It has been well documented that persons who are hospitalized with mental illness have a higher rate of human immunodeficiency virus (HIV) and HIV-related risk behaviors than does the general population (Cournos, Empfield, Horwath, & Kramer, 1989; Cournos, McKinnon, Meyer-Bahlburg, Guido, & Meyer, 1993; Hatem, Hurowitz, Greene, & Sullivan, 1990; McDermott, Sautter, Winstead, & Quirk, 1994; Sacks, Dermatis, Looser-Ott, & Perry, 1992). Cognitive deficits, impaired judgment, behavioral disturbances, diminished impulse control, and irrational thought processes, in addition to a high prevalence of substance abuse, make patients with a psychiatric condition more vulnerable to engage in high-risk behaviors and contract HIV than the general population (Carmen & Brady, 1990; Cournos et al., 1989; Hatem et al., 1990; Horwath, Kramer, Cournos, Empfield, & Gewirtz, 1989; McDermott et al., 1994; Steiner, Lussier, & Rosenblatt, 1992).

Until a treatment has been found, education may be the best defense to limiting the spread of HIV (Baer, Dwyer, & Lewitter-Koehler, 1988; Cournos et al., 1993; Steiner et al., 1992). Previous stereotypes have described patients with a psychiatric condition as asexual or neutered (Carmen & Brady, 1990), but these stereotypes are false and dangerous because clinicians may not give these patients the education and support they need to protect themselves from HIV. To the other extreme, many persons with mental illness engage in sexual activity that is impulsive, anonymous, or coerced (Carmen & Brady, 1990; Cournos et al., 1993; McDermott et al., 1994). Although some patients with mental illness engage in homosexual or bisexual behavior, because of their mental illness they may not be integrated into the gay community or have access to all of the information and support this community offers (Carmen & Brady, 1990). Their conditions indicate that persons with mental illness will have a greater need than persons without mental illness for information about HIV and acquired immunodeficiency syndrome (AIDS) and its modes of transmission. Although it was previously thought that patients with mental illness would be unable to learn or tolerate affect-laden or sexually charged material without signs of decompensation or sexual acting out, several studies have suggested that they can learn direct and concrete information regarding AIDS and make appropriate changes in their risk behaviors (Baer et al., 1988; Cournos et al., 1993; Goisman, Kent, Montgomery, Cheevers, & Goldfinger, 1991; Sladyk, 1990).

A review of the literature found a variety of methods that addressed HIV education for persons with mental illness. Lauer-Listhaus and Watterson (1988) described a psychoeducational group for HIV-positive patients on a psychiatric ward. Carmen and Brady (1990) described a drop-in group for both patients who were HIV positive and patients who were HIV negative. Sladyk (1990) described a didactic group with a focus on safe-sex practices.
for persons who were HIV negative and Goisman et al. (1991) described an educational curriculum for patients with mental illness who were HIV negative at a mental health center. This article describes an AIDS education program for persons with mental illness who are HIV negative or have never been tested for HIV at a state forensic psychiatric hospital. This program incorporates characteristics described above but also uses activities as a means of integrating the patients' learning experience.

Setting and Population

As a maximum security forensic facility, the psychiatric hospital in which this program was developed provides a highly structured, secure, supervised environment for those who have committed serious crimes or who are so impaired by mental illness that they are a serious danger to themselves or others. A psychiatric diagnosis is required for admission, and patients come from state and county correctional facilities and state psychiatric hospitals. The 150-member population ranges from 18 to 65 years of age, with the majority of patients between 22 and 36 years of age. Ninety-three percent of the population are men, and 7% are women. Fifty-two percent of the residents are black, 39% are white, 8% are Hispanic, and 1% are Asian. Fifty-two percent of the population has schizophrenia; 14% have other psychotic disorders; and the remaining 35% are equally divided between adjustment disorder, bipolar disorder, and major depression. There are approximately 600 admissions per year and about one half of those are readmissions.

