forward, as they would be ostracized to such an extent if they were tested for HIV or diagnosed with mental health issues."

From international policy to local front-line services, mental health and HIV tend to be separate, fragmented, and difficult to connect. Few policies, processes or services are willing or equipped to address both HIV and mental health: each tends to push the issue – or the patient – back to the other.
"In an all-too-human way, as service providers, what we don't understand and can't help, we often fear and avoid".

> "When a person with both HIV and mental health issues comes to a psychiatry group, the providers are scared, and try to get rid of them as soon as possible by sending them to the HIV services, who don't know how to deal with mental health, and who are scared too."

While there are many good individual examples of integrated programs that are successfully addressing mental health and HIV, they are unique and have not been adopted comprehensively, which raises the critical question: how can programs be scaled up to influence policy?

Through presentations and break-out sessions, Dialogue participants explored some of the health challenges across a number of populations which are particularly affected by HIV. These conversations were helpful in identifying issues and approaches which were widely shared across participants and populations. In addition, the sessions brought to light the specific challenges faced by the various groups as well as the approaches that work for some groups but may not be the most effective or appropriate for others.

Across these many overlapping circles of causality, association and relationships, participants brought a range of perspectives and lenses from their own lives, their research, and those of their clients. Certain vulnerable populations are over-represented in all prevalence numbers – those with HIV, mental illness, and substance abuse issues – and often poorly reached and supported by health services. Dialogue discussions raised a number of questions: how do needs, access issues, and service requirements converge and diverge among the most vulnerable populations – women, children and youth, people in post-conflict and disaster situations, men who have sex with men, people aging with HIV, Indigenous peoples, homeless people, new immigrants, people living with disabilities? Where do we have valuable lessons we can learn from? Which populations, sectors and countries are showing promising practices which others in the field can learn from? Are there profound differences which must be addressed differently in some countries with high HIV prevalence?

HIV and mental health also intersect in many ways with disability. The discussions ranged from how to provide more accessible services specific to the needs of these sub-populations, to whether HIV and/or mental illness could or should be considered disabilities, as well as what would some of the implications be if this approach were taken?.

Strategies for moving forward

Over the course of the three-day Dialogue, many promising practices to address HIV and mental health needs were discussed. An over-arching message from participants in these final sessions was that it is time to start moving from “look at all these problems we’ve got” to “look at the great solutions we have, let’s do more of these.”

> “Mental health problems are often sidelined because we’re too busy dealing with the HIV. But there are interventions, and we know they work.”

Participants suggested a number of key steps for moving forward. HIV and mental health need to be addressed in conjunction, in recognition of the ways they mutually affect one another. Participants thus emphasized the need for more holistic approaches to health. They identified a wide range of promising models for partnering across services, programs and policies. Integrating different kinds of services would increase accessibility and effectiveness, as well as reduce the stigma associated with the use of some types of care.

Participants saw a significant need to disseminate and scale up successful models of integrated care, and influence policy to support integrated approaches to mental health and HIV at various levels including the financial aspect. They emphasized the importance of demonstrating that effective interventions are in fact available, and that application of these interventions will improve HIV outcomes: HIV and mental health are not health issues which are competing, but rather, require the multidisciplinary approach that, in order to achieve progress with either issue, priority must be given to both.

Introduction

About the 7th International Policy Dialogue

The 7th International Policy Dialogue on HIV/AIDS and Mental Health brought together HIV/AIDS and mental health experts from governments, international agencies, academia and civil society around the world. It took place in Ottawa, Canada, from January 30th – February 1st, 2012, hosted by the International Affairs Directorate (IAD) of Health Canada, in collaboration with the Canadian Institutes of Health Research (CIHR), the Mental Health Commission of Canada (MHCC), the US National Institute of Mental Health (NIMH), the World Health Organization (WHO), and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

> “Mental health intertwines with physical health. By ignoring it, we are not only failing to address the enormous burden of mental health, but we are also increasing the burden of physical health challenges.”

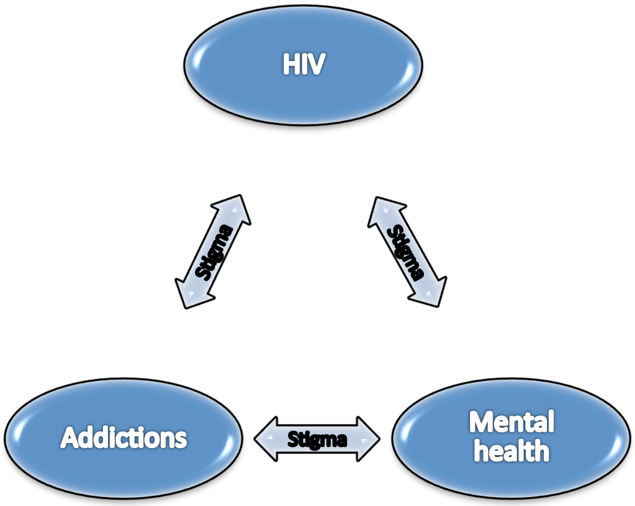
For three days, participants from Canada, the United States, Europe, Asia, New Zealand, and Africa worked together through plenary presentations, dialogue and “Knowledge Café” breakout sessions, to identify a wide range of challenges in providing support and services which address the interlinked needs of people living with, or vulnerable to, both HIV/AIDS and mental health . While it can be easy to be overwhelmed by the scope and scale of the problem, the Dialogue was marked by a positive determination to focus on what works, and how to scale up successful models.

The challenges, ideas and solutions summarized in this report came from participants and emerged through the Dialogue; these should not be considered as consensus views of all participants, nor of Health Canada. All the data and information included in this report was drawn from the Dialogue presentations and discussions; references are included in individual presentations.

What do we mean by HIV and mental health?

> “It is truly a multiplicity of complexities!”

The first and most striking aspect of the conversations which took place during the International Policy Dialogue was the extraordinary diversity of people, health challenges, needs and perspectives which are encompassed in the intersection of HIV/AIDS and mental health. Participants discussed ways in which being diagnosed with HIV can impair mental health and lead to substance abuse, and the ways in which, conversely, poor mental health and substance abuse can both increase vulnerability to HIV. The challenges of meeting the HIV prevention and treatment needs of those with substance abuse, or experiencing severe mental illness were



considered. In addition, participants looked at how HIV/AIDS itself can affect brain functions, causing neurocognitive impairments similar to premature aging.

High co-morbidities exacerbate these effects and the impacts each of them has on the others. There are complex and intersecting factors that lead to poor mental health, substance abuse, and traumatic situations – such as abuse, violence, conflict, systematic rape, homelessness – which may simultaneously increase the likelihood of all unfavourable conditions and situations.

What are the key needs?

Prevalence of poor mental health and HIV

Numbers vary considerably depending on the country, population, and approach of the various studies, but the outcome is consistently the same: people living with HIV/AIDS are suffering from an enormous mental health burden. Conversely, HIV is more common among people with poor mental health. The data highlighted here is drawn from many of the Dialogue presentations.[2] Given the likelihood that much – in some regions, perhaps most – poor mental health is unreported or undiagnosed, available data almost certainly underestimates the prevalence of poor mental health among people living with HIV/AIDS.

Depression

Depression was identified as the most common mental health issue among people living with HIV. Studies have found wide-ranging rates – from 35% to 44% in some cases, up to 60% in others, and, depending on the measures, even as high as 80%. While there are few studies of post-natal depression in HIV, reported rates of over 40% have been noted. The high prevalence of depression among people living with HIV means that the impact of the double stigma – HIV and mental health – is widespread.

Trauma and post-traumatic stress

The concept of trauma was integrally woven through the three days' discourse: for so many people living with HIV, trauma - violence, conflict, rape, child abuse - has played a major role in how they were exposed to HIV initially. Trauma can also accompany the diagnosis of HIV. Participants have found that HIV services which ignore to address the trauma caused by the initial diagnosis may have less success in keeping patients engaged in their physical health care: "with immigrant populations, the focus tends to be on what's happening to you right here and now with your HIV, but with little attention to anything in the client's lives before." The continuum of treatment care and support is critical with the delivery of the seropositive status. The importance of this approach is especially key on a multidisciplinary level in order to reinforce the importance of prevention and access to treatment messaging.

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[2] As noted in "Introducing the Dialogue", all data and information included in this report was drawn from Dialogue presentations and discussions; references can be found in individual presentations; see links in Annex B.

Anxiety

Anxiety is found among people living with HIV in both general forms as well as panic attacks, and has been found to lead to self harm as well as suicide. Participants reported a wide range of prevalence of anxiety disorders in those living with HIV; ranging from 13% - 80% depending on how and where it is reported.

The evidence base with regards to anxiety is not as definitive as that for depression; one challenge is that many instruments for assessment are more generalised in nature, for example, posing questions such as "do you feel anxious?" but failing to differentiate between a normal and abnormal response to a stressor, or use culturally-appropriate measures. As one participant noted, "The very concept of 'mental well-being' can be quite different for people coming from situations or countries where conflict, violence, abuse or other forms of trauma have been a part of their lives." Anxiety and stressors are a subjective interpretation, varying immensely from one individual to another. A range of factors and determinants need to be considered when determining one's level of mental health, however, many health professionals and those working with the mentally ill and/or those with HIV are not trained or equipped to formally assess the extent and gravity of mental illness.

Impacts of poor mental health on HIV outcomes

Mental health is important for HIV prevention. Poor mental health is associated with the risk of HIV infection in the first place, arising from drug use, riskier behaviour and higher numbers of sexual partners, sexual abuse, and unprotected sex: "your ability to stand up and say no may differ from when you are healthy." It is equally linked to higher risk of transmitting the infection on to others.

> "Poor mental health affects:
>
> - Vulnerability to HIV
> - Likelihood of not being diagnosed
> - Ability to adjust to being HIV+
> - Ability to maintain healthy relationships
> - Likelihood of transmitting HIV
> - Health seeking/ risk taking behaviour
> - Engaging /adherence to treatment
> - Suicide
> - Adaptation, resilience, coping."

Poor mental health reduces the ability to adapt to HIV status: people can be less able to acquire and apply health information, and coping, adjustment, symptoms, treatment, disclosure, support, and risk behaviour are all negatively affected when mental health is not optimal. The risk of self-harm and suicide increases as mental health declines.

