SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
HIV HEALTH SERVICES

# HIV MENTAL HEALTH SERVICES IN SAN FRANCISCO: ISSUES, CHALLENGES, AND OPPORTUNITIES

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# INTRODUCTION & SUMMARY OF THE PROCESS

Mental health services play a critical role in the Ryan White system of HIV care in San Francisco, providing both psychological and psychiatric support for persons living with HIV. Mental health services have long been ranked among the top 3 most important service categories by the San Francisco HIV Community Planning Council, and in the Council's most recent rankings, mental health services became the **# 1 core service category** for Fiscal Year 2024. Mental health services also receive a significant share of Ryan White CARE funding in San Francisco, including through Part A and B resources and through the federal government's Ending the HIV Epidemic (EHE) initiative, which is focused on newly diagnosed and virally unsuppressed populations. Ryan White Part A-funded mental health services made up **19.8%** of all dollars allocated for Ryan White core medical services in the San Francisco Eligible Metropolitan Area (EMA) during the most recent Ryan White Fiscal Year, not including mental health services that are part of the County's integrated HIV Centers of Excellence program. Part A mental health dollars are also the **third highest** allocated funded category of Ryan White Part A services overall, after only primary medical care and non-medical case management. HIV-specific mental health services have also received increasing support through the City and County of San Francisco, which has recently allocated expanded HIV mental health services funding specifically directed toward older persons with HIV, including long-term HIV survivors.

Yet despite increased mental health funding through the EHE initiative and the San Francisco General Fund, there has frequently been a lack of clarity regarding where HIV mental health service dollars are being spent, what individuals are receiving mental health services, and where any new mental health resources might best be spent to address key gaps and deficiencies in the system. This issue is complicated by the many possible levels and modes of activity that can make up what we call mental health services, and by differing personal perspectives on what the term mental health services means. While both public and private providers do an excellent job of utilizing existing mental health resources to meet the needs of persons with HIV, there is anecdotal evidence suggesting that some sectors of the HIV population may be having more trouble accessing services than others. Moreover, new and emerging mental health support approaches being utilized in other sectors and jurisdictions may offer potential strategies for more effectively spending new mental health funding should it emerge.

To shed new light on these issues, San Francisco HIV Health Services - the branch of the San Francisco Department of Public Health that oversees and administers local Ryan White HIV funding - commissioned an **external landscape analysis and**

**information-gathering process** designed to collect more information on where HIV resources are being spent and what populations are utilizing those services. More significantly, the process was designed to gather information from key informants working at a range of levels within both HIV and non-HIV mental health systems to determine the key gaps and barriers to care within the HIV mental health system, while seeking input from a diverse range of individuals living with HIV regarding their own experiences with the system.

HIV Health Services commissioned Robert Whirry, a well-respected Program Development Consultant with whom the division has a longstanding relationship, to conduct the assessment and provide a brief summary of findings and suggestions for system improvement for HHS to evaluate and implement. This resulting report is designed to provide a succinct overview of identified barriers, gaps, and issues identified through the information-gathering process, along with a series of potential approaches that could help address some of these issues given the current funding landscape. **The report is designed to serve as a new potential source of information to help support HIV Health Services in optimizing the mental health service while giving new information to providers, planners, policymakers, and the San Francisco HIV Community Planning Council.**

Overall, the consultant interviewed a total of **40** representatives of both HIV and non-HIV-specific public and private agencies and organizations offering mental health services in San Francisco. These interviews took place in the context of both one-on-one and group interviews between March and September, 2023, with participants representing a broad range of providers, community members, and HIV service specialists. **The key informant interviews collected information on barriers, gaps, and issues within the HIV mental health system, along with suggestions on how the existing system might be improved or enhanced.** The following individuals - listed below in alphabetical order- graciously gave their time to participate in the interview process:

- **Marcy Adelman, PhD**, Clinical Psychologist
- **Paul Aguilar**, Long Term Survivor Community Liaison, San Francisco AIDS Foundation
- **Robert Arnold**, LVN, Director of Integrated Care, San Francisco Community Health Center
- **Gregg Cassin**, HIV Health Counselor, Shanti Project
- **Agripina Ceja**, HIV Care Navigator, Shanti Project
- **Prescott Chow**, Co-Principal Investigator & Director, Pacific AIDS Education and Training Center
- **Vincent Crisostomo**, Director, Aging Services, San Francisco AIDS Foundation

- **Shawn Demmons**, MPH, Program Director, Pacific AIDS Education and Training Center
- **Sarah Dobbins**, MPH, PHD, PMHNP-BC, Psychiatric Nurse Practitioner, San Francisco Department of Public Health Whole Person Integrated Care, Street Medicine and Shelter Health
- **Cari Lee Donovan**, LCSW, Senior Behavioral Health Clinician, South Van Ness Adult Behavioral Health Services, San Francisco Department of Public Health
- **Joanna Eveland, MD**, Chief Medical Officer, Whole Person Care Program, San Francisco Department of Public Health Ambulatory Care Division
- **Dawn Evinger**, Communications Coordinator, Positive Resource Center
- **Kate Franza**, Managing Director, San Francisco Community Health Center
- **Braulio Garcia,** Executive Director, UCSF Alliance Health Project
- **Meredith Greene, MD**, Former Associate Medical Director, UCSF Home Health Care
- **Brad Hare, MD**, Chief of Infectious Diseases and HIV, Kaiser Permanente San Francisco
- **Bill Hirsh**, Executive Director, AIDS Legal Referral Panel
- **Lee Jewell, MA, AMFT**, Community Member, CAEAR Coalition Board of Directors Member
- **Lorena Jimenez**, HIV Services Manager, Shanti Project
- **Katy Katuzny,** Supervising Psychologist, UCSF Alliance Health Project
- **Helen Kim**, Clinical Social Worker Supervisor, Division of HIV, Infectious Diseases and Global Medicine, Zuckerberg San Francisco General Hospital
- **Joshua Laurel**, Associate Director of HIV Services, San Francisco Community Health Center
- **Courtney Liebi**, Coordinator, Getting to Zero San Francisco
- **Derrick Mapp,** Senior Services Care Navigator, Shanti Project
- **Ramon Matos,** Behavioral Health Services Co-Manager, UCSF Alliance Health Project
- **Ashley Mooney**, Behavioral Health Services Co-Manager, UCSF Alliance Health Project
- **Maceo Persson,** Special Projects Manager, San Francisco Department of Aging
- **Char Quarto**, LVN, Associate Director of HIV Services, San Francisco Community Health Center
- **Joe Ramirez-Forcier**, Managing Director, Employment Services and Training, Positive Resource Center
- **Johnny Rodriguez,** MSW, Program Manager, Black Health Center of Excellence San Francisco Community Health Center
- **Mary Shiels**, RN, MS, CNS, Associate Nurse Manager, Ward 86, Division of HIV, Infectious Diseases, and Global Medicine, Zuckerberg San Francisco General Hospital
- **Stephen Spano,** Staff Attorney, AIDS Legal Referral Panel
- **Liz Stumm,** Director of HIV Programs, Shanti Project

- **Chip Supanich,** Community Member, Shanti Project Board of Directors Member
- **Liliana Talero,** HIV Health Counselor, Shanti Project
- **Lori Thoemmes**, Former Executive Director, UCSF Alliance Health Project
- **Lance Toma, LCSW,** Chief Executive Officer, San Francisco Community Health Center
- **Alyson Trent**, HIV Care Navigator, Shanti Project
- **Marc Vincent, MA**, Program Manager, UCSF Center for Prevention of Heart and Vascular Disease
- **Michael Zaugg,** Program Director, Office of Community Partnerships San Francisco Department of Aging

In addition to key informant interviews, a total of **9** focus groups made up of persons living with HIV were convened between August and September 2023, which ultimately involved a total of **48** participants. These focus groups were designed to elicit information from a variety of subpopulations regarding mental health utilization and access issues, while seeking suggestions on how to improve or enhance the system. Focus groups were held in the context of both in-person sessions and Zoom-based sessions, and participants were provided with incentives for their participation. All sessions were recorded with full participant consent for recordkeeping purposes.