Development of the Program

The authors, an occupational therapist and a psychiatric nurse, shared several years of varied experience in working with persons with HIV and had a strong desire to develop a program addressing HIV and AIDS. We reviewed the statistics for our facility and determined that 5% of the population was HIV positive, 5% of the population had tested negative for HIV in the past year, and 90% of the population had never been tested or had tested negative for HIV 1 year before our review. Of the persons who had never been tested, none of the patients was exhibiting blatant, outward signs of an AIDS-related illness at the time of our review. Because our facility has a comprehensive testing, education, counseling, and treatment program for persons with HIV, we decided to focus on the large number of persons who were HIV negative and had never been tested for HIV. In light of the information found in the literature, we believed these persons would be likely to engage or were already engaging in high-risk behaviors and required education on HIV and AIDS.

Our first step was to conduct a needs assessment. A seven-item, short answer questionnaire, developed in both English and Spanish, was distributed and was completed by 30% of the persons who were HIV negative or had never been tested for HIV. This sample equally represented the various age groups, levels of functioning and male-female ratio of the population. Results showed that patients had either limited or inaccurate information regarding HIV and AIDS. Many of those surveyed were overly concerned about contracting the virus casually, and others did not realize the serious need for practicing safe sex or using clean needles. On the basis of this information, we developed a group program focused on education and prevention and targeted it specifically to persons who were HIV negative or had never been tested for HIV. The patients who were HIV positive were intentionally excluded from the program because the major focus of the program was prevention. Before implementation, the program was presented to the hospital staff members to educate them about the new program and alert them to be aware of questions, concerns, or psychiatric manifestations that the patients might present as a result of their involvement in the program.

Program Description

Because this program is a basic educational program for persons with mental illness and not a support group, all of the pertinent information for the AIDS Education Group was organized and prioritized into one 1½-hr session. Through this method, we believed the patients would receive the necessary information to learn about HIV and AIDS and prevent themselves from contracting HIV, but they would not be overwhelmed or overstimulated with too much information.

The program consists of three parts. The initial 30 to 40 min are devoted to a presentation of concrete information accompanied by a slide presentation. The following questions are addressed via the slides: (a) What are HIV and AIDS? (b) How does a person get HIV or AIDS? (c) How would you know you have HIV or AIDS? (d) What is the testing procedure for HIV? (e) What is the treatment for HIV or AIDS? and (f) How can I prevent myself and others from contracting HIV or AIDS? The slides contain pictures and short phrases describing the HIV virus, its modes of transmission, the signs and symptoms associated with HIV illness, and the AIDS-related opportunistic illnesses.

After the presentation, group members view one of two videotapes: Time Out: The Truth About HIV, AIDS and You (AIDS Films, 1989) (widely available in video stores) or Seriously Fresh (Hall & Warner, 1992). Both videotapes portray a realistic view of HIV and AIDS, focus on persons who are diagnosed with AIDS, and address ways to prevent contracting HIV. Because Seriously Fresh is geared to an audience of teenagers or young adults, it is reserved for groups with predominantly younger patients. Otherwise Time Out: The Truth About HIV, AIDS and You is shown. Before showing the videotape, the staff members review the theme and contents of the vid-
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The patients then participate in a structured group
activity designed to reinforce and evaluate their knowl­
edge about AIDS among psychiatric inpatients. Hospital and
Community Psychiatry. 39, 980-988.

chronic mentally ill. Hospital and Community Psychiatry 41,
652-657.

Cournos, F., Empfield, M., Horwath, E., & Kramer M.
(1989). The management of HIV infection in state psychiatric

Cournos, F., McKinnon, K., Meyer-Bahlburg, H., Guido, J.,
mental illness: Preliminary findings. Hospital and Community
Psychiatry. 44. 1104-1106.