Poor mental health also reduces HIV outcomes. Adherence to treatment is important for obtaining good outcomes in any situation, but the issue is particularly fraught in the case of HIV: expected levels of adherence are far higher than for most chronic illnesses, because there are potentially higher negative individual and public health consequences – from sub-optimal adherence to HIV medications. As one presenter explained, "In diabetes, if a person got 80% adherence, their physician would be thrilled - having expected it to be as low as 50%. In HIV we're asking for 90-95% adherence, and if you don't succeed, you get HIV drug failure, viral load rebound. Then you get drug resistance, then cross resistance. Then the ability to infect others – and to infect them with a resistant strain."

> "Depression worsens HAART adherence and treating depression improves adherence.
>
> In other words, studies consistently show that treating depression leads to reduced viral load."

Depression is in fact the single most consistent predictor of adherence across *any* medical condition: feelings of sadness and hopelessness, poor concentration, poor sleeping – all the hallmark symptoms of depression interfere with adherence. Studies have shown huge increases in both morbidity and mortality where depression is present in HIV positive samples. However, conversely, extensive research has proven that treating depression significantly improves treatment adherence, thus having a potential domino effect as well as decreasing risky behaviour and transmission of the virus.

HIV and people living with mental illness

"People can be turned away from services, in both directions."

Participants recognized that there is limited understanding of how to best provide HIV services to those who are severely mentally ill. Two particular challenges arose repeatedly throughout the Dialogue, coming from looking at service provision from "both directions".

Participants were challenged: "what is the impact on the kinds of support people might get, presenting with HIV while experiencing severe mental illness?" In their experience, there is a profound lack of awareness of mental health issues and realities, especially with respect to serious mental illness. Participants find a significant "fear factor" among providers, which makes them reluctant to deal with people whose health needs they don't understand, and don't know how to support.

Participants have equally found that "there are also challenges on the other side, such as providers not thinking of, or being aware of the mentally ill as sexual beings." Although there are clear links between poor mental health and riskier sexual behaviour, as well as vulnerability to sexual abuse, participants wondered how many mental health care providers are proactively addressing these issues with their patients? People living with poor mental health are often less able to choose healthy behaviors, make safer decisions in precarious situations, or defend themselves from dangerous activities. They are more likely to experience exploitation, exposure to violence and sexual assault. For those in institutional care, as well as those most at risk of infection, it is important to ensure access to HIV prevention information, condoms, testing and counselling.

Where mental illness remains deeply stigmatized, participants have found that "violations in mental health care services are massive and ongoing, and very deeply affect the lives of those affected. Living conditions in mental health institutions in Africa are so bad; sometimes it's actually better when the institutions just don't exist."

"What I could expect if I have poor mental health and HIV:
- Stigma and discrimination
- Trauma, vulnerability to abuse
- Difficulties finding/keeping employment
- Interactions with social assistance/benefits systems, poverty
- Interactions with health care and social service systems that are not designed to see overlaps in categories
- Lack of power/lack of choice in health care
- Falling through the cracks."

Substance abuse, mental health and HIV

The issues of substance abuse and mental health are not generally addressed comprehensively. Different funders, services, researchers and policies impact the manner in which substance abuse and mental health are addressed, especially with respect to those also being HIV positive.. While the challenges of addressing substance abuse flowed through the Dialogue, some key points became apparent as a priority, requiring distinct attention.

Injection drug use (IDU) is an enormous global problem, and especially in North America, is a major route of HIV transmission. Participants reported that almost 16 million people are believed to be users of injection drugs globally, and about 20% of them are infected with HIV. Looking at the issue from another perspective, there are approximately 3 million injection drug users among the 24 million or so people infected with HIV.

Injection drug users experience a significant burden of HIV disease, and participants noted that women who inject drugs often face an increased risk. Studies indicate that women who inject drugs are more likely to face violence, greater levels of stigma and pre-mature death. People with mental health disabilities may self-medicate with 'street drugs' in order to combat the symptoms of HIV and/or mental illness.

HIV and cognitive impairments

Experts in the field discussed that it is common for people living with HIV to experience cognitive impairments, similar to those associated with normal aging, but as one presentation highlighted, "in their brain images, they look 15 to 20 years older" than they should. These changes need to be recognized as a brain injury: "it's not their imagination, nor is it normal aging." Research ppriorities include better tools for diagnosis, and exploring treatments such as "brain exercises".

Cognitive impairment can be both isolating and stigmatizing. Many people, for example, find it more difficult to absorb what they are reading, remember names or new people, process new information, or keep track of fast or complex conversations. Consequently, cognitive impairments in HIV/AIDS are associated with fivetimes greater difficulty managing work demands and two to three times more unemployment; reduced ability to manage medications and; increased avoidance of social situations.

What are the barriers to meeting needs?

Little support for mental health

Many countries have few mental health services, and notable disincentives to making use of what's there. Participants commonly experienced a lack of interest and support on mental health on the part of governments and donors, and have found that "a lot of issues make it difficult to put this item on the agenda." Even when acknowledged, it is still a low priority - HIV is seen as a matter of life-or-death, but mental health is viewed as much less of an urgent public health issue. Consequently, there is little funding for mental health within HIV programs, and even less pressure on donors for such funding to be allocated. At the grassroots, people are reluctant to advocate for mental health services – as it could increase the stigma they already face.

> "How do you get your country to move on a problem it won't even admit exists? We cannot quantify, evaluate, or actually see them – we can't prove otherwise."

The problem is exacerbated as governments reduce their funding for many otherwise important issues, and shrinking HIV budgets focus increasingly on treatment to the exclusion of other services: "now that development aid is going down, mental health is the first to go everywhere. We were pushing for years to get mental health in on the agenda, and then it's just swept off."

"We've been trying to raise awareness among politicians – but there is a big reluctance to deal with this issue."

Policies and programs are fragmented

"The whole issue of people with two or three diagnoses – HIV, mental illness, addiction – makes providing services very difficult."

From international policy to local front-line services, mental health and HIV are separate, fragmented, and difficult to connect. Participants found themselves working in silos, and experiencing constant struggles to break down barriers and build coordinated approaches.

Participants described a number of examples of situations where both the HIV/AIDS and mental health sectors agreed that there was a large policy gap to be addressed, but each saw the problem as belonging to the other: "it's very difficult to bring both sides together." The same challenge is mirrored at the front lines, when HIV service providers see the mental health issues and send the person on to mental health services – who see the HIV and send the person back to HIV services. Neither is able to address the whole person and their multiple needs.

Stigma – double the challenge

Stigma continues to wield overwhelming and pervasive influence on policy and services. Discussions during the Dialogue constantly returned to the challenge of stigma – stigma that becomes doubled when addressing both HIV and mental health issues – or tripled with HIV *and* mental health issues *and* substance abuse. The toxic results can be paralyzing for all, including clients, providers and policy makers.

Research has found, and is echoed by participants, that stigma plays an important role in health outcomes. Fear of stigma stops people from seeking services, stops them from engaging in lower risk behaviours, stops women from leaving abusive situations, stops children from taking their HIV medications: "People are very reluctant to come forward, as they would be ostracized to such an extent if they were tested for HIV or diagnosed with mental health issues." Stigma can be a large contributor to behaviour which leads to the acquisition of HIV and transmission. As well, stigma can contribute to exacerbate mental health issues, and then exacerbate the burden of poor physical and mental health, hence hindering its treatment, in a myriad of ways.

Furthermore, in some countries the loss of a husband to HIV is not just a personal tragedy, but an economic and social one as well, due to the partner being ostracized following an HIV death in the family: "Realities are very different in the South. There is significant trauma associated with loss of a husband to HIV – inheritance, loss of livelihood, of the house – due to societal norms [i.e. the stigma of HIV]. Women also fear the loss of their children."

"Economic insecurity after the loss of a husband to HIV can be profound."

Fear among service providers

In participants' experiences, most HIV and mental health service providers have limited understanding of the health issues and challenges of the other's clients. Few seem either ready or equipped to recognize and support the needs of clients presenting with *both* mental health issues and HIV. Although some participants felt that the word "fear" overstated the problem, in the experience of many others, fear among providers can be a significant obstacle to providing good care and support.

Fear is a common response when providers are faced with what they do not know, and cannot help. Even in its mildest form, a patient is likely to sense a providers' reluctance to discuss health issues with which they are not comfortable – and so they stay silent as a result; "maybe the HIV patient feels like they shouldn't bother the physician with their depression, when there are already so many physical health issues to deal with. But maybe the physicians just aren't asking – and in fact, they say they don't ask, because they wouldn't know what to do anyways." When people do speak up, they may be shuffled back and forth between HIV and mental services, because providers are focusing on the condition they cannot cope with, rather than the needs that brought the client to them.

> "When a person with both HIV and mental health issues comes to a psychiatry group, the providers are scared, and try to get rid of them as soon as possible by sending them to the HIV services, who don't know how to deal with mental health, and who are scared too."

Need for a policy-relevant evidence base

> "What's not in print isn't proven, and won't draw funding to scale-up."

As participants worked to identify promising practices throughout the Dialogue, it became clear that while there were many good individual examples of integrated programs that were successfully addressing mental health and HIV, almost all of them seemed to be unique, small-scale, pilot projects. There is a severe lack of scale-up, exacerbated by the limited tendency to evaluate and report these kinds of integrated services initiatives in the research literature.

Population-specific needs

Through presentations and break-out sessions, Dialogue participants explored both shared and unique health challenges across a number of populations which are particularly affected by HIV, including women, aging people living with HIV, children and youth and migrant populations, amongst others.

Women

Two especially problematic gaps were identified in the discussions about HIV, mental health and women: the first is the paucity of research specifically with regards to women and, the second is the failure to address the realities of women's unique challenges and circumstances when providing services. The responsibilities associated with caring for children for example, may hinder caring for oneself (i.e. attending medical appointments). While women often engage in care when pregnant – to protect the baby – care stops once it no longer directly affects a child's direct health. In these cases, patients often overlook the fact that their health status directly and indirectly affects the children and surrounding family members.

> "In research, both women and mental health are regularly shortchanged. The evidence which encompasses both is scant."

