

Mental illness and HIV

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There is an assumption that HIV itself is the cause of mental ill health in people living with HIV/AIDS but is this always the case? Are we making assumptions about the relationship between HIV and mental health? And are the people with mental illness and HIV missing out on the care required?

What we see depends mainly on what we look for, or so John Lubbock (1834–1913), a noted anthropologist, once said. In the field of HIV research and care what we don't look for, we miss. In this case what we don't see, or continue to ignore even with available evidence, is the risk that people living with a mental illness (PLWMI) have to acquire HIV. There is little doubt that people living with HIV/AIDS (PLWHA) have higher rates of mental illness than the general population (Weiser, Wolfe & Bangsberg, 2004) but similar or even lesser rates to other groups with chronic illnesses such as diabetes (Moliffe, 2010), fibromyalgia (Rehm et al., 2010) and ulcerative colitis (Rubin et al., 2010). Though not so well researched in Australia but confirmed in US studies, is the high incidence of HIV risk behaviours in PLWMI (mainly depression/anxiety and psychotic disorders) in many sub-populations (Dausey & Desai, 2003).

What is missing from the data is the temporal relationship between mental illness and the acquisition of HIV. Did the mental illness have a direct effect? The large volume of research in PLWHA with mental illness has seemingly attributed mental health

disorders to either living with the virus or psychosocially-based stigma and internalised homo-negativity. There appears to be no temporal analysis of the possibility of a pre-existing disorder which may have a direct causal relationship to acquisition nor how that illness interacts with treatment and care afterwards.

The only available study that addressed HIV risk within PLWMI was undertaken in 1997 in Melbourne (Thompson et al., 1997)(see review) and showed that those with a serious mental illness had higher rates of participation in risk behaviours than the general community with meagre attention paid to prevention. Little has changed since then and with PLWMI being excluded from HIV strategic plans as a priority population, a change seems unlikely. A study reviewing people who used mental health services in Western Australia (Lawrence, Holman & Jablensky, 2001) found that during the period of 1980–1998, 19% of all HIV cases in the state came from this cohort with people with psychotic illnesses and substance abuse disorders most at risk. More recent research in the US has confirmed the continuing HIV risk behaviours among PLWMI with

associated difficulties in accessing and maintaining contact with care (Fremont et al., 2007).

Psychiatric comorbidity, the co-existence of either medical illness and psychiatric illness or multiple psychiatric illnesses, has strong links to poor medical outcomes. This is due in part to variable adherence to recommended treatments (DiMatteo, Lepper & Croghan, 2000). Psychiatric comorbidity is of particular concern for patients with HIV because of the influence of psychiatric illness on risk behaviours, medication adherence, and clinical course, as well as the fact that psychiatric comorbidity makes each of the component psychiatric illnesses more difficult to treat (Wagner et al., 2003) (see review). Psychiatric comorbidity in patients with HIV can foreshadow worse psychiatric and HIV outcomes (Pence et al., 2007) as well as increased risk behaviours for secondary transmission of HIV and the possible development of antiretroviral resistance due to poor adherence.

HIV services and mental health services cannot singularly effect change in this area. The National HIV strategy 2010–2013 (Australian Department of Health & Ageing, 2010) notes the existence of the higher risk of HIV in PLWMI and mental health disorders in PLWHA and encourages contact between the relevant services. However, a review by NSW Health (2005) of prior recommendations of

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a similar nature found that contacts between services were in existence but were locality-based, not formalised and dependent on individuals, making them vulnerable to staff change. There may be several reasons for this: possible latent homophobia given that homosexuality was once classed as a psychiatric disorder, HIV-related stigma, and unwillingness to broach HIV risk behaviours within mental health services. Further, unfamiliarity with mental health, associated legislation, and mental health care systems within the HIV sector also confound the lack of coordinated effort between HIV and mental health services.