Gossman, R., Bent, A, Montgomery, E., & Goldfinger, M.
mental illness. Community Mental Health Journal, 27, 189-

Conclusion

Although no formal study has been conducted to test the
patients’ learning and retention of the information re­
layed in the program, there have been some concrete,
observable examples of the integration of the material.
During the group activity portion of the program, the
patients have consistently developed sensible questions based on the information presented to ask
their peers. Subsequently, the patient group receiving the
questions has been able to collaborate to develop appro­
ciate, correct answers. Unlike other programs described
in the literature, this program incorporates activities and
a structured didactic videotape and activity sequence.
The use of the activity has demonstrated the patients’
ability to understand, learn, and verbalize the informa­
tion. Additionally, after the program, patients have ap­
proached the group leaders or other staff members with
appropriate questions and concerns. Through these
methods the patients are not only learning concrete, real­
istic information about HIV and AIDS, but they are also
enhancing their cognitive and social skills. Interestingly,
patients who had not been tested previously and patients
who may have engaged in high-risk behaviors since their
previous HIV test often request to be tested after attend­
ing the program. The next step would be to conduct a
formal study to measure learning and retention of the
material, the use of activity in this process, and the pa­
tient’s ability to integrate the information and prevent
himself or herself from contracting HIV.

Because this program has been in existence for 2
years, we have had the opportunity to reflect on means to
improve the program. First, a pretest and posttest at the
beginning of each group session are encouraged. The
questions and discussions throughout the group session are encouraged. The group leaders will sporadically ask for thoughts or ques­
tions and will address patients’ nonverbal behavior.
The group has been in existence for 2 years, has met
approximately 25 times per year, and has educated ap­
proximately 400 patients. Patients are only required to
attend once, and the same format and content is repeated
for each group. Only the questions and discussions of
each group vary. If a patient believes that it would be
beneficial to repeat the group, he or she is welcome to do
so. Initially, all of the patients who were HIV negative or
had never been tested attended a group session. Once
this entire patient population had an opportunity to at­
tend, participation focused on newly admitted patients
and those wishing to repeat the program.

References

AIDS Films (Producer and Director). (1989). Seriously
Fresh [videotape]. (Available from AIDS Films. 225 Lafayette
Street. Suite 1102, New York, NY 10012).

about AIDS among psychiatric inpatients. Hospital and
Community Psychiatry, 39, 980-988.

chronic mentally ill. Hospital and Community Psychiatry 41,
652-657.

Cournos. F., Empfield. M.. Horwath, E.. & Kramer M.
(1989). The management of HIV infection in state psychiatric

Cournos. F., McKinnon. K., Meyer-Bahlburg. H., Guido. J.,
mental illness: Preliminary findings. Hospital and Community
Psychiatry. 44, 1104-1106.

Gossman, R., Bent. A, Montgomery, E., & Goldfinger. M.
mental illness. Community Mental Health Journal, 27, 189-

(Available from Paramount Pictures. 5555 Melrose Avenue,
Hollywood. CA 90038).

Seroprevalence of human immunodeficiency virus in a state
psychiatric institution. Archives of Internal Medicine 150:
2209.

Horwath. E., Kramer. M., Cournos. F., Empfield. M., &
Psychiatry 40, 502-506.

tional group for HIV positive patients on a psychiatric service.
Hospital and Community Psychiatry 39, 736-744.

McDermott, B., Sautter, F., Winstead, D., & Quirk, T.
(1994). Diagnosis, health beliefs, and risk of HIV infection in
psychiatric patients. Hospital and Community Psychiatry 45,
580-585.

Seroprevalence of HIV and risk factors for AIDS in psychiatric
inpatients. Hospital and Community Psychiatry 43, 35-45.

Shadick, K. (1990). Teaching safe sex practices to psychiatric
patients. American Journal of Occupational Therapy. 44,
284-286.

about and risk factors for AIDS in a day hospital population.
Hospital and Community Psychiatry 41, 34-43.