Comprehensive Care For MSM: Mental Health & Substance Abuse

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Nothing to Disclose

LEARNING OBJECTIVES:

1. Minority stress and determinants of mental health problems
2. Common mental health problems among MSM
3. Screening questionnaires and treatment options
4. Mental health promotion

ETHNIC MINORITY GAY YOUTH ISSUES

	Visible			Invisible	
Experiences	Ethnic Minority Hetero	Ethnic Minority MSM	Non-Ethnic Minority MSM	Closeted Ethnic MSM	Closeted Non-Ethnic MSM
Racism	X	X		X	
Sexism	X	X	X	X	X
Discrimination	X	X	X	X	
Violence	X	X	X	X	
Potential Rejection		X	X	X	X
Internalized Homophobia		X	X	X	X
Stress from Hiding				X	X

Ryan & Futterman, 1998

ATTITUDES …

Negative Levels:
- Repulsion
- Pity
- Tolerance
- Acceptance

Positive Levels:
- Support
- Admiration
- Appreciation
- Nurturance

- 2nd degree citizen – victims of violence (bullying, inter-partner violence, abuse)
- **What are some possible consequences …**

(From GLSEN http://www.glsen.org)

YOUTH: DEVELOPMENTAL ISSUES

- **LGBT youth are:**
  - 2 to 3 times more likely to **attempt suicide**
  - Coming out is happening earlier
    - More likely to be **homeless** (~20-40% of homeless youth)
  - At higher risk of **HIV and STDs**

Same as for all adolescents, PLUS need to:
- Establish a comfortable sense of own sexual/gender identity (some need to negotiate both ethnic and sexual identity)
- Decide when and to whom to "come out"
- Deal with internal & external homophobia/transphobia, bullying, marginalization
- Deal with feelings of isolation; may receive limited support from family, peers, and other adults; lack role models

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VULNERABILITY TO POVERTY

- Children of LGB parents are especially vulnerable to poverty
  - African American children in gay male households have the highest poverty rate (52.3%) of any children in any household type
  - The rate for children living with lesbian couples is 37.7%
- Transgender respondents to the National Transgender Discrimination Survey (NTDS) were 4 times more likely than the general population to have a household income of less than $10,000

(Badgett, Durso, Schneebaum, 2013)

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DISPARITIES: HEALTHY PEOPLE 2020

Discrimination against MSM persons has been associated with high rates of:

- Psychiatric disorders[1]
- Substance abuse[2, 3]
  - Alcohol and drug use—stimulant use (methamphetamine, cocaine)—sexual risk-taking, and potential for infectious disease transmission
- Self Harm, suicide (4 times higher)[4], risk behaviors (HIV)
- Internalized self-hatred/homophobia, low self-esteem
- Tobacco[7]
  - Smoking is a leading cause of premature, preventable death
  - ~1 in 5 MSM in NYC smoke; If HIV-positive +smoke: bad oral health, HIV progression, abnormalities in brain cognition, and higher rates of mortality

[1]McLaughlin KA et al, 2010; [2]Ibanez GE et al, 2005; [3]Herek GM et al 2007; GLMA 2010; King 2008; Ibanez 2005; Herek 2007; Mayer 2014; [4]Remafedi G et al1998;

DISPARITIES: HEALTHY PEOPLE 2020 (II)

- Experiences of violence and victimization have long-lasting effects on the individual and the community[5]
- Personal, family, and social attitudes towards sexual orientation affects the mental health and personal safety of MSM individuals.[6]
- Fearing discrimination by health care providers affects access to health and mental health care[7]
- All ages – adolescence to the wisely older
- Worse among ethnic minorities and gender minorities

[5]Roberts AL et al, 2010; [6]Healthy People 2010; [7]NYCDHMH, Durazzo 2007; [8]Frost, 2013; Huebner, 2007; Hatzenbuehler, 2008; Meyer, 1995 and 2003

MOST COMMON MENTAL HEALTH PROBLEMS AMONG MSM

Nearly *half* of all Americans who have mental illness do not receive any treatment

Global Mental Health Treatment Gap – 75% people in low- and middle-income countries have no access to treatment

DEPRESSION

- About 40% of MSM will develop major depression in their lifetimes—twice the rate reported in other men (Bostwick, 2010)
- Predictors of major depression in MSM include the absence of a partner, experience of anti-gay threats or violence, and non-gay identification (Stall 2001)
- Alienation from the gay community has been associated with depression (Sandfort, 2006)
  - Group therapy that strengthens social integration could increase the effectiveness of standard treatments

ANXIETY

- Panic disorder (with and without agoraphobia), social phobia, and generalized anxiety disorder are more prevalent in MSM than in other men.
- More than 20% of MSM will develop a phobia, which is roughly twice the prevalence reported in other men (Bostwick 2010)
- In view of the increased likelihood of substance use in MSM, anxiolytics should be given sparingly.

HOW MUCH IS TOO MUCH?

PARTY DRUGS

- ***Methamphetamine,*** **crystal, Tina, meth, speed, crank**
- ***Methylenedioxymeth-ampthamine (MDMA)*****, or ecstasy or X**
- ***Ketamine*****, Special K or just K**
- ***Gamma Hydroxybutyrate*****, GHB**

- **Complexity of multiple substance use limits the usefulness of drug-specific interventions (Mimiaga 2008)**

BODY-IMAGE

- Internalization of societal pressure to conform to a specific body type
  - MSM to develop chronic anxiety
  - Increased exercise and dieting, or
  - Obesity as a way to reject social expectations and cope with depression
- Mental health services that affirm sexual identity and self-respect

SEXUAL COMPULSIVITY

- **Significant public health concern among MSM**
  - Co-occurrence with mental health problems and HIV infection
- **Associated with: internalized homophobia, anxiety, depression, emotional regulation, traumatic stress, childhood sexual abuse, intimate partner violence, and polydrug use**
- **MSM in couples with SC:**
  - Partnered with men both with low or high levels of SC
  - SC associated with low sexual satisfaction and low sexual communication.
  - If both have high SC, engaged in unprotected anal sex with a greater number of male partners outside their relationship.
  - SC unrelated to frequency of sex with main partners
- **Treatment? Combined medication/therapies**

SEX, DRUGS AND HIV

- Substance use during sex: HIV seroconversion.
- Metamfetamine, cocaine, and poppers: unprotected sex and HIV seroconversion (van Griensven 2010)
  - Increased sexual drive, sensation seeking, invulnerability, impaired negotiation skills (Koblin 2006; Drumright 2006)
  - Social norms, peer pressure, and selection of partners within substance-using networks (Stall 2003; Greenwood 2002)
- Effects on the immune system or alteration of pain thresholds
- For HIV-positive, substance use can cause decreased treatment adherence and virological suppression (Grierson 2011)
- Metamfetamine + planned 'highly active antiretroviral therapy holidays around their drug use' (Reback 2003)
- Metamfetamine-induced psychosis, cocaine-induced cardiac infarction, and hallucinogen-associated rhabdomyolysis (Nutt 2010)
- Steroids: unprotected sex and be prone to suicidal ideation and depression (Larance 2008; Bolding 2002)

Mental health and physical health are often inseparable

HIV/AIDS-associated social, psychological and neurological conditions have serious MH consequences

IMPACT OF MENTAL HEALTH/SUBSTANCE USE PROBLEMS:

- May affect interpersonal relationships
- May impair the quality of one's life
- May interfere with HIV treatment adherence
- May interfere with a range of self-care behaviors
- May be associated with unsafe sexual and drug use behaviors
- May impair ability to cope with daily events, including childcare
- May result in acting out verbally or physically

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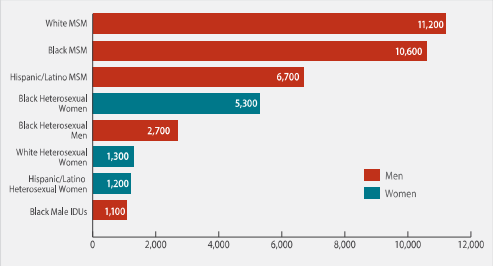
ESTIMATED NEW INFECTIONS IN THE US - MOST AFFECTED POPULATIONS, 2010



Source: CDC. Estimated HIV incidence among adults and adolescents in the United States, 2007–2010. *HIV Surveillance Supplemental Report* 2012;17(4). Subpopulations representing 2% or less are not reflected in this chart. Abbreviations: MSM, men who have sex with men; IDU, injection drug user.

