AIDS Prevention for People with Severe Mental Illness

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In current clinical work, a comprehensive program for people with severe mental illness must include a component for AIDS prevention. Evidence for this position includes the elevated rates of injection drug use and high risk sexual behaviors as well as high HIV seroprevalence rates among psychiatric patients that confirm the spread of the epidemic in this population. Primary prevention allows providers to protect HIV-negative patients from infection while simultaneously reducing the incidence of other sexually transmitted diseases, unplanned or unwanted pregnancies, and experiences with coerced sex. Secondary prevention for HIV-positive patients delays adverse health outcomes, reduces the risk of further HIV transmission, including to unborn and newly born children, and improves skills for coping with HIV-related illness and adhering to medical regimens. In this article, we describe specific prevention techniques for this population, in particular cognitive-behavioral risk reduction groups and individual counseling in the context of HIV testing. (*J Pract Psychiatry Behav Health* 1997;3:000–000)

KEY WORDS: AIDS, counseling, HIV infection, HIV testing, mental illness, risk reduction

A growing body of research supports routinely incorporating HIV prevention strategies into programs that treat people with severe mental illness—no program can consider itself truly comprehensive without such services. In this article, we outline the evidence for this position and present a model for establishing HIV prevention services.

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RATIONALE FOR HIV PREVENTION PROGRAMS

Risk Behavior

Since the early 1990s, dozens of studies have consistently documented high rates of HIV-related risk behaviors among people with severe mental illness in all areas of the country where studies have been conducted, including the northeast, south, and mid-west (see Table 1).[1,2]

Injection drug use with contaminated equipment is one of the most powerful modes of HIV transmission, and as many as 20% of patients with chronic psychotic illnesses have engaged in injection drug use.[2] But injecting drugs appears to be an intermittent behavior in this population, a behavior often neither expected nor detected by mental health staff who imagine injection drug users look quite different from the severely ill psychiatric patients they are treating.

Unsafe sexual activity can also easily go undetected, especially when clinicians hesitate to ask patients about it. Studies show that one-half to three-quarters of psychiatric patients have been sexually active in the past year in comparison to 88% of the general U.S. population.[1] Twenty to 40% have had more than one partner in the past year, as compared to the 17% base rate in the general population. The median rate of reported same sex behavior among mentally ill men is 13%, which contrasts with the lifetime U.S. base rate of 9%. Some studies show much higher rates, often among men who identify themselves as heterosexual.[2] Same sex behavior may occur with particular frequency when patients are housed in single gender settings such as hospital wards, shelters, or forensic units.

Because severe mental illness often interferes with maintaining competitive employment, patients are frequently indigent. Many live in poor urban neighborhoods where HIV infection has its highest concentration. Patients often depend on entitlements that keep them below the poverty level. "Survival sex," the exchange of sex for something essential such as food or shelter, is sometimes seen in these circumstances. Poverty may also interfere with purchasing condoms, even when patients are otherwise motivated to use them.

Difficulty in maintaining long-term intimate relationships can result in having causal sexual encounters or sex with high risk partners, such as injection drug users. In

TABLE 1. *HIV-Related Risk Behaviors Reported* Among People with Severe Mental Illness

- High rates of unprotected sexual intercourse
- Low rates of condom use
- Injection drug use associated with sharing drug paraphernalia
- Unsafe sexual activity when disinhibited by alcohol or illicit drug use or when exchanging sex for drugs
- *Trading sex for food, money,* a place to stay, etc. (survival sex)
- Sex with multiple or poorly known partners, or sex with those known to be HIV positive, to use injection drugs, or to have other risk factors for HIV
- Coerce sex
- Living in poor urban neighborhoods where HIV is *endemic*
- For men: elevated rates of same sex sexual activity
- For women: sex with *bisexual men*

addition, because of the high rate of comorbidity of severe mental illness and substance use, patients may be disinhibited by alcohol and illicit drugs, which makes it more difficult to practice safer sex. Safer sex practices are likely to be impossible to implement in situations where sexual coercion is involved, a problem that is well documented in this population. In addition to the risk of acquiring or transmitting HIV, the problems outlined above are associated with acquiring other sexually transmitted diseases, with unplanned or unwanted pregnancies, and with the risk of physical injury. Helping patients protect themselves from HIV infection also reduces the likelihood of these other health problems.

