Mental health diagnoses in HIV infected young people: a HIV in Young People Network audit

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Aims

• To assess prevalence of formal psychiatric diagnoses in young people vertically infected with HIV.

• To assess prevalence of behaviours indicating psychological distress in those without a formal psychiatric diagnosis.
Background

- The 2012 HYPnet mortality audit (1): 11 deaths in HIV infected young people 2003-11. 2 suicides, remaining 9 all with formal psychiatric diagnoses.
- Limited prevalence data – no UK data (2,3)
- Psychiatric diagnoses known to negatively impact HIV outcome (4).
- Potential underdiagnosis of psychiatric disorders in this population

Method

Retrospective case note review of:
• Patients vertically infected with HIV.
• Seen in either adult or transition clinic at participating HYPnet centres.
• Data anonymised and centrally analysed.
• Feedback given regarding access to psychological support services and potential improvements.
Patient Categories

- All patients
- Formal Psychiatric Diagnosis
- No Formal Psychiatric Diagnosis but behaviours indicating Psychological Distress
- No Formal Psychiatric diagnosis and No Psychological distress
Results

- 8 centres
- Data re 237/248 eligible patients (96%)
- 141 female (60%); 96 male (40%)
- Median age 20 years (range 16-27 years)
- Median age at HIV diagnosis 6 years
- 80 % BA, 6% BB, 5% WB, 9% other
Disease Markers

Data for 186/237 individuals (78%)

Median CD4 = 500 (28%)

CD4 < 200 = 32/186 individuals (17%)

77/186 detectable VL (41%)

Mean VL 12,812

26 VL >10,000; 6 VL>100,000
Patient Categories

Total number (n = 237)  
Median CD4 500

Formal Psychiatric Diagnosis (N = 51, 22%)  
Median CD4 414

No Formal Psychiatric Diagnosis but behaviours indicating Psychological Distress (N = 60, 25%)  
Median CD4 349

No Formal Psychiatric diagnosis and No Psychological distress (N = 126, 53%)  
Median CD4 577
51 patients (22%) in total with formal psychiatric diagnosis.
Patients with formal psychiatric diagnoses (N=51)

- Median age = 21
- Median CD4 414 (29%) (p< 0.002 compared to CD4 of population without psychological issues*).
- Median age of Psychiatric diagnosis = 18
- 26 (51%) with documented ongoing psychiatric diagnosis
- 8 /51 (16%) had required in-patient psychiatric care.

*Calculated via Mann Whitney U test
Risk Behaviors in patients with Formal Psychiatric Diagnoses (N = 51)

Patient Number

<table>
<thead>
<tr>
<th>Behaviour causing risk to self or others</th>
<th>Patient Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Harm</td>
<td>8</td>
</tr>
<tr>
<td>Suicide Attempt</td>
<td>9</td>
</tr>
<tr>
<td>Violence</td>
<td>8</td>
</tr>
<tr>
<td>Other Criminal Behaviour</td>
<td>4</td>
</tr>
<tr>
<td>Psychiatric In-patient</td>
<td>8</td>
</tr>
<tr>
<td>HIV Treatment Refusal</td>
<td>2</td>
</tr>
<tr>
<td>Drug/Alcohol Addiction</td>
<td>17</td>
</tr>
<tr>
<td>Inappropriate Sexual Be</td>
<td>9</td>
</tr>
<tr>
<td>Unplanned Pregnancy</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>
Prevalence of those with no formal psychiatric diagnosis, but behaviors indicating psychological distress

- 60/186 (32 %) of patients
- Median age = 20.5 years
- Median CD4 349.5 (21%).
- CD4 <200 = 13 (28 %)
  (p< 0.0004 compared to CD4 of population without psychological issues*)
- 28/46 (60.8%) with detectable VL.

*Calculated via Mann Whitney U test
Prevalence of behaviors indicating psychological distress in those without a formal psychiatric diagnosis (N = 60)

- Self Harm: 2
- Suicide: 2
- Violence: 5
- Other Criminal Behaviour: 4
- HIV Treatment Refusal: 51
- Drug/Alcohol Addiction: 3
- Inappropriate Sexual Behaviour: 1
- Unplanned Pregnancy: 7

Patient Number

Behaviour documented
<table>
<thead>
<tr>
<th></th>
<th>Psychology</th>
<th>Counselor</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Full time</td>
<td>Full time</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>By referral – not same day</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Available x2/wk – not same day</td>
<td>Nil</td>
<td>Voluntary</td>
</tr>
<tr>
<td>4</td>
<td>Part time – not same day</td>
<td>Nil</td>
<td>Peer Mentor</td>
</tr>
<tr>
<td>5</td>
<td>Available – not same day</td>
<td>Nil</td>
<td>Voluntary</td>
</tr>
<tr>
<td>6</td>
<td>Every clinic</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Every clinic</td>
<td>Nil</td>
<td>Liaison Psychiatry / Voluntary agencies</td>
</tr>
<tr>
<td>8</td>
<td>Full time</td>
<td>Access possible</td>
<td>Voluntary</td>
</tr>
</tbody>
</table>

All Clinics had good access to Physicians, Health Advisors, Clinical Nurse Specialists and Multidisciplinary team meetings.
Feedback from clinics re support services

- Poor interaction / communication between psychiatry and HIV services
- Difficult to access community mental health services: “out of area” / self referral / GP referral
- Limited availability of psychology services
- Issues of patient’s experiencing stigma re. HIV within psychiatric services
Recommendations

• Early psychology assessment & intervention pre transition in paediatric services
• Psychology on same day as young persons clinic.
• Direct referral pathways to community mental health services.
• Voluntary agencies and Peer Support.
• Clear communication and co-ordination of care between physical and mental health teams.
In Summary

• 22% of individuals had formal psychiatric diagnosis – similar to general population (5)
• However 1/3 of patients without formal diagnosis with psychological distress.
• 111/237 (46.8 %) requiring emotional and psychological support.
• Statistically lower CD4 counts in those with formal psychiatric diagnoses and especially psychological distress.
• Over half of psychiatric diagnoses emerging at time of transition.
• Vigilance for emergence of psychiatric disorders in paediatric and transition services and awareness of available psychological services and referral pathways.

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