Those same responsibilities make it harder to recruit and keep women in research studies. As women report and experience mental health needs differently, and require different services, "the implications from using male-generated evidence for care of women are troubling."

People aging with HIV

Living longer with HIV has a multitude of potential and often cumulative impacts, on physical, mental and cognitive health. These, in turn, affect the ability to work and generate income, create and maintain relationships, and be happy despite chronic pain, periodic disability and bereavement. Those who were part of the early years of the epidemic have had different experiences of trauma, treatment, stigma and political environments – which affect not only their health but even their sense of who they are and what HIV is. The experience and reality of different groups of long-term survivors can thus be very different, and continues to change all the time.

Participants felt it may be time to stop focusing on the *problems* of aging with HIV, and instead to seek what we can learn about *living best with HIV*. It is critical from a public health perspective, to learn lessons from other disciplines, and what interventions have demonstrated promising results in the aging population, as well as those which have rendered challenges.

African and Black Diaspora

Migration from countries of high HIV prevalence is leading to high HIV rates among African and Black Diaspora populations, particularly among immigrants, who may have complex health needs. There is little demand from or services for Black heterosexual men, despite a significant and growing need.

Recent Black immigrants often come from African countries with ongoing conflict, and have often dealt with social, cultural and political inequities. As one participant noted "social support is the biggest factor, but migrants - who have all the burdens of HIV and the trauma that may travel with them – are often very isolated." Immigrants may lack full legal status, and be afraid to access services for fear of deportation. Employment may be limited, or non-existent. The cost of care and medication may demand a choice between feeding one's children and treating one's own health needs.

Indigenous People

Discussions focused on Canada's First Nations and Inuit population, and the Māori peoples from New Zealand, all over-represented in HIV, mental health and substance abuse statistics. Participants emphasized the social determinants of health as particularly important for Indigenous peoples; the negative effects of colonialism, such as forced relocation, remain significant. Low rates of education and high rates of poverty, drug use, unemployment, poor housing, homelessness, and incarceration are common. Presenters described how "we still have massive issues around child abuse, child deaths through violence… Coming from a background where they have nothing, violence tends to be part of the package; we must address the whole package."

> "Unresolved trauma is something we deal with a lot. Throw in suicides and overcrowding, etc. – people are just numb. It's just overwhelming. You have to roll it back, there has to be a holistic approach."

There is need for greater involvement of Indigenous people in the design and delivery of services and in health research, to create models which are localized, culturally defined, age appropriate, and gender-specific. Care needs to be context specific, focused on resiliency, and community led.

Presenters emphasized the importance of addressing culture in both research and in service design and provision. Community cultural beliefs about health and healing matter, and these are very diverse. A lack of specificity can lead to generic or pan-Aboriginal approaches, which aren't always appropriate. A narrow focus on one symptom – such as injection drug use – rather than on whole persons, tends to fail. Often, Aboriginal/Indigenous populations are made of unique and complex vulnerable sub-populations, dramatically increasing their vulnerability to HIV infection, as well as co-infections (i.e. young Aboriginal female prisoner who has a history of injection drug use and sex work).

Aboriginal people experience:

- Later HIV diagnosis
- Slower uptake of treatment
- Less access to physicians
- Higher morbidity
- Shorter survival times
- A 3x higher mortality rate
- Greater psychological distress
- Depression rates 4-5x higher
- Suicide rates 3-5x higher; up to 9x higher in Inuit communities
- Drug/alcohol use much higher
- Much lower life expectancy
- Epidemic rates of TB
- Highest STI and birth rates in the country

Children and Youth

Participants noted that children make up 16% of all people living with HIV, almost all of them in Sub-Saharan Africa, where mother-to-child transmission is still a major route of infection. Children with HIV are more likely to be isolated; many have experienced traumatic events, including the loss of a parent and siblings, and have been subject to ostracizing and rejection by their community and families. Mental health among children with HIV is unsurprisingly poor, and may have implications on their mental and overall health for into their young adult and adult lives. One participant noted that "children only grow, develop and heal in the context of relationships. Without at least one loving caregiver, you are in so much trouble."

> "With children, you can't separate their physical and mental health."

With children and youth, disclosure raises a whole host of perplexing issues, not just about the child disclosing to others, but also when and what to disclose *to* the child. Developmental age has a huge range and who decides the child is "ready" for knowledge, to make decisions, to control their own care – is often difficult. Issues around adolescent sexual and reproductive health were also discussed. In Sub-Saharan Africa, where many girls are married at 15, it is common for girls to only find out they are HIV positive at antenatal care; one program found a 40% HIV rate in young pregnant women who presented to its clinic. There is key gap in providing adolescent-friendly services globally; a few interventions are underway, but have so far been very limited. High-income countries are challenged by the "invincible attitude of youth concerning HIV", and a growing belief that HIV is no longer a major threat.

> "How do you deal with the risk of open disclosure versus the heavy burden of secrecy?"

Gay men and men who have sex with men

The advent of HIV catalyzed many gay men into the forefront of the battle against HIV/AIDS, and into the political limelight in the process. Consequently, the HIV community has led the research and health care world in demanding, and helping create, research and care that is driven by users. In integrating HIV, mental health, substance abuse and other services, “we must be mindful, in developing policy and programs, that very important milestones have been achieved and lessons learned along the way: there is concern about dismantling what it took years to build.” Participants discussed how to best balance normalizing HIV with maintaining the positive aspects of HIV exceptionality, and of pursuing integration without being trapped by a “one size fits all” approach.

Post-conflict situations

Participants identified a need for an international recognition of the impacts of conflict and natural disasters, especially on women and children, who often bear most of their burden. When service providers feel overwhelmed with addressing the basics of survival, they may have difficulty envisioning how to address mental health issues under such circumstances. Further, refugee services are not set up to deliver HIV services, nor do they understand the inter-relationships of HIV with the conflict and with the mental health of the people coming to them for care. Care providers need training to understand the full range of health challenges people are facing, and how best to support them.

Disability, HIV and mental health

Participants debated whether either HIV or mental illness or both could be considered disabilities, whether people living with HIV and/ or mental health issues (or mental illness) would want to be considered as disabled, and what some of the implications of doing so would be. At the same time, it was recognized that both HIV and mental illness are already considered disabilities in some contexts and jurisdictions, e.g. for purposes of disability income and/or disability support programs, or for specific accommodations in employment or housing. Collaborative efforts among the HIV, mental health and disability sectors could have mechanisms to share knowledge and lessons learned more efficiently and effectively; nonetheless, communities are worried about losing their identify, as well as taking on the stigma that may come with the other issue. Participants agreed that it was important to “try to see positives in the relationship, what we can learn from each other to move things ahead.” Participants also discussed a range of challenges in making HIV and mental health services more accessible to people with a range of disabilities.

Participants noted that signatories to the United Nations Convention on the Rights of Persons with Disabilities have not only accepted those rights, but also explicitly agreed to act to enable and protect those rights. As countries map out their implementation strategies, it will be important for the disability, HIV and mental health communities to work together to ensure that critical questions are considered and well addressed during the development of national plans to implement the Convention.

Strategies for moving forward

Over the three-day Dialogue, certain ideas and solutions began to surface with increasing frequency in the discussions, and resonate across populations and issues. During the final day, participants identified key themes and specific areas they wished to explore in more depth.

Many promising practices to address HIV and mental health needs also emerged during the Dialogue discussions (see final section for brief summaries of all the promising practices which were identified through the Dialogue, and Annex A for more detailed descriptions). An over-riding message from participants in these final sessions was that it is time to start moving from “look at all these problems we’ve got” to “look at the great solutions we’ve got, let’s do more of these.”

Focus on the whole person

A constant theme throughout the Dialogue was the need for more holistic approaches to care. Participants highlighted the need to support the whole person, rather than treat a single disease while ignoring its interactions with other health needs.

Participants highlighted the need for service providers to identify specific opportunities for training and to work together, to learn what each does, and build comfort levels with health issues which are outside of the provider’s usual scope: “to bring an HIV lens into mental health and to bring a mental health lens into HIV.”

This issue was fundamental in discussions of Indigenous peoples’ health, where a promising model was presented: the “medicine wheel model”, developed by Mason Durie of New Zealand. The Māori philosophy toward health is based on a holistic health and wellness model, the idea that ‘if you wish to understand the man, you need to know the world in which he lives’; it can be applied to any health issue, whether it involves physical or psychological well-being.[3] Māori health is underpinned by four dimensions representing the basic beliefs of life – te taha hinengaro (psychological health); te taha wairua (spiritual health); te taha tinana (physical health); and te taha whānau (family health). These four dimensions are represented by four walls of a house; each is necessary to the strength and symmetry of the building.

The value of this kind of model is that it supports the full continuum of health, rather than trying to address single issues or diseases in isolation. For Indigenous peoples, explained one participant, “We believe in creating an integrated collaborative approach leading to health and self-sufficiency, and not just addressing health alone. Solutions must include … education, policy, employment, social and health services in an integrated way.”

Another interesting promising practice presented at the Dialogue was called “Housing First”, an approach which combines housing workers (who work with mostly private landlords) with mental health care workers, to find housing for people with extensive histories of homelessness, most coming from shelters or the streets: “the idea is to *start* with housing, rather than saying you’re not ready, you have to deal with your substance abuse, get your mental health issues under control first.” The Housing First program is currently being evaluated in a large-scale initiative across Canada; one of the key early findings is *starting* with providing stable housing - rather than trying to treat or fix the issues that may be keeping people out of housing - is having notable benefits for the person as a whole: “once people get housing and privacy, are able to be independent and feel safe, we’re finding that it’s only the beginning, then they’re thinking about the next chapter of their lives.” Once people have their own, dependable space, they are more motivated to deal with health care and treatment regimes, they want to go back to school, look for vocational training and explore the potential for employment.

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[3] For a description of the medicine wheel model, see http://www2.careers.govt.nz/educators-practitioners/career-practice/career-theory-models/te-whare-tapa-wha/

Successful models of integrated care

Having identified a need to provide more holistic care, participants repeatedly highlighted the importance of linking integration and partnerships. They shared a range of ways in which policies, programs and providers can be linked to more effectively address the needs of whole people, instead of addressing one health issue while ignoring the others that may be affecting it.