With HIV, a mental health disorder and a possible substance-use diagnosis create overlapping influences and congruences between the three (Stoff, Mitnick & Kalichman, 2004); any successful intervention should treat all spheres of influence without ignoring any of the co-factors. Treating all spheres of influence concurrently can be problematic due to the entrenched dichotomies between mental health and substance use services. Mental health staff generally view psychiatric issues related to substance use as the responsibility of AOD services though this is an inconsistent attitude and is influenced by the philosophy of the individual services (NSW Health, 2005). This view is slowly changing due to

some integration of the two branches. However, this is an historical anomaly that will take time to resolve.

This aside, forms of integrated care do exist. Most mental health care and HIV care is mainly provided by GPs in Australia. Recent research surrounding GP management of depression in gay men both with and without HIV in urban and rural settings (Newman et al., 2009) (see review) found that urban GPs were able to refer to specialist and multidisciplinary teams and were highly complementary of these services and the impacts these had on their ability to manage people with depression in their practices. It was noted by several participants that funding for these services was not assured due to changes in health priorities.

While this form of care—GPs referring out of their practice—cannot be considered fully-integrated, it does provide access to required specialist services and to mechanisms for provider collaboration. Multidisciplinary collaboration provides the circumstances to share expertise, reframe difficult situations and foster a broader-based use of available resources (Soto, Bell & Pillen, 2004).

Building formalised relationships between HIV services and mental health services is imperative to both the prevention of HIV and the identification

and care of PLWHA with mental illnesses. A great deal of knowledge between the two areas could be shared for the benefit of both. Destigmatising activities in mental health services which encourage open communication around risk between professionals and PLWMI may assist in decreasing HIV rates in Australia. Adding PLWMI to the target groups will raise the profile of this group and work toward its inclusion in prevention efforts.

References

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- DiMatteo, M. R., Lepper, H. S. & Croghan, T. W. (2000). Depression is a risk factor for noncompliance with medical treatment: meta-analysis of the effects of anxiety and depression on patient adherence. *Archives of Internal Medicine*, 160, 2101–2107.
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ARTICLE SUMMARY 1 HIV risk behaviours and HIV testing in PLWMI

This research is the first and only of its kind in Australia to assess risk behaviours in a population of people with major mental illness.

The study aim was to ascertain the prevalence of HIV risk behaviours within a group of psychiatric patients in both inpatient units (59%) and community-based mental health care (41%). Participants were interviewed only when able to provide written consent and the questionnaire used was the Risk Behaviour Questionnaire which inquires into demography, psychiatric history, risk behaviour and HIV-risk counselling/education. In total there were 45 participants of which 60% were male. The predominant diagnosis within the participants was schizophrenia (55%), depression (9%) and 7% had a diagnosis of bipolar disorder. All diagnoses were clinician-made not self-reported. Seventeen percent of participants reported injecting drug use with half of those sharing equipment, 10% of males had had anal sex with another male, 19% of females had had sex with a bisexual male, and 36% of participants had either paid for, or traded, sex for money or goods. While condom use was high it was

also inconsistent with 60% of sexually active participants either never using condoms or using them less than half the time. Only 16% of participants could recall being spoken to about their HIV risks with 35% ever having been tested for HIV. The authors reported that while about a third of the participants had been tested, very few had reported ever receiving any specific HIV education or counselling. While this study was undertaken 15 years ago it does broadly reflect the current situation particularly around sexual health and sexual risk in PLWMI. This lack of HIV prevention and awareness could lead to infections remaining undetected until late in the disease course and potentially contribute to spreading the virus amongst this group. One caveat on the research is that the participants were all linked with a mental health institution and not all PLWMI are, so they may be more difficult to access. More contemporaneous knowledge of this subject is required.

-  Thompson, S. C., Checkley, G. E., Hocking, J. S., Crofts, N., Mijch, A. M. and Judd, F. K. (1997). HIV risk behaviour and HIV testing of psychiatric patients in Melbourne. *Australian and New Zealand Journal of Psychiatry*, 31(4), 566–576.

