**HIV AND THE INTERSECTION OF MENTAL HEALTH ISSUES ASSESSMENT**

Purpose Statement

*To enhance the quality of life for individuals living with HIV in SC by addressing the intersection of HIV and mental health through awareness, risk reduction, and care coordination.*

**TELL US ABOUT POPULATIONS**

***Answering the following questions helps us develop ways to improve service delivery to the communities we serve.***

|  |  |  |
| --- | --- | --- |
| **Ethnicity** | **Race** (check all that apply) | **Current Gender Identity** |
| Hispanic or Latino  Non-Hispanic or Non-Latino  Prefer not to answer | African American/Black  American Indian/Alaska Native  Asian  White  Native Hawaiian/Pacific Islander  Non-Specified  Prefer not to answer | Male  Female  Transgender Male to Female (MTF)  Transgender Female to Male (FTM)  Transgender-Unspecified  Another Gender  Prefer not to answer |

1. Age:

15 to 20 21 to 30 31 to 50 51 to 64 65+

1. Zip Code: \_\_\_\_\_

**TELL US WHAT YOU KNOW ABOUT MENTAL HEALTH**

1. Having mental or emotional problems is a sign of personal weakness.

True False

1. Mental health problems are similar to other health problems.

True False

1. Mental health and physical health are inseparable.

True False

1. Depression is a healthy response to difficult situations.

True False

**TELL US ABOUT YOUR MENTAL HEALTH EXPERIENCE**

1. How long have you been living with HIV?

Less than 1 year 1-5 years 6-10 years 11-15 years 16-20 years

21+ years

1. At any time were you offered mental health services related to your HIV diagnosis?

Yes No

* 1. If yes, when?

During the first three months

During the first six months

During the first nine months

During the first year or beyond

After the first year

* 1. If yes, were you linked to a mental health professional?

Yes No

1. Were you receiving any mental health services *prior* to your HIV diagnosis, i.e. counselling, drug therapy, self-care, exercise, yoga?

Yes No

1. Have you ever used or are currently using recreational drugs and/or alcohol to cope with your HIV diagnosis?

Yes No

* 1. If yes, what was/were your substance(s) of choice?

Tobacco, vape, etc.

Marijuana

Hallucinogens (PCP, LSD/acid)

Stimulants (meth/Tina)

Methamphetamines

Inhalants

Opioids (heroin or painkillers, i.e. fentanyl, oxy, opium)

Alcohol

* 1. If yes, are you currently using?

Yes No

* 1. If yes, have or are you sharing needles?

Yes No

* 1. If yes, how much?

Occasionally  Daily  Weekly  Monthly

1. Have you received treatment for alcohol and/or drug use associated with your HIV diagnosis or treatment?

Yes No

* 1. If yes, were you using drugs and/or alcohol before your HIV diagnosis?

Yes No

* 1. If yes, did your drug and/or alcohol use increase after your HIV diagnosis?

Yes No

* 1. If currently receiving mental health services, is accessing the service convenient (appointment time, location, telehealth, etc.)?

Yes No

* 1. Is there anything preventing you from getting consistent mental health therapy/care/assistance? (Please check all that apply)

Transportation

Availability of HIV appointments

Stigma

Changes to your provider as required by the Ryan White Program and/or

health insurance

Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Were you advised of mental health support groups available to you?

Yes No

* 1. If yes, how did you learn about mental health support groups?

Provider Peer support advisor

Case Manager Community Health Worker (CHW)

Friend or family member Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. If no, did you seek out mental health support groups that may be available to you?

Yes No

* 1. If no, how would having this information be helpful to you?

1. Since your diagnosis, have you experienced any of the following? (Please check all that apply)

|  |  |
| --- | --- |
| Anxiety | PTSD (Post-Traumatic Stress Disorder) |
| Depression | Self-harm |
| Isolation/Loneliness | Sleep problems |
| Low Self-esteem | Suicidal feeling |
| Sexual Trauma | Domestic Violence |
|  |  |

1. If yes, did you receive a referral to help you deal with these things?

Yes No

1. If yes, please specify from whom or where you received your referral, i.e. primary care physician.
2. Please describe how your HIV diagnosis and/or treatment has impacted how you handle stress.
3. What mental health coping strategies, i.e. exercise, gardening, prayer, or meditation, have been most successful throughout the course of your diagnosis?
4. What mental health coping strategies have NOT been successful during the course of your diagnosis?
5. Please describe any stigma and/or misinformation related to mental health and HIV that you have encountered in healthcare.
6. Please suggest organizations and/or community members who can support individuals experiencing HIV and mental health issues.
7. We value your lived experience and feedback. Please share any other helpful information for us to know to improve the quality of life for individuals living with HIV in South Carolina.

*All assessment responses will be anonymous, meaning no one will be able to link a response to a specific person. Information learned from this assessment will be available on the South Carolina HIV Planning Council* [*website*](https://www.schpc.org/) *by the end of 2025.*

*If you are interested in learning more about or becoming a member of the South Carolina HIV Planning Council, please visit* [*https://www.schpc.org/about*](https://www.schpc.org/about)*.*