**Three community-based agencies provided significant support by working with the consultant to organize and conduct these focus groups: San Francisco AIDS Foundation (SFAF), San Francisco Community Health Center (SFCHC), and Shanti Project.**

- **San Francisco AIDS Foundation** organized and conducted **5** focus groups for: a) Mixed Serostatus MSM; b) MSM Long-Term HIV Survivors; c) Transgender and Non-Conforming (TGNC) Persons; d) Black / African American Men and Women; and e) Cisgender Women. **Vince Crisostomo** and **Paul Aguilar** were instrumental in organizing and convening these groups, with Vince serving as an expert facilitator of each group session. SFAF also generously donated the client incentives for these groups.

- **San Francisco Community Health Center** organized **2** focus groups consisting of: a) Transgender and Non-Conforming (TGNC) Persons and b) Current and Former Injection Drug Users. **Mark Heringer** led the effort to organize these groups, with support from **Martina Travis** and **Mackie Bella.**

- **Shanti Project** sponsored **2** additional focus groups - one comprised of existing Shanti Peer Volunteers, and the other a Spanish Language focus group attended by 27 total participants. The Peer Volunteer group was organized by **Nick Picciani,** while the

Spanish language group was co-organized by **Liliana Talero** of the Shanti Project and **Maricruz Moreno** of the San Francisco AIDS Foundation, with the latter focus group being held in person at SFAF.

Below is a summary of the focus groups, organizers, and participants:

**San Francisco AIDS Foundation-Sponsored Focus Groups:**

**1. Mixed Serostatus MSM Focus Group** - 7 Participants - August 4, 2023

**2. Long Term Survivor MSM HIV+ Focus Group** - 6 Participants - August 11, 2023

**3. Transgender & Non-Conforming (TGNC) Persons Focus Group** - 8 Participants - August 14, 2023

**4. Black Health Focus Group** - 4 Participants - August 29, 2023

**5. Cisgender Women Focus Group** - 6 Participants - September 1, 2023

**Organizers:**

- Vincent Crisostomo - Director, Aging Services
- Paul Aguilar - Long Term Survivor Community Liaison
- Dusty Araujo - Program Manager, Aging Services

**San Francisco Community Health Center-Sponsored Focus Groups:**

**6. Transgender & Non-Conforming (TGNC) Persons Focus Group** - 8 Participants - August 8, 2023

**7. Current and Former Injection Drug Users Focus Group** - 8 Participants - August 10, 2023

**Organizers:**
Mark Heringer – Capacity Building Program Manager
Martina Travis – TACE Program Supervisor
Mackie Bella – Clinical Research Coordinator

**Shanti Project-Sponsored Focus Groups;**

**8. Peer Volunteers Focus Group** - 3 Participants - August 15, 2023

**Organizer:**
Nick Picciani - Volunteer Program Manager

**9. Spanish Language Focus Group** - 27 Participants - September 29, 2023

**Organizers:**
Liliana Talero - HIV Health Counselor, Shanti Project
Maricruz Moreno - Case Manager, Latinx Health, San Francisco AIDS Foundation

**We are deeply grateful for the support provided by community members, persons living with HIV, and staff and planners at public and private organizations and agencies throughout San Francisco for making this report possible.**

# RYAN WHITE HIV MENTAL HEALTH SERVICES: RESOURCES & SERVICE UTILIZATION

## Overview of the Issue:

**The critical importance of mental health services in the overall continuum of HIV care is widely recognized**. According to the National Institutes of Health, the term mental health refers to a person's overall emotional, psychological, and social well-being. Good mental health helps people make healthy choices, reach personal goals, develop healthy relationships, and cope with stress.[1] Mental health issues are extremely common in the US, with **more than 1 in 5 adults** living with a mental illness.[2] In general, mental health issues can be categorized as either **any mental illness (AMI) -** defined as a mental, behavioral, or emotional disorder that can vary in impact, ranging from no impairment to mild, moderate, and severe impairment - or **serious mental illness (SMI),** defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Additionally, there are a multitude of life issues and conditions that can impact mental and emotional outlook, mood, attitude, behaviors, and well-being, including impacts related to exposure to trauma and life stressors, and impacts related to the use of substances.

The stress associated with living with HIV can significantly affect a person's mental health. According to the National Institute of Mental Health, persons with HIV have a significantly higher chance of developing mood, anxiety, and cognitive disorders than persons without HIV.[3] One meta-analysis found that persons with HIV are **twice as likely** to develop major depressive disorder than persons who do not have HIV.[4] This finding is echoed by studies which have found that **HIV-seropositive women** without current substance abuse exhibit a significantly higher rate of major depressive disorder and more symptoms of depression and anxiety than HIV-seronegative women with similar demographic characteristics.[5] Key issues contributing to mental health issues for persons with HIV include:

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[1] National Institutes of Health, *Mental Illness,* Updated March 2023, https://www.nimh.nih.gov/health/statistics/mental-illness

[2] Ibid.

[3] National Institute of Mental Health, *HIV and AIDS and Mental Health*, Updated November 2022, https://www.nimh.nih.gov/health/topics/hiv-aids

[4] Ciesla JA, Roberts JE, Meta-analysis of the relationship between HIV infection and risk for depressive disorders, *American Journal of Psychiatry*, 158(5):725-30, May 2001.

[5] Morrison MF, et al., Depressive and anxiety disorders in women with HIV infection, *American Journal of Psychiatry*, 159(5):789-96, May 2002.

- Experiencing a loss of social support, resulting in isolation;
- Experiencing a loss of employment or worries about finances and the ability to meet the cost of basic needs such as food and housing;
- Dealing with loss, including the loss of relationships or the death of loved ones from HIV;
- Stresses around telling others about an HIV diagnosis;
- Managing HIV medicines and medical treatment; and
- Dealing with stigma and discrimination associated with HIV/AIDS.[6]

According to the National Institute of Mental Health, the process of attempting to locate and secure mental health services can also **in itself** contribute to or exacerbate mental health symptoms among persons living with HIV.[7]