Seroprevalence

Engaging in risk behaviors is obviously not sufficient to acquire HIV unless one comes across infected individuals in the process. It is therefore important to understand the pattern of infection seen in a given geographic area. It has been estimated that about 1,000,000 people in the United States have been infected by HIV.[2] The Centers for Disease Control and Prevention (CDC), which have had primary responsibility for tracking the U.S. epidemic, have used various methods of recording cases of HIV infection and AIDS. The *incidence* of cases refers to the number of new cases appearing within a specified period of time. For example, the CDC provides data on the incidence of AIDS cases in the United States for a given year and on the cumulative incidence of AIDS cases since the epidemic began. *Prevalence* refers to the number of cases within a population at a particular point in time. Prevalence counts already existing cases as well as new cases, and excludes individuals who have died. *Seroprevalence* refers to using blood samples to establish prevalence.

Several other points are important in understanding how the HIV epidemic is tracked:

1. HIV infection is usually identified indirectly by testing for HIV antibodies, a method that did not become available until 1985.
2. Most available data concern the number of AIDS cases, which reflects the effect of HIV infections occurring many years previously.
3. While there is an extensive surveillance system for tracking AIDS cases, there are no general population seroprevalence studies; instead, select groups of people are tested for HIV and estimates of the number of infected people in a given region or subpopulation are then made from these results.

More than a dozen peer-reviewed HIV seroprevalence studies of people with severe mental illness have now been published.[3] Nine of these were conducted in New York City, an early epicenter of the epidemic, and document high rates of HIV infection among severely ill psychiatric patients, varying from 4% to 23%. The lowest rate was found on long-term state hospital wards serving an area of New York City with low to moderate AIDS case rates; the highest was found on a dual-diagnosis unit serving a Manhattan neighborhood that has some of the highest AIDS case rates in the nation. The few studies that have examined HIV seroprevalence rates in other geographic areas have found that psychiatric patients are at increased risk for infection in other areas of the country as well (e.g., HIV seroprevalence rates of 5.8% in Baltimore, MD and 5.5% in Columbia, SC). Obviously, seroprevalence rates vary with the type of patients sampled and the degree to which HIV is endemic. Women with psychiatric disorders are as likely to be infected as men, which contrasts with the fact that 80% of AIDS cases in the United States as a whole occur in men. In addition, dual diagnosis patients with comorbid substance use disorders have significantly higher rates of infection than those who do not use drugs or alcohol. Black and Latino patients have higher rates of infection than white or Asian patients, which is consistent with the epidemiology of HIV in the United States. For some time now, HIV has been moving from urban epicenters to suburban and rural communities. In one longitudinal study, HIV/AIDS was the leading cause of death among a group of psychiatric patients residing in semi-rural Suffolk

TABLE 2. Goals of HIV Prevention Strategies

Primary prevention

- Protect HIV-negative subjects from acquiring infection
- Reduce the incidence of other sexually transmitted diseases and unwanted/unplanned pregnancies
- Reduce the likelihood of unwanted/coerced sex

Secondary prevention

Reduce the risk of HIV-positive patients transmitting HIV to uninfected people

- Protect unborn and newly born children from maternal transmission
- Provide early access to antiretroviral medication to help prevent irreversible immune deficits
- Prevent or delay adverse health outcomes
- Improve skills for coping with HIV-related illness and adhering to medical regimens

County, NY, who were experiencing their first psychiatric hospitalization for a psychotic episode.[4] In those locations where HIV infection rates have remained low, we have the opportunity to employ prevention strategies before HIV becomes widespread.

PREVENTION STRATEGIES

Both primary and secondary HIV prevention strategies are essential (See Table 2). Primary prevention protects HIV-negative patients from acquiring HIV and simultaneously from other adverse outcomes such as coerced sex and unwanted pregnancy. It also reduces the chances of acquiring other sexually transmitted diseases, which increase biological vulnerability to HIV infection. Secondary prevention is aimed at patients who are already HIV-positive, with the goals of reducing further transmission, facilitating coping, postponing the onset of AIDS, and otherwise preventing adverse health outcomes.