At the front lines

Partnering with other service providers

Service providers are often small in both size and scope and lack the staff and resources to address the complex range of needs of their clients; for example, a participant leading an Aboriginal HIV service organization with a staff of four was not able to employ a psychiatrist, but has nonetheless found that its clients have a universal requirement for mental health support. In these kinds of service organizations, participants explained their growing understanding of how they need to build partnerships to better address client needs. In this case, the organization worked with a range of partners, their most important being other Aboriginal (non-HIV) organizations who could help their clients re-connect with Aboriginal culture and healing processes, for example traditional sweats.

Clients with significant mental health problems can use up a lot of resources in an HIV service organization, and yet still not receive the expert care they need. One participant shared an example of building increasingly close links between housing services for people living with HIV and for those living with mental health problems, so that clients could get joint support rather than fall through the cracks between both services. Other service providers described the need for similar partnerships with psychiatric services, to enable them to address clients' complex needs.

Creating integrated service centres

A primary goal of integration is to make services more easily accessible, cost-effective, safe, streamlined for more efficient service delivery and free from stigma. An example of a promising practice in this arena was an adherence-readiness intervention which incorporated psychological assessment – and psychological care – into HIV treatment decisions. The program involved collaboration between hospital clinicians working in HIV and psychology.

Integration shouldn't just be limited to health services; good models identified by participants also included health centres focused on immigrant populations, which provide not only culturally-appropriate health care, but also include immigration, employment and other social services. To enable better access for women, participants suggested models in which centres integrate daycare with healthcare. One particularly intriguing promising practice integrates physical and mental health with soccer; it has introduced over 200,000 youth to the idea of HIV self-care and prevention through a combination of soccer and health services in South Africa.

As services evolve and new ones are developed, participants placed priority on looking for where HIV and mental health skills and services could be clustered. Participants emphasized, however, that integration is not an excuse for a "one-size fits all" approach. Many lessons have been learned about how to address the needs of specific populations, and the uniqueness of each population should be built into – not subsumed by – more holistic approaches to services. For some populations, better access may be best achieved by integrated services which nonetheless target specific high-risk groups, such as men who have sex with men, or that deliberately reach out to draw in key under-users of services, such as Black men in North America.

> “We wait until there’s a problem and try and fix it, but it’s usually quite advanced by the time we find it.”

Finally, integrative approaches to care enable a focus on positive health: supporting and maintaining good mental health; living well and aging well with HIV; building coping skills and resilience in children that will help them get through their adulthood. One promising approach is to normalize mental health care through annual check-ups; participants identified a couple of simple methods easily used by any provider, such as two-question assessments being used in Europe and Vietnam.

At the policy tables

Participants noted that they all had opportunities to engage with funders and policy makers, and they should work to ensure such opportunities are well used. As a first step, funders should be more frequently engaged, and sooner and more substantively, in project and service planning and strategy.

Secondly, when policy makers are addressing particular issues, they should consistently be encouraged and assisted to connect the mental health and HIV sectors to address the challenge with joint expertise. The desired result is to produce common policy and programs in response to a shared problem. The current WHO discussion around an action plan on mental health was an example of where participants were working on such discussions about integrated approaches.

Thirdly, participants saw the need to continually demonstrate the value of integrating, and work to influence the structures, systems and funding envelopes that enforce silos. A promising practice in this regard was the Developing HIV/AIDS & Mental Health Programs in EU countries. One aspect of this program was capacity building at the front lines, with a focus on training those working in mental health to incorporate HIV/AIDS issues in their practice. Another aspect of this program was advocacy: working closely with policy-makers and from all sectors to develop effective ways of approaching HIV/AIDS-related mental health problems. There is a hope that this project will lead to the inclusion of a mental health component in national, regional and European HIV strategies and policies.

Another example of the need for integrated approaches to policy is arising as individual countries map out their strategies to implement the UN Convention on the Rights of Persons with Disabilities. Participants discussed ways to engage with that process and ensure that their countries’ implementation plans are created in a way that addresses, up front, the key challenges which arise in the intersections of disability, HIV and mental health.

Capture and disseminate the evidence

A key message arising from the Dialogue is that there are effective interventions at hand, particularly when it comes to addressing depression and HIV. Furthermore, there are many promising examples of partnerships and integrated approaches to mental health and HIV services which are not being disseminated to their potential. The next steps are to disseminate knowledge of the effective interventions and approaches more broadly and within various disciplines, and to help people appropriately adapt and translate them into different cultures, countries and circumstances.

The group identified a need for a definition of mental health with concrete approaches that will convince policy makers that mental health needs to be a priority into which financial, capacity and resources need to be invested.. Policy makers need concrete evidence to be able to demonstrate what works in mental health treatment in order to integrate it into more comprehensive policies and programs. There is a need to work at all levels of government, including local governments, to achieve this integration and to see progress.

Participants proposed creating a website to share experiences and best practices between communities that are already organized around HIV and related co-morbidity services, and those who are trying to get organized.

Participants also suggested that each of them had a need and a responsibility to encourage and help service providers evaluate and publish their models, in order to enable scale-up, and for successes to be able to influence policy. The importance of engaging policy makers earlier in services and research was emphasized again in this context, as an important means to facilitate the scale-up and spread of approaches that work.

Build partnerships and networks

Throughout the Dialogue, participants repeatedly highlighted the importance of establishing key partnerships. The section above describes a range of partnership building approaches to build integrated services and policy. In addition, past International Policy Dialogues have been important incubators on a number of -ongoing partnerships of a broader nature, exemplifying the critical nature of developing and nurturing partnerships which facilitate and enable the flow of knowledge and the lessons which have been learned.

In fact, the work of two of the networks which emerged from past Dialogues was woven throughout the current discussions about HIV and mental health. One of these networks is focused on furthering the United Nations Declaration on the Rights of Indigenous People[4], working with the International Indigenous Working Group on HIV/AIDS[5] that came out of the 5th International Policy Dialogue on HIV/AIDS and Indigenous Peoples in 2009.[6] HIV, mental health and substance abuse are three critically important issues for Indigenous communities; participants thus found this current Dialogue was catalyzing for that network, both expanding it through the development of new partners, and strengthening it through renewed ties with existing ones.

The second partnership engaged in the current Dialogue about HIV and mental health emerged from the 4th International Policy Dialogue on HIV/AIDS and Disability in 2009.[7] After that meeting, an informal network of key stakeholders was established, and further developed over the 2010 International AIDS Society (IAS) meeting in Vienna. Over the course of the current Dialogue, the network has further

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[4] For more information, see The United Nations Permanent Forum on Indigenous Issues (UNPFII), an advisory body to the Economic and Social Council (ECOSOC), with a mandate to discuss Indigenous issues related to economic and social development, culture, the environment, education, health and human rights: http://social.un.org/index/IndigenousPeoples.aspx

[5] See the International Indigenous Working Group on HIV/AIDS: http://www.iiwgha.com/en/#/about/

[6] For a description of the 5th International Policy Dialogue and a link to the report, see: http://www.unaids.org/en/resources/presscentre/featurestories/2010/june/20100610indigenousreport/

[7] For a description of the 4th International Policy Dialogue and a link to the report, see: http://www.unaids.org/en/Resources/PressCentre/Featurestories/2009/November/20091111DisabilityReport/

developed two goals: first, to re-define HIV/AIDS within the concept of “episodic disability”; and, second, to identify commonalities that exist across, in between, and through HIV, disability and mental health, and the benefits from making these linkages between countries and people. The intent is to identify approaches which address these goals without losing the exceptionality that has come to mark the HIV/AIDS community, and is part of its funding, ability to advocate, and focus in medical research.

On the final day of the Dialogue, as participants discussed the kinds of next steps they could undertake, a new network could be seen to be emerging. It began with a focus on ‘making the case for mental health funding in HIV programs’, and a preliminary strategy resulting from participants’ brainstorming is described further below.

De-mystify mental health

To move forward, participants suggested that “we must be very clear about priorities for action, what we are asking policy makers to do, what we want to change, and what evidence we have that it will help.” It was also seen as important to emphasize that integrating services is not about taking away scarce mental health resources to deal with HIV, nor is it about taking away HIV resources to deal with mental health.

Focus on clear and achievable goals

Participants concluded that for many decision makers, “mental health” sounds too vague and may seem overwhelming and too difficult to address. Several suggested that there is a need for a consistent and understandable definition, which would enable more effective communications about both the problem and how solutions can be pursued.

Ultimately, however, participants did not attempt to produce such a definition. Instead, some participants proposed a somewhat different approach, which was to select, from the broad array of HIV and mental health challenges, smaller goals that were compelling and achievable.

Some participants thus proposed, as a first key step, to identify a clear and manageable place to start: specific problems which have concrete and proven solutions. Depression and alcohol abuse were suggested as a starting place for the following reasons:

- They have the worst impact on transmission of HIV
- There is good evidence for their relationship to initiation and adherence to treatment, transmission and risky behavior (in contrast, although anxiety disorders are very prevalent, the evidence base is not as strong)
- There are effective interventions that improve HIV-related outcomes
- These are the two problems with the greatest health burden: depression is the most common mental health disorder; alcohol abuse the most common addiction
- These are two common challenges which exist around the world and in all populations affected by HIV
- Starting with these two issues can build foundations for broader approaches in the future

If the evidence is so overwhelming, why is nothing happening?

- Lack of clarity about what we mean by mental health: sometimes we mean illness, sometimes health, sometimes well-being
- Incorrect perception that this is an area where there are no interventions, or they are too complex to be scaled-up
- With regards to development assistance, donors are driven by the needs of recipient countries, and they are not asking for support for mental health care
- The influence of stigma can't be overestimated, and it reduces public and policy interest in addressing mental health
- The feeling that mental health is low priority - when people think about HIV needs, we're more used to talking about palliative care than mental health.

Demonstrate the value of linking HIV and mental health

Participants suggested the most effective way of getting mental health onto the HIV agenda was to demonstrate clearly to decision makers how addressing mental health will enable them to achieve better outcomes from existing HIV services and patients: "mental health care is a gap in current HIV strategies and programs, and leads to the cascade of people dropping out of treatment at every level."

