# Psychosocial factors affecting mortality in patients living with HIV: a retrospective audit and case presentation

Weston, N, Bodasing N.
Stoke Hospital, University Hospitals North Midlands NHS Trust.

## Introduction

- People living with HIV experience higher rates of psychological difficulty which impacts both physical and mental health.
- We had observed 4 deaths within the last 12 months from our cohort that all seemed to have been linked to poor mental health.
- An audit was conducted to determine the rate of mortality in our patients, and where adverse psychosocial factors appeared to play a key role whether adequate psychosocial support had been put in place.

## Aims

- What is the annual mortality in our cohort?
- What proportion of these were related to poor mental health?
- Did we screen these patients and refer for appropriate additional support?

## Methods

All patient records are kept in an online electronic database. Records were reviewed between 1st January 2013 and 1st October 2018. Post mortem/coroners reports were reviewed where appropriate/available.
Auditing standards were taken from: BHIVA guidance for psychological support for patients living with HIV.

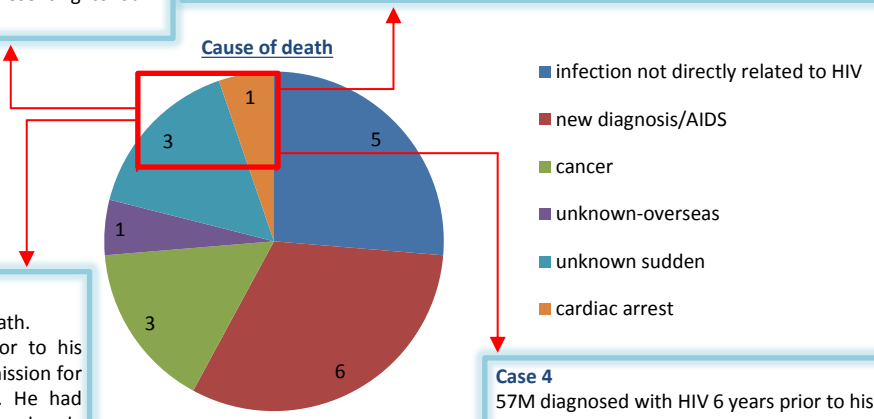
## Results

There were a total of 19 deaths. Annual mortality ranged from 1 to 6 deaths/year (median 3 deaths/year). The median age was 55 and 90% were male.
4 (21%) of these deaths were unexpected. All 4 deaths occurred during 2018 and were in men aged between 35-55. 3 of these deaths were directly related to poor mental health.

- In all 4 cases patients had been adequately screened for psychosocial issues.
- Only 2 of the 4 patients were offered and had access to special support services.
- 3 of the 4 patients dis-engaged with HIV services prior to their deaths.
- 2 out of 4 cases identified may have had earlier opportunities for referral to additional services

**Case 1**
43M diagnosed with HIV 3 years prior to his death.
Re-engaged with services 3 months prior to his death. Intermittent engagement with services was related to IV drug use and homelessness. He was found dead in a tent. The post mortem revealed he died from acute bronchitis and renal impairment due to heroin use and monkey dust.
He was known to the drug-liaison teams but had not been referred for psychological support upon re-presenting to our services.

**Case 3**
51M diagnosed with HIV 7 years prior to his death.
Longstanding history of mild depression but had always regularly attended his appointments. Last seen in HIV clinic 6months prior to his death. 3 months prior to his death, his wife stated that he became increasingly withdrawn and self-neglected but the patient refused to liaise with our support workers or see his GP. A GP home visit concluded that he had capacity to refuse treatment. He was found collapsed at home and had an out of hospital cardiac arrest.
Earlier opportunities for referral to psychological support may have been missed.




**Case 2**
37M diagnosed with HIV 9 years prior to his death.
Dis-engaged from HIV services 1 month prior to his death subsequent to an inpatient hospital admission for an intentional overdose of benzodiazepines. He had longstanding mental health issues and was already under regular review by psychiatry services.
In the month leading up to his death neither HIV teams or community support teams could get hold of him.
He died of a cardiac arrest following use of stimulants on a night out with friends.

**Case 4**
57M diagnosed with HIV 6 years prior to his death.
Known to have a complex medical and psychosocial history and had seemed well from a mental health perspective when last seen in HIV clinic 2 months prior to his death. Circumstances around his death are unclear but may be due to his chronic medical problems.

## Conclusion

- Dis-engagement from our service was recognised as a significant event.
- Males between 35-55 years may be particularly at risk of death related to poor mental health.
- Better awareness and access to mental health services is needed for at risk groups.

## Changes to practice

- Use of PHQ2/GAD2 questions during consultations for early identification of at risk patients and to facilitate early referral to specialist services.
- More frequent clinic review in at risk individuals.
- Consideration of HIV specialist nurse community visits for those at risk who DNA.
- Liaison with local psychological services to improve referral pathways.

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