



HIV MENTAL HEALTH TREATMENT ISSUES

HIV and People with Severe and Persistent Mental Illness

Introduction. HIV infection has been a growing problem among patients with severe mental illness, and efforts to address it have lagged far behind the urgency of the problem. This fact sheet summarizes the issues.

Epidemiology. Seroprevalence studies of psychiatric inpatients in the Northeast have shown rates of HIV infection varying from 4% among long-stay state hospital patients up to 23% among those on an acute dual diagnosis unit for people with combined mental illness and alcohol/substance use disorders. Women were as likely to be infected as men. Unfortunately, the peer-reviewed literature contains little information about outpatients and is silent on epidemiology in other U.S. regions. In one of the few non-hospital based studies, 19% of men attending a psychiatric program located within a homeless shelter in New York City were HIV seropositive. In another study that was not focused on seroprevalence, AIDS was the leading cause of death in a sample of 320 patients between 20 and 40 years of age who were being followed in a longitudinal study of individuals experiencing their first psychiatric hospitalization for a psychotic episode. This study was conducted in suburban and semi-rural Suffolk County, New York, suggesting the worrisome nature of the HIV epidemic among psychiatric patients outside of cities known to have high AIDS case rates.

Risk Behavior.

Drug Use. Studies show that patients with severe mental illness have lifetime rates of an alcohol or substance use disorder of between 20% and 75%, depending on the sample studied. Studies specific to patients with severe mental illness show recent injection drug use in 1% to 8% of patients and past injection drug use in 5% to 20% of patients. Seroprevalence studies support the powerful link between HIV infection and injection drug use in this population. One study demonstrated that psychiatric patients with any alcohol or drug use diagnosis had elevated rates of sexually transmitted diseases, which are both co-factors in HIV-transmission and markers of unprotected sex.

Sexual Behavior. Studies show that a majority of patients with severe mental illness have been sexually active in the past year. Patients' sexual activity, which is often not recognized by providers or policy makers, has demonstrated links to many HIV-related risk factors, which include the following:

- Low rates of condom use
- Buying and selling sex

- Poorly known partners of undetermined HIV status
- Partners who have been identified as injection drug users or as having HIV/AIDS
- Multiple partners
- Coerced sexual encounters
- For women: partners who are bisexual men; partners who are violent and/or have alcohol/substance use disorders
- For men: rates of same-sex sexual activity that exceed rates in the general population

Environmental factors. Circumstances known to be common among people with severe mental illness that increase the risk of acquiring HIV infection include:

- Residing in urban areas that are endemic for HIV
- Being institutionalized in shelters, prisons, and hospitals where HIV is prevalent, rates of same-sex sexual activity are high, and condoms are usually unavailable
- Poverty due to limited entitlements, which interferes with purchasing condoms and obtaining family planning services, and promotes exchanging sexual favors for shelter, food, etc.
- Stigma, which, along with poverty, interferes with access to medical and family planning services

Detecting HIV. Many at-risk patients have never been tested for HIV. In the four New York based studies that compared the results of anonymous seroprevalence testing to clinician knowledge of patients' HIV infection, the rates of detection have varied from 12% in a state hospital setting to 68% on an acute psychiatric unit in a general hospital setting. Detection may vary with the intensity of medical oversight, and is clearly quite low in certain settings.

Risk Assessment and HIV Testing. Risk assessment should always be incorporated into the psychiatric assessment of patients with severe mental illness. Obtaining accurate and candid disclosure of intimate sexual activity or illegal drug use depends on forming an adequate therapeutic alliance which ensures confidentiality and uses language that patients are comfortable with, and understand. HIV testing should be offered routinely to those who are pregnant, have risk histories or medical findings suggestive of HIV infection, or are being admitted to hospitals with seroprevalence rates that exceed 1%. Careful pre- and post-test counseling is important, and when appropriate, providers who



know the patient well should be involved. It would be stigmatizing to propose mandatory testing targeting this group, and justification would be lacking since most people with severe mental illness have capacity and AIDS knowledge comparable to the general population.

Access to Medical Care/Reproductive Services.

Patients with severe mental illness often have difficulty accessing adequate medical care, and it is well established that this population has higher morbidity and mortality with common medical illnesses. In the case of HIV/AIDS, special attention needs to be given to access and integration of medical, mental health, alcohol/substance use, and reproductive/family planning services. Changes in mental states occurring in HIV infected patients require medical assessment to rule out organic causes.

Adherence. Adherence has long been a focus in the treatment of people with severe mental illness. The common assumption that this population is less likely than others to properly take prescribed medication is not supported by the medical literature, which shows that the general population has similar adherence problems. Moreover, psychiatric patients are familiar with both the emphasis on maintenance medication and with stigma, so having a second stigmatizing illness that requires ongoing medication management may be easier to accept. Even patients in homeless shelters can follow antiretroviral regimens when all the necessary supports are in place. Patients with severe mental illness need to be assessed individually and without preconceived bias regarding their ability to follow an antiretroviral regimen. Stabilization of the psychiatric condition prior to beginning an antiretroviral regimen is an essential step. Involvement of significant others and the use of directly observed therapy are useful adherence strategies. As with other populations, only patients who are ready to adhere should be started on antiretrovirals, since intermittent use leads to the dangerous problem of viral resistance (see APA fact sheet on adherence).

Education and Training. Both patients and providers need continuous updates about HIV/AIDS. Educational materials can be provided to patients easily and inexpensively, but knowledge must be paired with skills training. Administrative support for education, adequate risk assessment, and preventive interventions is essential.

Prevention. Primary prevention efforts to reduce the risk of acquiring or transmitting HIV have been shown to be effective for people with severe mental illness. These emphasize skills-building and rehearsal of safer strategies, including negotiating condom use. Such skills must be reviewed repeatedly with patients to maintain gains. Providing condoms is important in both institutional settings and for the majority of outpatients who live well below the poverty level. Access to clean needles and syringes is important for those who inject drugs. Secondary prevention

efforts aimed at decreasing the morbidity and mortality associated with HIV must include risk assessment and HIV antibody testing to identify infected patients, better access to medical care, and efforts to promote adherence to anti-retroviral treatment.

Psychopharmacology. The combined medical treatment of HIV infection and severe mental illness raises concerns about the psychopharmacologic management of patients. The literature, which is still quite sparse, suggests that most psychotropic drugs can be used safely but the dosage may need to be adjusted depending on the stage of HIV illness, the presence of neurocognitive impairment, and drug-drug interactions caused by competitive metabolism in the liver's cytochrome P-450 system. Of note in the treatment of patients with combined psychotic illness and late stage HIV infection is that standard neuroleptics, especially high potency medications like haloperidol, can be associated with severe side effects, especially extrapyramidal symptoms. These include parkinsonism that is unresponsive to usual treatments and the rapid onset of neuroleptic malignant syndrome or tardive dyskinesia. Using the lowest possible doses and selecting the newer "atypical" antipsychotic medications are helpful strategies.

Conclusion. No program for people with severe mental illness can consider itself comprehensive unless it incorporates services aimed at detecting HIV, preventing acquisition and transmission of infection, and providing links to medical assessment and treatment for those patients who are already infected.

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