Intergovernmental Health Policy Project
The George Washington University

STATE HEALTH REPORTS

MENTAL HEALTH, ALCOHOLISM, & DRUG ABUSE

Special Issue

No. 52, November 1989

Mental Illness and AIDS: An Overview

Editorial Note: This issue represents somewhat of a departure from previous special editions of State Health Reports. In the past, SHR has reported on state or other public programs and initiatives that address the service or treatment needs of mentally ill persons. The following article does not discuss the details of any specific program. Rather, it is aimed at raising the awareness of federal, state and local policy makers to the emerging issues that need to be dealt with concerning HIV infection and mental illness. The article will serve as background for what will be the first meeting of nine national mental health organizations as a group to discuss the impact of HIV infection and AIDS on the mental health field. The meeting, scheduled for January 11-12, 1990, will provide a unique opportunity for policy leaders and clinical experts within the nine organizations to share experiences, concerns and future plans with regard to HIV and persons with mental illness. The National Institute of Mental Health has contracted with IHPP to hold the meeting, with the goal of working toward a consensus on policies and programs relevant to the mental health consequences of HIV infection and AIDS. A report on the meeting is expected to be available in the spring. In the future IHPP and its AIDS Policy Center expect to focus on the issues surrounding drug abuse and AIDS. Special thanks to David Harvey at the National Association for Protection and Advocacy Systems for his collaboration in preparing this article and to Linda Demkovich of IHPP for her suggestions and editorial skills. — Lee Dixon, Deputy Director, IHPP

Policy Overview

Since the early 1980s, when the AIDS epidemic began to be part of the public's consciousness, policy makers and public health experts have debated ways to resolve a range of complex, often controversial issues. Voluntary versus mandatory testing, preserving an individual's privacy versus protecting the public's right to know, finding not only the dollars but also the most humane way to care for people who contract the deadly virus -- all have posed challenges that, to varying degrees, remain unresolved. The epidemic has also spurred a search for effective prevention and education programs to stop the spread of the deadly disease.

For the mental health community, the increased incidence of the human immunodeficiency virus (HIV), the agent that causes AIDS, presents special challenges. The mental health system -- already overburdened with the huge influx of homeless mentally ill -- must prepare itself to respond to an even greater demand for services by a new population of patients: those who suffer from mental illness and become infected with HIV as well as those in whom the virus triggers emotional or mental disorders. On the long list: residential, habilitative and rehabilitative services; child welfare and social services; health and education services; and community and institutional services.

The etiology of HIV infection in those people already diagnosed with mental illness appears to be the same as for the rest of the population: primarily, high-risk sexual behavior and/or IV drug use. Though there have been concerns about behavioral disorders that result in biting, biting has not been shown to be an efficient means of transmitting HIV-

(MMWR, June 23, 1989, p.14). In theory, if there is blood in mouth of a person who bites and the bite tears the victim's skin, transmission could occur, though the risk is minimal. Studies show that infected blood (through transfusion of contaminated blood or blood products, IV drug use and needlestick injuries), sexual transmission and perinatal transmission are the only significant methods of transmitting the virus (Friedland & Klein, 1987).

Little is known, however, about problems unique to mental illness, such as interactions between drugs used to treat HIV and psychotropic medications. And only recently have mental health researchers begun to report on the behavioral, psychological and neuropsychiatric consequences of HIV infection and been able to differentiate the dementia that can occur when the virus attacks brain cells from the depression that can come from knowing one has AIDS.

The concerns about HIV infection in the mentally ill population have intensified over the following issues: 1) infection control procedures and the ability of mental health facilities to implement them; 2) sexual behavior within facilities; 3) confidentiality and duty to warn; 4) placement of clients in community settings or in the least restrictive environment; 5) HIV testing; and 6) management of non-compliant or recalcitrant patients. The Centers for Disease Control (CDC) recent pronouncements calling for early HIV testing and access to treatment have particular ramifications for persons with mental disabilities who are under state guardianship, because of the problems of obtaining informed consent and preserving confidentiality as well as the limited availability of services.