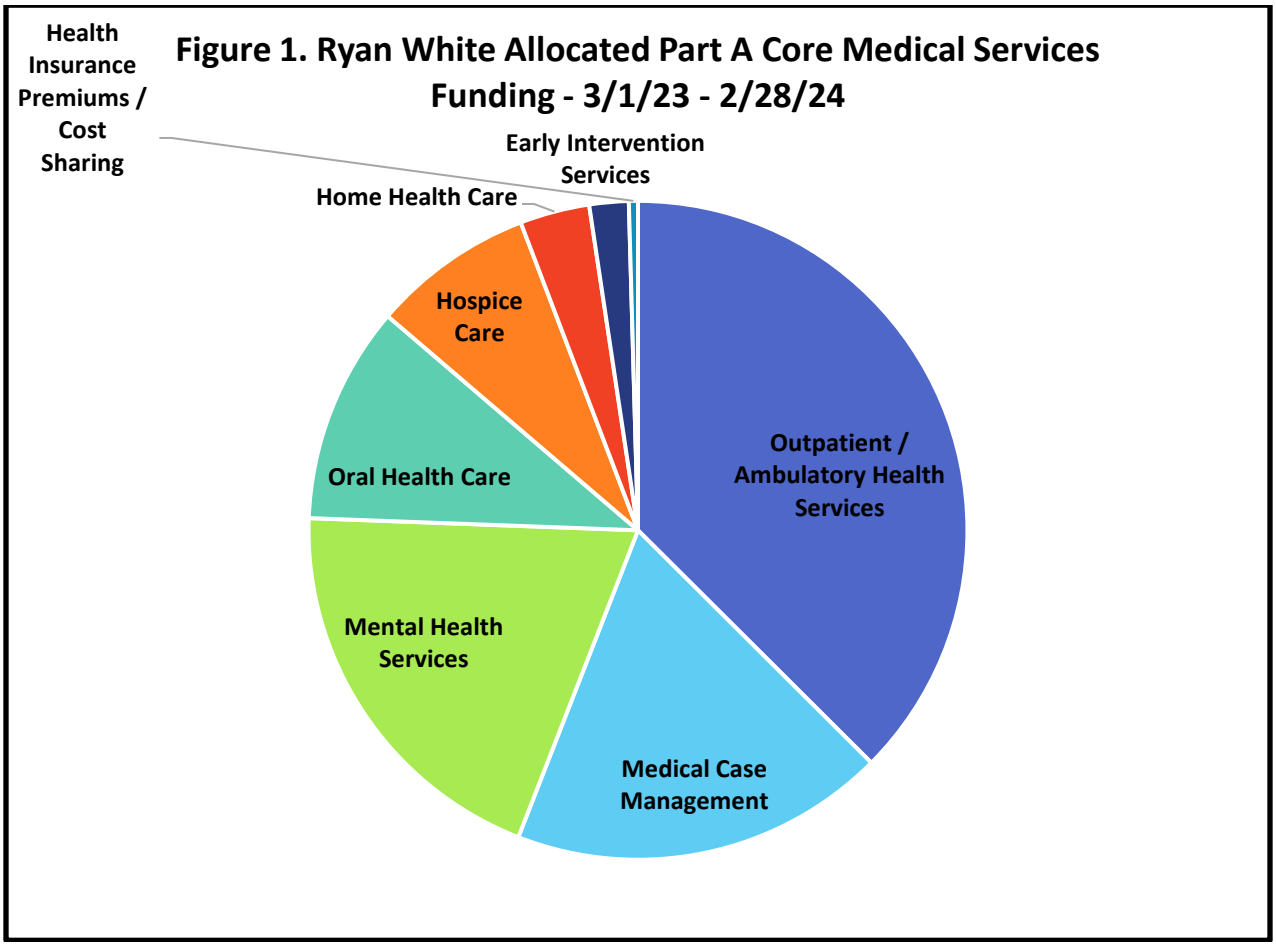
**Mental health issues can also contribute to substance use and the frequency of substance use disorders (SUDs).** Studies have consistently found that persons with mental health conditions such as anxiety, depression, or post-traumatic stress disorder (PTSD) may use drugs or alcohol as a form of **self-medication**.[8] While these substances may temporarily alleviate some symptoms of mental health disorders, they often make the symptoms worse over time. Additionally, brain changes in people with mental disorders may enhance the rewarding effects of substances, making it more likely they will continue to use these substances. **Substance use and SUDs can also contribute to the development of other mental disorders.** Substance use may trigger changes in brain structure and function that make a person more likely to develop a mental disorder.

Additionally, even when well controlled by antiretroviral treatment, HIV infection can result in chronic body inflammation. This inflammation can trigger neurological complications by damaging the spinal cord and brain, which form the central nervous system. Despite effective anti-retroviral therapies (ART), people with HIV are still at risk for central nervous system diseases associated with HIV. These diseases can be neurological, affecting the nervous system, or neurocognitive, affecting cognition or mental processing.[9]

[6] National Institute of Mental Health, *HIV and AIDS and Mental Health* Op Cit.
[7] Ibid.
[8] National Institute of Mental Health, *Substance Use and Co-Occurring Mental Disorders,* Revised March 2023, https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health
[9] National Institute of Mental Health, *HIV and AIDS and Mental Health* Op Cit.

**HIV Mental Health Resources & Service Utilization in San Francisco:**

**In San Francisco, the public HIV system of care continues to make significant investments in mental health services in order to address these and other challenges.** During the most recently completed Ryan White fiscal year, between March 1, 2022 and February 28, 2023, a total of **$1,548,552** in Part A funds was expended on HIV mental health services, representing **19.8%** of all expenditures for Ryan White core medical services and **12.9%** of expenditures for all Ryan White services combined. As noted above, mental health services are currently the **# 1 core service category** as ranked by the San Francisco HIV Community Planning Council, and Part A mental health dollars are the **second highest** funded category of Ryan White Part A core medical services (see Figure 1)

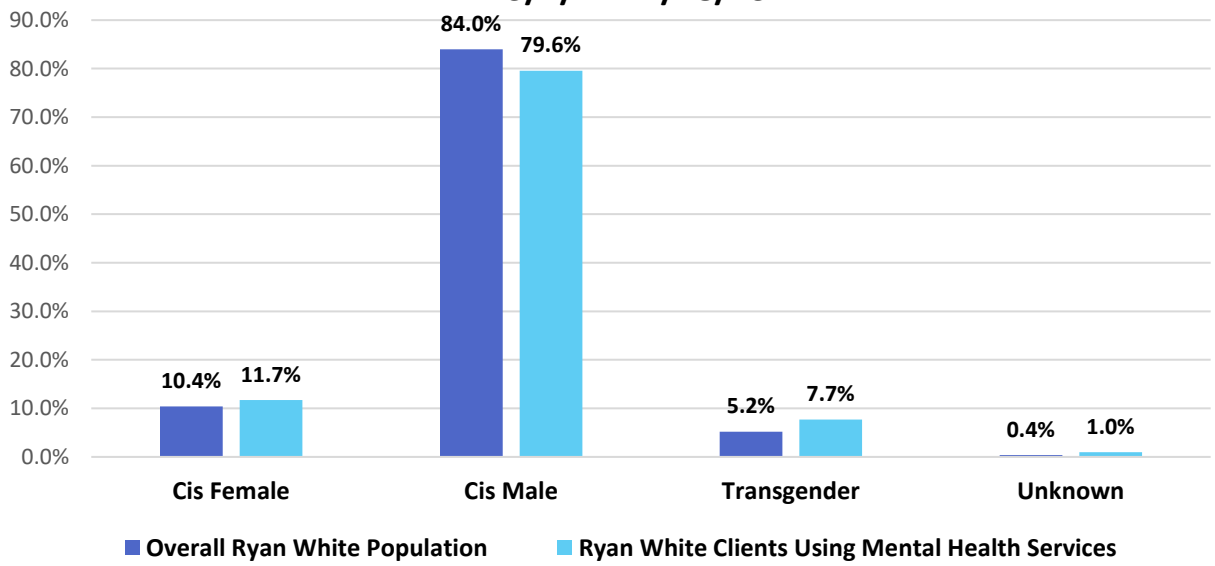



**Mental health services are a widely utilized Ryan White service.** Between March 1, 2022 and February 28, 2023, a total of **994** unduplicated individuals received Ryan White Part A-funded mental health services in San Francisco, representing **17.7%** of all persons who received Part A services during that period. Put another way - and including

Centers of Excellence clients - this means that roughly **1 in every 5** Ryan White clients received Part A-funded mental health services during the 2022-2023 Ryan White fiscal year. Ryan White-funded mental health allocations funded a broad range of mental health services, including individual and group counseling, mental health assessments and referrals, and psychiatric services.