There is a large body of literature addressing HIV prevention in general, and a growing number of publications that focus on prevention among people with severe mental illness.[5] Several principles have emerged from this literature (see Table 3).

Among the most consistent and important findings in the HIV prevention literature are that improvements in knowledge about the risks posed by HIV are not sufficient to change unsafe behavior. Unless people can personalize the risk, find the motivation to act more safely, and believe in their capacity to execute the skills needed to make appropriate changes, knowledge alone will not modify behavior. On a practical level, this means that distributing booklets and pamphlets on HIV or lecturing patients about

TABLE 3. Principles of AIDS Prevention Strategies

- Providing education about HIV risk is necessary, but not sufficient, to produce a change in behavior
- Intensive interventions with multiple sessions and a maintenance component are necessary to produce lasting behavior change
- Interventions must address multiple cognitive and behavioral risk determinants, including
  - intention and motivation to change behavior
  - belief in ability to implement safer practices
  - behavioral skills to use condoms properly
  - social and assertiveness skills to negotiate safer sex and avoid coercive sex
  - for injection drug users: behavioral and assertiveness skills to avoid sharing needles, syringes, and other drug paraphernalia
- Useful strategies to teach prevention include
  - ensuring that interventions are entertaining and engaging
  - using warm-up exercises to increase comfort about discussing sex
  - identifying specific risk triggers for unsafe behavior
  - modeling and role-playing safer behavioral strategies and the skills needed to achieve them
  - focusing on problem-solving skills
  - providing practice in generalizing to real-life risk situations
  - making condoms available anonymously and free of cost
  - facilitating access to needle exchange and other programs tailored to injection drug users
  - training participants to become peer educators and advocates for safer behavior

safer behavior is not by itself of much use. Clinicians need to take a much more active approach, largely based on cognitive-behavioral skills training, which is quite similar to the models currently in use in psychosocial rehabilitation programs for patients with psychiatric disabilities.[5] Just as in these programs, repetition and booster sessions are essential to facilitate and maintain change. This is true for HIV prevention in general with any group of people, and is also consistent with other clinical interventions aimed at improving outcomes for people who have severe mental illness.

To date, the only randomized outcome trials of HIV risk reduction interventions for people with severe mental illness have used a group format with 4 to 15 sessions.[5] The short-term results are optimistic, demonstrating patient improvements in HIV-related knowledge and intentions to act more safely, and even more important, behavioral changes such as increases in the proportion of intercourse occasions protected by condoms and reductions in the number of sexual partners. However, studies over longer periods of time are needed.

Group interventions are an efficient way to work with patients and allow patients to become facilitators or prevention advocates among their peers. The addition of this peer component has been shown to improve the outcome of small group HIV risk reduction interventions for this population.[5]

HOW TO START AND MAINTAIN AN HIV RISK REDUCTION GROUP

As part of a federally funded grant from The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, the authors have had considerable experience implementing or helping others implement HIV prevention programs. Our goal is to work with people with mental illness to help them make responsible decisions regarding sexual behavior, avoid activities which place them at risk for HIV and other sexually transmitted diseases, and learn to negotiate safer sex behaviors with their partners. Most clinical programs will choose to conduct prevention using the group format described above. Leading these groups requires basic knowledge about HIV and reasonable comfort discussing sexual issues. Both professional staff and paraprofessionals can assume this role, as long as they are comfortable talking about sex and drug use.

Most patients enjoy talking about sex, especially if the topic is presented in an engaging manner. It is important to respect patient differences in sexual norms and mores across cultures, religious and ethnic groups, and life stages. Some clinicians have expressed concerns about how to get patients to attend. Incentives such as food, small prizes, and transportation money help induce patients to participate. But if the group is sufficiently engaging, such incentives are usually unnecessary.