Epidemiology & HIV Disease

A recent General Accounting Office study reviewed existing forecasts of cumulative AIDS cases and concluded that nationwide by the end of 1991, a "realistic range" of between 300,000 to 485,000 persons will be diagnosed with AIDS.

Thus far, the AIDS caseload has shown a significant regional concentration; the distributional patterns are expected to change, however, as the proportion of cases among different ethnic populations and inner city IV drug users increases. For example, blacks currently represent just over 12 percent of the total U.S. population and Hispanics, 8 percent; as of November 1989, those two groups represented 25 percent and 15 percent, respectively, of the population of persons with AIDS. The numbers correspond to rates of IV and "crack" cocaine drug use in ethnic populations and may relate to lack of knowledge, inadequate access to medical or education resources and/or inner-city poverty and economic status. These poorer, less educated populations also have traditionally turned to public institutions for psychiatric and medical care when they become ill, representing a disproportionate share of those treated in state or other public mental facilities.

Other mentally ill adults who are not members of a minority group are also expected to be at risk for HIV infection because of high-risk behavior that may be associated with an acute episode of their illness or IV drug use.

Of particular concern to mental health professionals and policy makers is HIV infection among the young. In July, the CDC reported that 1,681 infants and children under age 13 had AIDS. According to Public Health Service estimates, by 1991 there will be 3,200 cases of pediatric AIDS in the U.S., with at least 10,000 to 20,000 HIV-infected children (Morgan & Curran, 1986). Further estimates suggest that over the next five years, HIV may become the largest infectious cause of mental retardation and encephalopathy in children under 13 (Diamond & Cohen, 1987) -- with obvious implications for mental health services.

Clinical Course

The mental health manifestations of HIV infection on people without a pre-existing mental illness include symptoms of regressed behavior, apathy, social withdrawal, depression and some organic psychosis. As HIV brain diseases progresses, a person with AIDS may have moderate or severe dementia that can include psychomotor retardation, total persistent organic psychosis and severe motor weaknesses. The incidence of central nervous system dysfunction in infants and children with symptomatic HIV infection ranges from 78 percent to 90 percent in various studies (Diamond & Cohen, 1989). The presence of HIV in the central nervous system may lead to progressive encephalopathy, evidenced by loss of developmental milestones, intellectual deficits and impaired brain growth (Diamond & Cohen, 1989) and eventually, death.

Psychiatric research and journals have

begun to deal in depth with mental illness caused by HIV (Gabel, 1986; Halstead, 1988) as well as with the incidence of HIV in state mental facilities (Horwath, 1989). As the knowledge base improves, facilities will be increasingly challenged to distinguish between mental illnesses that result from HIV infection and those that have other organic causes.

Impact on Institutions

In preparation for the January meeting of nine national mental health organizations, IHPP mailed 60 questionnaires to representatives in mental health facilities representing each of the participating organizations. The questionnaire sought information on the priorities and concerns of professionals in treatment and clinical settings.

Among their prioririte s were patient management, particularly of adolescents with emotional or mental disorders -- especially runaways and street youth -- and patient education. Respondents also expressed worries about how to cope with patients who display violent or sexual behavior that may put other patients or staff at risk of contracting HIV and about the liability of institutions that have knowledge of the risk involved but fail to prevent tranmission of the virus. Finally, they voiced concerns about the lack of access to services and called for the development of a continuum of care, including outpatient, psychosocial, residential, rehabilitation and support services.

A majority of the 28 individuals at public and private facilities who responded to the questionnaire reported a significant overlap of minorities, gay and bisexual men and drug users in their patient population. In addition, respondents were asked to estimate the percentage of their patient population that was HIV positive. While it cannot be determined whether these patients were infected with HIV before or after becoming mentally ill, 11 of the clinical facilities reported that between 10 and 20 percent of their patients were HIV positive. While the IHPP survey was designed to identify policy, program and clinical issues and not to provide statistical data, these figures from outpatient settings appear to be reasonably consistent with a June 1988 report by Goldrum and Associates, which found that seven of 97 patients (7.2 percent) who were hospitalized in inpatient psychiatric wards were infected with HIV. All seven had used intravenous drugs and one had a history of homosexuality.

