

**nam**

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# hiv treatment update

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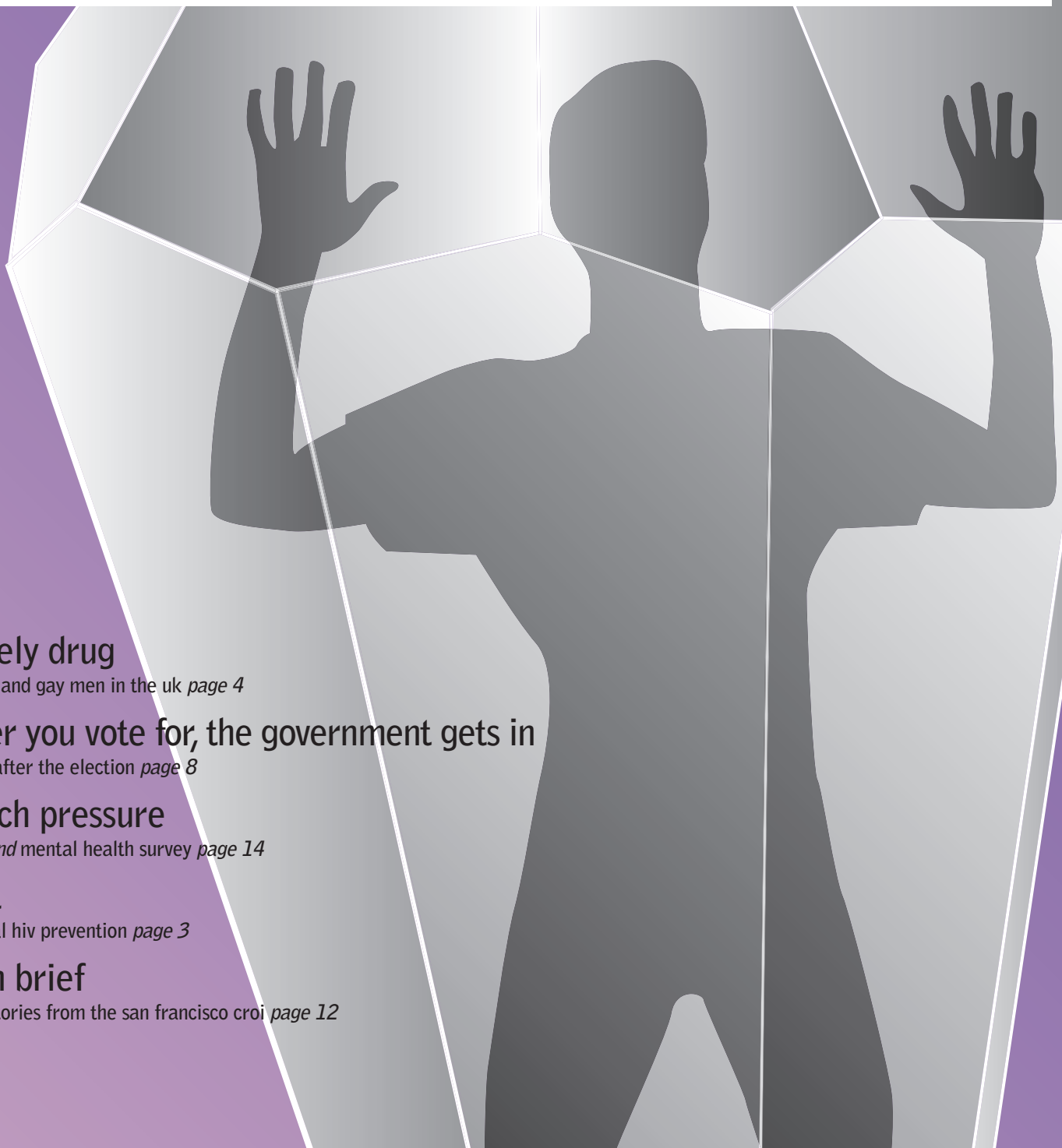
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Gus Cairns

## in this issue

From the Houses of Parliament to the sex clubs of Vauxhall: it feels like we're covering the extremes of the HIV epidemic this month.