There is controversy over whether to conduct single- or mixed-gender groups. There is concern that the use of mixed groups will inhibit women from fully participating. On the other hand, generalization to real-life risk situations requires women to negotiate with men, and we have had success conducting mixed-gender groups in which women practice being assertive with men about having safer sex and avoiding unwanted sex. At times, a mixture of single-gender and mixed-gender sessions may be appropriate.

The question of including sexually abstinent patients in these groups also arises. We recommend doing so. First, patients who are abstinent today will not necessarily be abstinent forever. Second, many patients have reported using what they learned in the group to talk to their friends and families, including their adolescent children, about HIV, birth control, and other topics the group covers. For example, in one of our groups, an elderly patient took a large number of condoms and said with an embarrassed look that they were for her grandchildren. And finally, abstinence is a legitimate choice of life style, so that abstinent members offer one approach for other group members to consider.

Regarding drug injection, mental health care workers have a variety of philosophies about how best to intervene, and often debate whether the goal should be complete abstinence, reduction of injection, or harm reduction, which involves promoting the use of clean needles, syringes, etc. We advocate the latter approach through one-on-one counseling, display and practice of equipment cleaning procedures, and institutional policies that do not make receiving drug abuse treatment contingent on being totally drug-free.

In groups that include patients of mixed HIV status, we do not encourage patients to reveal a positive result. However, in many cases they choose to do this. If a program has a large enough number of patients who know they are HIV-positive, it may be useful to separate them from the general population of patients and run a group specifically tailored to their concerns. It is very important for group leaders to add 15 minutes at the end of each session for participants to discuss personal issues privately. Group leaders should be prepared with lists of local referral sources, including testing sites.

The Use of Videos

When a television set and a VCR are available, videos can be used to stimulate discussion. Many helpful videos are available. It is best to show 5–10 minute segments with immediate discussion afterwards. Before the session, group leaders should watch and carefully choose the segment, to make certain they are familiar with the content. Videos should be appropriate for each group. Some videos may be too explicit for some populations. Factors to be considered are age, cultural background, gender, and sexual orientation.

Specialized Groups

Modifications in the usual risk reduction group can be made to suit the needs of special populations. For example, groups for homeless patients need to address risk behavior that occurs in public places; those for exclusively HIV-positive patients need to emphasize coping and access to medical care; and groups that take place in forensic settings often need to deal with strict prohibitions against condom distribution.

Handling Problems in the Group Sessions

Most of the problems that arise when conducting these groups can be readily managed. In general, psychotic remarks such as "The condoms are poisoned" can be ignored. Participants should be redirected toward appropriate behavior, and unrelated issues should be referred to the patient's clinicians.

Sometimes, patients become distracted or focus on the wrong topic. When this occurs, there are a number of approaches to try:

1. Bring the discussion back to the topic at hand: "Something I said must have gotten you off the topic. We were talking about . . ."
2. Ask the person to focus on the session's topic.
3. Explore the person's discomfort and try to learn what is bothering him or her.

All leaders should remember that when questions arise to which they do not have the answer, the best response is to defer answering and then report back with the correct answer in the next session.

HIV TESTING AND INDIVIDUAL COUNSELING

Individual counseling also has an important role in HIV prevention and occurs most often in the context of conducting HIV testing. Table 4 lists some of the indications for conducting HIV testing.

Encouraging patients to learn their HIV antibody status has many important implications for primary and secondary prevention. In particular, those who test positive have an opportunity to accept what is now known as highly active antiretroviral treatment (HAART), which should begin long before clinical symptoms appear. The principle of HAART is that viral replication should be suppressed as fully as possible throughout the course of HIV infection to prevent irreversible immune deficits.[6] If the patient is known to have a positive HIV antibody status, the clinician can monitor HIV disease progression by repeated measures of viral load (the amount of circulating virus in the blood) and CD4+ T-lymphocyte counts (the primary white blood cell involved in the body's immune system response to HIV). These biological markers are used to adjust the HAART regimen and to begin other medications in a timely way to prevent HIV-related opportunistic infections. Finally, pregnant women who know they are HIV-positive can take antiretroviral treatment during pregnancy, delivery, and/or the post-partum period, a strategy that dramatically reduces the chances of a woman passing HIV infection on to her baby. For all these reasons, HIV testing should be routinely offered to patients being treated for severe mental illness.