The 1988 Harvey-Elliot study of state and county mental hospitals in the U.S. supports the above information. A self-administered questionnaire was sent to the infection control officer in each of the 288 facilities; it covered HIV/AIDS education of patients and staff, policy development, patient management and approximate seroprevalence rates. The 85 hospitals (in 37 states) that responded reported infection rates comparable to the figures given above.

Hospitals answering the Harvey-Elliot survey reported marked increases in AIDS and AIDS-related cases over the three-year period spanning 1985-1987. Although fewer than half reported patients with AIDS, AIDS-Related Complex (ARC) or HIV-related neuropsychiatric complications, the data show that more state and county mental hospitals are encountering patients with these conditions. Most have already identified patients with HIV infection, as distinct from AIDS, and most are also confronting an increasing number of patients with AIDS and ARC.

The number of hospitals reporting between one and ten cases of AIDS nearly doubled from 1985 through 1987, from 18 percent to 30 percent. Even so, in 1987 more than 60 percent of the hospitals reported no cases of AIDS. The number of hospitals identifying psychiatric inpatients as being HIV positive also increased, from 24 percent in 1985 to more than 67 percent in 1987. Eight percent of those hospitals reported having 11 or more patients who were HIV seropositive in 1987, up from one percent in 1985.

Almost a fourth of the hospitals cited patients who were suffering from HIV-related neuropsychiatric complications in 1987, compared with just 10 percent in 1985 (although three-fourths failed to identify any patients with such complications in 1987). Because of testing policies, the above numbers probably underrepresent the true numbers. This underscores the need for epidemiological studies such as those being conducted by the Research Foundation for Mental Hygiene in New York. That effort will estimate 1) HIV infection among the severely mentally ill in two state hospitals in the New York City area; and 2) the extent of risk-taking behavior, by sampling 200

inpatients in two state hospitals in the city, including a homeless unit.

HIV Testing

Since they finance, manage and regulate public mental health facilities, states clearly have jurisdiction over testing in those institutions. Upon admission to a clinic or hospital, a mentally ill person is routinely given a number of tests. State laws differ, however, on mandatory, routine and voluntary HIV testing of persons in mental health facilities and the many of the facilities themselves appear to be struggling with the issue of when and where to test and which specific groups (forensic patients, civilly committed patients, patients with clinical symptoms of HIV infection) should be given priority. Nonetheless, if a patient carries out a physical or sexual attack within the facility, some staff may decide to mandatorily test to determine the patient's HIV status.

Missouri, Texas and **Wisconsin** have approved mandatory HIV testing of patients in mental health facilities. In **Missouri, HB 1151 and 1044 (1988)** authorizes the Department of Mental Health to perform HIV testing without consent on participants in the methadone treatment program for IV drug abuse or on any individual under the department's care and custody who has refused testing, if there are reasonable grounds to believe person is HIV positive and poses a threat to others. In **Texas, HB 1829 (1987)** authorizes testing of: (1) residents and clients of residential facilities run by the Department of Mental Health and Mental Retardation, provided test results would change the patient's medical or social management and the test is conducted in accordance with confidentiality guidelines; (2) patients undergoing a medical procedure that could expose health care personnel, only if the board of health determines the procedure constitutes possible exposure. And in **Wisconsin, AB 678 (1987)** authorizes the medical director of a developmentally disabled or mental health facility to test patients for HIV without their consent, if the director determines that the patient's conduct poses a significant risk of transmitting HIV to others in the facility.

