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The HIV epidemic was discovered in the early 1980s, and the response from the medical community was remarkable. Health care providers committed their time and careers to the cause of a group of people afflicted with an unknown and fatal illness. We are now some 25 years into the epidemic and have discovered that CNS inflammatory sequelae of HIV infection have significant neuropsychiatric consequences, including cognitive impairment and mood disorders. Over a similar period, the hepatitis C epidemic has been identified with similar neuropsychiatric sequelae. Preexisting psychiatric disorders increase the risk behaviors for infection, and injection drug users with psychiatric disorders are at high risk for coinfection. Overall, this suggests that psychiatric disorders increase the risk of infection with HIV and hepatitis C virus (HCV), and infection with these viruses increases the risk of neuropsychiatric disorders.

Douaihy and colleagues\(^1\) review the complex pattern of neuropsychiatric comorbidity in the HIV and hepatitis C epidemics in the United States. The authors note that cognitive impairment, mood disorders, and substance abuse all increase the risk of getting infected with HIV and HCV, while by virtue of CNS inflammation (as well as other possible mechanisms), both viruses increase the likelihood of cognitive impairment and mood disorders. They point out that even the treatment of hepatitis C (ie, interferon) leads to neuropsychiatric dysfunction. They go on to describe the early but mounting evidence that coinfection with both viruses increases the risk of neuropsychiatric disorders even further. They review the data showing that coinfected patients are more socially and financially disenfranchised and therefore are less likely to be treated, are less likely to benefit from treatment, and require more resources than other patients. They review the grim data on outcomes and quality of life for coinfected patients and describe the barriers to effective care for these patients.

In a quarter century, through the use of new drugs for HIV and HCV infections, we have done wonders for many persons infected with either of these 2 viruses, and we have fought the HIV epidemic to something of a standstill here in the United States. What is unfortunate is that we have known about the neuropsychiatric issues for these patients for much of the last quarter century, and yet resources to treat their neuropsychiatric conditions remain sparse and disorganized. Despite data from model programs showing that integration of addiction and mental health treatments with HIV treatment improves outcomes, such integrated treatment remains exceptionally rare. Instead of its integration, treatment continues to be unintegrated and “carved out.” Mental health treatments (which ultimately reduce medical costs) come through budgets that are separate from medical care, and therefore the various competing agencies aiming to conserve their resources make it the “other guy’s problem.” This leaves the psychiatric conditions that place persons at risk for HIV infection and hepatitis C untreated in the most vulnerable populations. The psychiatric conditions that increase the risk of infection also interfere with treatment, and infection with HIV and HCV make those psychiatric conditions worse. In addition, because diagnosis is far more complex and cumbersome in HIV/HCV-coinfected patients, as Douaihy and colleagues point out, it requires greater expertise and effort.

To make matters worse, the current emphasis in medicine funding is not on the wise use of resources but on resource conservation. As a result, clinics are expected to see more patients, to see them faster, to use fewer resources, and to have better outcomes. This leads to subtle pressure on clinics to avoid resource-intensive “high utilizers,” the very patients who are at highest risk for unsuccessful treatment. These patients are likely to have poorer outcomes, need more care, and consume more clinic resources. In a sense, we have “disincentivized” (espionage slang for killing or
disabling an enemy) clinics from caring for the very patient populations that are getting and spreading these infections. Douaihy and colleagues describe the subcortical dysfunction seen in persons infected with both HIV and HCV, and it is clear that these patients will need even more supervision and resources than they did before they were infected. The use of visiting nurses has become nearly impossible because of the lack of reimbursement for services. Sheltered housing with expert treatment is extremely sparse for those with chronic mental illness, for substance abusers, and for cognitively impaired patients (eg, those with mental retardation or HIV-associated dementia); for patients suffering from all 3 simultaneously, it is nearly nonexistent. Even more tragic, such patients respond well to optimal treatment, with some patients returning to baseline and others dramatically improving.

We are currently spending our health care resources to provide medical care, psychiatric care, and addiction treatment in separate settings and without any coordination among these resources. We treat persons with HIV infection and hepatitis C but provide only the scarcest resources for the treatment of those with neuropsychiatric conditions, which then, in turn, serves to complicate treatment of their viral infections.

Education for prevention is essential, but education alone is insufficient to change the behaviors caused by addictions, psychiatric disorders, and cognitive impairment—behaviors that have been shown to be factors for increased risk of HIV infection and hepatitis C. However, targeted interventions directed at modifying these behaviors appear to work, so then why are we not eagerly providing these resources? Regrettably, it may be because the mentally ill do not vote, have scarce financial resources, and have no organized political or social voice to advocate for better treatment. We know that treatment saves money in the long run: the cost of treating HIV is vastly greater than the cost of treating the conditions that promote it. Yet, we have to beg for financial table scraps to provide even minimal treatment.

Ironically, although HIV infection and hepatitis C are more and more often conditions of vulnerable populations, including those who are marginalized and non-white and/or with neuropsychiatric conditions and addictions, Ryan White, the poster child recruited to obtain funding for HIV care, was a white boy with hemophilia from a fairly small city in Indiana. Our president announced in 2003 that HIV was one of the highest priorities for his administration and then promptly decreased funding for the Ryan White programs that provide one of the only funding streams for the comprehensive care of vulnerable patients.

Douaihy and colleagues have succinctly summarized the complexity of the problem we face in treating HIV-infected persons coinfeected with HCV, and we need to use the information that they have summarized to fight for the resources we need for our patients. The failure to provide integrated comprehensive care to persons with HIV infection and hepatitis C in a way that includes neuropsychiatry, neurology, substance abuse, social and vocational rehabilitation, and aggressive long-term follow-up for relapse prevention is a profound embarrassment to this country and our culture. As their review clearly shows, we need to do better, and model programs have even shown us how to do better; sadly, we have yet to do so. Poorly integrated health care and underfunding of care for the most marginalized and vulnerable populations have made it difficult for even the most dedicated care providers to meet the needs of their patients.

We need to demand more resources for our patients, and we need to spread the knowledge that those resources do work when used effectively together. This is information every HIV care provider needs and needs to address.

Glenn J. Treisman, MD, PhD
Professor of Psychiatry
Johns Hopkins University School of Medicine
Director of AIDS Psychiatry
Johns Hopkins Hospital
Baltimore

Reference

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Editorial Comment: Neuropsychiatric Aspects of HIV/HCV Coinfection—What Every HIV Care Provider Needs to Know and Address

Links: