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Psychiatric Patients and AIDS: The Forensic Clinician Perspective

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ABSTRACT: A survey was completed by American Academy of Forensic Sciences (AAFS) Psychiatry and Behavioral Science members regarding their opinions on acquired immunodeficiency syndrome, (AIDS)-related issues. A considerable range of opinions was found, probably reflecting such differences in society. There was general agreement that psychiatric hospitals should not be allowed to refuse AIDS patients and that education about AIDS is useful for psychiatric patients. There was also support for notifying the public health department, known sexual contacts, and hospital staff about human-immunodeficiency virus (HIV)-seropositive patients.

KEYWORDS: psychiatry, acquired immunodeficiency syndrome (AIDS), surveys, psychology, hospitals, public health, informed consent, confidentiality, insurance companies, education, civil commitment, HIV-antibody testing

Since its initial reporting in 1981 [*1,2*], the acquired immunodeficiency syndrome (AIDS) has become a national [*3*] and international public health problem [*4,5*]. AIDS is caused by a retrovirus, the human immunodeficiency virus (HIV). The HIV virus destroys human T_4 lymphocytes, which are necessary for proper functioning of the immune system [*6*]. After T_4 lymphocyte depletion, the now AIDS-afflicted individual is susceptible to a host of opportunistic bacterial, fungal, and viral infections with a subsequent fatal course [*7*]. Presently, no cure or vaccine is available [*8*].

Recent public health statistics demonstrate the enormity of the AIDS problem in the United States. As of 29 Aug. 1988, a total of 72 024 cases of AIDS had been reported in the United States, reflecting an increase of over 12 500 cases since 15 April 1988 [*9*]. At the present rate, the United States Public Health Service projects a cumulative total of 365 000 diagnosed cases, with 263 000 cumulative AIDS deaths by the end of 1992 [*9*].

It is known, however, that the AIDS virus can be transferred by sexual intercourse, contact with contaminated blood via transfusion or sharing of intravenous drug paraphenalia, and in utero from an afflicted mother to the fetus [*10*]. Hence, two public health approaches

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to control the spread of AIDS have been implemented. The first seeks to eliminate the routes of possible HIV transmission through public education about unsafe sexual behaviors and intravenous drug usage. The second uses HIV-antibody testing to identify those individuals infected with the AIDS virus and preventing viral spread by these individuals. In addition, blood, blood products, and organs that are transferred from one person to another are tested for the presence of HIV antibodies [*11*].

HIV-infected or HIV-seropositive individuals who also have mental disorders often present challenging problems for psychiatrists and other mental health care providers. Knowledge of one's HIV seropositivity is a stressor that can easily evoke depression and anxiety. In addition, direct neuropsychiatric effects can result in depression, psychosis, and cognitive impairment [*12–18*]. Moreover, numerous legal, ethical, and social problems arise after an individual is identified as a potential HIV transmitter [*19–22*]. Discrimination against individuals with the HIV virus may be experienced in all facets of an individual's life, including employment, school, and housing. Public opinion surveys suggest that the majority view in this country is indeed one of discrimination against HIV-infected individuals [*23*]. Professional organizations such as the American Psychiatric Association (APA) have attempted to deal with the AIDS crisis and have written guidelines [*24,25*]. Nevertheless, these guidelines have not and likely cannot address the multitude of ethical and legal issues presented by these patients.

Because of the many complex issues and our belief that forensic psychiatrists and psychologists would be knowledgeable about the medical, psychiatric, and legal facets, we conducted a survey of the membership of the Psychiatry and Behavioral Science section of the American Academy of Forensic Sciences (AAFS). Our purpose was to examine the perspective of forensically inclined clinicians on some controversial issues that concern HIV-infected psychiatric patients.

Methods

A 1-page survey was mailed to the 104 members, fellows, and provisional members (94 psychiatrists, 10 psychologists; 4 of these had Canadian addresses) of the AAFS Psychiatry and Behavioral Science section whose membership was active as of 1 Aug. 1988. The survey requested members to indicate the following demographic information: specialty, degree(s), sex, and age, with the member's name being optional. Ten statements, with one statement broken into four parts, were to be rated with the use of a five-point Likert scale indicating the degree of agreement of the member with the particular statement (1 = strongly agree, 3 = neutral; 5 = strongly disagree).

A stamped addressed envelope was enclosed with the survey. Six weeks were allowed for completion and return of the surveys.