HIV AMONG MSM

Gay, bisexual, and other MSM represent approximately 2-3% of the US population

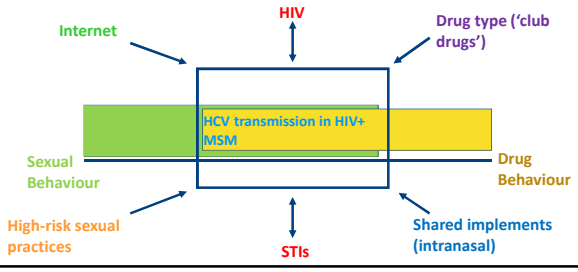
Yet are the population most severely affected by HIV

- In 2010,
  - MSM ~63% of new HIV infections in the US
  - Young MSM (aged 13-24 years) ~72% of new HIV infections among all persons aged 13 to 24, and 30% of new infections among all MSM.
- 2008 to 2010: HIV infections among young black/African American gay and bisexual men increased 20%.
- 2011: ~500,022 (57%) persons living with an HIV diagnosis in the US MSM, or MSM who also inject drugs.

HEPATITIS *C: HIV/HCV COINFECTION*

- 10%-30% of those with HIV also have HCV (HIV deaths due to HCV)
  - Hemophiliacs – >90%
  - IDUs – 70%-90%
  - MSM – 5%-10%

Biological vs Behavioural/Environmental



HIV NOWADAYS...

- **Potent antiretroviral treatments - emerging treatments**
  - Easier to adhere
  - Living longer
  - Improved Quality of Life
  - Chronic disease model
  - Yet…Resistance Testing
- **HIV and Hepatitis C Virus (HCV)**
  - 50%–90% among HIV-infected injection drug users (IDUs).
  - 2.3-5.3% among Meth Users (non-IDUs)
  - HCV infection progresses more rapidly to liver damage in HIV-infected persons.
  - HCV infection may also impact the course and management of HIV infection.
- **Treatment Cascade**
  - Treatment as Prevention - PrEP/Microbicides
- **Vaccines?**
- **Cure - Timothy Ray Brown…**

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Mental and Substance Use Disorders

Both HIV and HCV affect the brain - neurocognitive problems

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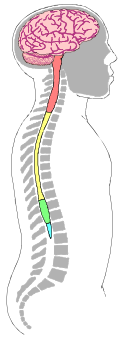
Psychiatric Disorders, especially *Depression and mild Neurocognitive disorder*, are common, under-diagnosed, under-treated, and negatively impact quality of life, adherence, HIV transmission, morbidity and mortality and prevention

DEPRESSION AND HIV-RELATED MORBIDITY/MORTALITY

- Numerous studies across many countries demonstrate the association of depression with increased morbidity and mortality among people with HIV infection.
- Contributing factors include the association of depression with
  - Failure to access HIV care and treatment
  - Failure to adhere to antiretroviral medication once it has been started
  - Possible direct effects of depression on the immune system

NEUROCOGNITIVE SEQUELAE

- HIV has affinity for the central nervous system
  - Crosses blood brain barrier
  - "Inflammatory cascade"
  - Direct neurotoxic effect
  - Inflammatory proteins may lead to oxidative stress and neuronal injury or apoptosis



Nath (2002)
Steiner, Haughey, Li, Venkatesan, Anderson, Reid, et al. (2006)

NEUROCOGNITIVE FUNCTION IN HIV

- Combination antiretroviral treatment (ART) reduces the incidence of HIV dementia, whereas overall prevalence of neurocognitive deficits remains high and comparable to pre-ART levels.
- Symptoms have changed with ART-- more memory and executive dysfunction problems.
- The best prevention of neurocognitive deficits appears to be earlier treatment of HIV that prevents low CD4 cell counts (< 200).

