

HIV/AIDS and mental illness: ethical and medico-legal issues for psychiatric services

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ABSTRACT

Objectives: To investigate and address some of the ethical and medico-legal issues associated with the HIV/AIDS epidemic in South Africa and the management of people with mental illness. **Design:** Qualitative/exploratory/Participatory process. **Setting:** The Gauteng Health Department. **Subjects:** Key stakeholders. **Outcome measures:** Areas of consensus/concern. **Results:** Policy guidelines for the province have been written. They include guidelines on HIV testing and treatment and the practice of universal precautions as well as for education programmes for patients and staff, especially with regard to patient sexuality. Confidentiality is considered to be critical, and specific guidelines are suggested regarding when confidentiality may be breached. Special attention is paid to the management of patient exposure to HIV infection through assaults and injuries while in hospital. The issues related to managing children and youth in specialized psychiatric hospitals are highlighted. Many of the difficult issues relate to the degree of capacity of a mentally ill person to give informed consent, as well as the serious implications of a diagnosis of HIV infection. **Conclusions:** This work highlights the complexity of the issues involved in the care of mentally ill people who are exposed to HIV infection. It is hoped that the guidelines will help to raise awareness of these issues and guide clinicians and hospital managers in difficult situations.

Keywords: HIV/AIDS, Mental health, Ethical, Medico - legal

Introduction

HIV/AIDS is a serious epidemic facing South Africa. The recent Nelson Mandela HSRC 2002 household survey reports an overall HIV prevalence rate of 11.4% (males: 9.5%; females: 12.8%) in South Africa.¹ The prevalence rate in the 15 to 24 year-old age group was found to be 9.3% (M: 6.1%; F: 12%) and was 15.6% (M: 12.8%; F: 17.7%) in the 25 to 49 year-old age group. Mpumalanga, Gauteng and the Free State had the highest provincial prevalence rates (14.1%, 14.7% and 14.9% respectively). There are few South African prevalence studies amongst mentally ill populations due to the difficulties in obtaining informed consent for testing. A study of 200 consecutive acute admissions conducted at Weskoppies Hospital in 2000 showed a prevalence rate of 9%.² Of these, 78% were male and 22% were female. Most had experienced a previous psychotic episode, had a history of substance abuse, low levels of education, with 50% showing no clinical signs of HIV infection. This prevalence rate appears to mirror the general community prevalence of the infection and the expectation is that as prevalence rates rise in the general population, so will they rise in inpatient psychiatric settings. In order to assess the impact of this rising number of HIV-positive pa-

tients in mental health services, a study was commissioned by the Gauteng Health Department.³ This suggests that HIV infection will have a significant impact on mental health services, and the report outlines the increased service needs and resources that will be required. Aside from these global issues, are the difficulties that clinical staff face in dealing with people with a dual diagnosis of HIV infection and a severe psychiatric disorder. The implications of the presence of people with such dual diagnoses in acute and chronic psychiatric inpatient settings are considerable, and give rise to many complex ethical and medico-legal dilemmas.

Methods

During 1999, the Gauteng Health Department received requests for advice from the specialized psychiatric hospitals in the province regarding the management of in-patients in the context of the HIV/AIDS epidemic. As a result, two participatory workshops were held in Gauteng (in November 2000 and 2001), involving a range of health care professionals working in specialized psychiatric services in the province. The aim of the workshops was to clarify and debate the medico-legal and ethical issues involved, and to assist the psychiatric hospitals in developing policies regarding the management of situations which could arise in patient care and in the management of the hospitals. The National Department of Health: Directorate Mental Health and Substance Abuse also published policy guidelines on HIV/AIDS and mental illness, largely based on the APA Guidelines in 2001.⁴ In addition, legal advice was sought from the Aids Law Project at the University of the Witwatersrand.⁵

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The major areas covered in the workshops and the document were:

- Guidelines on HIV-testing
- Issues regarding confidentiality and disclosure of HIV status
- Management of sexuality in acute and chronic in-patients settings.
- Management of assaults in psychiatric hospitals
- Management of children and adolescents in in-patient settings.