On the one hand, we tour the corridors of power to find out what will change in HIV service provision after the election (page 8). As Lisa Power points out, whoever wins, their promises will mean nothing if they're swept aside by a wave of cutbacks in public spending. HIV, sexual health and contraception organisations are so concerned that they've joined together to create ShoutLoud ([www.shoutloud.org.uk](http://www.shoutloud.org.uk)) a national campaigning resource for people working in the field.

On the other hand, we're talking to people at the sharp end of HIV prevention – literally, if reports of an increasing use of injection amongst gay men who use meth are anything to go by (page 4).

Crystal meth is a casualty of the 'crying wolf' phenomenon. There have been so many warnings, about this drug causing a disaster in the gay community, that some commentators still feel that trouble with meth is only ever going to happen to a handful of hardcore men in London. Yet one thing history has taught us is that sudden outbreaks of HIV are most likely in populations whose existence is downplayed or ignored.

The thing that links policy advisers in the House of Commons with gay men just across the Thames is prevention work, and how difficult it is to make the case for it in a climate where it's hard enough to maintain standards in treatment.

One of the less comforting findings reported from the recent retrovirus conference (page 12) was that while new HIV infections seem to be declining in a lot of populations, gay men – at least in France – were the one population where they remain high. It would be too easy for cash-strapped health authorities to throw their hands up and conclude that nothing works for gay men.

The equal-and-opposite tendency is to embrace the latest 'magic bullet' in HIV prevention. This time it is giving everyone with HIV antiretroviral drugs, and in *Upfront* opposite we examine why it's going to be hard to make that work too.

The truth about HIV prevention is that there are no shortcuts to helping people reduce their vulnerability to acquiring or transmitting the virus. Offering people a combination of strategies and empowering them to use them is what works.

HIV prevention is not about 'risk behaviours', it's about people, and specifically, as our interviewees in the crystal meth piece emphasise, it's about socialising people, helping bring them in from the cold. As we are reminded once again by the *HIV in Mind* survey (see page 14), one of the key experiences that a high proportion of people with HIV have in common is a sense of being isolated and marginalised by their infection.

Feeling lonely can make people behave in odd ways, including having a lot of high-risk sex and/or using drink and drugs to dull the pain. Until that's addressed, the human need for contact will run ahead of any strategy for containing HIV.



### hiv treatment update

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# The ideal and the real in HIV prevention

“Mass screening of all AIDS sufferers could wipe out the disease within 40 years,” was the Daily Mail’s headline regarding the most widely reported speech at the recent Conference on Retroviruses and Opportunistic Infections (for news from the conference, turn to page 12 or for more, visit [aidsmap.com/croi2010](http://aidsmap.com/croi2010)). If we could put the vast majority of HIV-positive people in the world on antiretroviral drugs (ARVs), that is.

The World Health Organization’s Brian Williams in fact went further in his claim. “I believe if we used antiretroviral drugs we could effectively stop transmission of HIV within five years,” he said.<sup>1</sup>

Scientifically, this makes sense. If you reduce a person’s viral load, they will become a lot less infectious.

The Partners in Prevention study of long-term couples of different HIV status (see page 13) found that putting the positive partner on HIV therapy reduced the chances of HIV transmission by 92%. That’s better than the rate achieved when people try to use condoms all the time (typically 80 to 85%).

Putting everyone on treatment feels like a simple answer to an infection that has shrugged off complex ones like vaccines. Maybe the answer was staring us in the face all along, and treating more people with HIV may indeed, in the long run, become an important part of stopping the HIV pandemic.

But there are four different reasons why it won’t happen overnight.