Seven other states have laws governing mandatory testing or authorized testing by hospitals of persons who are incompetent. They are: **Connecticut, Delaware, Georgia, Hawaii, Idaho, Rhode Island and Washington.** Fourteen, meanwhile, have laws on testing in emergency situations **(Florida, Illinois, Indiana, Iowa, Louisiana, Maine, Michigan, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Utah and West Virginia).**

Based on information from the Harvey-Elliot survey, it appears that most facilities have specific criteria for testing that include: 1) clinical signs of HIV disease consistent with CDC definitions; 2) patients whose behavior makes them candidates for potential infection; 3) patients previously diagnosed as HIV-infected, where a confirmation is required; and 4) harmful exposure within the facility.

Survey results also indicate that while voluntary testing is widespread among mental hospitals, only a few administer tests routinely upon admission. And though more than a fourth of the hospitals that responded to the survey conduct some form of mandatory testing, most target the tests for specific groups of patients such as IV drug users and those who exhibit or have practiced high-risk behaviors.

Specifically, the findings reveal that 72 hospitals (85 percent) of the hospitals make voluntary testing available to their patients; seven (8.2 percent) conduct routine testing as part of the admission process; and 24 (28.2 percent) carry out some form of selective mandatory testing. Of the hospitals that conduct testing, 12 (17 percent) perform some combination of voluntary, routine or mandatory testing. This may indicate that facilities are not implementing uniform policies and that confusion regarding who and under what circumstances testing is done persists.

Most of the 24 hospitals that have established mandatory testing for some patients test those that they have reason to believe are infected with HIV. Seventeen of the 24 conduct mandatory testing of patients who exhibit clinical signs of HIV infection; 13 test high-risk patients such as identified homosexuals or IV drug users; six test forensic patients; and four test patients who pose a potential risk of harmful exposure.

Some argue that mandatory testing of mental patients is warranted because workers and other patients need to be protected against exposure and because the institution needs to be protected against liability claims of negligent exposure. Special medical and social treatment

-- especially with developments in early drug therapies and treatment -- can be made available once patients with HIV are identified, they add, and just as important, patients need to know their HIV status in order to change high-risk behavior.

Others contend that if institutions are adequately implementing infection control guidelines and making counseling, health education and voluntary testing available, risks of exposure, liability and special treatment needs will be minimized.

Confidentiality

Balancing the rights of those with HIV or AIDS -- including the mentally ill -- with the duty to warn and to protect the public against potential exposure has become one of the major challenges facing the policy makers and health professionals dealing with the disease.

By law as well as professional codes of ethics, the providers of mental health services are obliged to maintain the confidentiality of medical records. Breaches of confidentiality can lead to discrimination in housing, services and employment.

Because most mental health facilities have opted to place HIV-related information in patient records, they have worked at the same time to enforce and strengthen confidentiality procedures. Many public health experts believe specific legislation is also required to reinforce patient confidentiality. People with chronic mental illness are already likely to have experienced social stigma and discrimination, they say, and those infected with HIV will feel doubly disadvantaged.

The concern of some advocates is that patients should always be treated according to their clinical behavior rather than their HIV status. Studies demonstrate that knowledge of HIV status does not necessarily lead to changes in behavior, they say, adding that the risk of discrimination, denial of services and infringement on civil rights are too great to warrant mandatory testing.

More than 30 states have enacted new laws providing for some range of confidentiality protection for HIV test-related information and eight others have acted to strengthen confidentiality provisions in existing communicable or sexually transmitted disease laws. **Connecticut SB 812**, enacted this year, is the only one of the 30 to single out mental health facilities. The measure stipulates that HIV-related information may be disclosed to employees of state-operated mental hospitals if the hospital's infection control committee determines that a patient's behavior poses a significant risk of transmission to another patient. Disclosure will only be allowed if it is likely to prevent or reduce risk of transmission and if there are no reasonable alternatives to achieve the same goal and preserve confidentiality of the information.

Duty to Protect

Although state law generally requires providers to protect confidentiality of their client or patient's medical information, there are situations in which competing obligations to protect third parties from harm may arise. Providers who fail to provide such protection could be charged with liability or negligence.