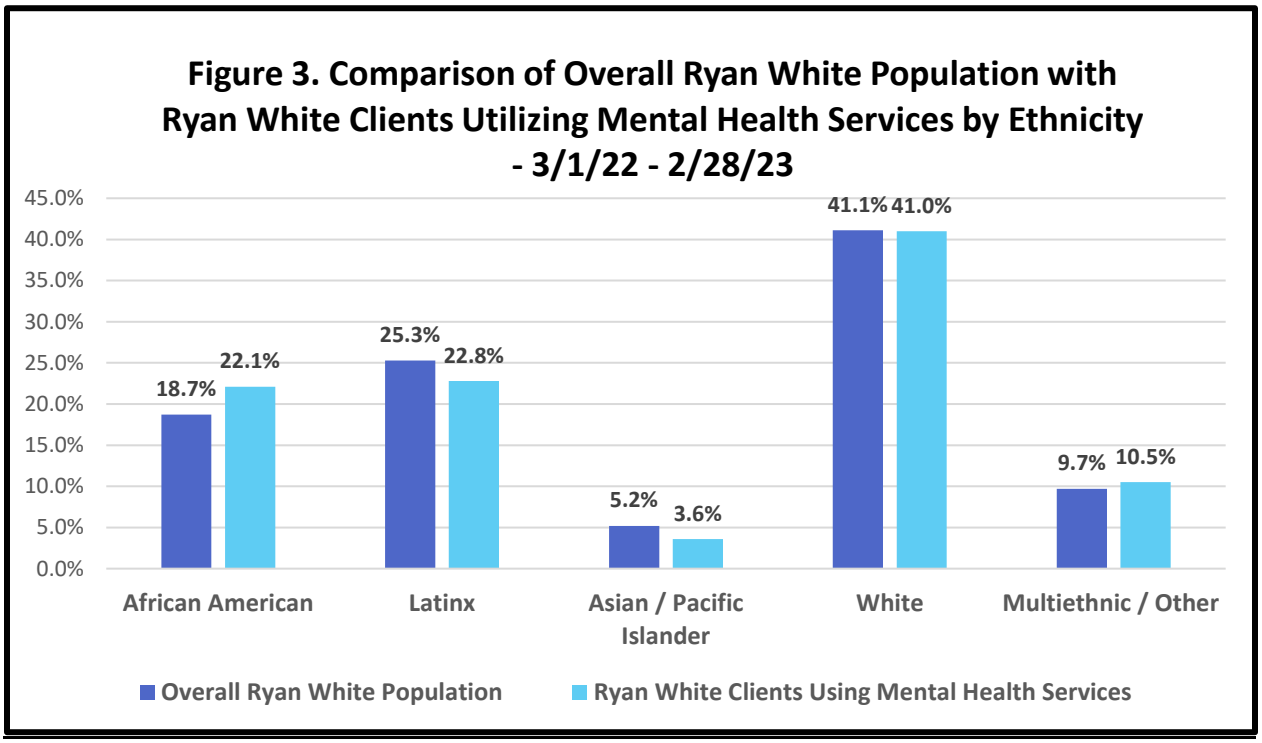
**Mental health services serve a broad spectrum of persons living with HIV in San Francisco.** Persons accessing mental health services largely mirror the overall demographics of the Ryan White population, and in many cases achieve higher rates of utilization among traditionally underserved groups as compared to the Ryan White population as a whole. For example, in regard to gender identity, while **10.4%** of all Ryan White clients are cis women, **11.7%** of persons who utilize Ryan White mental health services are cis women. Similarly, while **5.2%** of all Ryan White clients are self-identified transgender persons, **7.7%** of Ryan White clients who utilize mental health services are transgender (see Figure 2).

**Figure 2. Comparison of Overall Ryan White Population with Ryan White Clients Utilizing Mental Health Services by Gender - 3/1/22 - 2/28/23**




Similarly, in terms of ethnicity, while African Americans make up **18.7%** of all Ryan White clients, they comprised **22.1%** of clients accessing mental health services in FY 22-23. However, by contrast, both Latinx and Asian / Pacific Islander communities are under-represented in regard to mental health services. Latinx persons comprise **25.3%** of Ryan White clients but make up **22.8%** of clients utilizing mental health services.

Meanwhile, Asian / Pacific Islanders comprise **5.2%** of the total Ryan White population but make up only **3.6%** of persons utilizing mental health services (see Figure 3).




Finally, in terms of the age of Ryan White clients utilizing mental health services, there is a slight overrepresentation in mental health services among persons between the ages of 40 and 64, and an underrepresentation among persons with HIV between the ages of 25 and 39 and persons 65 and older. Persons between the ages of 40 and 49 make up **17.8%** of all Ryan White clients but comprise **21.2%** of Ryan White clients utilizing mental health services, while persons between the ages of 50 and 64 make up **42.5%** of Ryan White clients while comprising **44.1%** of mental health clients. Meanwhile, persons ages 25 to 39 make up **18.2%** of all Ryan White clients but only **17.1%** of Ryan White clients who use mental health services, while those ages 65 and older make up **20.6%** of Ryan White clients but only **17.2%** of clients utilizing mental health services (see Figure 4).

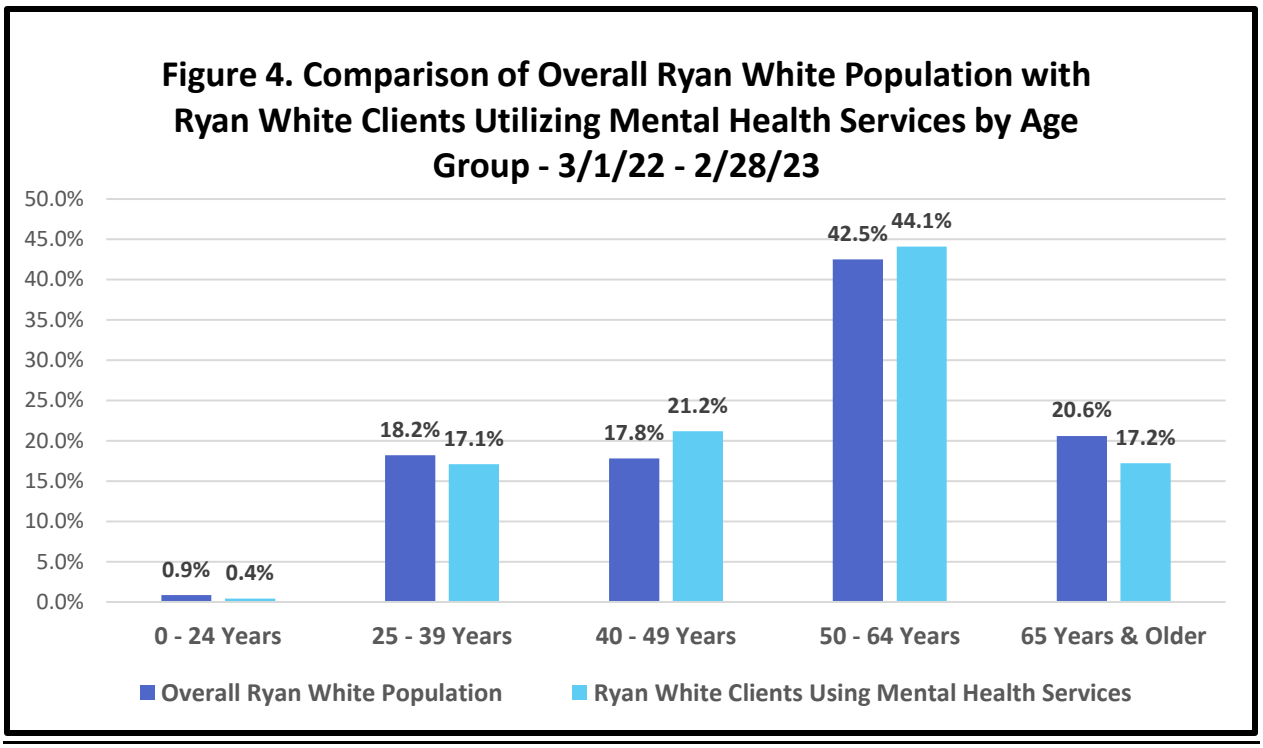


Figure 4. Comparison of Overall Ryan White Population with Ryan White Clients Utilizing Mental Health Services by Age Group - 3/1/22 - 2/28/23
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
0.9%
0.4%
18.2%
17.1%
17.8%
21.2%
42.5%
44.1%
20.6%
17.2%
0 - 24 Years
25 - 39 Years
40 - 49 Years
50 - 64 Years
65 Years & Older
Overall Ryan White Population
Ryan White Clients Using Mental Health Services

# ISSUES & CHALLENGES
# IN THE CURRENT HIV MENTAL HEALTH SYSTEM

## INTRODUCTION

**The San Francisco Ryan White HIV mental health system delivers a broad range of highly effective psychological and psychiatric support services to meet the needs of low-income persons living with HIV. These services are critical for preserving the health and well-being of persons with HIV, and play an essential role in helping these individuals achieve and maintain HIV medication adherence and viral suppression.** Public and private providers of HIV mental health services work assiduously, often under acute budget and staffing pressures, to deliver high-quality, trauma-informed, and culturally and linguistically tailored mental health services to clients living with HIV, and report high levels of client satisfaction with services received along with strong levels of mental health service adherence. As noted in the previous section, Ryan White-funded mental health services provide a vital lifeline for well over **1,300** unduplicated, low-income clients each year, virtually all of whom would be unable to access mental health care without these programs. Additionally, public and private agencies and programs provide mental health and behavioral health services for **thousands more** persons with HIV through public and private insurance programs and in association with a wide range of non-HIV-specific health and social services. This system - while often fragmented - nevertheless ensures that **many** persons with HIV have access to high-quality mental health programs that are essential to their health and well-being, and that contribute significantly to ending the HIV epidemic in San Francisco.