Heaton, et al, J Neuroviral, 2011

HIV-ASSOCIATED DEMENTIA

- Prevalence pre-HAART:
  - 17% - 25%
- Prevalence post-HAART:
  - 1% - 10%
- While incidence and prevalence have dropped since HAART, prevalence now on the rise as patients live longer

Dore et al. (2003)
McArthur et al. (1994)
Grant et al. (1999)
Sacktor et al. (2001)

HIV ASSOCIATED NEUROCOGNITIVE DISORDERS

NIMH WORKING GROUP, NEUROLOGY 2007

Asymptomatic neurocognitive impairment (ANI),

HIV-associated mild neurocognitive disorder (MND)

HIV-associated dementia (HAD)

Milder impairment is under-diagnosed and may be present even when patients are otherwise well controlled (e.g., stable ARV regimen, undetectable viral load)

DIFFERENTIAL DIAGNOSIS OF MENTAL STATUS CHANGES IN PEOPLE LIVING WITH HIV/AIDS

Look for underlying biological cause – differential diagnoses

1. Medications: HIV, psychiatric, other
2. Substances: Alcohol, drugs, herbal, over-the-counter, other
3. Non-HIV medical problems (e.g. HCV neurocognitive illness and other dementias, thyroid disease, syphilis)
4. HIV-related illnesses:
   - Brain (CNS) lesions or infections
   - Non-CNS illnesses (e.g. hypogonadism)
5. Sleep Disorders

+/-

- HAND*
- Psychiatric syndromes
- Psychosocial issues

*HIV Associated Neurocognitive Disorders

HAND - HIV ASSOCIATED NEUROCOGNITIVE DISORDERS

- Severe dementia rarely develops in patients on effective ART
- Most patients with mild neurocognitive impairment are clinically stable
- HIV disease biomarkers (viral load or CD4) are not associated with impairment
- Cardiovascular disease and inflammatory markers are associated with impairment
- Neuroimaging and cerebrospinal fluid studies *could* provide new mechanisms to improve our understanding of HIV-associated neurocognitive disorder
- Optimum HIV therapy is necessary, but not sufficient, to avert cognitive impairment
- Neither higher CNS-penetrating combined antiretroviral therapy nor adjuvant treatments have proven to be effective to reverse HIV-associated neurocognitive disorder
- Treatment to address inflammation and cardiovascular risks seems to be a rational approach

SCREENING QUESTIONNAIRES AND TREATMENT OPTIONS

NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE RECOMMENDATIONS FOR HEALTH CARE PROVIDERS:

- Provide a welcoming environment for men who have sex with men (MSM)
- Take a sexual history as a routine part of primary care and remember that MSM may not identify as gay
- **Routinely screen for alcohol, drug use, tobacco use, depression**, HIV, and other STIs
- Counsel on consistent condom use and the new HIV prevention medications, PEP and PrEP & condom use (CDC)
  - Comprehensive set of prevention services (risk-reduction and adherence counseling, condom access, diagnosis and treatment of STIs)
  - Accompanied by monitoring of HIV status, side-effects, adherence, and risk behaviors at regular intervals
- Vaccinate against human papillomavirus (HPV), hepatitis A virus, and hepatitis B virus

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Some Easy to Use Screening Tools: PHQ-2, PHQ-9 and GAD-7

- Readily available online at no charge (**FREE!**)
- Already translated into **MULTIPLE LANGUAGES!!!!**
- Well studied in general medical populations
- **EASY** to administer or self administer
- Can be used to **SCREEN AND/OR MAKE A DIAGNOSIS**
- Can be used to **FOLLOW** patient's progress

www.hivguidelines.org

Screening for Depression: PRIME-MD PHQ2

Over the last two weeks how often have you been bothered by any of the following problems:

▪Little interest or pleasure in doing things.