Specifically, as a result of Tarasoff v. Regents of the University of California, the California Supreme Court imposed a duty on psychotherapists to protect third parties from the potentially dangerous acts of clients. In U.S. v. Louis Markus and Youngberg v. Romeo, the U.S. Supreme Court expanded on an institution's constitutional responsibility to provide a safe environment, with qualified and professional staff, for people committed to facilities under civil procedures. This means warning staff of aggressive behavior, sexual behavior or an infection that could put others at risk.

Accordingly, these court decisions hold that physicians and therapists -- because of their unique position resulting from their training, experience and relationship to patients -- have a responsibility to foresee harm to others and take steps to prevent the transmission of contagious diseases. Generally, the duty to protect is limited to identifiable victims -- that is, persons known to be at risk. The implications of these court decisions for institutions and providers serving people with mental disabilities are unclear, however.

At least eight states permit physicians to decide whether or not they will warn third parties under certain circumstances. The laws either 1) protect physicians from liability if they choose to disclose a patient's HIV status in

order to warn a partner or spouse (at least four states); or 2) release them from liability if they fail to make this disclosure (at least seven states). Only Colorado and North Carolina imply a modified duty to warn in their reporting requirements. These two states say that physicians discharge their duty to warn if they comply with the state's HIV reporting requirements. After the physician's report is submitted, the duty to warn shifts to the health department, under its partner notification activities. Beyond these general measures, the states are relatively silent in terms of giving physicians guidelines to decide when, if ever, it is appropriate or essential to warn spouses or other third parties who may be in direct contact with a person who is HIV-infected.

Non-compliance and Statutory Responses

Under their civil statutes, 19 states have made it a crime for anyone infected with HIV to knowingly expose another person to the virus. Thus, mentally ill persons who are HIV positive and have been educated and advised on how to prevent transmission may be subject to prosecution if they behave in ways that knowingly put others within a mental health facility at risk of infection. There are, however, questions about mitigating factors -- their diminished capacity to understand the consequences of their actions, the effect of medication on their ability to learn or the impulsive behavior that may be characteristic of their mental disability -- as well as whether and under what circumstances the facility may invoke restrictive measures, including isolation or quarantine.

Eighteen states have enacted specific laws to deal with HIV-infected recalcitrant individuals. Many of the laws provide for mandatory testing, confinement and isolation procedures. More often, however, states have adopted regulations that permit public health officials to isolate "recalcitrant" persons who continue to engage in high-risk behaviors. Before restricting freedom, however, most of the new laws require that individuals receive due process protections; if they are deemed dangerous to the public health, a series of measures from least restrictive (e.g, compulsory education, counseling) to most restrictive (e.g., cease and desist orders, isolation) must be applied.

All states, under their police power and public health laws, have authority to combat the transmission of dangerous communicable diseases by taking reasonable steps to restrict a person's freedom of movement or association. (ABA: The Legal Issues, Hofstra Law. Rev.) (IHPP) All states also have isolation authority for sexually transmitted diseases. (IHPP Comm & Sex. Trans Diseases) As of February 1988, 12 states had added AIDS, by law or regulation, to the list of communicable diseases and seven had interpreted their sexually transmitted disease regulations to cover AIDS.

Patient Management

Respondents to the IHPP questionnaire consistently ranked patient management issues among their top policy concerns. In particular, they expressed concern about adolescents with emotional or mental disorders, especially runaways and street youth who are impulsive, recalcitrant, use alcohol or drugs and are not connected with the service system. Another of their concerns involved patient education, especially for patients who may lack mental acuity because of the side effects of psychotropic medications or may be cognitively impaired because of a mental illness.

The Harvey-Elliot study, which sought information on patient management issues, reported that 80 percent of responding state and county mental hospitals "always" counsel patients "known or suspected" of having HIV infection about prevention and that 19 percent "frequently" counsel. Only one hospital said it "seldom" counseled such patients and none said they "never" providing counseling. One in five of these hospitals does not provide counseling about prevention of HIV transmission as a standard practices with all patients, however. Meanwhile, 14 percent of the respondents indicated that they have segregated patients with HIV at some point in time, compared to 68 percent that said they seldom or never resorted to segregation. On the issue of excluding patients from community services, 71 percent indicated this "seldom" or "never" occurs; 7 percent said it "always" or "frequently" occurs.