**At the same time, the needs assessment revealed a range of challenges facing the San Francisco HIV mental health system.** This is in large part the result of the assessment's specific focus on **issues, barriers, and service gaps** within the system, as opposed to placing an equal weight on those aspects of the system which are working well and are effectively meeting the needs of low-income persons with HIV experiencing psychological and psychiatric issues. **For this reason, the list below should <u>not</u> be seen as an indication that the existing system is not currently providing effective and impactful services, but rather as an exploration of areas that could benefit from expansion or restructuring should additional funding become available.** It is hoped that the list can serve as a jumping-off point for exploring new ways of better organizing and delivering services to meet the full range of HIV mental health needs in the city, given the reality of existing funding.

The list of issues and barriers below is divided into **two sections**. The first section focuses mainly on input received from key informant interviews, including from group

interviews conducted with Ryan White-funded HIV mental health agencies. The second section summarizes client input and comments received through the focus group process. However, there is necessarily overlap between these two sections, since many of the key informant interviews involved persons living with HIV who are utilizing or in need of mental health services.

**SYSTEMIC AND AGENCY SERVICE ISSUES:**

- **There is a widely perceived shortage of mental health and substance use disorder treatment services for persons with HIV in San Francisco, including psychiatric services.** Virtually all providers would prefer a service environment that not only has many more mental health and substance use providers, but that also includes a greater number of behavioral health assessment, navigation, and support personnel to coordinate care, manage individual clients, and increase rates of behavioral health retention for persons with HIV. **Providers recognize that this is not only a local problem, but a national one.**

- **There is an underlying dichotomy in the current approach of the HIV mental health system between services that are focused on persons who are not virally suppressed - including newly diagnosed persons and persons not in treatment - and services that are focused on meeting the often urgent needs of persons who are virally suppressed and stably engaged in care.** The federal Ending the HIV Epidemic (EHE) framework prioritizes services to persons who are **not** stably engaged in care and/or who are **not** virally suppressed, since these individuals are most likely to experience disease progression or to transmit HIV to others. This is related to the ultimate goal of EHE, which is to eliminate HIV transmission by ensuring that everyone living with HIV receives adequate treatment and support. However, the vast majority of persons living with HIV in San Francisco **are** virally suppressed and in care, yet still face urgent mental health service needs related to difficult and complex life circumstances, anxiety, depression, isolation, loneliness, substance use, past trauma, and other factors. These individuals not only require mental health care to reduce suffering and alleviate mental health symptoms, but to sustain their overall wellness and quality of life and ultimately **prevent** them from falling out of care or becoming non-compliant with HIV medications.

- **While many clients are able to access emergency services when they are not virally suppressed, are unhoused, or are unlinked to medical services, it can become more difficult to access these services once their lives are stabilized and they are fully engaged in HIV treatment.** Many aspects of the current system are geared to people in crisis or persons who are not virally suppressed - a situation that can sometimes

leave clients without services when they are stabilized, despite the fact that they continue to have many unaddressed needs. Paradoxically and unintentionally, this can provide a **disincentive for clients to remain healthy**, since a greater range of services can be accessed more quickly for clients who are disconnected from care or who are not virally suppressed.

- **There is a severe shortage of qualified and licensed mental health providers who are based in or willing to relocate to San Francisco, which often results in long-term vacancies for already-funded mental health positions in the city.** While this has been a problem for many years, the issue was exacerbated by the COVID-19 pandemic, which saw many therapists move to other locations, in part because of their increased ability to provide remote counseling services from any location in California. The high pressure, high volume service environments that typify many HIV service settings can also result in high levels of **staff attrition** among mental health providers.

- **At the same time, there is a severe shortage of mental health professionals who are members of historically marginalized groups such as persons of color, persons who speak a language other than English, and transgender / non-binary populations.** While agencies make continual attempts to recruit mental health providers from underrepresented groups, the task is difficult, particularly since such providers are in high demand in virtually all jurisdictions.

- **Many highly experienced HIV mental health professionals are aging out of the system and entering retirement, resulting in a declining number of HIV-specialist mental health providers who are highly experienced in working with persons with HIV, including providers who understand the needs of older persons living with HIV from a personal perspective.** This issue is affecting all levels of HIV care and support, and is one that is expected to become more acute over the coming decade.

- **As mental health professionals retire, many providers note that there is no organized system to ensure that clients whose provider is retiring are given a warm handoff to a new provider to avoid disruption of services.** This issue is parallel to the issue persons with HIV face when providers leave their positions unexpectedly.

- San Francisco is home to a relatively large population of persons with HIV who are living with severe and persistent mental illness, including clients dealing with conditions such as schizophrenia, bipolar disorders, major depression, and borderline personality disorder. These mental health conditions are often complicated by substance use disorders. **The current HIV mental health system does not have the**

**resources to efficiently and effectively address the needs of individuals with severe mental illness who appear at community-based HIV agencies seeking services while in crisis.** Agency staff often scramble to respond to the needs of these individuals, working to identify immediate services or resources for them which the agencies themselves cannot provide. This can in turn take up valuable hours of staff time that could be spent providing services to multiple clients with less acute issues.

- **The task of assessing, diagnosing, and treating persons with HIV who are affected by mental health disorders is often complicated by the effects of substance use and polydrug use, which can magnify or contribute to behavioral health symptoms.** Underlying issues such as depression, anxiety, or psychosis often lead individuals to self-medicate, which in turn can make it difficult for these individuals to remain in HIV treatment. In some cases, agencies may seek to diagnose, refer, or even treat substance-using persons with mental illness before their substance use issues have been identified and separated from their mental health conditions.

- **Similarly, many older adults with HIV who present with mental health issues may have cognitive difficulties related to age that are currently not being recognized by the system.** Some of these mental health and cognitive issues may be separate from one another while others may be overlapping. There may be a need for greater awareness of age-related cognitive challenges among service providers, along with expanded use of neuropsychological testing to assess issues around memory and cognition.

- **While many providers express frustration with the way the current HIV mental health system remains "siloed" from the larger mental health and social service system in San Francisco, the realities of HIV funding at times implicitly encourage agencies and programs to segregate services for persons with HIV from the overall mental health system.** A less segregated system could potentially allow for greater integration of services and expanded resource-sharing among behavioral health service providers. However, the relatively high levels of local and federal funding specific to persons with HIV continues to encourage the maintenance of a separate mental health service system specific to persons with HIV.

**ISSUES FOR PERSONS LIVING WITH HIV:**

- **Persons living with HIV in San Francisco are often frustrated by the difficulty involved in finding out what mental health services are available to them.** The system as a whole can often be confusing for clients seeking services, with a lack of clarity and coordination in terms of how or where to access services. Many clients

express frustration that there is no centralized directory, clearinghouse, or other resource that could allow them to learn what agencies and programs are providing HIV mental health services in San Francisco and to whom, along with more detailed information such as populations of focus, types and duration of mental health services provided by each agency, and whether or not waiting lists currently exist.

