MENTAL HEALTH CHALLENGES RELATED TO HIV-AIDS IN DEVELOPING COUNTRIES

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The HIV-AIDS pandemic is concentrated in developing countries of the South where resources are limited and poverty, inequality, political instability and environmental threats are widespread. Furthermore, the burden due to HIV-AIDS is not limited to individual mortality, morbidity and disability, but impacts profoundly on the social, cultural and economic structures of society. Developing countries with high prevalence rates are characterized by falling life expectancy, a shrinking young adult population, declining workforce and a fast-growing population of orphaned children[1]. These social and economic changes have occurred and continue to occur in precisely those regions of the world that are least able to deal with them. The crisis brought by HIV-AIDS is largely over in better resourced developed countries; but it remains a major threat within Africa, South and Southeast Asia, parts of Central America and some former Soviet-bloc countries, including Russia[2].

The direct and indirect effects of HIV-AIDS on mental health are diverse and well-known. HIV infection is a risk factor for almost all common mental disorders as well as substance use disorders and cognitive impairment/dementia[3]. It also increases individual risk for developing psychosis. Psychotic disorder in the context of HIV-seropositivity may have a number of causes. These include: neurological complications of the immune compromised state (e.g. infections and tumours of the brain); side-effects of anti-retroviral medication (ARV) (e.g. efavirenz); stress of receiving the HIV diagnosis or of living with a life-threatening disease; and direct infection of the brain by the HI virus. A psychotic illness may occur at any stage of the course of HIV-AIDS – in some cases as early as sero-conversion. The global clinical experience of managing individuals with HIV-related psychosis indicates that very often treatment is prolonged, difficult and requires complex approaches[4]. The clinical state typically fluctuates, including psychotic, mixed affective and cognitive symptoms, and rarely responds quickly to a single antipsychotic regimen. Clinicians often find themselves forced to combine psychotropics, and unpredictable disorganized behavior often necessitates involuntary admission. The addition of antiretroviral medication has been shown to be an effective treatment strategy in achieving remission of the psychotic illness.

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It is clear that HIV-related psychosis constitutes a significant clinical challenge. But this disorder raises a number of other important challenges which I argue are particularly difficult to manage within low-resourced developing country contexts. In the first instance there are serious ethical issues which, in low-resourced contexts, confront the clinician with a dilemma. For example, psychotic individuals often lack capacity to consent to treatment and this impacts not only on decisions regarding the need for sedation, voluntary versus involuntary care and the use of antipsychotic medication, but also impacts on decisions regarding initiation, continuation or discontinuation of ARVs. There are compelling reasons for initiating or continuing ARV treatment in psychotic individuals, namely: ARV treatment appears to augment antipsychotics in inducing remission from acute symptoms; and interruptions of ARV treatment are discouraged because this is a major cause of the development of resistance to ARV regimens. On the other hand, many HIV clinicians are hesitant to initiate or continue ARV treatment in people whose mental disorder may render them unreliable and therefore at risk of non-adherence. Within developing countries contexts, monitoring of follow-up and adherence to ARVs is often compromised by multiple barriers to care including poverty, lack of access to services and even absence of services in rural and remote areas[5, 6].

Another ethical challenge relates to safety and risk to others (other patients as well as health personnel) during the course of inpatient care for individuals who are HIV sero-positive and manifesting disorganized, aggressive symptoms of psychosis. Many institutions in developing countries lack adequate health personnel and facilities to nurse such individuals in safe conditions that minimize risk to others. Within such contexts, highly regrettable incidents may and do occur, where staff and other patients are assaulted and put at significant risk of being infected. This is a challenge that is too often left to institutional staff and managers to handle which is unfair and inappropriate. Minimising such risks should be the responsibility of local, regional and national governments; and mental health professionals working in such contexts should advocate strongly for their governments to implement measures throughout all services to protect patients and staff from unacceptable risks.

Individuals living with HIV-AIDS and suffering a major mental disorder such as psychosis are too often burdened with double stigmatization – the stigma of liv-

ing with HIV-AIDS and the stigma of having a mental illness. While this is a global phenomenon, there is good evidence that generally both forms of stigma are more prevalent in developing countries.[7] Poorer public education and awareness of mental disorders and HIV-AIDS combined with absent or inadequate human rights legislation encourages an environment in which stigma can proliferate. This is by no means the case in all developing countries - some have made huge progress in safeguarding the rights of individuals vulnerable due to their HIV or mental health status. However the burden of such stigma is carried by developing societies where multiple social, health-related and political needs are concentrated.

Psychotic illness attributable to HIV-AIDS also impacts on and complicates the process of understanding and documenting the epidemiology of psychosis. It is important for all public health systems to generate epidemiological data on psychosis so as to accurately measure the burden due to major mental illness and plan appropriate mental health services. In regions where HIV prevalence is very high, HIV-AIDS is responsible for a higher proportion of cases of psychosis. For example, in KwaZulu-Natal, South Africa, approximately a quarter of cases of first-episode psychosis are due to HIV-AIDS infection[8]. This translates into higher incidence and prevalence rates of psychosis and complicates efforts to map the epidemiology of psychoses in such countries. This makes planning of appropriate mental health services a greater challenge. It also places the added responsibility on clinicians and health service planners of ensuring that appropriate screening, detection and treatment services are available and accessible at all levels of health care.

This brings us to the question: What specific mental health services and what specific psychiatric training are required to manage the additional burden related to HIV psychosis and other HIV-related mental disorders? At the primary care level, screening for mental disorders is indicated in individuals testing positive for HIV. Such screening should include both evaluation of mental state and some form of brief screen for cognitive impairment that is easily doable in the primary care setting (such as the International HIV Dementia Scale.) Most individuals with HIV psychosis require in-patient care for a period at least; and it is usual practice to conduct a range of investigations to exclude organic complications due to the immune-compromised state. While the majority of patients can be managed within general psychiatric settings it may, in some countries with a particularly high burden of HIV-AIDS, be strategic to develop specialized mental health and psychiatric services for those suffering HIV-related mental disorders. These units are best placed at secondary and tertiary levels of care where clinicians have access to specialized investigations and interventions (such as neuro-imaging, neurological evaluation, neuropsychological testing and multidisciplinary treatment.) In South Africa for example, these specialized multidisciplinary services are being developed in various centres as part of the ongoing development of Neuropsychiatry as a sub-specialist discipline of both Psychiatry and Neurology. In tandem with these service developments, HIV Psychiatry and Neuropsychiatry are developing as academic and research disciplines – building knowledge and skills in this field and providing a career path for health professionals from a range of disciplines (including Psychiatry, Psychology, Neurology, Public Health, etc.)

In conclusion, psychiatric complications of HIV-AIDS (particularly HIV Psychosis) represent a significant added burden for mental health services and professionals in developing countries with high HIV prevalence rates. It may be strategic in such contexts to make use of the 'HIV bandwagon' to leverage funding and support for mental health services and training development – by linking HIV-AIDS to mental health. This is already happening in some countries where significant international and national funding is available for HIV-AIDS-related services, training and research. Scaling up mental health care in developing countries is not an easy challenge since the context (developing country) implies low resources and the topic (mental health) implies low national priority. While undoubtedly HIV-AIDS adds to the overall burden of psychiatric disorders in these contexts, stressing the links between the disease and mental health may be a useful strategy for strengthening and expanding general mental health care coverage and capacity in these countries.

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