A document outlining policies, procedures and guidelines has been written and distributed to all management and clinical staff in the psychiatric hospitals, and is available on request from the author.⁶

Participants at the workshops were given information regarding HIV and AIDS, the relationship between HIV and mental disorders, and policies and approaches developed in other parts of the world.⁷⁻⁸ A series of case scenarios was developed in order to stimulate debate and to help to clarify the issues. The workshops raised many concerns, particularly of an ethical or medico-legal nature, but a number of areas of consensus were achieved. Consultation with the AIDS Law Project assisted us in answering most (but not all) of the questions raised.¹

Results and discussion

HIV-testing:

The consensus reached regarding testing for HIV in in-patient psychiatric settings was that National policy guidelines⁹ and other general ethical guidelines^{10, 11} should be followed as far as possible, and that testing should be voluntary with full informed consent (VCT) from the patient concerned. The indications for testing without the consent of the patient are limited to emergency situations, or where there is a clinical indication for testing and the patient concerned is incapable of giving informed consent. Clinical indications are outlined in the document as well as procedures for obtaining proxy consent. The issue of proxy consent was debated in some detail, as the stigma of HIV infection sometimes makes it difficult for such consent to be obtained from family members. It was finally agreed that such consent should be obtained from family members or next of kin unless there is evidence to show that this would not be in the patient's best interests; however, the consent could be for testing only, and not for disclosure, which should still be to the patient first as far as possible (usually on recovery from the acute phase of the illness). However, the finding from the Weskoppies study² that 50% of the in-patients who tested positive for HIV on admission were asymptomatic raises questions about the recommendation that tests should only be conducted when clinically indicated. Nevertheless, testing would still have to be voluntary, and this emphasizes the need to promote VCT in these settings.

Confidentiality and disclosure:

The principle of confidentiality and disclosure to the patient first was upheld. It was agreed that the patient should decide who should be informed. Clinical staff directly involved in the patient's treatment should be informed in order to provide more effective treatment. The principle of informing the minimum number of people was also upheld. It was emphasized that patients with known HIV infection could not be sepa-

rated from other patients whose status was not known, and that the practice of universal precautions should be emphasized in all institutions. It was also agreed that it was not permissible to inform fellow in-patients of anybody's HIV status. Disclosure to family members and sexual partners should be with the patient's informed consent, unless this is not possible. If the patient is incapable, then the principle of the patient's "best interests" should apply. In the case of the patient refusing to inform identifiable people who would be at risk of contracting the infection, this would have to be done following specific guidelines and with full documentation of the steps taken in the patient's clinical records. One of the more intense areas of debate was around the management of in-patients who were known sexual offenders or potentially dangerous to others in some other way. It was finally agreed that HIV status could still not be disclosed to other patients in such cases, but that there should be intensive education around HIV in such settings, practice of universal precautions and proper supervision of patients who posed a threat to others. However, there are still concerns regarding how implementable this is, in the context of severe staff shortages in psychiatric hospitals. An issue that remains difficult to resolve is how to communicate information regarding HIV status to clinicians who provide follow-up community care, without prejudicing patient confidentiality.

Management of sexuality in psychiatric in-patient settings:

Implementation of the Mental Health Care Act of 2002 will entail a shift in attitudes and practice with regard to this issue.¹² It was agreed that education programmes and proper supervision (particularly in acute settings) are critical. Perhaps the greatest changes in approach will need to be in chronic in-patient settings, although if deinstitutionalisation is effective, this could involve fewer numbers of patients. A zero-tolerance approach to sexual abuse is emphasized, and for hospitals to ensure that there are adequate and appropriate channels to report and investigate allegations of (physical and sexual) abuse.

Management of physical or sexual assaults on patients:

One of the major areas of concern was the provision of post-exposure prophylaxis to patients who had been exposed to a high-risk assault. At the time that the workshops were held, the policy of the Department of Health was to provide post-exposure prophylaxis (PEP) to staff members according to defined protocols¹³. However, this was not extended to patients, and given the prevailing debates around the issue in government, there was no clear directive that PEP could be provided to patients. However, since then, as we are all aware, the treatment scenario for HIV has changed to some extent. The AIDS Law Project also recommended that the Department would be liable if a patient contracted HIV as a result of such exposure in hospital, and they had not been provided with PEP. One of the issues that has not been clearly resolved is if the patient concerned refuses PEP. What if the patient is not capable of making an informed decision at the time? What would the medico-legal consequences be if a patient refused to take PEP while acutely mentally ill and not competent to make such a decision, and subsequently sero-converted? Or on the other hand, if such a patient refused, but their decision was over-ridden (in their "best interests"), and then developed adverse side-effects from the medication? These issues highlight the complexity of dealing with this kind of disease in a

mentally ill population.