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Rehm, S. E., Koroschetz, J., Gockel, U., Brosz, M., Freyhagen, R., Tolle, T. R. & Baron, R. (2010). A cross-sectional survey of 3035 patients with fibromyalgia: subgroups of patients with typical comorbidities and sensory symptom profiles. *Rheumatology*, 49, 1146–1152.

Rubin, D., Dubinsky, M., Panaccione, R., Siegel, C., Binion, D., Kane, S. & Hopper, J. (2010). The impact of ulcerative colitis on patients' lives compared to other chronic diseases: a patient survey. *Digestive Diseases & Sciences*, 55, 1044–1052.

Soto, T., Bell, J. & Pillen, M. (2004). Literature on integrated HIV care: a review. *AIDS Care*, 16(1), 43–55.

Stoff, D., Mitnick, L. & Kalichman, S. (2004). Research issues in the multiple diagnoses of HIV, mental illness and substance abuse. *AIDS Care*, 16(1), 1–5.

2 Care of PLWHA with and without mental illness

This US study compared 295 PLWHA with severe mental illness who had contact with public health agencies in Los Angeles and 1294 PLWHA without severe mental illness. PLWHA with a severe mental illness were more likely to have; difficulty obtaining care, problematic hospital care, poor health status and more disability days when compared to PLWHA who did not have severe mental illness. Potential problems accessing care for PLWHA and severe mental illness were partially offset by case management provided by mental health services, possibly due to the case manager's role in advocacy.

Fremont, A. M., Young, A., Chinman, M., Pantoja, M., Morton, S., Koegel, P., Sullivan, G. & Kanouse. (2007). Differences in HIV care between patients with and without severe mental illness. *Psychiatric Services*, 58, 681–688.

3 Emergency psychiatric care

This retrospective study is the first of its kind. The records of 28,817 unique patients using a psychiatric emergency centre in Seattle were reviewed with the aim of estimating the prevalence of HIV amongst the patients. The authors reported that 2% were HIV-positive, these people were more likely to be male and homeless. Diagnostically they were also more likely to be showing signs of dementia (3 times more likely), be suicidal, abusing substances or diagnosed with borderline personality disorder. Psychiatric emergency centres are a relatively new development in the treatment of mental disorders in Australia and little research has been done in this setting.

Murray Bennet, W., Joesch, J., Joesch, J., Mazur, M. & Roy-Byrne, P. (2009). Characteristics of HIV-positive patients treated in a psychiatric emergency department. *Psychiatric Services*, 60, 398-401.

4 Adherence to antiretrovirals in PLWMI

This study assessed adherence to antiretrovirals (ARVs) among PLWHA with a serious mental illness via electronic measures and self-reporting over a two week period. Forty-seven people were enrolled with 40% demonstrating at least 90% adherence and 31% showing less than 50% adherence. Self-reported adherence to psychotropic medications was high at 86% which is higher than adherence to these medications in HIV-negative PLWMI suggesting a flow on from the emphasis on adherence to ARVs. This data suggests that PLWHA with mental illness are capable of adhering to ARVs at similar levels to other HIV populations with assistance.

Wagner, G., Kanouse, D., Koegel, P. & Sullivan, G. (2003). Adherence to HIV antiretrovirals among person with serious mental illness. *AIDS Patient Care & STDs*, 17(4), 179–186.



Resources of interest

The Black Dog Institute is an educational, research, clinical, community-oriented facility offering specialist expertise in depression and bipolar disorder.

<http://blackdoginstitute.org.au/>

The Centre for Mental Health Research on AIDS is part of the US National Institute of Mental Health and has a broad selection of information on mental health and its interaction with HIV.

<http://www.nimh.nih.gov/about/organization/dahbr/center-for-mental-health-research-on-aids/index.shtml>

MoodGYM is a free online Cognitive Behavioural Therapy program for preventing and coping with depression. This may be of assistance to rural PLWHA or people who are reluctant to attend or have limited access to mental health services.

