

Serious mental illness and HIV/AIDS

A previous editorial¹ emphasised the need for leadership from all sectors of society in tackling the HIV/AIDS epidemic. This certainly does not exclude a critical role for mental health practitioners.

There is growing global recognition of the interrelationship between mental health and HIV/AIDS and in developing countries, where the impacts of the pandemic are by far the greatest, we need increased efforts to better understand these interactions and to intervene effectively. In this editorial we look specifically at relationships between severe mental illness (SMI) and HIV/AIDS. Psychiatrists and other mental health practitioners are increasingly encountering patients living with HIV/AIDS and need to manage them effectively. Similarly, however, practitioners dealing directly with HIV/AIDS need greater understanding of the mental health issues related to HIV/AIDS.

Interactions between HIV/AIDS and mental health are 'bi-directional'. That is, HIV/AIDS impacts on mental health and mental health on HIV status. For example, cognitive impairment and dementia can be caused by viral infection in the central nervous system, and depression and anxiety may result from a positive diagnosis or from difficulty dealing with stigma and discrimination.² Equally, however, poor mental health and substance abuse are risk factors for HIV infection. Moreover, once a person is infected the course of the disease may be influenced by his or her mental well-being.³

In the USA people with SMI are around 20 times more likely to be infected with HIV than the general population. In 1997, when the population HIV prevalence was 0.4%, nearly 8% of people with SMI were infected.⁴ This was highest among people with co-morbid substance abuse and mental illness (18.4%). Adequate similar research in Africa is lacking, yet clearly with current prevalence rates similar proportions are arithmetically impossible; nonetheless there are good reasons to believe that people with SMI are likely to have elevated HIV prevalence levels. In the USA and Europe a significant number of people living with HIV and AIDS (PLHA) receive mental health treatment. For example in one US study,⁵ 27.2% of HIV-positive patients took psychotropic medication while many more received psychotherapeutic intervention. We do

not know what proportion of PLHA in South Africa receive mental health care, but from anecdotal information the figure is very low.

The reasons why people with SMIs are likely to have elevated HIV prevalence include both additional risk factors for contracting HIV and consequences of HIV infection.

Risks can be separated into 'input' and 'output' causes, i.e. factors external and internal to the individual with mental disorder. Some of the more important 'input' factors that increase susceptibility are: (i) that as result of their mental disorder, some individuals are less receptive to 'normal' HIV prevention education, which may result in their engaging in behaviours that increase their risk of contracting HIV; (ii) a number of people with mental disorder are susceptible to abuse, including sexual abuse; (iii) people with SMI may be perceived as not needing prevention education (this arises in part because of perception that the life of a person with SMI is somehow less important and partly due to an erroneous belief that people with mental disorder are not sexually active/should not be sexually active); (iv) both HIV and mental illness are related to poverty – people with SMI and living in extremely poor conditions are therefore at additional risk of HIV infection; (v) a number of people with SMI are at risk for HIV infection because of multiple sexual partners; and (vi) a number of people with SMI live in chronic care institutions, which may increase their risk. Despite the fact that so far the three studies that have measured HIV prevalence in South African psychiatric hospitals have found similar rates of infection to the general population,⁶⁻⁸ institutions are 'closed systems' and once HIV penetrates, it is easily spread. Moreover, the likelihood of infection is increased, especially for men, owing to the fact that institutions are often single sex and anal intercourse is in itself high HIV-risk behaviour. While certainly if long-stay institutions can keep HIV out these institutions could prove protective, it is unlikely that the virus will not be introduced at some stage.

While the specifics of the disorder and the personality of each individual will bear on whether or how mental illness affects behaviour, some of the 'output' factors that increase HIV risk include highly impulsive behaviour, poor assertiveness and

ability to have control over sexual relations (for example the ability to say no to sex or no to unprotected sex), caring little about self or others and therefore not bothering with sexual protections, and co-morbid substance abuse.

Before looking at some of the consequences of HIV/AIDS linked to SMI, it is worth examining sexuality among people with SMI. While no figures are available from South Africa, information from the USA is informative. McKinnon and Rosner,⁴ summarising a range of studies, report the following: one-third to one-half of sexually active psychiatric inpatients and outpatients were found to have multiple sexual partners within a year of interviews being conducted; among psychiatric patients 5% had had sex with a partner in the past month whom they had known for only one day; sexual activity among psychiatric patients was characterised by the non-use of a condom; 14% of outpatients reported having unwanted or pressured sex in the past year; having multiple sex partners was nearly three times as likely among patients with positive symptoms of psychosis; and trading sex was more than three times as likely among patients with schizophrenia than among patients with other diagnoses.⁴ Clearly people with SMI are an important risk group.

Psychotic symptoms may follow HIV/AIDS infection as direct or indirect consequences of the disease. HIV invades the brain early in the infection process and in a certain proportion of people psychotic symptoms manifest, especially in late-stage AIDS.⁹ Manic episodes are above the population norm in people with HIV (around 5%), especially at more advanced stages of the disease, and are the most common reason for psychiatric hospitalisation in the HIV-seropositive population in the UK.¹⁰ Symptoms of severe mental illness may also manifest as a complication of medical illness related to HIV, such as tuberculosis. It may also happen that people with controlled mental illness may relapse following the stress of learning that they are HIV-positive. Finally, some patients have adverse reactions to some of the antiretroviral treatments, particularly efavirenz, and medications used to treat opportunistic infections.

