

BHIVA Standards of care online consultation comments

7 October 2012

Standard 6: Psychological care

12 September 2012

Matt Williams sent the following message:

Very good, I hope it is able to be implemented.

13 September 2012

Lorraine Sherr sent the following message:

Psychological support reads really well, covers core and key areas and is a real leap forward that it is there. May just want to add that life circumstances should include pregnancy. A sentence about HIV clustering in families and the needs of children and adolescents and transitions to adult care challenges may also help.

2 October 2012

Paul Declé from Forum Link sent the following message:

This one is more of an observation.

Section 1 Rationale

Paragraph 3 second line makes reference "see figure below", there is no figure below.

3 October 2012

Dr Ann Fitzgerald, CPsychol, Counselling Psych from On behalf of Surrey HIV Network sent the following message:

Respondent: Dr Ann Fitzgerald, CPsychol, Counselling Psychologist on behalf of Surrey HIV Network

These comments should be taken in the context that the standard is a really welcome addition to our understanding of holistic care across the lifespan.

- Paragraph Three: 'The stepped-care approach..... (see figure below)'. I assume you will be including the full stepped care model figure and reference in the final document?
 - Paragraph Three: 'This model provides a framework for comprehensive assessment and provision of psychological support to meet the full range of needs for people living with HIV.' While the framework provides types of assessment and interventions required at the four levels for me the focus of the model is to primarily facilitate planning and considering access to services. I would suggest the following alternative wording 'This model provides a framework to plan and enable access to the psychological support services required to meet the full range of needs for people living with HIV'
 - Paragraph Three Second sentence: 'While the particular services available locally may determine how such support is provided and by whom, all aspects of assessment and support described in the model should be available regardless of geographic location.' I think that this sentence is ambiguous and somewhat abstract and aspirational. I'm wondering if it is possible to be a bit more specific as to what is meant here e.g. links between mental and physical health services etc. For example if someone is identified to be suffering from an adjustment disorder (HIV related) where can they go? There are probably too complex for IAPT services and within secondary care they need to have symptoms of psychosis or be severely risky to access a recovery community mental health team. Furthermore who is responsible for linking up services as this can be a very challenging task in practice with increased service thresholds and reduced funding.
 - I think it is important to mention NICE Guidelines somewhere in the document. Although there is not a specific HIV guidelines there are a number of relevant documents e.g. CG91 Depression with a chronic physical health problem.
 - I think that there should be an additional paragraph about the transition between screening, signposting, assessment and interventions/treatment. The document seems to move seamlessly from screening to treatment (Paragraph 2 to 3) with no indication of the complexity of this stage about services being available to co-operate and develop cross service pathways, easier access, thresholds, referral criteria etc. In practice this is a hugely complex and difficult stage with many barriers to accessing other services. The document as currently written seems to ignore the issues with this stage of the process which are essential to operationalising the standards.
 - Quality Statements: Suggested inclusion of the following statement. Be aware of added stigma and discrimination associated with psychological difficulties.
 - Quality Statements: Suggested inclusion of the following statement. Be aware of diversity, cultural, ethnic and religious factors and the impact of these on patient presentations and attribution systems for psychological distress.
 - Measureable and Auditable Outcomes: Suggested inclusion of the following sentence. Regular evidenced patient focussed MDT meetings to include clinical lead for psychological support.
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3 October 2012

derrick g from none sent the following message:

the problem with me was i didnt want to seek help for my psychological and mental issues associated with been hiv +.. i just thought i didnt deserve it..

maybe its time to make some decisions for those who need help but cant bring themselves to ask for it

6 October 2012

Rwankore Molly Kate from TASO(The AIDS Support Organisation - Uganda) sent the following message:

Am a social worker by profession and in TASO organization I work in the psychosocial counseling department s a Senior Counselor. I have also lived positively with HIV for 23 years now.

I want to sincerely thank you for the whole package of standard care. the following can be added under psychosocial care.

1. Need for laws to protect people living with HIV in relation gender based violence and protection from negative consequences arising after partner notification and other relatives notification.

