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; Sladky, 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. Sladky (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 56% 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 or 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-
videotape for the patients. The intention of this solemn, realistic view of the illness is to motivate the patients to take measures to prevent themselves from contracting HIV. After the videotape is shown, patients are given an opportunity to ask questions or express thoughts or concerns.

The patients then participate in a structured group activity designed to reinforce and evaluate their knowledge of the information presented. An example is an activity in which the patients are divided into two groups. Each group is responsible for developing five or six questions and answers to present to the other group, and each group alternates in asking questions. The purpose of the activity is to assist the patients in recalling and integrating the material presented to them. Questions and discussions throughout the group session are encouraged. The group leaders will sporadically ask for thoughts or questions 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 approximately 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 attend, participation focused on newly admitted patients and those wishing to repeat the program.

Conclusion

Although no formal study has been conducted to test the patients' learning and retention of the information relayed 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 patient groups 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 appropriate, 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 information. Additionally, after the program, patients have approached the group leaders or other staff members with appropriate questions and concerns. Through these methods the patients are not only learning concrete, realistic 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 attending 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 patient'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 onset would have permitted us to measure learning more objectively. Additionally, patients' long-term ability to retain the information, practice safe sex, and remain HIV negative would also be important to ascertain. Finally, the comparison of this type of structured group to other types of groups (e.g., drop-in) or learning formats would be important.

References