Treatment of co-morbid HIV and psychiatric problems is important. Most psychiatric medication is tolerated in conjunction with antiretroviral therapy (ART). However, because psychotropic medications can interact with HIV-related medications, where patients are receiving both it is important to monitor dosages and adverse reactions carefully.⁴ Where there is a negative interaction or poor

tolerance, the psychotropic drugs need to be re-evaluated and may need to be changed. In advanced HIV infection, atypical antipsychotic drugs are the first-line treatment of psychotic symptoms. Where a person on ART is being started on psychiatric medication the principle of 'start low, go slow' should be applied.

HIV dementia and new-onset psychosis or mania are indications for ART, even if the CD4 count is above 200/ μ l. A problem experienced by some people with SMI is acceptance onto AIDS treatment programmes. This is inexcusable when ART is needed to treat the psychiatric disorder as mentioned above. Studies have found that people with mental illness are poor adherers to medication, including adherence to ART,¹¹ and this, together with the importance of achieving high levels of adherence to ART medication to prevent the development of resistant strains of the virus, has sometimes led to the exclusion of people with SMI from ART roll-out. While understandable at one level, it is discriminatory and all efforts should be made to help people with mental disorders to achieve better adherence levels (by providing additional support) rather than excluding them from ART.

Other implications of the association between mental illness and HIV/AIDS are that health personnel providing HIV treatment need to be much more aware of the mental health issues involved, including how to treat psychiatric difficulties and/or refer. Similarly, people working in mental health need to be highly vigilant with regard to the possibility of HIV infection and to refer where necessary. From an HIV prevention point of view, programmes specifically targeting people with SMI are needed. This could easily become part of routine in- and outpatient programmes. Condoms, together with proper education, need to be made available and easily accessible to people with mental disorders both in and outside psychiatric hospitals. Advocacy and professional groups need to put HIV/AIDS firmly on their agendas. They need to lobby for proper prevention and treatment services, to provide support and education to PLHA and their families, and to ensure that people with SMI are not unjustifiably discriminated against and excluded from ART treatment.

Melvyn Freeman

*Human Sciences Research Council
Pretoria*

Rita Thom

*Tara H Moross Centre
Johannesburg*

1. Stein DA, Seedat S, Emsley RA. HIV/AIDS in Africa – a role for the mental health practitioner? *South African Journal of Psychiatry* 2005; **11**: 12-15.
2. Cournos F, Forstein M, eds. *What Mental Health Practitioners Need to Know About HIV and AIDS*. San Francisco: Jossey-Bass, 2000.
3. Ickovics JR, Hamburger ME, Vlahov D, et al. Mortality, CD4 cell count decline, and depressive symptoms among HIV-seropositive women. *JAMA* 2001; **285**: 1466-1474.
4. McKinnon K, Rosner J. Severe mental illness and HIV/AIDS. In: Cournos F, Forstein M, eds. *What Mental Health Practitioners Need to Know About HIV and AIDS*. San Francisco: Jossey-Bass, 2000.
5. Vitiello B, Burman MA, Bing EG, et al. Use of psychotropic medications among HIV-infected patients in the United States. *Am J Psych* 2003; **160**: 547-554.
6. De Villiers A. Prevalence of HIV and hepatitis B virus in psychiatric treatment facilities in the Western Cape Province, South Africa. MMed thesis, University of Stellenbosch, 2003.
7. Singh D. Prevalence of HIV in hospitalised psychiatric patients. Abstracts XIII International AIDS Conference, Durban, 2000: 126.
8. Van Brandis-Martini P, Van Wyk S. HIV seroprevalence and associated factors in two hundred acute psychiatric admissions to Weskoppies Hospital. MMed thesis, University of Pretoria, 2001.
9. Cournos F, Bakalar N. *AIDS and People With Severe Mental Illness*. New Haven: Yale University Press, 1996.
10. Catalan J, Meadows J, Douzens A. The changing pattern of mental health problems in HIV infection: the view from London. *AIDS Care* 2000; **12**: 333-343.
11. Ammassari A, Antinori A, Aloisi MS, et al. Depressive symptoms, neurocognitive impairment and adherence to highly active antiretroviral therapy among HIV- infected persons. *Psychosomatics* 2004; **45**: 394-402.



South African Society of Psychiatrists (SASOP)

14th National Psychiatry Congress

*"Facts & Values in
Psychiatric Practice"*



The South African
Society of
Psychiatrists

Royal Swazi Sun, Swaziland

10 – 14 September 2006



CONGRESS ORGANISERS

For any information pertaining to the Congress,
please contact Sonja or Eileen at Londocor Public Relations on
Tel: +27 11 768-4355 Fax: +27 11 768 1174
or e-mail sonja@londocor.co.za or eileen@londocor.co.za
www.sasop.co.za

Printing kindly sponsored by



Answers That Matter.