Firstly, the reduction in transmissions seen in Partners in Prevention won’t necessarily apply to everyone. This was a group of long-term heterosexual couples, primarily monogamous. They had low levels of sexually transmitted infections

(STIs) and casual sex, and most sex was vaginal. A tougher test of ARVs would be to see if they can reduce infections in gay men who have unprotected anal sex, high numbers of partners and high levels of STIs.

Secondly, over the next few years the world will find it hard enough to treat the people who are in imminent danger of death, let alone put everyone on therapy. In one study from South Africa, the country’s twentyfold expansion of therapy in the last four years did not prevent a quarter of people on the waiting list for drugs dying before they got a single pill. While such urgent needs aren’t being met, is it realistic to talk of putting everyone on therapy?

Thirdly, using HIV therapy as a public health measure will not work if it rides roughshod over people’s fears of being identified as HIV-positive and stigmatised in their communities. A poster from Uganda<sup>2</sup> echoed something that’s been seen amongst gay men in the global north: the more likely people are to have HIV, the more likely they are to avoid testing. These will be exactly the people testing drives miss. Treatment as prevention simply won’t work unless programmes are put in place to address the stigma of HIV *before* the testing caravan rolls into town.

Lastly, making a real dent in incidence by means of treatment is simply a very, very hard thing to do.

It is possible. One of the most hopeful studies presented at the conference was from San Francisco (see page 12). It showed that very high rates of testing and treatment may be starting to bring the rate of new infections down. Only one in seven San Franciscans with HIV doesn’t know it.

But HIV incidence and prevalence only improve slowly with increases in testing and treatment. A high proportion of infections (maybe a third) are spread by very recently infected people who haven’t been diagnosed.

And the sum total of people with HIV won’t decline fast because HIV-positive people are staying alive to be counted.

Even with rates this high, only a minority of the HIV-positive population may have an undetectable viral load. In San Francisco 85.5% of people with HIV are now diagnosed; 78% of these get linked to care; 90% of these take ARVs; and of these, 72% become virally undetectable.

Do the sums: even with such high testing and coverage rates, only 43% of San Franciscans with HIV have an undetectable viral load.

Treatment as prevention will need to be *truly* universal to work.

That doesn’t mean it’s not worth trying. We need radical answers if HIV prevalence is not going to spiral ever upwards as people live longer on treatment. Brian Williams said “the only thing that’s going to be more expensive than this is not doing it”.

In the long run, it may be better for anyone with HIV to be on the drugs than not. Yes, side-effects may wait along the line as we get older, but so will the long-term effects of having HIV, which are probably worse.

In the end, treatment as prevention and optimal HIV treatment may amount to the same thing.

## Correction

In last month’s *Upfront* on HIV drugs and cardiovascular disease, we stated that the D:A:D study did not collect data on kidney disease. In fact D:A:D has been collecting data on creatinine levels, a marker of kidney disease, since 2006 and in a letter to *The Lancet* 18 months ago, the researchers wrote that adjusting for kidney disease made no difference to the association between abacavir and heart attacks.<sup>3</sup>

# the lonely drug:



## crystal meth in the uk

There are increasing signs of problematic methamphetamine use amongst some gay men in the UK. *Gus Cairns* reports.

## What is methamphetamine?

Methamphetamine – meth, crystal, ice, tina, Christine, *yaa baa*, Nazi speed – is a chemically altered version of amphetamine (speed). Amphetamine was first synthesised in 1887 and marketed from the 1930s to 1960s as a decongestant and slimming aid. It keeps people awake and leads to a heightened sense of euphoria and self-confidence. It was banned in the UK in 1964 and the USA in 1971.

*Methamphetamine* was synthesised in 1918 and was distributed by the Nazis, who thought it would make the ideal keep-awake pill for the armed forces (other countries used it too). It was banned in Germany just three years later. It certainly kept soldiers battle-ready, but it also took days for them to get over the exhaustion it caused. From the start, it had a bad reputation.