TABLE 4. Reasons for Conducting HIV Testing

- The patient asks for HIV testing.
- The patient has risk factors such as drug injection or risky sexual behaviors.
- The patient is diagnosed with a sexually transmitted disease.
- The patient is pregnant.
- The patient has developed a positive TB skin test and resides in an area with a high rate of HIV infection.
- The patient has physical signs that are suggestive of AIDS or HIV-related illness.
- The patient has psychiatric symptoms that suggest central nervous system dysfunction.

Many states have legal regulations for pre- and post-test counseling for HIV testing.[7] Because New York State's laws are among the most stringent and comprehensive, they are helpful as a guideline. The New York State guidelines provide a useful model for humane testing and counseling, and promote both primary and secondary prevention goals (See Table 5). Readers from other states may wish to refer to the *Synopsis of State AIDS Laws*.[8]

The patient's psychiatrist or therapist can provide the HIV counseling if he or she is prepared to carry out all the required tasks. HIV counselors do best when they have six core qualities: empathy, respect, warmth, genuineness, immediacy, and concreteness.[7] The counselor must demonstrate these qualities even in the face of the intense emotions that frequently emerge in the course of counseling sessions. The counselor also needs to be able to ask open-ended questions while remaining sensitive to the possibility that this may be stressful to the patient. Because psychiatric patients sometimes react to open-ended questions by becoming more thought disordered or disorganized, the counselor may need to shift gears and use a more structured approach. This could include asking questions that require only a yes or no answer, or suggesting a few options for responses in a multiple choice style.

TABLE 5. New York State Requirements for Pre- and Post-Test HIV Counseling

- An individual being tested must sign an informed consent form. If the individual is incapable, informed consent may be given by a person who is legally authorized to do so.
- The informed consent must include:
  a) an explanation of the test, its purpose, the meaning of the results, and benefits of early diagnoses and medical intervention.
  b) an explanation of the voluntary nature of the test, of the individual's right to withdraw consent at any time, and of the availability of anonymous testing, in which the results are not linked with the person's name.
  c) an explanation of confidentiality and the circumstances under which the information may be disclosed with or without the individual's agreement.
- A discussion must be offered of AIDS and HIV-related illness including possible discrimination that may occur if a positive test result is revealed, as well as legal protection against that discrimination.
- Information about risk behaviors for contracting HIV must be provided.
- Test results must be given to the individual with counseling or referrals for counseling that cover the following areas:
  a) coping with the emotional consequences of learning the result.
  b) discrimination problems that disclosure of a positive result can bring.
  c) behavior change to prevent transmission or contraction of HIV infection.
  d) information about available medical treatments
  e) discussion of notifying at-risk contacts

There is scant literature on HIV testing and counseling in a psychiatric population. Clinical experience suggests that the mentally ill patient may require more than the single session of counseling and will need a careful assessment of the capacity to consent to testing. During the pre-test counseling session, the patient's risk factors for HIV should be elicited. This requires an open and explicit discussion of sexual behavior and substance use. The counselor must also ask about the patient's plans *after* receiving the test results. For example, if patients believe they might become suicidal if they test positive, testing should be postponed until this problem has been resolved.

Post-test counseling occurs when the counselor meets with the patient to convey the HIV test result. The counselor should ask the patient to explain his understanding of the result and correct any misconceptions. The counselor must help the patient deal with emotional responses to the result and discuss who can provide further help. It is also important to talk to the patient about whom to inform and what to tell them. Psychiatric patients may need extra time to process all this information.

When a positive result is being given, patients can be expected to react with anxiety about their health and future. In extreme cases, denial, suicidality, depression, assaultiveness, and worsening psychiatric symptoms have been observed in people with severe mental illness who receive a positive test result. However, most patients handle this news without severe problems. While home kits are currently available from pharmacies to perform anonymous testing for HIV by mailing in a blood sample obtained with a lance, we do not encourage this approach with severely ill psychiatric patients.

Patients with positive test results need to be referred to a health-care provider, so the counselor must be aware of the available hospitals, clinics, public health facilities, and private physicians who treat HIV-positive patients. The patient with mental illness frequently needs help establishing follow-up care and may benefit from concrete interventions by the counselor, such as calling to make an appointment for the patient or arranging for someone to accompany the patient on the first visit. Alternatively, the mental health team that usually works with the patient may be in the best position to insure such follow-up.

If the counselor works in a state that requires disclosure of a positive test result, the counselor should discuss this with the patient, being very specific about the reasons for disclosure and answering any questions the patient might have.

One-on-one counseling can also be useful outside of the HIV testing situation, either in the course of ongoing therapy, or as a specific intervention for patients who are not comfortable in a group setting or are in need of additional help. In general, patients are uncomfortable bringing up the subject of sex, so the staff member must be prepared to introduce the topic. The ease that the staff member demonstrates in discussing sex will affect the patient's anxiety level. Assuring confidentiality and normalizing any patient discomfort can set a more relaxed tone. Questions about sexual functioning should be asked in a nonjudgmental, accepting manner, and discussions about reducing risk behaviors should be tailored to the particular patient's unique circumstances.

OBSTACLES TO CREATING A PREVENTION PROGRAM

A recent survey of 600 licensed mental health care providers[9] throughout New York state found that 96% believe that HIV services are somewhat important or essential for the patients they serve, and 85% of providers have treated patients they know to be HIV infected. Yet many offer limited HIV services: 30% complete an HIV risk assessment as part of intake, 53% provide HIV risk-reduction interventions, 19% provide HIV-positive support groups, 41% make condoms available, and 12% offer HIV testing on site. The HIV-related service that is most often provided is passively offering HIV/AIDS literature on the premises: 68% of providers do so; however, as discussed earlier, this is the least effective form of intervention.

Staff Discomfort

In the multidisciplinary settings where people with severe mental illness are usually treated, many staff feel too uncomfortable to talk directly about sex with patients. Few have had any classroom instruction in human sexuality, which results in two related problems: the staff is not comfortable talking about sex, and many mental health professionals feel that it is intrusive to raise sexual topics with patients. When an explicit discussion of sex was taking place at a staff training in a state psychiatric hospital, a supervising psychiatrist said, "I don't have any problems with these sexual words but why can't we just call them all 'private parts?" Some clinicians have prejudices that prevent them from openly discussing sexual issues with people who are gay. In one residential program, we trained a worker who had recently lost his brother to AIDS. He was angry at all gay men and allowed this anger to overwhelm the training. His personal feelings also made him a judgmental counselor, which is always counterproductive for patients. At still another agency where we provided training, two very committed staff members began a group. To their dismay, most therapists at their agency discouraged their patients from attending. It was necessary to return for an additional two hours of training in which therapists raised numerous concerns. They feared that patients would become too sexual, that discussing the subject was inappropriate, and that patients shouldn't be engaging in sex anyway. Eventually, staff anxiety was alleviated and they began making referrals to the prevention group.

Some staff believe that talking to patients about sex may encourage sex among a vulnerable population or lead to inappropriate behavior or sexual exploitation—arguments that echo those made against sex education programs in schools. In hundreds of educational sessions regarding HIV, other sexually transmitted diseases, and family planning, we have never encountered any patients who inappropriately acted out sexually as a result of these discussions. Many mental health professionals are reluctant to bring up sexual issues and safer sex with patients on the grounds that it will interfere with the therapeutic relationship. Certainly there may be some small risk here, but the epidemic nature of HIV requires clinicians to understand the benefits of HIV education and respond accordingly.

All staff need to be aware of how their personal values, attitudes, and beliefs regarding "appropriate" sexual behavior may affect patient care. For example, people reared in a fashion that associates sex with shame or whose religion prohibits sex for anything other than procreation may have more difficulty with open discussion of sexual matters. Some believe HIV is God's punishment, others that all HIV-positive patients are promiscuous. Even members of one risk group often have negative feelings about other groups. At some programs, staff have punitive motives for requesting training, such as stopping specific patients from having sex, an unrealistic goal for HIV prevention groups.