- 0=Not at all
- 1=Several days
- 2=More than half the days
- 3=Nearly every day

▪Feeling down, depressed or hopeless

- 0=Not at all
- 1=Several days
- 2=More than half the days
- 3=Nearly every day

If the score is 3 or more, move to the PHQ9.

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	0 +	___ +	___ +	___
Total Score =				___

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people	
	Not difficult at all ___
	Somewhat difficult ___
	Very difficult ___
	Extremely difficult ___

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	Somewhat difficult			___
	Very difficult			___
	Extremely difficult			___

For initial diagnosis, if there are at least 4 checked boxes in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Diagnostic Instrument for Generalized Anxiety Disorder: GAD-7 – Items

Rated from 0-3

1. Feeling nervous, anxious or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

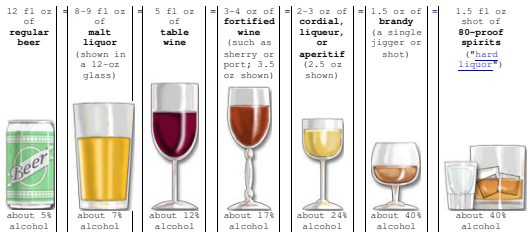
QUESTIONS TO IDENTIFY PTSD (POST TRAUMATIC STRESS DISORDER)

In your life, have you ever had any experience that was so upsetting, frightening, or horrible that you:

1. Have nightmares about it or think about it when you do not want to?
2. Try hard not to think about it or go out of your way to avoid situations that remind you of it?
3. Are constantly on guard, watchful, or easily startled?
4. Feel numb or detached from others, activities, or your surroundings?

Also ask about intimate partner violence

References and more tools: **www.hivguidelines.org**



Screening for Hazardous Alcohol Use: Audit-C Questionnaire

- **There are 3 questions:**
  1. How often do you have a drink containing alcohol?
  2. How many standard drinks containing alcohol do you have on a typical day?
  3. How often do you have six or more drinks on one occasion?
- **Each item is rated on a five-point scale used to identify hazardous alcohol use.**
- **The Audit-C is easily accessed online at no charge – FREE!!!**

Screening for Substance Use: Cage-AID

(CAGE-Adapted to Include Drugs)

Target Population: Adults and Adolescents > 16

1. Have you ever felt the need to *cut* down on your use of alcohol or drugs?
2. Has anyone *annoyed* you by criticizing your use of alcohol or drugs?
3. Have you ever felt *guilty* because of something you' ve done while drinking or using drugs?
4. Have you ever taken a drink or used drugs to steady your nerves or get over a hangover (*eye*-opener)?

A total of ≥ 2 may be suggestive of a problem

References and more tools: **www.hivguidelines.org**

TOBACCO: THE CLINICIAN'S ROLE IS CRITICAL

Most who smoke see clinicians
It is critical (and simple) to be prepared
The **5 A's**
- **A**sk about tobacco use
- **A**dvise to quit
- **A**ssess willingness to attempt to quit
- **A**ssist in quit attempt
  - Medication and Counseling
  - Interventions to increase likelihood to motivate in the future
- **A**rrange follow up

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(Milko, 2014)

HIV-RELATED NEUROCOGNITIVE DISORDERS

- There are no simple screening tools to diagnose asymptomatic impairment or mild neurocognitive disorder. Simple tools (such as the MMSE) pick up advanced cortical deficits.
- Neuropsychological testing takes 1-4 hours
- Multiple co-morbidities and aging complicate the differential diagnosis

Valcour, et. al. CID, 2011

MANAGEMENT OF DEPRESSION/ANXIETY

- Assess before starting treatment
- Stabilize on antidepressant before treatment
- Establish care with counselor, psychiatrist, primary care giver before treatment
- Immediate evaluation if suicidal. May need to discontinue treatment.