Management of Children and Adolescents in in-patient settings:

The consensus of opinion here was that these are a high-risk group both as far as psychiatric disorder and HIV infection are concerned, and their mental disorders should be treated vigorously. This group also requires intensive supervision while in hospital, and age-appropriate educational interventions regarding sexuality and HIV infection. One of the major controversial areas is whether condoms should be provided to adolescents in in-patient settings. The AIDS Law Project consider it to be irresponsible not to provide condoms in such settings, whereas clinicians working in these settings do not agree, but rather propose a total prohibition on sexual activity in these settings, (if possible, and with proper supervision), as well as individual risk assessment in order to prevent exposure to or transmission of the infection.

Conclusion

It is clear that while there has been some consensus and clarification of issues as a result of the process undertaken in Gauteng, there are still many areas of debate and controversy. They have very serious implications and the need for further debate and discussion is clear.

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The craziness of HIV/AIDS ethics

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Compare the epics of two viruses, HIV and SARS. The latter has infected a few thousand, has a mortality rate of around 6%, but generated panic in the Far East and gentle Toronto. In China a quarantine centre for 1000 was constructed within a week, and filled quickly with unwilling patients. Elsewhere airports screened boarding passengers with thermal guns, and returning school children from Hong Kong were placed in quarantine in England. Suspected cases were not subjected to arduous pre-test counselling and not required to sign informed consent. In fact there do not seem to have been any 'soul searching' treatises on whether these measures enjoyed any ethical sanction. In comparison, HIV has a much higher mortality rate, and has already killed tens of millions. Considering that HIV is causing profoundly much more devastation one could be excused for wondering why draconian measures to uncover and treat this infection causes ethical revulsion. Millions of HIV victims can die at least in comfort knowing that their supposed past shameful sexual behaviours will remain hidden from their peers. However, HIV's special status has been enhanced by the publication of official codes of management, such as that issued by the Health Professions Council of South Africa (HPCSA), and all medical practitioners are obliged to follow these guidelines.¹

Nevertheless psychiatrists can find themselves confronted by surprisingly tricky dilemmas. Although psychiatrists establish singular fiduciary relationships with their patients, the latter are often cognitively impaired and may actually represent a significant (and imminent) risk to others.² Forensic psychiatrists, who generally conduct assessments outside the usual therapeutic relationship (as they are 'objectively examining' the individual) are particularly concerned with the safety of others, and may be hampered by the official guidelines.

Consider two such cases:

- I. A 35 year old woman, with no past psychiatric history, presents with cognitive decline and depression. After pre-test counselling she refuses an HIV test. She and her family insist that she is just depressed and ask you to treat her accordingly. She does not improve, and is fired from her job. She asks for a psychiatric report to apply for an insurance pension. Again she refuses to be tested, even though she is obviously impaired. Ironically, if it was possible that she may have had hepatitis B or neurosyphilis, which are also sexually transmitted and potentially fatal, testing would have been done as a routine investigation.
- II. A paedophile is admitted for observation following a charge of rape of a ten year old girl. He admits to strong sexual urges for young girls, but refuses to be tested. He has not been convicted and therefore cannot be forced to undergo testing. If he were found to be positive the victim could be informed, and possibly other past victims could be traced.

Many psychiatric patients are institutionalised involuntarily for varying periods in lock up facilities where they are sexually exposed to others (either by coercion or consent). After discharge they return to resume relationships with unsuspecting partners. Often pre-test counselling is not possible, because the patient may be too psychotic, depressed or otherwise impaired. Who is the psychiatrist really protecting?

HIV should not be regarded as a special illness, but as a catastrophe that can only be combated by being relentlessly exposed. We should therefore aim to protect the community, and simultaneously find rational ways of dealing with our ethical squeamishness.

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