



Psychiatric disorders among people living with HIV/AIDS in IRAN: Prevalence, severity, service utilization and unmet mental health needs



Behrang Shadloo^a, Masoumeh Amin-Esmaeili^{a,*}, Abbas Motevalian^b, Minoo Mohraz^c, Abbas Sedaghat^d, Mohammad Mehdi Gouya^{d,e}, Afarin Rahimi-Movaghar^a

^a Iranian National Center for Addiction Studies (INCAS), Tehran University of Medical Sciences, Tehran, Iran

^b School of Public Health, Iran University of Medical Sciences, Tehran, Iran

^c Iranian Research Center for HIV/AIDS (IRCHA), Tehran University of Medical Sciences, Tehran, Iran

^d Iranian Center for Communicable Disease Control (CDC), Ministry of Health and Medical Education (MOHME), Tehran, Iran

^e School of Medicine, Iran University of Medical Sciences, Tehran, Iran

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ABSTRACT

Background: HIV and psychiatric disorders are closely correlated and are accompanied by some similar risk factors.

Objective: The aim of this study was to assess psychiatric comorbidity and health service utilization for mental problems among people living with HIV/AIDS in Iran.

Methods: A total of 250 cases were randomly selected from a large referral center for HIV treatment and care in Tehran, Iran. Psychiatric disorders in the past 12 months including mood, anxiety, and substance use disorders were assessed through face-to-face interview, using a validated Persian translation of the Composite International Diagnostic Interview (CIDI v2.1). Severity of psychiatric disorders, social support, socio-economic status, service utilization and HIV-related indicators were assessed.

Results: Participants consisted of 147 men and 103 women. Psychiatric disorders were found in 50.2% (95% confidence interval: 43.8–56.6) of the participants. Major depressive disorder was the most prevalent diagnosis (32.1%), followed by substance use disorders (17.1%). In bivariate analysis, psychiatric disorders were significantly higher among male gender, single and unemployed individuals and those with lower social support. In multivariate regression analysis, only social support was independently associated with psychiatric disorders. Among those with a psychiatric diagnosis, 41.1% had used a health service for mental problems and 53% had received minimally adequate treatment.

Conclusion: The findings of the study highlight the importance of mental health services in the treatment of people living with HIV/AIDS.

1. Introduction

There are 36.7 million people living with HIV/AIDS (PLWHA) in the world [1]. Although the annual incidence of HIV infection is decreasing globally, HIV prevalence is rising due to development of more effective treatment and higher survival [2]. Therefore, the health system is now facing emerging challenges of non-communicable diseases and mental health problems among PLWHA [3].

In Iran, there are about 35 thousand registered cases of HIV infection, identified through health care and surveillance systems [4]. In Iran, HIV prevalence in general population is 0.15% [5]. However, the country suffers from concentrated HIV epidemics among injecting and

non-injecting drug users [6,7]. While the global burden of HIV/AIDS has been declining in the last decade [8], it is projected that the burden will continue to grow during the next 10 years in Iran [9]. HIV treatment and care is widely available in Iran [5], there are more than a thousand Voluntary Counseling and Testing (VCT) centers and 162 health facilities that provide anti-retroviral therapy (ART). In 2014, among those eligible for receiving ART, 20.1% were receiving it [5]. Psychosocial services for PLWHA and their families are provided through 48 “Positive Clubs” across the country [5].

HIV, psychiatric disorders and substance use disorders are closely correlated and are accompanied by similar risk factors. They also share common consequences such as stigma and discrimination [10]. Mental

* Corresponding author at: Iranian National Center for Addiction Studies (INCAS), Tehran University of Medical Sciences, No 486, Qazvin Square, South Karegar Avenue, Tehran, Iran.
E-mail addresses: dr.m.a.esmaeeli@gmail.com (M. Amin-Esmaeili), amotevalian@tums.ac.ir (A. Motevalian), minoomohraz@ams.ac.ir (M. Mohraz), rahimia@sina.tums.ac.ir (A. Rahimi-Movaghar).

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illnesses and substance use disorders can act as risk factors for HIV acquisition [11–14]. Globally, injecting drug use is a major route of HIV transmission [1]. It accounts for 66% of the HIV cases in Iran [4]. Impaired judgment, diminished inhibition and engagement in high risk sexual behaviors, lack of insight, and poor self-care and neglecting physical health have been proposed as the underlying mechanisms [15].

On the other hand, HIV infection can serve as a risk factor towards development of psychiatric disorders [16,17]. Stressor of sero-conversion, chronic adjustment with a life-threatening disease, fear of stigma and discrimination, and CNS invasion of the virus as well as adverse effects of anti-retroviral (ARV) medications may all contribute to establishment of a psychiatric disorder [15,18].

Although there is a bi-directional correlation between mental disorders and HIV infection, this reciprocity goes beyond. Psychiatric disorders can affect the disease's course, clinical outcome and progression towards AIDS through disturbances in immune system modulation, poorer access to treatment and care, and lack of optimal treatment adherence [19–22].