Some staff believe that people with severe mental illness are too disorganized to acquire and use hard street drugs like heroin and cocaine or deal with the needles, syringes, and other injection equipment involved in their use. Others believe their patients' mental illnesses will prevent them from learning necessary HIV prevention information, but in fact most patients attending risk-reduction groups report very positive feelings about the experience; they are attentive and engaged and quite capable of following the material presented.

Sometimes staff concerns about their own health cloud the discussion of HIV among patients. If a staff member in the program has died from AIDS, volatile arguments can arise about what to tell patients. One side holds that no better lesson about the dangers of HIV could be offered than informing patients that a beloved staff person has died from AIDS. The other side often argues that it would be inappropriate to reveal details of staff members' personal lives. Gay staff members often worry about what to do if they run into a patient at a bar. There are no clear answers to these questions, which were clearly easier to answer before the advent of HIV. Nevertheless they can be addressed in a supportive atmosphere by people who are motivated to help their patients protect themselves.

Common concerns about HIV counseling can be seen in some of the anonymous comments given to us by staff undergoing training to provide HIV counseling services.

> "I feel I'll come off either too callous or almost condescending."
>
> "What if someone becomes violent and lashes out?"
>
> "I'm concerned about not allowing my body language or facial expression to get in the way."

"What if someone were to come on to me physically during an interview and all of my efforts to redirect do not work?"

"What if someone starts to fantasize about me during the interview?"

"I am concerned that I will not have enough correct information to give at the appropriate time."

It is obviously essential to train mental health professionals to feel they have strategies to handle these fears. Otherwise, they are unlikely to conduct adequate counseling.

Following a recent training, a provider came up to us and told us how "informative and enjoyable" she found our training. She then listed the dozens of HIV workshops she had attended over the years. So we asked her how patients reacted to her HIV work, to which she answered, "I could never talk to my patients about this." The real challenge involved in HIV prevention with people with severe mental illness is to convince the thousands of mental health care workers who have attended countless seminars and training sessions about HIV ***to bring all that information and skill to their day-to-day work.***

Religious and Cultural Differences

The diversity of religious, cultural, or generational differences between people must be treated with respect, but not at the risk of impeding the task of helping patients stay safe. Some cultural preconceptions border on bigotry. We've attended cultural diversity training sessions in which the concepts voiced included views such as, for African American men, "unexpected and volatile behavior is the norm," for Latino men, "seductive behavior is the norm," and for Latina women, "passivity and submission is the norm." We reject these stereotypes and believe individuals can be quite different even within a single culture. Despite the fact that many religious denominations are opposed to condom use and other forms of family planning, it is often still possible to develop prevention services. For example, we have learned that Catholic agencies have no problem with open discussion of sexual material. Most have allowed us to discuss condoms, as long as we also presented the church's opposition to their use. Some have even looked the other way while we distributed condoms in front of their site. It is important for clinicians and educators involved in HIV work to develop strategies for working with religious sponsored agencies, since in many communities these agencies provide much of the care both for people living with HIV and for people with mental illness. We have yet to find a single culture in which direct intergenerational talk about sex is encouraged. Nonetheless, we feel there is an important difference between respecting areas of comfort and discomfort and allowing them to prevent staff from developing HIV risk reduction strategies.

Institutional Obstacles

Institutional obstacles can also be a problem, including lack of administrative support for a prevention program and lack of funds for such basics as condoms. Yet the modest amount of money prevention requires could save millions of dollars in medical care that HIV infected patients will need later.

CONCLUSION

The need for AIDS prevention programs for people with severe mental illness is now clear. Early evidence suggests that the cognitive-behavioral groups described in this article are successful in reducing HIV-related risk behavior, giving staff the opportunity to empower their patients with the skills they need to protect themselves. Counseling individual patients to undergo HIV antibody testing has significant medical benefits for those who learn of their HIV infection early, particularly in allowing for the early use of antiretroviral agents to suppress virus replication and prevent irreversible immune deficits. Because severely ill psychiatric patients often need help maintaining good physical health, mental health providers have an important role to play in the early detection and treatment of HIV infection in their patients.

Editor's Note: A patient-family handout on the prevention and treatment of HIV/AIDS in people with mental illness is included on p. XX.

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