Amphetamine drugs cause the nerve cells to release heightened amounts of the neurotransmitters dopamine and serotonin. Dopamine provides elementary pleasure and energy while serotonin boosts self-esteem. Amphetamines wring the dopamine out of nerve cells, and it takes days for them to start producing normal levels again. At the peak of a methamphetamine high, you'll have about 12.5 times the normal amount of dopamine in your brain. That's why the rush is so fierce and long.

It's a drug of abuse across the world, and not just amongst gay men. There's an association with sex: south-east Asia has had a problem with *yaa baa* ('mad pills' in Thai) since the early 1990s, and sex workers and their trucker clients were the first consumers there. In one US study<sup>1</sup> heterosexual men who used meth were twice as likely to have sex with multiple partners as non-users.

## Gay men and meth

In the global north, however, the phenomenon that has caused the most alarm is the epidemic of crystal meth use that started amongst gay men in the western USA in the early 1990s, spread to the east coast around 2000, and shows signs of becoming a problem in London's gay scene now.

Coverage of meth, especially in the USA, bordered on the hysterical to start with. This community alarm was countered in

other quarters by a cautious response that some saw as complacent.

One factor is that meth use is high, not amongst all gay men, but amongst very specific populations of gay men, and not everyone is equally vulnerable to developing dependency. Few researchers have examined exactly *why* some men are so fiercely attracted to this drug, and others immune to its thrills.

Research has tended to concentrate on the *medical* damage caused by the drug: its association with HIV infection, poor adherence, and drug resistance. But some think it is the psychological and social consequences of meth use that are more important: psychological illness and an often rapid disintegration of a stable lifestyle.

## How many use it?

In the USA, meth use in gay men may have passed its peak. Initial reports on a Centers for Disease Control survey<sup>2</sup> suggest that in New York the proportion of gay men who used meth at least once a year peaked in 2004 at 14%. Four years later the figure was 6%. In harder-hit San Francisco, meth usage declined from 22% to 13% in the same period.

In the UK, the Gay Men's Sex Survey in 2005<sup>3</sup> found that only 3% of the whole sample had used methamphetamine and that only 0.3% were frequent users of the drug. Usage amongst certain groups was much higher, though. In London gay men it was 7%; amongst HIV-positive gay men in London it was 20%; and in HIV-positive men with multiple partners it was 35%. *Frequent* use was rare, however. Another survey in 2003-05 found that 20% of users of London gay gyms had used methamphetamine in the past year.<sup>4</sup> However, three-quarters of users said they'd only used the drug once or twice. Only eight out of 750 men surveyed used it once a week or more.

Statistics from both London and New York show a dichotomy between little or no use amongst most gay men, but considerable use in a few.

In New York a study looking at 450 gay men who used drugs on the club and party scene found that 65% had used methamphetamine in the last four months.<sup>5</sup> But there was considerable variation in use – a lot of men were

managing a lifestyle involving use every few weeks, while a minority would be either high or coming down most of the time.

## The early response

Campaigners felt that publicly funded gay men's sexual health agencies were slow to respond to meth in the USA and the same accusation has been directed at organisations in the UK too. In the USA, Peter Staley, a former bond trader and founding member of ACT-UP, launched a controversial anti-meth campaign when the gay men's health organisations wouldn't do it.

"I'm not anti-drug," he told the US PBS network in 2006, "but this is a different beast... We are seeing people with white-collar jobs, the boyfriend of 15 years, the two dogs, the Manhattan condo, losing everything in six months. Being able to handle other drugs before is no guide to whether you'll be able to handle this one."

He tells *HTU* that the link with sex is crystal's real hook: "People say 'Try this, you'll have the best sex of your life,' and unfortunately, there's quite a bit of truth in that... because it lowers inhibitions.

"If you happen to have great sex on crystal the first time," says Peter, "It can set up major problems. Your brain wants to repeat that first high."

The peak age for getting into meth is 35 to 45, and HIV-positive men are much more likely to use it. Understandably, they're also the group of gay men more likely to experience sexual dysfunction, the fear of rejection, and poor body image. Meth crashes through those inhibitions and can make you feel like a porn star. Until the comedown.