- **Persons attempting to access mental health services often confront a complex and frustrating system that can require frequent callbacks, conflicting messages, and long waiting periods to simply learn about services or to participate in an initial assessment.** For persons with HIV in crisis who are dealing with complex life issues and challenges, or who have experiences of past trauma that have already made it a challenge to seek services, this process sometimes inadvertently derails their search for mental health services before it has begun.

- **Persons with HIV who do identify an appropriate provider – particularly those seeking one-on-one mental health care and psychiatric services - must often wait for long periods of time before being able to see a mental health therapist.** Clients report that this problem is particularly problematic when they are in a personal crisis or experiencing acute symptoms. Many clients report that they are sometimes not contacted for weeks or months during the waiting period, and must call themselves to see where they stand in the waiting process.

- **As a result of funding and staffing limitations, mental health agencies providing free or low-cost one-on-one counseling usually must place limits on the number of consecutive sessions in which an individual can participate.** Similarly, both public and private insurers also often place limits on the number of covered mental health visits a client can access in a calendar year. Many clients stated that they felt that this limited period of time is not long enough for them to deal with and process all of the mental health issues they face. Some clients felt that at the moment they had built a strong foundation of trust and history with a therapist, the therapeutic period ended, leaving the client to begin the process of waiting for an entirely new therapist if they wished to continue receiving counseling. Often, there is a significant waiting period before being connected to the next counselor, and clients note that they must again begin to retell their story and establish a new therapeutic relationship from scratch.

- **Not every patient / therapist match is a perfect one, and the current system can make it difficult for clients to be rapidly linked to a new therapist when they are dissatisfied with their initially assigned counselor.** In some cases, where a new counselor option is not immediately available, clients must wait for long periods before being paired with another therapist. Some clients choose to continue with a

therapist with whom they do not feel a strong rapport simply because they need mental health support immediately.

- **Many clients express a desire to receive counseling services from a therapist who at least in some ways mirrors their own backgrounds and characteristics.** Many transgender individuals, for example, state they often feel safer and more comfortable entering a therapeutic relationship with another trans person who directly understands their struggles and needs, as opposed to a counselor who may not fully appreciate the specific traumas and barriers they have faced. Similarly, long-term MSM HIV survivors often state that they would prefer to obtain counseling services from another older MSM – preferably one living with HIV - who can appreciate the struggles and past trauma of older men with HIV who faced early "death sentences" and who had to endure the death of countless friends and loved ones, with the resulting loneliness and isolation of that experience.

- **In many cases, as a result of a lack of qualified personnel and limited financial resources, mental health counseling services are provided by younger trained interns who are completing their required hours of postgraduate supervised experience.** While this can often result in highly effective therapeutic relationships for many clients, it can be frustrating and unsatisfying to other clients, such as older individuals who sometimes feel that they need to "teach" the intern about their own reality.

- **Spanish-speaking clients report that there are fewer counseling options available with Spanish-speaking therapists, which means they must speak in English in order to access therapy**. However, because English is not their primary language, these clients feel they are not able to express their full range of issues and needs as clearly and fully as they would be able to do if they were speaking to a counselor in their native language. There is also a lack of understanding of the cultural and linguistic differences that exist between different Spanish-speaking countries. Clients spoke of a tendency to lump all Spanish-speaking individuals together as a single cultural entity, when in fact there are significant differences between Spanish speakers from different nations. And of course, for individuals who exclusively speak Spanish, the lack of Spanish-speaking therapists serves as an even greater barrier to accessing mental health services.

- **Older persons living with HIV - including long-term survivors who have lived with HIV for 30 years or more - have special and urgent mental health service needs which must continue to be a key part of the HIV mental health service continuum**. As of the end of 2021, **72%** of all persons living with HIV in San Francisco were age 50

and older (n=11,295) while fully **one-third** were age 65 and older (n=3,563). Many of these individuals are long-term survivors who were initially told that they had only 1 or 2 years to live, and who saw virtually all of their friends and loved ones die as a consequence of the virus. In the process, these individuals endured devastating trauma and loss which continues to impact the quality of their lives and mental health today. Many older persons with HIV - regardless of when they were infected with the virus - face issues of loneliness, isolation, anxiety, poverty, depression, substance use, and medical conditions that are both related and unrelated to HIV and the long-term use of anti-retroviral therapy**. In many cases, the COVID-19 pandemic and its accompanying experience of loneliness, isolation, and fear further triggered past trauma.** Some mental health providers stated that many older people living with HIV have minimized their mental health needs because of the difficulty in letting feelings in without the support of someone to process them with – a condition that in turn amplifies a personal sense of isolation and alienation. Also, despite the rapid growth of the older HIV population and the fact that an increasing percentage of older persons with HIV will be over the age of 65 and require more specialized care, some interviewees stated that the HIV mental health system has not significantly evolved over the past decades, and has not produced new models to either meet the growing demand for support or to ensure the availability of specialized, tailored mental health services specifically for an aging population. This issue of evolving the HIV care system to better serve older persons with HIV now and in the future may be an issue meriting further study.

- **When asked whether their individual case manager was helpful in locating needed mental health or substance use treatment services, a significant percentage of clients stated that they did not currently have a case manager, had never had a case manager, or were no longer in contact with their case manager because of a lack of adequate support or a dissatisfaction with the level of services received.** While having a case manager provides no guarantee that a client will access or receive HIV mental health services, it has been an unintended finding that so many clients are unaware of the support a high-quality case manager might provide them in helping pinpoint their needs and access services. Many clients stated that they were not aware of what a case manager was, or how a qualified case manager could help them assess their needs, receive HIV treatment support, and be linked to needed services. This is also an issue area that may merit additional exploration.

- **There are conflicting views on whether in-person or remote mental health services are the most desirable method of accessing one-on-one counseling services.** One of the results of the COVID-19 pandemic has been the development of new models for computer-based counseling sessions which in many cases have increased the rate of

appointment adherence and increased client satisfaction with services received. Some clinicians report that COVID facilitated a sea change that has enhanced the delivery of mental health services at a pace that might have taken 20 or 30 years without the pandemic. Conversely, some clients with HIV expressed a strong preference for in-person mental health services, feeling this resulted in a more personal, effective therapeutic experience.

- **There are still high levels of stigma regarding mental health services within many communities and subpopulations.** Some Spanish-speaking individuals, for example, note that seeking mental health services is still often viewed as shameful or as a sign of weakness that can cast a negative light on a client's entire family. At the same time, some African American clients are skeptical of the effectiveness or importance of mental health counseling, seeing it as an unnecessary luxury service for privileged populations that has little relevance for them. Some providers note that this can be a particular issue for populations who view the current system as skewed toward white LGBTQ+ persons and who are resistant to accessing mental health services that are seen as geared to men who have sex with men. Providers note that stigma regarding accessing mental health services also extends to clients who have a fear of psychiatric treatment or of long-term use of psychotropic medications.

# POTENTIAL APPROACHES & STRATEGIES TO ADDRESS ISSUES IN THE SAN FRANCISCO HIV MENTAL HEALTH SYSTEM

Despite limited influxes of funding through the Ryan White Ending the HIV Epidemic (EHE) initiative, the generally static nature of Part A funding creates significant limitations on the amount of new Ryan White dollars that can be used to address mental health service issues. **In light of this reality, it seems important to consider new approaches that have the potential to address at least some of the issues facing the HIV mental health system using either no new expenditures or relatively modest expenditures.** These new approaches could be supported through avenues such as expanded EHE support, increased San Francisco General Fund support, or reallocation of existing Part A dollars, although none of these are guaranteed.

**Respondents were continually asked throughout the needs assessment process to offer ideas and suggestions on how the HIV mental health system could be improved using strategies that did not involve large influxes of new public funding.** This process yielded a number of exciting concepts and potential activities that are summarized below. The concepts are loosely organized by topic area, although there is necessarily some overlap among these sections. Some concepts address stated gaps and barriers within the HIV-specific mental health system, while other address the need to **remove HIV from its traditional silos and build new collaborations that can draw more resources and support for non-HIV specific providers and resources.** The list below is also in no way intended to serve as a set of recommendations or prioritized action steps, but rather as a list of **potential activities** that could help improve and enhance the existing HIV mental health system given current fiscal realities.