When asked to suggest areas for further development, a majority said the top priority should be educating people with mental illness about HIV; most expressed concerns about how to carry this out, however. Other priorities were the appropriate use of segregation and coping with violent and sexual behavior on wards where patients and other staff are at risk for contact with blood or other body fluids.

Liability

Respondents to the IHPP survey also indicated extreme concern about liability -- particularly such issues as whether institutions or staff would be held liable for monetary damages if they failed to prevent HIV transmission when they had knowledge of risk of exposure and whether institutions would be held liable for failing to protect staff and patients against HIV exposure.

Although the courts and state legislatures are still defining liability as it relates to HIV, the general principles of law and precedents that address individual responsibility for the injury and rights of others and employer and employee responsibility will have bearing on civil claims of liability.

Specifically, claims of liability might be brought against an agency or facility on claims of negligent transmission between clients or workers in the following situations: 1) failure to provide a safe environment; 2) negligent worker exposure; 3) failure to maintain confidentiality; and 4) failure of duty to protect patients and staff.

Providers of mental health and disability services have additional concerns about liability, apart from those voiced by general medical hospitals and physicians. Where it is determined that clients lack the ability to avoid high-risk behavior, persons with mental illness can be at increased risk of 1) contracting HIV or other infections or 2) transmitting HIV to an unsuspecting partner. How this affects the provider's responsibility to exercise protective and supervisory measures raises questions as to when and if they will be held responsible for the decisions and actions of their patients and employees.

While there has not been enough experience with the issue to identify a trend, the expectation is that HIV liability claims against agencies and facilities caring for persons with mental disabilities will be difficult to uphold in courts of law because of the nature of HIV, its delayed onset of symptoms, statutes of limitation and the difficulty associated with burden of proof. But as knowledge of HIV infection and the technology used to treat and detect HIV diseases evolve, this situation may change. If agencies and facilities effectively institute universal precautions and infection control procedures defined by the CDC and the Occupational Safety and Health Administration, claims of liability may be reduced.

Access to Services

Segregating services in inpatient, community and residential facilities and separating patients with HIV infection from the general population have led to concerns about access. Persons with mental illness already have complex medical (health and mental health), residential and rehabilitative needs. HIV infection increases the range of services -- including specialized medical and/or social services -- that those people may need and may in turn require the facility to hire additional staff and incur greater financial costs.

In establishing priorities for services for persons with mental illness who are also infected with HIV, respondents to the IHPP questionnaire highlighted the need for a continuum of care -- including outpatient, psychosocial, residential, rehabilitation and support services. Because most inpatient settings are not equipped to manage and treat patients with a full-blown diagnosis of AIDS and psychiatric problems, patients who need to be placed in inpatient psychiatric units are being refused treatment, they said. They added that while other parts of a hospital may be better equipped to deal with AIDS patients, there is a lack of coordination and integration of mental health services, to the point that individuals who become disruptive or unmanageable may be discharged. And, as the lifespan of persons with AIDS lengthens, there will be an ever increasing need for more services in addition to medical treatment. For those reasons, most recommended establishing new psychiatric units to manage and treat mentally ill patients with AIDS.

A separate IHPP survey conducted earlier this year, the results of which were published in September, found that during FY 1989, state governments had appropriated slightly more than $300 million in state-only non-Medicaid funds for a wide range of AIDS-related programs and services. Of the total, $65 million, or 26 percent, was targeted on patient care services. **California, Florida, Massachusetts** and **New York** each allocated more than $5 million for patient care, while eight other states provided between $1 million and $5 million. Eighteen states reported some level of support through state-only dollars for mental health

counseling and support services to persons with AIDS and HIV infection.