There is scarcity of knowledge regarding mental health problems and service utilization of PLWHA in Iran. Moreover, literature in this regard lacks implementation of structured diagnostic tools. In this study, we examined prevalence, severity and correlated factors of psychiatric disorders in the past 12 months, as well as the pattern of health service utilization for mental disorders in a group of HIV patients in a main referral center for HIV treatment and care in Tehran, Iran.

2. Methods

This is a cross-sectional study on 250 randomly selected HIV⁺ patients from the referral center for HIV treatment and care in Tehran, Iran. The study was approved by the Ethics Committee of Tehran University of Medical Sciences in Iran.

2.1. Field work and sampling

Participants who were 15–64 years of age, able to communicate in Persian language, physically and cognitively competent to complete the interview and whose HIV infection had been diagnosed at least four weeks prior to the interview were eligible for this study.

The study was conducted at the Imam Khomeini Hospital's HIV treatment and care center, from mid-2012 to early 2013. The center provides HIV counseling and testing as well as HIV treatment and care services (free of charge anti-retroviral treatment, CD4 count and viral load assessment). Systematic random sampling was applied for selecting the eligible participants. During the field work on each day, the first case was selected using a random number from the list of the referring clients and subsequent cases were recruited using a fixed interval. On each working day, an average number of three interviews were carried out from the center's 25 daily referrals. Those who refused to cooperate were substituted by cases matched by their gender and anti-retroviral regimen, whether receiving ART or not, on the same day. Participation in the study was voluntary and informed consent was obtained for the interview. Patients would not face any limitation in receiving services if they rejected participation in the study. Participants were welcomed with refreshments and a snack. Referral to free of charge mental health services, located at the same center, was provided upon request but no monetary incentive was given. All interviews took place in a private setting. All questionnaires and databases were kept confidential.

Interviewers consisted of three clinical psychologists, having prior experience in working with psychiatric patients and implementing similar questionnaires. They received intensive training during the preliminary phases of the survey about ethical issues, interview, process of sampling and field work. A quality control protocol was implemented in different stages of field work and data management. Participation rate

was 93%.

2.2. Measures and instruments

We used a package of instruments which was adapted from the comprehensive battery used in the Iranian National Mental Health Survey (IranMHS) [23]. The paper and pencil version of questionnaires were filled out by interviewers through face-to-face interviews. The questionnaires used in this paper are as follows:

Composite International Diagnostic Interview (CIDI v2.1) was used to assess the prevalence of mental disorders over the past 12 months. The validity of the Persian version of CIDI has been previously evaluated [24]. The included diagnoses consisted of depressive disorders, bipolar disorders, panic with or without agoraphobia, agoraphobia, social phobia, generalized anxiety, obsessive-compulsive and post-traumatic stress disorder, and drug and alcohol use disorders. Illicit drugs included opioids, cannabis, stimulants, hallucinogens and inhalants. Bipolar disorders were assessed using the lifetime version of the instrument and others were evaluated using the past 12-month version. Somatoform disorders were assessed using a World Health Organization screening instrument recommended for primary care settings. Moreover, questions about suicidal ideation and attempts, and aggressive behavior were also included. History of perpetrating physical aggression in the past 12 months, including destruction of properties, physical violence towards family members or others were asked through four questions. Serious aggressive behavior was defined by either requiring medical treatment of the victim or leading to legal consequences.

Sheehan Disability Scale (SDS) was used to assess the degree of disability associated with the psychiatric disorders, in four domains of work performance, household responsibilities, social life and intimate interpersonal relationship. Psychometric properties of SDS have been assessed and have showed good reliability and validity indices [25]. We assessed the severity of psychiatric disorders based on the following definitions:

- Serious mental disorders consisted of either bipolar I disorder, physiological dependence to a substance; OR diagnosis of a mental disorder with severe impairment in two or more domains of functioning based on SDS; OR a suicidal attempt in the last 12 months in the presence of any psychiatric disorder;
- Moderate mental disorders were defined as a presence of a mental disorder with moderate impairment in at least two domains of SDS, or substance dependence without physiological dependence, and lack of criteria for serious mental disorders;
- Mild disorders were those which were neither serious nor moderate.

We assessed health and non-health service utilization for mental health problems by using a questionnaire previously developed and adopted in IranMHS. Health service utilization was defined as having accessed any healthcare provider including mental health professionals and general practitioners in the past 12 months. It consisted of hospitalization, outpatient service use, hotline and telephone counseling services, referring to pharmacist for refilling a physician's prescription and drug harm reduction services. Non-health services included alternative medicine (e.g. herbal medicine, acupuncture and pray-writers), attending self-help groups and direct referral to pharmacist without prescription. Minimally adequate treatment (MAT) for mental health services was derived from the definition used in World Mental Health Survey [26], as either having made at least two visits in the last twelve months, or having made a visit to the health-care system for a mental health issue in the past month.

Data on demographic characteristics, perceived social support and socio-economic status were also gathered. Regarding socio-economic status, participants were classified as high, moderate and low in equal proportions according to their household's specifications and assets

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