Some participants thus developed plans to work together to develop a compelling one-page factsheet that sets out key facts about HIV and mental health, including prevalence; the relationships between depression, alcohol abuse and HIV; and interventions that are evidence-based, cost-effective, and have proven impact on HIV outcomes. Participants suggested they would focus on what current programs are achieving, and how the inclusion of mental health services will improve outcomes and help decision makers achieve their existing indicators.

Make the case for funding mental health

As participants have found little interest among HIV/AIDS funders in supporting mental health, many of them concluded that they needed to create the demand themselves, "by talking with the people who decide where the funding goes." Participants thus outlined a strategy they could pursue in order to influence governments, policy makers and programs to invest in mental health together with HIV/ AIDS. Their purpose was not to advocate for new mental health strategies or funding, but rather to show how they can help decision makers incorporate mental health services into their existing approaches, and thereby increase adherence and better achieve their existing goals.

> "Mental health is the gap that they need to address, to achieve the goals they have already set out."

"Taking IAS 2012 by storm"

Mental health and HIV has never before been a topic at the biennial International AIDS Society Conference. Participants saw the upcoming IAS 2012 as the natural place to engage wider audiences and draw broader attention and interest to several key themes which emerged from the Dialogue.

A network of participants interested in pursuing the challenge of making the case for mental health funding in HIV programs began to emerge through the Dialogue. That group developed preliminary plans to mobilize networks and champions around a coherent, simple, shared message – presented in the form of highly-compelling factsheets - all throughout the IAS 2012 meeting. In addition, they hoped to develop a satellite session focused specifically on mental health and HIV. Ultimately, the goal for an HIV and mental health plenary was approved for IAS 2014.

The group also began to explore ways to connect information, experts and champions to support people in each country in building local coalitions and working with their own decision makers and to move forward with the proposals laid out in the factsheets.

Promising practices: in brief

Many promising practices to address HIV and mental health needs were presented as well as emerged during the Dialogue discussions; these are listed below, and described in more detail in Annex A.

In brief: Promising Practices Presented during the Dialogue

Practice	Goal	Key elements
Case Study of The Benefits of Brain Fitness Program	Test a tool to help people maintain their best cognitive health with HIV and aging	Diagnosing HIV-associated cognitive impairments, and using “brain exercises” to improve cognitive function
Developing HIV & Mental Health Programs in EU countries	Provide support for people with double/triple diagnosis in new EU member countries	Regional research, training mental health workers to deal with HIV; creating network of expert centers which act as resources; advocating for policy change
Supportive Therapy for Adherence to Anti Retroviral Treatment	To help better prepare patients to achieve good adherence before starting HIV treatment	Assessing readiness and addressing gaps prior to starting treatment by building adherence skills and health belief self-efficacy; addressing knowledge gaps and mental health issues
Deployment-Focused Intervention Research	To identify interventions that work in real-world situations, with effective adaptation to specific populations, cultures and circumstances	Tailoring/ conducting research where care takes place, using proven interventions which attend to culture and available resources, and guide policy
The Hotel Study	Longitudinal study to assess co-occurring disorders in very socially-disadvantage populations at risk of losing housing in Vancouver	Identify and address needs of population living in “single-occupancy hotels” in Vancouver’s downtown Eastside, most in poverty, and have been previously homeless
Positive Spaces Healthy Places	Determine whether stable housing can help prevent HIV and improve HIV care	Canada's first longitudinal community-based study , to identify needs, options, and factors that affect housing status and stability, health and HIV
At Home/ Chez Soi	Demonstration project/ multi-site trial in 5 Canadian cities testing different ways to implement “Housing First”	$110M program in five Canadian cities, with integrated research; combines housing and supports, prioritizes stable housing as first step to better health services and social supports
Standards for psycho-logical support for adults living with HIV	Develop standards for psychological support for adults living with HIV	Developed in broad partnership, not aimed at a specific professional group, but rather apply to all providers, promoting positive mental health, in clinical and community settings

Speaking Books for HIV/Aids and Mental Health Literacy	To provide critical health information about HIV and mental health in contexts of low literacy, poverty	Speaking Books provide critical health information, address stigma and discrimination, provide support where few health workers, raise awareness
2-Spirited People of the 1st Nations	To create a space where people can grow and come together as a community, fostering a positive image, honouring our past and building a future	Provide HIV/AIDS education, outreach, prevention, support and counselling, harm reduction education, health promotion, incorporating traditional Aboriginal healing

In brief: Promising Practices Emerging from the Dialogue

Practice	Goal	Key elements
WhizzKids United South Africa/ Africaid	HIV & AIDS prevention, care, treatment and support to youth through football	Uses the game of football to educate adolescents about life skills, gender equality, health, HIV and AIDS prevention
Lifesavers condom covers	Increase awareness, education about importance of condom use	Pauktuutit Inuit Women created country-food flavoured condom covers - funny, attention-getting
Diffusion of Effective Behavioral Interventions	Create resource for prevention service providers	Annually updated online Compendium of Evidence-based HIV Prevention Interventions - behavioral
Talking points	To help people talk to their doctor about HIV treatment	A web tool, creates a list of treatment questions and issues to take into the doctor
Positive Outlook	Working with HIV, Depression and Rehabilitation: Build front line capacity to identify and address depression	Developing and piloting a mental health training course with front line HIV and rehabilitation workers across Canada
Masivukeni (let's wake up)	Adherence to HIV care intervention being piloted in South Africa	Provides detailed protocol for counselors –non-professional peers - to follow when helping non-adherent patients
International Indigenous Working Group on HIV/AIDS	Strengthen international response to HIV/AIDS through networking, sharing of wise practices, and knowledge transfer	Increase international integration, inclusion in research policy and program development, accuracy of data, capacity building
CIHR Institute of Aboriginal Peoples' Health	Advance a national health research agenda	Made possible significant Aboriginal research initiatives and scholarships in Canada
National Aboriginal Youth Council on HIV/AIDS	Aboriginal Youth created a Strategic Action Plan for HIV/AIDS	Inventory of existing Aboriginal, youth-specific HIV prevention messages/programs, lit review, recommendations

Special Needs Clinic	Mental health services for children, adolescents and parents	Capacity to treat multiple members of a family, with each person addressed in family context
Ontario HIV and Substance Use Training Program	Training for service to increase knowledge of HIV/AIDS	Two-day interactive training course, addresses key HIV, mental health and substance abuse topics, including medical, legal, counselling, others
iSpeak	Exploring perspectives, needs and challenges of African, Caribbean and Black heterosexual men in Ontario	Identifying knowledge gaps, research needs; developing research team and study, strengthen program and policy responses
Regional Psychosocial Support Initiative	Ensure that all children have access to quality social and emotional support	Lessen impact of HIV and AIDS, poverty and conflict among children and youth in 13 countries in East and Southern Africa
Positive Leadership Development Institute	Support people living with HIV to realize their leadership potential	Includes core leadership training, Board, Governance, and Communications
AIDS Bereavement and Resiliency Program of Ontario	Build worker, agency and community resiliency in the face of AIDS-related multiple loss and transition	Helps organizations to retain invaluable professional staff and volunteers, including board members
African Centre for Childhood	Training to support people working with and caring for children at risk, their families and communities	Open Distance Learning Certificate Programme, with 500 students across 8 countries having completed programme
HIV Clinical Resource	Central, online resource for HIV service providers	Includes: Clinical Guidelines; Best Practices; Educational Tools; Quality Improvement Materials and software; and Clinical Performance Data
HealthyHousing.ca	Dedicated to providing information related to Housing and HIV/AIDS across Canada	Info about services for people living with HIV and service organizations, as well as research and advocacy for policy makers

Annex A: Promising Practices

Models presented during the Dialogue

Policy/ Program/ Project:	**Case Study of the benefits of the Brain Fitness Program**
Presented by:	Sean Rourke
For more information:	http://www.utpsychiatry.ca/members/seanb-rourke/ www.catie.ca/fact-sheets/other-health-conditions/hiv-and-brain

Goal

Test a tool to help people maintain their best cognitive health with HIV and aging

Key elements

- Diagnosis of HIV-Associated Cognitive-Motor Complex
- “Brain exercises”
- Before and after-testing of cognitive function

Details

The “Brain Fitness Program” uses a computerized and self-administered cognitive rehabilitation intervention, 1 hour of exercises 5 days per week for a total of 40 sessions. The exercises are designed to speed up auditory processing, engage working memory, and encourage efficiency of neural networks involved in memory processing. The exercises adapt to the individual’s level, and give constant feedback about progress.

In general, we need to pay more attention to brain health: overall, what is good for your heart is good for your brain: i.e. eat well, get lots of rest, get physical exercise, don’t drink too much or smoke, lower stress level.

Outcomes so far

In the case study, the Brain Fitness Program intervention improved cognitive ability after 8 weeks, especially in:

- complex attention / working memory (multi-tasking ability)
- learning (ability and quickness in learning new information)
- verbal fluency (increased ease in finding words to express oneself)
- complex psychomotor efficiency (cognitive speed)

From a personal view, participants reported great relief in simply being able to participate in complex conversations with much greater ease and comfort, and less stress and anxiety than they were accustomed to.

If the cognitive benefits also translate into significant and lasting impacts on the ability to perform complex everyday functioning tasks and activities, the intervention may offer real potential for those who want to continue working and those who want to return to work.

Our research unit will be starting a larger intervention trial to formally test the effectiveness of the BFP in people with HIV- contact us if you are interested.

Policy/ Program/ Project: **Developing HIV/AIDS & Mental Health Programs in EU countries**

Presented by: Robert van Voren

For more information: http://www.gip-global.org/p/27/364/-/c17/mo100-cg%7C19=Mental%20Health%20and%20AIDS/ms7-36/developing-hiv-aids-%26-mental-health-programs-in-new-eu-countries

Goal

To improve the quality of life of people with double/triple diagnosis (HIV/addiction/mental illness) in new EU member countries by increasing awareness of the relation between HIV/AIDS and mental health problems among professionals in relevant sectors and disseminating best practices existing in old EU member countries in the area of integrated approaches towards mental health and HIV/AIDS.