Education

Because sex is a primary means of HIV transmission, HIV education programs ought to incorporate a discussion of sexual issues. Historically, however, the subjects of sex and sexuality among persons with mental illness have been taboo, rarely discussed in public forums or with patients. Over the past 15 years, there has been some shift in public attitude that has allowed some increased attention to these issues. Recent studies have focused on client, parental and institutional attitudes, sterilization issues and sex education -- issues that have new urgency because of HIV and AIDS.

Often overlooked in forming disability policy are the rights of persons with mental disabilities to sexual expression. Gebhard (1973) and Mulher (1975) demonstrated that problems concerning sexuality and persons with mental disabilities have more to do with the attitudes of staff and caregivers than with clients themselves.

The Harvey-Elliot study found that AIDS education training in state mental hospitals appears to have been provided to a wide range of staff; it also appears, however, that hospitals have either conducted educational programs only once or covered the issues in the context of other sessions. This affects education programs for patients, since in most cases it will be staff who educate patients.

While virtually all of the hospitals (99 percent) provide HIV education for staff, only 52 (61 percent) do so for patients. In better than half of the 52 institutions (55 percent), however, patient training is carried out on an ongoing basis, either through group therapy or specific sessions.

Concluding Remarks

In an article published in the Fall 1989 issue of Health Affairs, David Mechanic, director of Rutgers University's Institute for Health, Health Care Policy and Aging Research, and Linda H. Aiken, Trustee Professor of Nursing and Sociology at the University of Pennsylvania, noted the "mounting concern within public psychiatric hospitals about how to reorganize inpatient care in response to increased numbers of HIV-positive patients." The spread of HIV and AIDS among the mentally ill and IV drug users, "if not approached carefully, could overwhelm our mental health capacities, social services and public hospitals and destroy the fragile structure we have been working so hard to develop," they concluded.

To avert that outcome, it is clear that mental health policy makers at all levels of government must consider taking a wide range of actions, including:

o conducting epidemiological research on the incidence of HIV infection among mentally ill persons in facilities and determining the extent of high-risk behavior within such facilities;

o addressing when and for whom mandatory testing should be considered and the ramifications of performing such tests without informed consent;

o adopting confidentiality guidelines that are specific to mental health facilities;

o clarifying guidelines, regulations or laws on the responsibility of mental health professionals to advise spouses, partners and/or facilities of a person's HIV status;

o developing guidelines for the treatment and management of non-compliant patients who are HIV positive;

o committing additional resources to provide services over a continuum of care;

o establishing sex and AIDS education curriculums for people with mental illness; and

o providing for ongoing staff training programs.

By developing and implementing these and other initiatives, mental health policy makers can have in place the laws, guidelines and/or programs that will help them address what is becoming an increasingly serious problem. It is our hope that this special edition of State Health Reports on Mental Health, Alcoholism and Drug Abuse has raised the level of awareness and knowledge regarding mental health and AIDS as the legislatures prepare for the 1990 sessions and executive branch officials in the states begin to develop their proposals and programs for the coming fiscal year.

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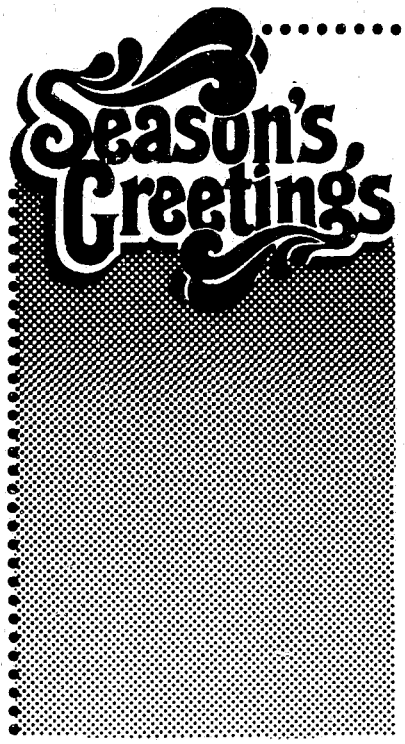

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