Results

Of the 104 surveys 61 (58.7%) were returned, with 58 (61.7%) psychiatrists and 3 (30%) psychologists completing surveys. The return rate for our single mailing is substantial considering that the average return rate from a single mailing is 46% [*26*] and the response of psychiatrists to such mailings is lower in comparison to the response of other groups [*27*]. The average age of the 59 respondents who gave their age was 53.32 years, with a standard deviation of 11.71 years. The youngest respondent was 34 and the oldest 80.

Even though 61 surveys were returned, Item 2 received 59 responses and Items 4, 5, and 9 received 60 responses. All other items received 61 responses. For each item, the average rating and standard deviation were calculated and are given in Table 1. We discuss each of the survey items separately and then conclude with collective consideration

TABLE 1—*Opinions of respondents on AIDS questions.*

Item	Average[a]	SD[b]
1. Informed consent of patient required for HIV testing	2.54	1.57
2. If not competent, consent of guardian should be obtained for HIV testing	2.61	1.56
3*a*. Known sex contacts should be informed if HIV seropositive	1.75	1.22
3*b*. Ward hospital staff should be informed if HIV seropositive	1.79	1.28
3*c*. Other psychiatric inpatients should be informed if HIV seropositive	3.59	1.41
3*d*. Public health department should be informed if HIV seropositive	1.64	0.98
4. If major mental disorder, civil commitment for high-risk behavior proper	2.39	1.57
5. If personality disorder, civil commitment for high-risk behavior proper	3.31	1.55
6. Public health department should be sole unit to coordinate action if HIV seropositive	2.61	1.35
7. Insurance companies should be allowed to ask for HIV testing results	3.31	1.38
8. Psychiatric hospitals should be permitted to refuse HIV seropositive patients admission	4.11	1.13
9. HIV seropositive patients should be prosecuted if competent to stand trial	2.81	1.46
10. Education of psychiatric patients about AIDS is useless	4.75	0.72

[a]Scoring points: 1 = agree strongly, 3 = midpoint, and 5 = disagree strongly.
[b]SD = standard deviation.

of the results. A separation of responses by professional disciplines or age did not reveal any statistically significant differences, so these data are not included in the table.

Discussion

Item 1: HIV antibody testing should require the informed consent of the patient.

The responses indicate a slight agreement (average = 2.54) that informed consent be required prior to performing the HIV antibody test. However, the standard deviation of 1.57 was consistent with considerable variability to the responses.

What is remarkable about HIV antibody testing is that physicians do not obtain informed consent for other laboratory tests. For example, rapid plasma reagin tests (RPRs) for syphilis and purified protein derivative tests (PPDs) for tuberculosis, which comprise part of the routine admission work-ups for medical inpatients, rarely if ever find the physician explaining the nature and purpose of the laboratory test, the alternatives to the laboratory test, and so forth to the patient. Yet for HIV antibody testing, written informed consent is generally required before testing. Washington, for example, has recently enacted a statute that goes further and mandates pre- and post-test counseling for everyone before HIV antibody testing, apparently even those who can give informed consent [*28*]. The stigma associated with HIV seropositivity and the poor long-term prognosis probably accounts for the difference in the varying procedures for different laboratory tests.

The lack of strong agreement on this issue by respondents is reflective of the differing opinions in society about the need for informed consent for HIV testing and probably

depends on how much weight one places on the adverse consequences associated with AIDS for the infected individual and for society at large [*29,30*].

Item 2: If the patient is not competent, the consent of the nearest relative, conservator, or guardian should be required.

The average response (2.61) and standard deviation (1.56) to this item is similar to that of Item 1. This item reflects the principle of substituted judgment for those who are incapacitated cognitively by their mental disorder—whether or not it is due to the AIDS virus. Presumably, those who believe that informed consent is necessary also believe that it continues even when the patient is unable to give it. Although a statistical analysis of covariance was not performed comparing the responses of Items 1 and 2, 42 of the 61 respondents gave the same rating for these 2 items.

*Item 3*a*: With regard to a positive HIV-antibody test result, known sexual contacts should be informed, regardless of the patient's desires.*

Respondents tended to favor notification of known high-risk contacts of HIV seropositive individuals in concert with the present APA AIDS policy guidelines [*24*]. Standard deviation of 1.22 suggests more response cohesion for this item when compared with Items 1 and 2. Many jurisdictions do not require notification of a HIV seropositive patient's known sexual contacts, although permissive disclosure by the physician is allowed in some states [*31*]. Public health officials do not face this dilemma in their efforts to contain other sexually transmitted diseases. For example, in the cases of syphilis and gonorrhea, known contacts of either sex, whether or not they are spouses, are notified by the public health department. Nonetheless, HIV seropositive status involves more stigma than other sexually transmitted diseases. It is not possible to determine from the ratings—because the survey does not collect explicit data on this point—whether respondents believe sexual contacts should be notified even if the patient promises to abstain from participation in high-risk activities or, alternatively, to notify the contact him or herself.