A mother who have capacity to give alternative feeds(formula feed)can end up breastfeeding if she realizes that spouse will chase her out of her home in case she is found out, hence will go on re infecting spouse and getting reinfected as well. in process chances are high that adherence to medication will be poor. THERE IS NEED TO ALLIE FEARS BY PUTTING PROTECTIVE MECHANISM IN PLACE.

2. The gender mainstreaming slogan should be replaced with more conclusive Ideology that is specific and with budgeted work plan to enhance gender action plan activities as a department. In this department a lawyer with gender training component should be also attached.

3. There is a lot of property grabbing from widows and orphans they are also chased away from homes by relatives after death of a spouse or parents. Hence there is now way the psychosocial issues will be adressed if there is no machinery imbedded in the psychosocial intervention

4. If this standard package is approved in your country it will be used by developing countries so please incorporate a gender lenses approach as you address HIV issues.

5. Will need a FEEDBACK as this a concern to me as, a person that has physically experienced gender based violence and have watched the clients problems escalate because of this problem. And this too is directly failing HIV prevention.

7 October 2012

Lindsay Short from Calderdale and Huddersfield NHS Foundation Trust sent the following message:

Access to psychological services can be limited in many parts of the country. The likelihood of having a level 4 practitioner to act as clinical lead with an expertise in HIV will quite rare outside of a few big centres. The cost of providing in house psychology will be increasingly difficult as the level 3 tariff would only apply to those under the care of a consultant psychiatrist. In general psychological services are under alot of pressure due to demand on their services and with the current and future economic climate with savings having to be found may be increasingly challenging

7 October 2012

Will Chegwiddden from Rehabilitation in HIV Association sent the following message:

We feel that more is required in this standard to specifically highlight the importance of screening, assessment and treatment of neurocognitive disorders. We would make the following suggestions:

That a specific paragraph is inserted in to the first section of this standard that highlights neurocognitive disorders:

“Screening for cognitive impairment should be carried out regularly as described in the Standards for Providing Psychological Support for Adults Living with HIV. Where concerns are raised, individuals living with HIV should have access to further assessment and rehabilitation provided by suitably competent professionals. This may include locally embedded services or require referrals to community rehabilitation services including occupational therapy, neuro-psychology, speech and language therapy and neuro-psychiatry and social care. Individuals living with cognitive impairment may also require access to ongoing social care.”

We would also suggest adding a specific statement in the quality standards:

“People living with HIV should have access to a range of cognitive rehabilitation and support services appropriate to their needs.”

Rationale : It is documented that for patients with HIV related cognitive impairment specialist rehabilitation can result in improvements in cognitive function. In addition the psychological impact of an HIV diagnosis can be reflected in reported cognitive impairment. Introduction of strategies can enable individual to cope better and reduce symptoms of anxiety and depression that could be exacerbating cognitive functioning. People living with long term conditions who develop strategies to manage their condition are better at drug adherence, hospital attendance and are less likely to be admitted to hospital.

We also feel that these standards should specifically reference referral to lifestyle management and functional rehabilitation aspects of psychological care. We would recommend the following change:

“Clear pathways should be developed and adopted between services providing HIV clinical treatment and those offering psychological support. Psychological support should be delivered through a network of providers with different levels and types of expertise in

psychological issues for people living with HIV. Psychological support should include access, when necessary, to local mental health services, including psychiatric and community support, as well as to social and legal services and services managing the functional impact of psychological difficulties. Services should be planned to provide seamless integration across levels of psychological support, including transitions between services for people of all ages living with HIV. For more information about the stepped-care model, please refer to...”

7 October 2012

Jacqueline Stevenson from African Health Policy Network (Ffena) sent the following message:

Our research carried out to feed into the development of the Standards for Psychological Support for Adults living with HIV found that many Africans living with HIV preferred to access non-clinical sources of psychological support. To ensure parity in services and outcomes, clinical services must engage with these groups, including community and faith groups, and build referral pathways that incorporate these support sources.