DEPRESSION: WHEN TO REFER FOR URGENT PSYCHIATRIC EVALUATION

1. **Patient is suicidal and/or has just made a suicide attempt**
2. **Patient has symptoms of psychosis or severe agitation**
3. **Patient has mixed depression and mania**

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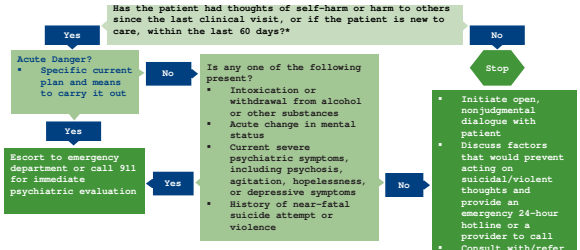
SUICIDE

www.hivguidelines.org



Questions for suicidal ideation: *Since your last visit [or last 2 months]:*
- *Have you wished you were dead, or wished you could go to sleep and not wake up?*
- *Have you had actual thoughts of killing yourself?*

Questions for violent behavior: *Since your last visit [or last 2 months]:*
- *Have you lost your temper to the point where you would hurt someone?*
- *Have you hit or slapped someone? ...What about grabbing and shaking?*

REFERRALS

Provide clear directions and communications

If possible have the name of the referral…
- If known to you…better
- If not…can you develop a network of referrals

Even better if the patient can meet the referral while with you in advance…

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AGENTS USED FOR DEPRESSION IN PATIENTS WITH HIV

Antidepressants (also for Anxiety)
- SSRIs
- SNRIs
- TCA (tricyclic antidepressants)
- Other antidepressants

Psychostimulants

Hormonal treatment—check for / treat ↓ testosterone levels in men and women

Benzodiazepines can be used for anxiety after antidepressants have been exhausted, especially among those with substance use problems

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ASSOCIATIONS BETWEEN DEPRESSION TREATMENT AND ART USE AND OUTCOMES

- Use of antidepressants + psychotherapy, or psychotherapy alone, associated with increased ART utilization (N = 1,371)
- Compliant SSRI use associated with improved HIV adherence and laboratory parameters (CD4 cell count and viral load)
- Among 158 HIV+ homeless/marginally housed people followed every 3 months between 2002-2007: Antidepressant treatment associated with
  - 4 times the likelihood of accepting ART
  - 2 times the likelihood of achieving viral suppression

Cook et al., AIDS Care, 2006 Horberg et al., JAIDS, 2008; Tsai et al., Arch Gen Psych, 2010

EVIDENCE-BASED PSYCHOTHERAPIES FOR DEPRESSION, ANXIETY, PTSD, SUBSTANCE USE DISORDERS, HIV RISK REDUCTION…

- Many brief evidence-based psychotherapies have been studied, proved efficacious in research settings (and sometimes effective in clinical settings), and manualized.
- These manualized interventions include treatment for depression, anxiety disorders, and alcohol/substance use disorders.
- Manualized interventions may be targeted to individuals or groups.
- **Hardly ever used…**
  - Manualized interventions can be taught to providers with limited mental health background.
  - Examples: cognitive behavioral therapy, motivational interviewing, interpersonal therapy/interpersonal counseling, exposure therapy, psychodynamic strategies, and supportive approaches.

SUBSTANCE USE AND RISK REDUCTION INTERVENTIONS

- Few interventions specific to MSM have reduced the frequency of substance use or related risks.
- Substance use during high-risk sex findings are mixed, some found no changes (Mansergh 2010), or did not reduce sexual risk, although use decreased (Morgentern, Wainberg 2009).
- Motivational interviewing, cognitive behavioral therapy, and couples' therapy for alcohol-misuse disorders in MSM (Morgenstern, Wainberg, 2007; Velasquez 2009).
- Several small, abstinence-based studies methamphetamine-dependent MSM showed reductions in both substance use and HIV-related risks (Shoptaw 2008)
- In methamphetamine-using HIV-positive MSM, a harm reduction intervention lessened the frequency of unprotected sexual risk behaviors, even with continuing drug use (Mausbach 2008)

Because data suggest that many MSM presenting for alcohol treatment also have comorbid drug-misuse disorders, culturally tailored interventions specific to the needs of MSM are needed.

