In the UK, the majority of HIV testing occurs in sexual health and antenatal services. Studies outside of the UK have found patients with severe and enduring mental illness to be a high-risk group for blood-borne viruses (BBVs; HIV, hepatitis B and hepatitis C), with reports of HIV seroprevalence of up to 23%, hepatitis B up to 25%, and hepatitis C up to 20%. Individuals with severe mental illness who are sexually active have been found to engage in elevated rates of sexual risk behaviours. Routine BBV testing in psychiatric populations is not widespread in the UK, although findings from other countries suggest such a practice would be ‘sensible’, with mental health services being in a very important position for HIV prevention. This service improvement project allowed us to assess the acceptability and practicality of routinely offering BBV tests to patients with severe mental illness in a UK acute psychiatric in-patient setting.

In total 18% (10/57) of the consenting patients and 13 individuals (12%) in the entire cohort showed serological evidence of past or current infection with a BBV or had a known history of BBVs. Four individuals with current or past infections were identified for the first time including one person dually infected with HIV and hepatitis B. A further nine patients were already known to services. Among the three individuals with HIV one was a new discovery and was referred to specialist support services. Of the participants with hepatitis B serological results showed one had spontaneously cleared the virus and the other three were referred for follow-up (two surface antigen positive and one core antigen positive). All seven individuals with hepatitis C were already known to services.

Testing for BBVs in a psychiatric setting was acceptable to the majority of patients with severe and enduring mental illness and feasible to deliver. The strategy was successful in identifying and engaging in appropriate care for previously undiagnosed BBV-infected individuals. However, testing was delivered by staff within the service improvement team and further work needs to be conducted to find ways to integrate BBV testing sustainably into standard clinical procedures.

At the outset there were concerns among some staff about patients’ capacity to provide informed consent and about the possibility that offering tests might be disturbing to patients. In practice it was straightforward to obtain consent. Previous research indicates that the vast majority of individuals with schizophrenia are able to provide informed consent. An educational intervention across more than one session can allow many of those with a reduced capacity to provide informed approval. Capacity in mental health patients varies over time and some in this cohort who lacked capacity initially were able to consent to BBV testing when re-approached at a later date. Similarly, patients welcomed the offer of a test even when deciding to refuse and reacted with appreciation for the service’s interest in their entire well-being rather than appearing distressed.

In conclusion, the routine offering of BBV testing was both acceptable to patients and feasible in this in-patient mental health setting. The project was small and not intended to establish the epidemiology of BBVs among our in-patients and it was carried out in an area where the background population rate of BBVs is high. However, the prevalence in our cohort was strikingly high,
results which are consistent with studies elsewhere suggesting that people with severe mental illness are at increased risk of BBVs. Hepatitis B and C and HIV are treatable conditions; but it is vitally important to diagnose them early. For instance most deaths from HIV occur in those who are detected late, whereas treatment markedly reduces infectiousness and hence, potentially, population spread. There is a strong case for a study to establish the prevalence of BBVs in patients with severe mental illness nationally and for the routine offer of testing to this group nationally, particularly in areas of high-population prevalence. If BBV interventions are to be included as a routine part of patients’ care, additional resources and staff training will be required.

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Table 1 Acceptability of testing for blood-borne viruses (BBVs; HIV, hepatitis B and hepatitis C) in psychiatric in-patients

<table>
<thead>
<tr>
<th></th>
<th>Approached (n = 105)</th>
<th>Capacity (n = 87)</th>
<th>Consent gained (n = 57)</th>
<th>Consenting individuals with newly identified BBV</th>
<th>Consenting individuals with known BBV</th>
<th>Non-consenting individuals with known BBV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV</td>
<td>Hepatitis B</td>
<td>Hepatitis C</td>
<td>HIV</td>
<td>Hepatitis B</td>
<td>Hepatitis C</td>
</tr>
<tr>
<td>Male</td>
<td>67 (64)</td>
<td>56 (64)</td>
<td>41 (72)</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>38 (36)</td>
<td>31 (36)</td>
<td>16 (28)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

a. One person with dual (HIV-hepatitis B) diagnosis.

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References


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