Key elements

- Research – needs analysis. Almost all available research is North American, nothing from former USSR.
- Education - Focus on building capacity of people, training those in mental health to deal with HIV/AIDS issues.
- Create a network of expert centers on mental health and HIV/AIDS which act as resource centers to motivate and educate change agents and to develop de-stigmatization, education and training programs for people with HIV/AIDS, carers, families and the general population.
- Advocacy - Work closely with policy-makers and opinion-formers from all sectors to develop effective ways of dealing with HIV/AIDS-related mental health problems. Ideally, the project will lead to inclusion of mental health component in national, regional and European HIV strategies and policies.

Details

The Global Initiative on Psychiatry (GIP) was founded in 1980 to fight political use of psychiatry against dissenters, especially in the USSR; there are now 38 countries involved. Human rights are still at core of our work. We found there was no way to work in mental health without dealing with HIV issues; GIP has thus been involved in HIV/AIDS and mental health for 10 years.

The organization is action-oriented. We try to help reformers set up and implement projects, making use of local expertise. HIV came to fore particularly in Russia and Ukraine, where there is a massive epidemic; unfortunately, donors won't fund projects there, as they are not considered developing countries; nor do their governments welcome this kind of work.

A big issue is helping the carers, both family and professionals as well, as the support mechanisms for them are often not there.

Outcomes so far

We are now trying to make use of our and Board expertise to do similar project in Africa: building capacity on mental health for secondary caregivers working with people living with HIV/AIDS, in Zimbabwe, funded by the European Commission. "We are focusing on AIDS orphans: children who only know life associated with death; mourning and sadness are an integral part of their lives. We give them an area where for small bit of life, they don't have to deal with death."

Policy/ Program/ Project:	**S**upportive **T**herapy for **A**dherence to **A**nti- **R**etroviral **T**reatment (STAART)
Presented by:	Louise Balfour
For more information:	www.socialsciences.uottawa.ca/psy/eng/profdetails.asp?id=138 www.hivnet.ubc.ca/clinical-studies/canadian-hiv-trials-database/ctn-198/

Goal

To help better prepare patients *before* starting HIV treatment by:

- Building adherence skills
- Increasing health belief self-efficacy
- Increasing psychological readiness to start treatment
- Empowering HIV patients to feel more engaged and in control of their treatment

Key elements

1. Assess HIV medication readiness, HIV treatment knowledge, and depression
2. Provide adherence intervention which responds to the needs identified in their readiness scores, may include education, co-development of adherence strategies, psychological interventions, adherence practice, etc.
3. Re-assess HIV patient readiness (e.g. at 4 weeks)
4. Start treatment when scales indicate adequate readiness

Details

Although guidelines indicate that providers should assess readiness, they do not say *how*, and no such tools could be found. Our team developed and validated two tools, to measure readiness and treatment knowledge, to build a set of three validated, evidenced-based, and easy-to-use questionnaires. All are self-report measures (i.e. patient fills them out in the waiting room in 5-10 minutes), and they can be scored by health care providers in 5 minutes, who can then provide real time feedback to patients.

“Research shows that knowledge is important for adherence, and depression is the single most consistent predictor of adherence across any medical condition. Feelings of sadness and hopelessness, poor concentration, poor sleeping – all the hallmark symptoms of depression interfere with adherence. But we’ve proven that treating the depression improves the adherence, so we need to identify it quickly, and do something about it first.”

Outcomes so far

The HIV Readiness Scale predicts not only adherence, but also CD4 counts at 6 months follow-up.

The STAART Adherence Study evaluated the adherence intervention through an RCT in 2006. The STAART intervention increased readiness and lowered depression, resulting in increased adherence and decreased viral loads at 6 months follow-up.

Policy/ Program/ Project: **Deployment-Focused Intervention Research**

Presented by: Milton Wainberg

For more information: http://asp.cumc.columbia.edu/facdb/profile_list.asp?uni=mlw35&DepAffil=Psychiatry

Goal

To identify interventions that work in real-world situations, with effective adaptation to specific populations, cultures and circumstances.

Key elements

To test a Deployment-Focused Intervention Research approach with two specific interventions; we:

- Tailored and conducted research where care takes or will take place
- Using evidence-based interventions/principles
- Attending to culture
- Addressing resources
- Incorporating inexpensive technology
- Guiding policy

Details

This research approach develops interventions that can and will be delivered beyond the research project: we are thinking about dissemination and uptake from the get-go, and involving key policy makers in the planning from the beginning. We ensure that the interventions can practically be delivered by the available level of service providers: physicians don't have time, so we use task-shifting. Interventions must be cost-effective, the briefer and simpler the better, so we use a stepped-care model, moving up only when needed, according to severity.

We developed a four-stage translational model to adapt interventions to culture, which involves much more than language (we adapted both for Brazil: one for HIV patients in primary care; and in the other, for psychiatric patients in care). The four stages are: 1) Optimizing Fidelity – HIV Prevention Principles; 2) Optimizing Fit – Adaptation Principles; 3) Balancing Fidelity and Fit – Intervention Adaptation; 4) Pilot Testing and Refining – Final Intervention.

Outcomes so far

We were able to successfully adapt and implement the two interventions, and demonstrate their effectiveness in our target populations. Some findings from each of the two projects include:

- In patients with more severe health challenges, our stepped-care model proved effective, and the project showed that an inexpensive technologically-based intervention that places little additional demands on clinic staff is feasible and potentially efficacious among these patients.
- This inclusive research process led to us completing recruitment 7 months ahead of time.
- Counselors with no prior experience with specialized substance treatments were able to deliver the intervention.
- By using a tool that was designed together with key decision makers, we became partners in this work, instead of calling them after the study is done with results, but little credibility.
- We are holding dissemination Conferences with participation of Brazilian researchers and coordinators of *both* mental health *and* HIV/AIDS programs of the Brazilian Ministry of Health.
- The project has been instrumental in planning future activities with those who fund and implement: research, training, services implementation and policy.

Policy/ Program/ Project: **The Hotel study**
Presented by: William Honer
For more information: http://www.bcmhari.ca/faculty/honer-william.php

Goal

Longitudinal study to assess co-occurring disorders in a very socially-disadvantaged population at risk of losing housing in Vancouver.

Key elements

- Identify and address needs of population living in 'single-occupancy hotels' in Vancouver's downtown Eastside; most live in significant poverty and have been previously homeless
- Previous studies have identified very high rates of drug abuse, HIV, Hepatitis C, injected drug use

Details

- To obtain robust numbers, approach has been to try and recruit every person living in a specific hotel; getting about 90%, with retention of 75%-85% at one year
- Detailed baseline assessments - start with neurological exam, physical, MRI, virology, hematology
- Follow participants monthly with basic information, and at one year, repeat full-scale assessment
- Providing health services opportunistically, as problems are identified and participants willing

Outcomes so far

Only preliminary information so far, but among findings is a lot of undetected chronic illness:

Significant drug dependence:
- Mostly multiple substance abuse: tobacco, cocaine, alcohol, and associated health risk behavior, e.g. risky sex
- Injected drug use - half are in daily use, but shared syringes are rare, almost all use exchanges (75% use InSite)
- Shared pipes for crack create high risk for transmission of Hepatitis c

Mental illness:
- 85% have one, psychosis is surprisingly high, in about half, while one third have mood disorders
- Virtually everyone in this population has been exposed to horrifying trauma experiences, but overall diagnosis of post-traumatic stress disorder is surprisingly low
- About half have been treated for mental illness at some time, but only 9% ever institutionalized

Cognitive functioning:
- After a battery of tests, memory is a big concern,
- Neurological illness widespread
- Two-thirds describe having head injuries in past, but we find more when assessed: we can see aneurysms, risk of stroke - many examples of loss of brain tissue related to all sorts of different causes

HIV
- Rates of HIV are 19%; we only found one person whose status had been unknown
- 95% have virus suppression even though adherence in less than 50% - these people can be treated
- HIV detection and care is high, sets a standard for mental illness, where few being treated and cared for

Policy/ Program/ Project: **Positive Spaces Healthy Places**

Presented by: Jay Koornstra

For more information: http://www.pshp.ca/

Goal

Determine whether stable housing can help prevent HIV and improve care, through Canada's first longitudinal community-based study on housing, health and HIV.

Key elements

Study objectives:

1. Establish a baseline and ongoing analysis of housing status of people with HIV in Ontario
2. Examine factors affecting housing status and stability of people with HIV, the impact on physical and mental health and access and utilization of health care, treatment and social services
3. Determine housing options desired or required by people with HIV that ensure access to health care, treatment and social services
4. Identify the range of housing and supportive housing options currently available to people with HIV in Ontario
5. Identify characteristics of appropriate housing and supportive environments for people with HIV that would be applicable at various stages of the disease course
6. Determine variations in housing and homelessness experiences of people with HIV

Details

People with HIV/AIDS who experience housing instability are more likely to have addiction and substance use issues (31 – 54%); experience a higher prevalence of depression (50-64%); have lower CD4 counts, higher viral loads, and higher mortality rates. They are less likely to access services or adhere to treatment.

Moving increased depression –moving more than 3 times, made a big jump; a sense of belonging in one's neighborhood was important, creating it or maintaining it kept/ brought depression down.