<http://moodgym.anu.edu.au/welcome>

Clinical Research Unit for Anxiety & Depression (CRUFAD) is a research unit focusing on online education and treatment for depression and anxiety.

www.crufad.com

The Mental Illness Fellowship of Australia Inc. provides information, self-help and advocacy to PLWMI and their families.

www.mifa.org.au

5 Primary care of depression

This qualitative paper reported on interviews with 16 GPs (all S100 prescribers) from two cities (Sydney and Adelaide) and a rural coastal town on how depression in HIV-positive and HIV-negative men is managed. While the authors noted consistency with other studies on management of depression in general practice, several themes emerged that were notably different. Higher frequency of contact between the GP and the patient allowed longer term evaluation of mental state, access to specialist mental health teams was of benefit but not available in rural settings, and there was a willingness among patients to take medication for depression. Further, GPs noted the need to balance the pharmacological treatment with patients' experience of sexual side effects. General practitioners also noted that some of their patients presented with substance use and social isolation issues. The GPs interviewed displayed detailed knowledge of the behaviours, lifestyle impacts and life circumstance of their client base.

Newman, C., Kippax, S., Mao, L., Rogers, G., Saltman, D. & Kidd, M. (2009). Features of the management of depression in gay men and men with HIV from the perspective of Australian GPs. *Family Practice*, 26, 27–33.

6 Maintaining mental health contact in PLWHA

This prospective study conducted in the USA collected data from 132 PLWHA presenting for mental health care. Data was analysed to assess variables predicting the potential of the subjects to return for care after initial assessment. 68% returned for care while 32% did not. Those that dropped out of care had higher levels of perceived barriers to mental health care, higher levels of HIV related stigma, were non-Caucasian and had lower t-cell counts. Those that did return were more likely to be engaged in primary care providing further evidence of the importance of continuing relationships between primary care and HIV related services.

Reece, M. (2003). HIV-related mental health care: Factors influencing dropout among low-income, HIV positive individuals. *AIDS Care*, 15(5), 707–716.

7 HIV in PLWMI

This review article provides an overview of HIV within the PLWMI population of the US noting a prevalence rate of HIV over 7 times higher than the general population. The article concludes that PLWMI are not being targeted for HIV risk reduction, are less likely to be tested and less likely to receive treatment. The results suggest that specific programs are required with systemic efforts to strengthen HIV prevention in this group. These efforts could take the form of voluntary testing with mental health organisations, upskilling mental health professionals HIV risk reduction strategies and improving diagnosis of mental illness within HIV care.

Weiser, S., Wolfe, W. & Bangsberg, D. (2004). The HIV epidemic among individuals with mental illness in the United States. *Current HIV/AIDS Reports*, 1, 186–192.

8 HIV prevention in PLWMI

This US based National Institute of Mental Health group studied 99 PLWMI males attending mental health clinics. Of this group only 16% used condoms more than half the time. The groups were randomised to either a 7 session group and a one off video intervention was used as the control. Both groups showed reduction in partners but more importantly the intervention group reduced unprotected sex by 79% with this reduction sustained over 12 months. This study shows that it is possible to decrease risk markedly amongst PLWMI.

The National Institute of Mental Health Multisite HIV Prevention Trial Group. (2006). HIV prevention with persons with mental health problems. *Psychology, Health & Medicine*, 11, 142–154.

Action points

- Contemporaneous research into the HIV risk behaviours of people with mental illness in Australia must be conducted.
- People with major mental illness must be included in HIV and other BBV prevention efforts
- People with major mental illness should be added to the priority populations for HIV prevention.
- Continual and formal relationships and policy development between HIV services and mental health services should be seen as a priority.
- Stigma reduction activities related to homophobia and HIV phobia should be formalised within mental health services with the assistance of HIV related services.