SUBSTANCE USE TREATMENT

- MSM who use substances have unique, complex, and often unmet health needs.
- Providers of health care and treatment for substance misuse should be sensitive to issues such as discrimination, homophobia, and other social factors that affect health outcomes and access that are faced by MSM and other LGBT clients.
- In view of the high prevalence of mental health concerns in MSM who use substances, integrated services and interventions could provide improved benefits.
- Effective and scalable pharmacological and behavioral interventions and structural and community approaches are urgently needed to reduce comorbidities associated with substance use in MSM.
- Finally, more research is needed into sources of resilience in substance-using MSM and how to use these strengths to ease recovery.

BARRIERS TO TREATMENT

1. Patient Level: stigma of mental illness; internalized homophobia; desire to be strong and tough; there is nothing wrong; fear; lack of knowledge; cultural; previous negative experiences
2. Intervention Level: the side effects of antidepressants manifest before the therapeutic effects
3. Provider Level: failure to screen, detect, discuss, treat
4. System Level: limited funding/availability of mental health services; lack of provider training

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Mental Health Promotion

MENTAL HEALTH PROMOTION

- IT DOES NOT REPLACE MENTAL HEALTH TREATMENT OR ACCESS TO MH CARE
- Mental health promotion often refers to positive mental health, rather than mental illness
- Create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles.
- A climate that respects and protects diversity and basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion.
- Little is known about the effectiveness of mental health promotion initiatives specifically targeting MSM.
- The evidence of effective mental health promotion in the general population is still emerging.

MENTAL HEALTH PROMOTION ACTIONS CAN INCLUDE

- Strengthening individuals
  - increase social connections, build self-esteem and self-efficacy, life and coping skills, relationships and parenting skills;
- Strengthening organizations
  - ensure inclusive, responsive, safe, supportive and sustainable environments for health, developing partnerships across sectors and implementing evidence-informed approaches to their work;
- Strengthening communities
  - increase social participation, inclusion and cohesion, improve physical and social environments; implementing anti-bullying strategies in schools and workplaces, providing childcare and self-help networks, increasing citizenship and engagement and increasing awareness across sectors and communities of mental health and wellbeing issues;
- Strengthening whole societies
  - whole sector approach to reduce structural barriers to mental health through interventions designed to counter stigma and discrimination, reduce inequalities through facilitating access to education, employment, housing and support for more vulnerable community members

BEST PRACTICES FOR MENTAL HEALTH FACILITIES WORKING WITH MSM CLIENTS

- Educating staff to foster inclusive behaviors
- Addressing harassment and intolerance of peers who are also in the treatment program
- Implementing training requirements for personnel
- Developing program policies that recognize the needs of MSM clients
- Acknowledging the emotional and sexual lives of MSM clients

MSM MH PROMOTION NEEDS

- While MSM have the same basic mental health prevention and promotion needs as members of the general population,
- Yet, they also have additional unique issues that are related to social discrimination, personal and community social and behavioral risk factors, and certain unique medical conditions In promoting and supporting the mental health of MSM individuals
- The following needs have been identified in the literature:
  - having a sense of belonging and connection;
  - being supported with the coming out process;
  - ensuring safe settings and environments;
  - being able to access socially and culturally appropriate mental health services and support; and
  - being able to interact with affirming and respectful mental health professionals who are educated about MSM communities

(Johnson, et al., 2008; Corboz, et al., 2008; Rankine, 2008)

TIPS FOR MH PROMOTION

- Sleep Hygiene
- Healthy Food
- Drinks➔
  - If Hepatitis (none)
- Healthy Exercise
- Friendships, community
- Positive psychology, behavioral activation, etc.

RESILIENCE

- Despite widespread stigma and discrimination, most MSM people are physically and emotionally healthy and don't engage in risky behaviors.
- Both internal and community-derived resilience can be protective factors in the health and mental health
- According to a 2013 Pew Research Center study of LGBT Americans, most respondents viewed their sexual orientation/gender identity as either a positive aspect of their lives (34%) or as something that does not make much difference either way (58%).

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ATTITUDES …

Negative Levels:

- Repulsion
- Pity
- Tolerance
- Acceptance

Positive Levels:

- Support
- Admiration
- Appreciation
- Nurturance