## Training and Capacity-Building Strategies:

- **Develop and provide detailed, specialized training to HIV medical and psychosocial case managers and behavioral health and client navigation staff on HIV mental health conditions and available services in San Francisco.** This training would ideally include information on: a) basic mental health symptoms and conditions as they affect subpopulations of persons with HIV; b) the intersection of mental health and substance use issues and conditions; c) the structure and approach of various types of mental health services; and d) the specific mental health services available to persons with HIV in the city, including public and private HIV and non-HIV-specific programs. The goal of this training would be to increase the capacity and quality of case management, client navigation, and other staff to support persons with HIV in

locating and securing appropriate mental health and substance use treatment services, including potentially expanded client advocacy in relation to mental health placement.

- **Develop a training program for non-HIV-specific mental health providers in San Francisco that broadens knowledge, understanding, and clinical competency to serve general HIV populations and HIV sub-populations such as long-term survivors, persons with co-occurring disorders, members of ethnic and linguistic minority groups, and transgender and gender-diverse populations.** This training could be developed to fulfill Continuing Education Unit (CEU) requirements and provided as a multi-part series designed to increase the ability of non-HIV-specific behavioral health providers to better serve and address the needs of persons living with HIV from a wide range of backgrounds, in turn potentially reducing burdens on the HIV-specific mental health system.

- **Develop and provide training to staff of agencies that provide HIV mental health services for persons with HIV who have severe and persistent mental illness as it affects persons with HIV, including identification of resources available to address the needs of this population.** This training would include information on conditions and symptomology of severe mental illness, including information on the intersection of mental health and substance use issues. The training would also provide an overview of the local system of care for persons with severe mental illness; information on emergency resources to address the needs of these clients; and practical advice on effectively and sensitively supporting persons with severe mental illness in the context of existing agency procedures and systems.

- **Explore the expanded use of neuropsychological testing to assess issues around memory and cognition among older persons with HIV.** As noted above, some older adults with HIV - particularly those who report mental health conditions - may have age-related cognitive difficulties that are currently not being recognized by the system. An increased incorporation of testing designed to pinpoint age-related neuropsychological issues - including orientation and training in the use of these scales - could enhance the quality and effectiveness of services being delivered by the providers.

- **Develop and disseminate a set of best practices for identifying, nurturing, and supporting peers and consumers with HIV to make the transition to becoming behavioral health professionals.** Many HIV service agencies employ some form of full-time, part-time, or stipended Peer Specialists or volunteers who provide support to clients in a variety of areas. These peers are persons living with HIV who come

from a diverse range of backgrounds, experiences, and orientations. Some agencies have had considerable success in identifying committed Peer Specialists with strong communication skills and supporting those peers in training to fill a variety of behavioral health roles such as Alcohol and Drug Abuse Counselors, Licensed Mental Health Counselors, and Clinical Social Workers. Building the capacity of HIV mental health agencies to identify and support peers to become behavioral health professionals could help fill some of the gaps that currently exist in regard to mental health providers who better represent the full range of ethnic, linguistic, gender, age, and other characteristics of persons living with HIV in the city.

**Collaboration, Information, and Resource-Sharing Approaches:**

- **Convene a meeting between the San Francisco HIV service community and the San Francisco Department of Disability and Aging Services to explore new potential programs that utilize the Department's resources to augment services for older persons with HIV.** The San Francisco Department of Disability and Aging Services – a unit of the San Francisco Human Services Agency – manages a plethora of resources and programs specifically designed to promote health, safety, and independence for older adults ages 60 and older as well as veterans and people with disabilities of all ages, including supportive services, classes, recreational and socialization programs, and educational programs. While the agency has developed specialized initiatives for sexual and gender minorities, **the agency has not yet developed specialized programs for persons with HIV.** In large part this is due to the ongoing "siloization" of HIV services, through which persons with HIV are routinely assigned to other agencies and programs because of the distinct resources that exist for this population. **The Department is eager to collaborate with the HIV service community to develop and publicize programs that utilize the Department's diverse resources to augment the services that currently exist for older persons with HIV.** These resources could provide valuable new services for older individuals living with HIV.

- **Convene a meeting with representatives of the San Francisco Behavioral Health Access Line to ensure the quality, effectiveness, and appropriateness of information and support provided by the Line to persons with HIV, and extensively publicize the Line to HIV providers in the city.** Through its Treatment Access Program (TAP), the Behavioral Health Services Division of the San Francisco Department of Public Health provides a toll-free access line for persons seeking mental health and substance use treatment services. While it is unclear how frequently this line is used by persons with HIV, it could serve as a potentially valuable resource. By ensuring that the line provides high-quality and sensitive support to persons with HIV and

then broadly publicizing it throughout the HIV service community, the system could take advantage of a pre-existing resource to expand access to behavioral health service referral and linkage.

- **Publicize the availability of the California Mental Health Peer-Run Warm Line to HIV providers in San Francisco.** The California Mental Health Peer-Run Warm Line is a non-emergency resource for anyone in California seeking mental and emotional support. The Warm Line provides assistance via phone and web chat on a nondiscriminatory basis to anyone in need to address mental health issues such as challenges with interpersonal relationships, anxiety, pain, depression, finances, or alcohol/drug use. The Warm Line has the potential to serve as a valuable resource for persons with HIV seeking support from peers to address non-emergency behavioral health issues.

**Strategies Involving New or Expanded Service Approaches:**

- **Explore the expansion of peer support services as a strategy for increasing social support resources for persons with HIV while providing new avenues of community engagement for persons providing peer services.** Consumer-based peer services are a well-established approach to supporting persons with a broad range of conditions through trained peers who are reflective of the backgrounds, life experiences, and personal perspectives of the persons they assist. San Francisco offers many high-quality peer support programs that provide invaluable support to persons living with HIV, such as Shanti's longstanding volunteer peer support model and the San Francisco Community Health Center's Peer Ambassador program. The San Francisco Positive Resource Center (PRC) also operates a program that trains persons with HIV to become **Certified Peer Mental Health Specialists** whose work is directly reimbursed through Medi-Cal. These Specialists are paired with clients and receive ongoing clinical supervision from PRC staff. RAMS also maintains a similar, non-HIV-specific program along with a range of programs such as an intensive, 9-month Peer Internship training program. **While peer support services cannot replace mental health services through trained professionals, they could serve as a valuable source of support for persons with HIV that in some cases could lessen the need for mental health services or reduce mental health symptoms or pressures.** In San Francisco, these services could be particularly impactful while persons are awaiting placement in mental health services or to augment or reinforce traditional therapeutic relationships. Peer support programs also benefit the individuals delivering services, by providing social contact, an opportunity to contribute to their communities, and in some cases, augmented income.

**One approach to expanding peer services could be through a pilot program in which persons living with HIV who are members of underserved subpopulations, such as older individuals, transgender persons, and/or Spanish-speaking communities are recruited and trained to provide peer support to other persons with HIV, receiving stipends that augment their income without jeopardizing their public benefits status.** These trained peers could be paired with one or more persons with HIV to provide regular, one-on-one support through check-in phone calls, texting, meeting for coffee, attending a movie or social event, or accompanying clients to medical appointments. This could not only help alleviate social isolation and alienation for persons with HIV, but would also benefit the peer staff themselves by providing opportunities for socialization and for forming their own supportive networks. This program would ideally be coordinated with and linked to existing mental health service programs in order to maximize the value of peer services as an enhancement of the overall HIV mental health system and to ensure that peer support providers receive adequate ongoing supervision and support.