Outcomes so far

- Demonstrated that housing = Prevention, Health, Good health care, Good policy, Reduced transmission
- Provided evidence that has catalyzed a range of new investments in housing for people living with HIV
- Organizations like Bruce House often lack resources and expertise to appropriately support people living with HIV/AIDS and having mental health / addiction issues; we are now collaborating with other experts and community organizations to supply services we could not provide alone, and to influence policy together.
- Innovative programs such as Intensive Case Management and housing supplements are essential components in addressing the mental health, substance abuse, and housing needs of people living with these HIV co-morbidities.
- Started a national collaboration to influence national/provincial policy around HIV, housing and health
- Continuing to influence the Canadian Government to create a national housing strategy

Policy/ Program/ Project: **At Home/ Chez Soi**
Presented by: *Tim Aubry*
For more information: http://www.mentalhealthcommission.ca/English/Pages/homelessness.aspx

Goal

Demonstration project/ multi-site trial in 5 Canadian cities testing different ways to implement "Housing First"

Key elements

- $110M federal funding over 5 years, mostly supports services but also includes research integrated from start
- "Housing First" approach include a huge premium on choice; scattered sites (mostly private units); rent supplement to ensure only 30% income is spent on rent; and an emphasis on making sure rent is paid
- Housing workers work closely with mental health workers. Treatment and support services are voluntary, individualized, culturally appropriate, portable. Model is being extended to include primary care, vocational supports, and special populations
- There are no conditions on housing readiness; participants are not required to engage in treatment

Details

- Largest community mental health project combining housing and support in the world
- Requirements are that rent is paid direct to the landlord, and weekly visits by support team
- Most participants are from shelters or streets – 80% absolutely homeless, extensive histories of homelessness
- All have one or more serious mental health issue – many reported multiple, concurrent disorders with substance abuse; 35% reported symptoms of moderate to high suicide risk
- Over 90% have at least one chronic physical health condition, self-report 23% Hep B/C, 4% HIV
- Face multiple challenges: 94% were unemployed, 55% did not complete high school, very severe poverty
- Really worked hard to integrate primary care by linking or bringing on teams – it's not just mental health
- Homelessness costs Canadians $1.4B per year

Outcomes so far

- Re-housing is an expected part of Housing First; it may take several different apartments before people find a place that works out. About 70% are still in first, 20% in second: seeing beginning of housing stability
- Idea is to start with housing, rather than saying you're not ready, you have to deal with your substance abuse, get your mental health issues under control first. "We're finding that once people get housing - privacy, being independent, feeling safe – it's only the beginning, then they're thinking about the next chapter of their lives." They want to go back to school, look for vocational training, so service array is one area that needs more work
- Anecdotally – what we're hearing so far is how transformative it's been for people. The level of appreciation is overwhelming

Policy/ Program/ Project: **Standards for psychological support for adults living with HIV**

Presented by: Ruth Lowbury

For more information: http://www.medfash.org.uk/

Goal

Develop standards for psychological support for adults living with HIV

Key elements

- Developed in partnership with the British Psychological Society and the British HIV Association
- Needed to start with agreement on definition of psychological support
- Key to success - Consciously designed not to be specific to any one professional group; the standards include promoting positive mental health, and apply to all providers in clinical as well as community settings
- Published November 2011

Details

- British Psychological Society wanted to take forward a recommendation to develop standards, came to us as we have a history of developing standards
- The project was undertaken in response to reporting of very different practice across the country; there can be very limited infrastructure for psychosocial support
- Although a lot of good medical guidelines for HIV exist, there is nothing that addresses the psychological side of needed care
- The partners included many of professional and voluntary organizations

Process:

- First step was to produce definitions of the standards we were going to support
- We checked priorities with key stakeholders and modified them
- Drafts were posted for consultation, comments were invited, drafts were refined
- We formally sought endorsement from all the professional organizations on working group, to give it legitimacy, credibility and strength with the people we wanted to use it.

Outcomes so far

- Eight standards were produced, with clear pathways in a stepped model of care
- Ongoing dissemination is being undertaken by the individual stakeholders, who are acting as champions and seeking opportunities for further funding if/ where can
- Next goal to produce a brief summary that is more readily accessible
- We didn’t originally have the capacity to deal with issues for children; another group is now addressing

Policy/ Program/ Project: **Speaking Books for HIV/Aids and Mental Health Literacy**

Presented by: Elizabeth Matare

For more information: http://www.sadag.org/

Goal

To provide critical health information about HIV and mental health in contexts of low literacy, poverty

Key elements

- Created "Speaking Books" to address stigma and discrimination, provide support where health workers are few
- Communities empowered to look after their health, as their health is their responsibility
- Some books targeted to children, distributed in schools, as a lot of children need this care
- Hard cover, colourful local illustrations, 16 pages with 30-second soundtrack per page
- Distributed through Home-Based Care Workers and Health Promoters during capacity building workshops
- Multi-lingual, using appropriate languages for the region, and role models for soundtrack
- Local reach and Access through clinics, hairdressers, taxi ranks, taverns, women's clubs, weddings, bus stations, churches, mines, football games
- Produced for the Regional Psychosocial Support Initiative (RePSSI) with various partners

Details

- In South Africa, 1 in 10 people have HIV, and 1 in 5 has mental health issues – but there is no recognition of the existence of latter. National strategies for HIV/AIDS are explicit and don't include mental health. Donor driven programmes on HIV/AIDS fund physical health problems, but complete exclude mental health, so how do you integrate services?
- Stigma and discrimination are high, providers few, and most remains undetected/unaddressed
- Global illiteracy is high, and a potentially life-threatening health issue: it limits understanding of medical procedures, prescriptions, ability to navigate the health system; and confuses medical regimen.
- Books are based on country-specific needs assessment for health care information on HIV and mental health

Outcomes so far

- Speaking Books open discussion on stigmatized health care issues, in privacy, and address stigma, attitudes
- Helping early recognition of mental health problems, diagnosis and treatment options
- They appeal to several senses, help focus attention and are more effective at conveying accurate messages; messages are heard as well as seen and easily retained
- In the absence of trained personnel, the tool empowers self-education in local languages
- Don't use electricity
- Encourage social/behavioural change
- Free standing, cost effective and good impact with a multiplier effect: each book reaches at least 27 people
- Proven to be a solution in raising the profile of HIV/ AIDS and mental health
- Useful step in larger efforts to reduce stigma, raise awareness, and influence government policy towards greater recognition and integration of mental health

Policy/ Program/ Project: **2-Spirited People of the 1st Nations**
Presented by: Art Zoccole
For more information: www.2spirits.com/

Goal

To create a space where Aboriginal 2-Spirited people can grow and come together as a community, fostering a positive image, honoring our past and building a future - bridging the gap between 2-spirited lesbian, gay, bisexual, and transgendered communities, and our Aboriginal identity.

Key elements

- Provides HIV/AIDS education, outreach, prevention, support and counseling, harm reduction education, health promotion
- Incorporates traditional Aboriginal healers and medicine people into helping out people going through a mental health issue; provides social, cultural and recreational activities
- Works in partnership with other Aboriginal agencies (who serve about 70,00 Aboriginal people living in Toronto) to connect clients with services such as traditional sweats, visiting Aboriginal elders
- Works with regional government to provide harm reduction approaches and interventions- exchange, condoms, crack kits – and mental health services.

Details

"I consider us to be living behind the sandbags in this war."

We have found 100% of our clients are experiencing mental health issues, including depression, substance abuse; we are addressing a wide range of complex issues with only a few staff, and no psychiatrist in the agency.

A key component of our agency is being the place where people can always go, no matter what – we don't force them to go to appointments, or to change; rather, we work with them in the condition in which they want to be served. For our clients, we are their last resort.

Outcomes so far

- One-of-a-kind agency, must address stigma and discrimination not only of HIV, but also homophobia; we developed a non-discrimination policy, took out to and worked with to Aboriginal agencies across Toronto.
- Counselling and referrals, practical assistance (with a client list of two hundred plus).
- Outreach and education includes workshops, presentations, group discussions, talking circles and training sessions.
- Volunteer and development services program includes community events, volunteer programs, social and cultural events (with assistance from traditional spiritual people); we have eighty active volunteers.
- Long-term care program includes Buddy Program, Palliative Care and Long-Term Care.
- Research program, curriculum development project to address the health access needs of Two-Spirited people.

Suggestions emerging from Dialogue discussions

Project	Goal	Key elements	For more information:
WhizzKids United South Africa Operated by Africaid	Deliver excellence in HIV & AIDS prevention, care, treatment and support to youth worldwide through the medium of football	Uses the game of football to educate adolescents about life skills, gender equality, health, HIV and AIDS prevention; 3 month programme: • Health Academy – counselling, support, testing, treatment • Life Skills • Mixed Gender League – becoming teammates rather than victims • Peer Education	http://www.whizzkidsunited.org/ *(Can follow-up with Louise Balfour)*
Lifesavers condom covers Pauktuutit Inuit Women of Canada	Increase awareness, education about importance of condom use	• Country-food flavoured condom covers – meant to be funny and catch attention	http://www.pauktuutit.ca/hiv/downloads/Posters/condom_poster.pdf
Diffusion of Effective Behavioral Interventions (DEBI) project US Centers for Disease Control and Prevention (CDC)	Create resource to respond to prevention service providers who requested evidence-based interventions that work	• Annually updated online Compendium of Evidence-based HIV Prevention Interventions includes behavioral interventions that have been scientifically proven to significantly reduce HIV risk. • Now includes over sixty evidence-based individual-level, group-level, and community-level HIV behavioral interventions. • Training and technical assistance (TA) are provided to ensure sustainability of these effective intervention programs.	http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm
Talking points NAM, UK	To help people talk to their doctor about HIV treatment, to optimize treatment and improve adherence	• A web tool, creates a checklist to take to the doctor • Helps build up a list of important issues to talk about, to help ensure the most appropriate treatment is selected and adherence issues are addressed • CATIE in Canada is to revise the tool, use in Canada as a funky app to download onto smart phone.	http://www.aidsmap.com/resources/Talking-points/page/2142225/
Positive Outlook: Working with HIV, Depression and Rehabilitation Canadian Working	Builds capacity for front line AIDS and other health care and rehabilitation workers to identify and appropriately address depression among people living with or vulnerable to HIV or other	• Developing and piloting a course with front line HIV and rehabilitation workers across Canada • Often those most likely to encounter people living with mental health issues are the least likely to have any relevant training, aren't able to deal with difficult clients and end up frustrated with being unable to do anything.	http://www.hivandrehab.ca/EN/information/care_providers/PositiveOutlookWorkingwithHIVDepressionandRehabilitation.htm

