How Locally Specific Factors May Impact the Delivery of HIV-Related Services to the Severely Mentally Ill in Washington, DC

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To the Editor,

MENTAL ILLNESS IS A known barrier to HIV care in public health care settings.^{1,2} Estimated HIV seroprevalence among the Severely Mentally Ill (SMI) individuals in the US is 6.9%,³ but there is a lack of evidence-based strategies to engage them consistently in HIV-related services such as testing, prevention, (early) diagnosis, and linkage with care.⁴ Although adults with mental illnesses are more likely to have been HIV-tested than those without mental illness, the high prevalence rates suggest that additional preventive efforts targeting this population are needed.⁵

With 2.5% HIV seroprevalence among its residents, Washington DC is a home to the most severe urban HIV epidemic in the US.^{6,7} There have been improvements across multiple affected sociodemographic groups in DC between years 2008 and 2012: linkage to care within 3 months of HIV diagnosis increased from 57.3% to 85.7%; the rates of viremia suppression increased from 57.4% to 61.0%; average CD4 count at time of diagnosis increased from 330 to 435; and late testing decreased from 56% to 44%.⁶ However, the surveillance efforts have not specifically identified SMI individuals as a risk group, so it is not clear to what extent SMI individuals have been included in, or benefited from, these advances.

Reported barriers to providing HIV testing to SMI individuals include patient-related (e.g., cognitive problems, inadequate insight, inability to navigate services) and structural factors (e.g., staff shortage, inadequate training, time pressure).⁸ Here we describe additional factors that might be specific to Washington DC and may affect the delivery of HIV testing or other HIV-related services to SMI individuals.

Within a larger qualitative study, we conducted three focus groups, with 14 providers (6 social workers, 6 case managers, 1 nurse practitioner, 1 nurse) from eight DC-based outpatient community clinics, who serve SMI clients. All participants were females, mostly white ($n=12$); mostly in their 30s ($n=5$) and 40s ($n=4$), with experience in care-giving settings ranging from 5 to 29 years. Our qualitative analysis drew on Grounded Theory.⁹ Coding was conducted by the second and

fourth authors, and inter-rater reliability verified by running Coding Comparison queries, utilizing nVivo Version 9 (QSR International Pty Ltd.). The participants' DC-specific narratives clustered into three themes, as follows.

(1) DC as a "magnet for the mentally ill"

Many SMI individuals migrate to warm areas in the fall or winter, and return to DC around June. While transiency of SMI people is not DC-specific, the participants believed that it was particularly prominent in DC, because of its unique appeal as the nation's capital. There is a steady influx of new SMI patients who need to be connected with services, and the providers often have only few months available to engage them in care.

Provider #1: *"(DC) is a magnet for the mentally ill. They come here because of what they think the government can do (for them) or because they think the government is watching them, so the best place to be is smack dab in the middle... And we get them because the secret service catches them down by the White House and brings them to our agency... It is an interesting problem that we have, certainly different from the chronically mentally ill population I dealt with in Florida because we didn't have them gravitating to the city because it was the nation's capital."*

(2) DC as two disconnected cities

The providers described two contrasting, disconnected faces of Washington DC that operate at different levels. The less affluent part of DC operates more like a small town, and that has real impact on HIV clinic attendance.

Provider #2: *"DC is kind of like two functioning cities simultaneously... the people who are poor and uneducated and live in parts of the city that are not on a tourist map, not part of the image that people have of Washington DC, (and) people who live in the affluent part of the city (and) are not always aware of what that other city has going on everyday..."*

Provider #3: *"If you walk in to (an HIV clinic located in a low-income community), there's a high likelihood that one of your peers is somewhere around and sees you walk in."*

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Provider #2: “They might see their cousin when they are walking in...”

Provider #3: “Exactly. Or whoever they met last night, y’know, out and about.”

Provider #2: “It has that small town feel”

Provider #3: “when a person can more anonymously walk in, that might increase access to care...”

Furthermore, the providers believe that the underprivileged part of DC, primarily located in South-East DC, is stuck in the past when it comes to social attitudes, knowledge, and beliefs about HIV transmission, prevention, and treatment.

Provider #4: “(When I travel to HIV conferences around the country), there is this sort of optimism—you take your medicine, there’s less stigma, there’s confidence that people can survive. That optimism is much more difficult to communicate in DC because of the stigma and the lack of education about the virus. Our clients (have) inaccurate beliefs about HIV transmission; they don’t have up-to-date, accurate information about how medications work and how it’s transmitted...I feel like we are at least 10–15 years behind the rest of the country.”

Interviewer: “Why is DC behind?”

Provider #5: “Poverty. Poor education. Cultural acceptance.”

Provider #6: *The behaviors that people engage in that get them infected, there’s a lot of judgment against people’s lifestyles ...*

(3) Artificial District Boundaries

Although DC and its suburbs form a continuous metropolitan unit, the suburbs belong to other states (i.e., Maryland and Virginia). This artificial geographic boundary impedes the delivery of HIV-related services. One provider, who works primarily with HIV-affected families, described her predicament:

Provider #7: “We have people calling all the time because Maryland doesn’t have a (free clinic) that will do permanency planning. We offer free services to our families (but we) are restricted to DC. So we can’t help anybody in Maryland or Virginia (although) we want to help everyone. And we might have space to help everyone. We have never had a waiting list since I got here.”

These narratives suggest that unique socioeconomic, cultural, and administrative characteristics of DC may pose barriers to optimal delivery of HIV-related services to SMI individuals. Those characteristics include: (1) steady flow of transient SMI individuals in and out of DC, interfering with consistent engagement in services; (2) underprivileged DC communities not fully benefiting from available services due to limited HIV knowledge and social stigma; and (3) artificial District boundaries interfering with optimal service delivery.

This study was limited by the relatively small sample size. The purposive sampling did not enable us to assure optimal distribution of provider types and demographics, or estimate the representativeness of the sample in relation to overall

pool of DC-based providers working with SMIs. The focus on locally-specific factors limits generalizability to other geographic areas. Nevertheless, this diverse group of professionals provided a consistent and coherent portrayal of the current state of the delivery of HIV-related services to the SMI individuals in DC.

In conclusion, DC-specific contextual factors may interfere with optimal delivery of HIV-related services to SMI individuals. Future studies should quantify the relative impact of these factors and inform development of specific structural interventions.

Author Disclosure Statement

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