- **Conduct a survey among HIV mental health providers assessing the need for expanded psychiatric services, including the specific gaps and degree of need that exist within each organization.** Such a survey would identify how many clients have unmet or under-addressed psychiatric service needs at each agency and what specific kinds of psychiatric services could best address those needs (e.g., crisis psychiatric intervention, ongoing medication monitoring, clinical supervision, etc.).

- **Explore the possibility of supporting a full-time Psychiatric Nurse Practitioner who travels between HIV agencies on a rotating basis, or who serves clients from a central location on a designated day or days each month, in order to respond to psychiatric service gaps and needs at specific organizations.** Psychiatric Nurse Practitioners (PNPs) are advanced practice registered nurses who are trained to provide care to patients struggling with serious mental health and psychiatric conditions. Although not medical doctors, PNPs take on a role similar to a psychiatrist, and are able to diagnose conditions and to prescribe and monitor psychotropic medications at a lower salary level. Having a shared Psychiatric Nurse Practitioner whose time is divided among mental health service sites in need of psychiatric support could be a cost-effective approach to expanding access to psychiatric services for persons with HIV. The Psychiatric Nurse Practitioner could also support agencies that provide street-based services to unhoused populations by providing street-based psychiatry on a rotating basis.

- **Explore the possibility of opening an HIV-specific mental health drop-in center program that provides multidisciplinary, co-located behavioral health assessment,**

**linkage, navigation, and treatment services, along with psychiatric assessment services, in one location during designated times each week.** Having a range of mental health services available on a drop-in basis in a single location – or in several rotating locations – would allow persons with HIV to receive assessment and treatment from multiple providers while receiving support to access needed mental health services from on-site behavioral health navigation staff. If operated by a licensed agency, this model could incorporate extensive Medi-Cal billing to help support the costs of operating the center. The center could also incorporate on-site counselors or peers to provide an opportunity for clients to simply talk to someone about how they are feeling and to receive the support needed to go forward with sustaining and improving their lives. Additionally, for persons with HIV who have internalized stigma or pre-judgments in regard to mental health services, the opportunity to have an initial positive contact with a mental health professional could prove invaluable in increasing their interest in accessing mental health services on a longer-term basis.

- **Explore the development of a freestanding HIV Peer Wellness Center similar to that operated by RAMS for non-HIV-specific populations in which volunteers with HIV plan and lead a variety of education, enrichment, and support programs that in part address the mental health needs of persons with HIV.** The RAMS Peer Wellness Center offers a wide range of learning and socialization opportunities led by trained peers who offer a broad range of programs and services (see sample activities calendar at the end of this report). These include drop-in support groups for men, women, and trans persons; classes in gardening, music appreciation, and writing; and an impressive array of recreation and socialization opportunities. A similar program tailored to the needs of people with HIV – or specific sub-populations of persons with HIV – could prove a valuable addition to the spectrum of HIV mental health services in the city specifically addressesing isolation, loneliness, stigma, and depression.

- **Explore the development of a new quality of life metric that evaluates the importance of factors such as personal fitness, mobility, social support, anxiety and depression, physical pain, and degree of positive outlook in addition to viral suppression.** Dr. Meredith Greene participated in the CDC / HRSA Advisory Committee on HIV, Viral Hepatitis, and STD Prevention and Treatment (CHAC) which worked to develop a new metric that gives **equal weight** to quality of life as a goal and outcome of HIV services in addition to viral suppression. Applying such an approach within not only the HIV mental health system but the entire system could help address some of the gaps between services directed to non-virally suppressed populations and services that provide long-term support to more stable, virally suppressed persons.

- **For HIV clients whose depression and other mental health conditions have begun to be alleviated through counseling or therapy and who have achieved a degree of mental health stability, explore the impact and effectiveness of a model in which clients could scale back their engagement in mental health services from ongoing weekly sessions to shorter or less frequent sessions, such as monthly therapy sessions or 10-15-minute check-in sessions every 2 weeks.** Such a model might help ensure some level of continuity and support for clients who have developed effective therapeutic relationships with their treatment provider and have achieved some measure of mental health stability. It could thus reduce the funding of full weekly therapy sessions without permanently ending the patient-counselor relationship. Ideally, for clients who relapse or encounter new crises or challenges, the option of restarting more regular sessions would be available.

- **Develop a coordinated program that expands and publicizes the availability of facilitated drop-in support groups and programs for persons with diverse mental health and substance use treatment needs.** If well planned and well publicized, such an approach could allow individuals to access free, ongoing social and therapeutic support in concert with persons from similar ethnic, gender, age, language, sexual orientation, and other backgrounds, in some cases forming useful and lasting social and supportive networks. While many drop-in groups currently exist in San Francisco, they are not broadly publicized outside of the individual agencies that sponsor the groups, and are not planned and presented in a way that maximizes their potential benefits to the full range of persons living with HIV.

**Findings Related to the Concept of a Mental Health Services Directory or Clearinghouse:**

- As noted above, many clients who participated in focus groups expressed a desire to have a **printed and/or online directory** available of all mental health services available to persons with HIV in the city. Ideally, this directory would include the types of behavioral health services provided by each agency or program; the subpopulations in which agencies specialized or had expertise; and whether or not a waiting list currently existed. Because the majority of focus group participants did not regularly use computers, a printed directory was the preferred option. A related suggestion involved the idea of establishing a **mental health services clearinghouse or ombudsman's office** that persons seeking mental health services could call to receive referrals and linkage information, or to address waiting lists or other issues in connecting to mental health care.

The consultant spent a considerable amount of time following up on these suggestions, and seeking input from a wide range of providers on how such a directory or system could be organized. There were several key findings from this information-gathering process that may be useful to consider in determining whether a directory and/or clearinghouse may be the best approach for helping to improve access to mental health services:

- At least 2 individuals who had organized or were currently organizing an HIV-related resource directory described the inordinate length of time and resources needed to compile these directories (at least a year); the fact that the complexity of the San Francisco system made it virtually impossible to identify all providers; and the fact that by the time the directories are published, much of the information would already be out of date. These factors would make it difficult to maintain up-to-date information on waiting lists, particularly since as soon as available resources were announced, they would likely quickly be filled by persons seeking services.

- The cost of hiring the staff needed to operate a mental health clearinghouse would be comparatively large, particularly since providers believed that more than one staff person would be needed to respond adequately to the demand for information. Moreover, the problem would not address key issues such as waiting periods, length of treatment, and shortages of diverse mental health staff.

- Perhaps most importantly, providers pointed out that there were other mental health referral resources already in place in the city – particularly the City's Behavioral Health Access line - which, if better equipped to meet the needs of persons with HIV, could provide a pre-existing resources for providing referrals to HIV mental health services without the need for extensive new funding.

**Potential Areas for Future Exploration:**

- As the population of persons living with HIV expands, older persons with HIV will make up a greater and greater proportion of the San Francisco HIV population, including a greater proportion of persons 65 and older who have progressively greater medical and psychosocial needs. **It could be valuable to explore how the entire Ryan White system will need to change over the coming years to respond to the growing older HIV population, including developing new models for providing specialized care to these populations, such as multidisciplinary collaborative programs, expanded psychiatric services specifically for geriatric populations (geropsychiatry), or an HIV and Aging Center of Excellence.**

- **Similarly, it could be useful to request that the SF HIV Surveillance and Epidemiology Unit conduct a modeling process projecting the size and demographic characteristics of the 50 and older HIV population in San Francisco as it expands over the next 20 years.** Ideally, this would project incremental expansions in the size of the population every 5 years while providing a breakdown into 10-year age groups. This information could serve as a powerful reality check on the coming expansion of the aging HIV population, while offering specific signposts to facilitate planning and service modifications.

- As noted above, many clients with HIV stated that they either did not currently have a case manager, had never had a case manager, or felt that their existing case manager had little or no impact on their ability to access and remain in care and treatment. One obvious effect of this was that clients felt compelled to do their own research to locate and secure mental health services. **It could be impactful to examine the extent to which Ryan White clients actually have a medical or psychosocial case manager and the extent to which those who have a case manager are unsatisfied with the quality or impact of the case management services they receive.**