Project	Goal	Key elements	For more information:
Group on HIV and Rehabilitation	episodic illnesses	- Develop a network of all course participants as a mechanism for ongoing support and sustainable learning.	
Masivukeni (let's wake up) South Africa Columbia University	Adherence to HIV care and treatment intervention being piloted in South Africa	- Based on a proven dyadic-focused adherence intervention called "SMART Couples" - Provides detailed protocol for counselors to follow when helping non-adherent patients - Provides patients with interactive activities and videos that help explain the importance of adherence - Enlists support from someone in their social support network so that together they can understand the importance of adherence	http://masivukeni.ccnmtl.columbia.edu/
International Indigenous Working Group on HIV/AIDS	Strengthen the collaborations between international Indigenous communities and stakeholders in the fight against HIV/AIDS, through the networking and sharing of wise practices, and promoting culturally-appropriate knowledge transfer	- Increase integration of HIV/AIDS and Indigenous peoples at the international level - Improve meaningful inclusion of Indigenous peoples in research policy and program development - Ensure Indigenous peoples are more accurately represented in HIV/AIDS epidemiological data - Increase support for capacity development to integrate HIV/AIDS and Indigenous peoples - Ensure that Indigenous and Aboriginal HIV/AIDS issues are presented at the IAS in Vienna	http://www.iiwgha.com/en/#/homepage/
CIHR Institute of Aboriginal Peoples' Health Canada	Fosters the advancement of a national health research agenda to improve and promote the health of First Nations, Inuit and Métis peoples in Canada, through research, knowledge translation and capacity building	- One of the 13 Institutes created as part of the Canadian Institutes of Health research (2000) - Made possible significant Aboriginal research initiatives and scholarships in Canada - Developed to help fill in the gaps in our knowledge why the health of Aboriginal people is worse than the health of other Canadians - Not only focused on illness, but on wellness too. For instance, we want to know how factors such as Aboriginal culture and spirituality can affect health and wellness	http://www.cihr-irsc.gc.ca/e/8668.html *(Can follow-up with Louise Nadeau)*
National Aboriginal Youth Council on HIV/AIDS	Aboriginal Youth from across Canada worked together on a National Aboriginal Youth Strategic	- Create an inventory of existing Aboriginal, youth-specific HIV prevention messages/programs - Review selected literature on HIV/AIDS prevention messages for	http://caan.ca/2010/08/31/canadian-aboriginal-aids-network-12th-

Project	Goal	Key elements	For more information:
Canada	Action Plan for HIV/AIDS	Aboriginal and Indigenous youth - Make recommendations on how to design, develop and implement effective Aboriginal, youth-specific HIV prevention messages	annual-general-meeting/?lang=en
Special Needs Clinic New York-Presbyterian Morgan Stanley Children's Hospital/ Columbia University Medical Center USA	Provides comprehensive mental health services for children, adolescents and parents infected with HIV or living with HIV in the family	- Innovative model of care has capacity to treat multiple members of a family, with the individual mental health problems of each person addressed in a context of attention to the needs of family - Deals with mood, anxiety and children's attention and behavior; family conflicts; and coping with illness and adherence - To support adherence, works closely with HIV primary care providers - Team includes psychiatrists, psychologists and clinical social workers, along with case managers and a teacher	http://childrensnyp.org/mschony/specila-needs-clinic.html
Ontario HIV and Substance Use Training Program Canada	Provides training to substance use, mental health and allied service providers in Ontario in order to increase knowledge of HIV/AIDS and to promote skills development	- Focus on front-line service providers - Funded by Fife House and provincial government - Two-day interactive training course - Services are offered free of charge across the province - Workshop Topics include: HIV/AIDS 201, Harm Reduction, HCV and HIV Co-infection, Substances 101, Stigma and Discrimination, Disclosure and Legal Issues, Counselling Issues	http://www.ohsutp.ca/
iSpeak: Exploring the HIV-related perspectives, needs and challenges of African, Caribbean and Black (ACB) heterosexual men in Ontario Canada	Engage African, Caribbean and Black (ACB) heterosexual men in the response to HIV, and engage researchers, service providers, policy makers and other stakeholders to address the HIV-related needs and circumstances of ACB heterosexual men	- Understand the HIV- related needs, challenges and priorities of ACB heterosexual men, and possible strategies to address them; - Understand the current program environment, identify gaps in the knowledge base, and determine research needs to support programs and policy; develop a research team representing primary stakeholder interests; develop at least one research study to address the most pressing priority; and - Initiate a process to strengthen program and policy responses related to ACB heterosexual men among ACCHO members.	http://www.srchiv.ca/en/index.php/research/project/ispeak#abstract
Regional Psychosocial Support Initiative (REPSSI)	To ensure that all children have access to quality social and emotional support.	- Working to lessen the devastating social and emotional impact of HIV and AIDS, poverty and conflict among children and youth in 13 countries in East and Southern Africa - Maintain partnerships with governments, development partners, international organisations and NGOs in the region.	http://www.repssi.org/ *(Can follow-up with Melissa Sharer)*

Project	Goal	Key elements	For more information:
Africa		- Provide technical advice and assistance to partners who implement programmes which strengthen communities' and families' ability to care for and protect their children and youth.	
Positive Leadership Development Institute Canada	To support people living with HIV to realize their leadership potential and increase their capacity to participate meaningfully in community life	- Partnership between and Ontario AIDS Network and Pacific AIDS Network - Core Leadership Training to identify personal values and philosophy; develop leadership skills and practices; gain community knowledge and awareness. - Board and Governance training - "Bored? Get on Board!" - Communications	http://ontarioaidsnetwork.on.ca/pha_leadership.php
AIDS Bereavement and Resiliency Program of Ontario Canada	To build worker, agency and community resiliency in the face of AIDS-related multiple loss and transition	- Assist workers to maintain high levels of human service - Helps organizations to retain invaluable professional staff and volunteers, including board members - Helps communities to respond effectively to the diverse groups now requiring support	http://www.abpo.org/
African Centre for Childhood Africa	To build partnerships for the development and delivery of situated supported distance learning to support people working with and caring for children at risk, their families and communities	- Models of disclosure - Partnership of REPSSI, University of KwaZulu-Natal, UNICEF - Open Distance Learning Certificate Programme, with 500 students across 8 countries having completed - Developing a degree programme - Designed to enable people working with children at risk to begin obtaining a formal educational qualification which would enhance their effectiveness in working with children at risk and to place them on a clear path to professional and educational development.	www.acchildhood.org/ *(Can follow-up with Lorraine Sherr)*
HIV Clinical Resource USA	To serve as a central, online resource that equips individuals who provide services to HIV-infected individuals with current, state-of-the-art tools to ensure delivery of the highest quality HIV clinical care	- Collaboration of New York State Department of Health AIDS Institute, Johns Hopkins University - Tools include: Clinical Guidelines for the medical management of children, adolescents, and adults with HIV infection; Best Practices related to HIV clinical care; Educational Tools including teaching slide sets on HIV-related topics; Quality Improvement Materials; HIV-specific quality improvement software; and Clinical	http://www.hivguidelines.org/

Project	Goal	Key elements	For more information:
		Performance Data	
HealthyHousing.ca Canada	Dedicated to providing information related to Housing and HIV/AIDS across Canada	• Easy-to-use map of services related to HIV/AIDS and/or Housing across the country • Research and publications, articles written specifically for People Living with HIV/AIDS, Service Providers and Researchers, local info • Opportunity to ask questions to HealthyHousing.ca's Panel of Experts • Intended for People Living with HIV/AIDS, AIDS Service Organizations and Housing Providers; Researchers and Policy Makers	www.HealthyHousing.ca

Annex B: Dialogue Agenda

Monday, January 30, 2012	
08:30 – 09:00	**Registration**
09:00 – 09:30	Welcome and Introductions
09:30 – 10:45	Opening Panel: An Overview of HIV/AIDS and Mental Health • *Lorraine Sherr (Overview: HIV and mental health need)* • *Sean Rourke (neurocognitive)* • *Robert van Voren (human rights)*
10:45 – 11:15	**Break**
11:15 – 12:00	Facilitated Discussion
12:00 – 1:00	**Lunch**
13:00 – 15:00	Knowledge Café #1: Promising Practices in HIV/AIDS and Mental Health Policy and Programming amongst Specific Populations • *Women – Julie Maggi* • *Ageing and Long-term survivors – Louise Nadeau* • *African and Black Diaspora – Wangari Tharao*
15:00 – 15:30	**Break**
15:30 – 17:00	Panel Discussion: HIV/AIDS, Mental Health and ARV compliance • *Sean Rourke (neurocognitive)* • *Darien Taylor (adherence)* • *Louise Balfour (adherence)*
Tuesday, January 31, 2012	
09:00 – 10:30	Panel Discussion: Promising Practices in HIV/AIDS and Mental Health Policy and Programming amongst Indigenous Peoples • *Randy Jackson* • *Tracy O'Hearn* • *Art Zoccole* • *Rawiri Evans*
10:30 – 11:00	**Break**
11:00 – 12:00	Panel Discussion: HIV, Mental Health and Disability • *Emelia Timpo* • *Wendy Porch / Elise Zack*
12:00 – 13:00	**Lunch**

13:00 – 14:30	Knowledge Café #2: Promising Practices in HIV/AIDS and Mental Health Policy and Programming amongst Specific Populations • *Children and Youth – Melissa Sharer* • *MSM – Dr. Francisco Ibanez-Carrasco* • *Post-conflict – Ilana Lapidos-Salaiz*
14:30 – 15:00	**Break**
15:00 – 16:30	Panel Discussion: Promising Practices in HIV/AIDS, Mental Health and Substance abuse • *Milton Wainberg* • *William Honer* • *Louise Balfour*
Wednesday, February 1, 2012	
09:00 – 10:15	Panel Discussion: Promising Practices in HIV/AIDS, Mental Health and Housing • *Jay Koornstra* • *Tim Aubry*
10:15 – 10:45	**Break**
10:45 – 12:00	Plenary Discussion: Best Practice, Common Challenges, and Key Themes • *Ruth Lowbury* • *Elizabeth Matare* • *Taghi Yasamy* • *Rapporteur Report, followed by facilitated discussion*
12:00 – 13:30	**Lunch**
13:30 – 14:45	Open Space Discussions: Where Next?
14:45 – 15:15	**Break**
15:15 – 16:15	Plenary Discussions: Where Next?
16:15 – 16:30	Wrap-Up and Next Steps • Gloria Wiseman, Director, International Affairs Directorate, Strategic Policy Branch, Health Canada

Annex C: List of Participants

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USAID

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Tracy O'Hearn
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Colleen Price
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Canadian Treatment Action Council
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Sean Rourke
Professor of Psychiatry
Scientific and Executive Director
Ontario HIV Treatment Network
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Melissa Sharer
Senior Care and Support Officer
John Snow Inc (JSI)
AIDS Star-One Project
Washington, DC

Lorraine Sherr
Professor
Clinical Psychologist
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Gregory Springer
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