*Item 3*b*: With regard to a positive HIV antibody test result, ward hospital staff should be informed if the individual is a psychiatric inpatient, regardless of the patient's desires.*

Although many states do not allow a physician to share HIV status with other health care personnel involved in a patient's direct care, respondents favored informing the unit psychiatric staff of the HIV seropositive status of an inpatient. The APA AIDS policy guidelines [*25*] do not suggest that other staff be made aware of a patient's positive HIV status. However, at least one commentator suggests that the unit's entire psychiatric staff may be considered a single entity and therefore be privy to this data [*32*]. Notification of other staff would be consistent with policies of sharing relevant information with other health-care providers. Sharing of medical data would, of course, imply that other staff understood the importance of confidentiality and would not reveal the data to others. After this survey was taken, as of 1 Jan. 1989, California changed its position to allow permissive disclosure by physicians of a patient's seropositive status to the patient's other health care providers [*33*].

*Item 3*c*: With regard to a positive HIV antibody test result, other psychiatric patients should be informed if the individual is a psychiatric inpatient, regardless of the patient's desires.*

For this item there was a slight trend towards favoring nondisclosure to other inpatients of the positive antibody status of an HIV-infected inpatient. This certainly would be in

keeping with protecting the confidentiality of medical information of a patient, especially other psychiatric inpatients. Interestingly, the APA recommends informing other patients of an HIV seropositive inpatient's status if the HIV seropositive patient is uncontrollable [*25*]. The APA, however, contends that this should not be a "substitute for adequate clinical care," which itself can be subject to wide variation in interpretation.

*Item 3*d: *With regards to a positive HIV antibody test result, the public health department should be informed, regardless of the patient's desires.*

Only full-blown AIDS is universally reportable to the public health department in all jurisdictions. HIV seropositivity is not reportable to public health authorities in many jurisdictions [*34*]. In contrast, a positive RPR indicating infection with syphilis or a positive culture for gonorrhea triggers immediate reporting to the local public health department, with swift contact tracing. The inability to do the same task for HIV seropositivity may seriously hamper public health efforts to decrease HIV transmission. In our sample, respondents expressed moderately strong agreement in favor of reporting a patient's HIV seropositivity to the public health department. Moreover, the standard deviation of 0.98 is considerably lower than the previous three items, suggesting more concurrence with such reporting.

Item 4: High-risk behavior resulting in potential HIV transmission should be considered sufficient for invoking civil commitment, based upon dangerousness to others, of individuals with major mental disorders.

For this item, respondents expressed moderate agreement with use of civil commitment to involuntarily hospitalize individuals with major mental disorders who participate in high-risk behaviors. The linking of the high-risk behavior to the mental disorder can be problematic. Such linkage is oftentimes difficult to establish in cases that do not involve HIV transmission but rather clearcut potential for serious physical harm. Some writers raise the problem of HIV transmittability as fitting the criteria for dangerousness as meant by civil-commitment statutes [*35*]. Others have noted that psychiatry is increasingly called upon to contain a patient's potential violence [*36*] and this may be extended into preventive detention on a psychiatric basis for HIV-infected individuals [*37*]. Given the estimate that psychiatric inpatients have an increased prevalence of HIV infection compared with the general population [*38*], these clinicolegal situations are likely to become increasingly more commonplace.

Item 5: High-risk behavior resulting in potential HIV transmission should be grounds for civil commitment in individuals with personality disorders.

In contrast to the previous item, respondents expressed slight disagreement with civil commitment of individuals with personality disorders who participate in high-risk activities. Interestingly, some statutes do not prohibit the use of personality disorders as mental disorders for the purpose of civil commitment. In some ways, those with personality disorders who persist in high-risk behaviors may be more dangerous than those with major mental disorders. Moreover, many patients with personality disorders may have an adjustment disorder which can be treated and is primarily responsible for a patient's dangerousness.

Item 6: The public health department should be the sole organizational unit in charge of coordinating the follow-up and necessary police power actions for psychiatric patients who are HIV seropositive and thereby potentially harmful to others.

A slight agreement was expressed by respondents that the public health department and not the mental health profession (or any other group) should be the principal professional group in charge of containing HIV transmittability whether or not psychopathology exists. Stone advocates this position [*39*]. Psychiatrists generally do not play any greater role than other treating physicians in containing other communicable or sexually transmitted disease, so it would seem plausible that HIV transmittability should be no different. In addition, a centralized focus with the public health department as the sole unit in charge of efforts to decrease transmittability certainly makes organizational sense. Theoretically, AIDS in this respect shares similarities with diseases such as syphilis and tuberculosis. The major essential difference is the significantly worse prognosis for AIDS.

Item 7: Insurance companies should be allowed to ask whether HIV testing has been performed and, if so, to insist on release of the test results.

Respondents expressed slight disagreement with this statement. In actuality, the law in some states may allow insurance companies to perform HIV antibody testing before issuing policies. Application for life or health insurance constitutes a voluntary act and informed consent is therefore not required [*28*]. The issue involves balancing the right of insurance companies to maintain their business profits against the needs of individuals and public health. Reporting to insurance companies could discourage individuals from obtaining HIV antibody testing, thereby increasing the public-health problem. Maintaining public health was probably seen by most respondents as a higher value than protecting insurance company profitability. Perhaps this problem illustrates the need for the recent call for the termination of private insurance and institution of a national health insurance policy [*40–42*].

Item 8: Psychiatric hospitals should be permitted to refuse to admit HIV seropositive patients.

There was moderate to strong disagreement expressed by respondents to this statement. To physicians and health care providers, refusal to treat a certain class of patients that do not represent a high risk if reasonable precautions are instituted would be discriminatory and a shirking of professional responsibility to care for the ill. Most respondents seemed to be cognizant of this responsibility.

Item 9: HIV seropositive psychiatric patients who engage in high-risk behaviors while hospitalized should be prosecuted if they are competent to stand trial.

The average of the responses suggest a very slight agreement with this statement, although the standard deviation of 1.46 suggests considerable variance of opinion. It is unclear why this difference was found. Recent psychiatric literature has called for the prosecution of physically violent psychiatric inpatients [*43,44*]. It may be argued that unless they meet the NGRI (not guilty by reason of insanity) standard of the jurisdiction, then they should be no different from other patients or individuals who commit violent crimes and are competent to stand trial.

Item 10: Education of psychiatric patients regarding AIDS is useless.

This item had the most agreement among the respondents. The overall consensus was that education was not useless. However, this does not necessarily reflect that education is useful. Reservations about educational efforts have been raised [*45,46*]. Unfortunately, we presently have little documentation regarding the actual efficacy of education in the prevention of HIV transmission.

Concluding Remarks

Analysis of the results indicate general support for AIDS education for psychiatric patients and some support for informed consent before HIV antibody testing. Respondents favored notification of the public health department, ward hospital staff, and known sexual contacts. There was slight agreement towards allowing the public health department to be the sole agency in charge. There was opposition to psychiatric hospitals being able to refuse admission of HIV seropositive patients. Although there was a trend toward admitting to a psychiatric hospital those with major mental disorders who engaged in high-risk behaviors, there was a slight trend against admitting such people with personality disorders. There was some opposition toward notifying other psychiatric inpatients and general opposition towards permitting insurance companies to have access to HIV antibody test results. There was very little consensus about prosecuting psychiatric inpatients who engage in high-risk behaviors.

AIDS-related laws are rapidly changing and vary considerably by jurisdiction [*34,47,48*]. For example, in California, very strict confidentiality was the rule until permissive disclosure to the spouse of an HIV seropositive patient was adopted by the legislature and signed by the governor in September 1987. Legislative change in 1988 provided for expansion of permissive disclosure to any high-risk partner of an HIV seropositive patient as of 1 Jan. 1989. Clearly, the balance between the duties of confidentiality and disclosure are changing. Even though public opinion as reflected by the changing laws (social policy) has shown disagreement, some of this may be the result of a lack of knowledge about AIDS. Professional organizations like the American Psychiatric Association and American Medical Association have adopted or proposed guidelines on how to deal with the situation that can arise when treating HIV-infected patients [*24,25,49*]. However, our survey suggests that professionals, even with knowledge of psychiatry, behavioral science, and the law, vary widely as to how they view the dilemmas presented by the AIDS crisis, mirroring some of the strong differences of opinion in society. The results of our survey indicate wide differences of opinion. Some of the responses suggest disagreement with the guidelines of professional organizations. In the AIDS crisis, there are no absolute moral and ethical rights and wrongs, so it is not surprising that there is disagreement among the AAFS members surveyed. The clearest finding from the study is that wide differences of opinion exist for most items surveyed among AAFS members, which most likely reflects the differences in society at large.

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