The nearest equivalent to Staley in the UK is probably Gary Leigh, who set up the internet site LifeorMeth.com after he "witnessed the pain and degradation inflicted on friends and acquaintances by meth" in the USA.

The deterioration was particularly noticeable around 1998, he says, when *Viagra* arrived, overcoming a side-effect that had previously put a lot of men off meth – 'crystal dick' erectile dysfunction.

He got very frustrated with the lack of interest he perceived in gay men's sexual health organisations. "Armed only with anecdotal evidence and not the scientific proof they were demanding, I found myself stumbling around in the dark."

He insists that any message other than total abstinence from meth will confuse gay men – not a message drug agencies who aim at harm reduction would necessarily agree with. "By aiming different campaigns at different levels of user you risk sending out mixed messages. The universal message has to be non-negotiable – *don't use crystal!*"

### Is the problem increasing in the UK?

We have few hard data on current trends, only increases in demand noticed by some London agencies.

Flick Thorley is the clinical nurse specialist for HIV and mental health at the Chelsea and Westminster Hospital in London. A soon-to-be published survey found that 25% of gay men attending the Chelsea and Westminster Hospital's sexual health clinic said they had used crystal. More data will be published soon.

She doesn't feel that much could have been done to prevent the current increase in use, but sees an urgent need for new types of services to help increasing numbers of meth casualties.

"I don't see people until they're really on their knees," she says. "By the time people come here they may be displaying overt psychosis or their social network has completely disintegrated.

"Drug projects in the main do not see many gay men, and they're also not

used to dealing with a situation where sex and drug addiction are reinforcing each other."

She is also concerned that gay meth users are moving rapidly from smoking the drug to injecting it – as happened in Australia. One co-infection specialist told *HTU* he thinks that a significant proportion of hepatitis C co-infections in gay men may be due to injecting drugs.

The message has now got through to health charities. Gordon Mundie, gay men's group worker at the Terrence Higgins Trust (THT), is one of a new generation of gay men's health workers who have started to witness increasing damage.

"THT was running a group for gay men with drug problems called *Are You Losing Control?* till the end of last year, when it lost funding. It wasn't aimed at meth users but suddenly they started to dominate – at one point we had a group of eight, five of whom were injecting meth users.

"Men are not reporting problematic use till it's way out of control. They don't believe they *can* talk about drugs to HIV workers, they don't want it on their records, and criminalisation of HIV transmission comes up regularly as a reason not to talk. I think there's a clear discrepancy between the numbers ...reporting problems and actually having ones."

A particular problem, explains Mundie, is combined use with the drugs GHB and GBL (gamma-hydroxybutyrate and gamma-butyrolactone). You can't sleep on crystal but you may be able to if you

add GHB, and it can take the edge off meth paranoia. Unlike methamphetamine, GHB and GBL produce physical dependency and withdrawal symptoms. Some of the symptoms experienced by meth users in crisis may be caused by GHB withdrawal.

There are signs that statutory agencies are now responding and THT is putting together a proposal for funding for a much more comprehensive counselling, support and recovery programme for gay men, which will include measures not previously considered necessary for the gay community, such as residential drug rehabilitation. "Should we have anticipated this before?" Mundie asks. "Absolutely."

The proportion of gay men turning up at Antidote, the LGBT service at the Hungerford Drug Project in London, who cite crystal as their main problem is increasing. The project has been in talks with the police and the Home Office about how to handle the growing problem and, like THT, are hopeful of more government support.

I talked there to Monty Moncrieff, client services manager, and David Stuart, a volunteer who works with men with meth problems.

Between 2005 and 2008, the number of men contacting Antidote with drug problems increased by 42%. 2005 was the first year any of them cited meth as the problematic drug: 5% of the total. By 2008 this had tripled to 15% and by September 2009 this had gone up to 20% of clients. Since then, the proportion with meth as their main problem has continued to climb.

## Methamphetamine and HIV

There is a clear association, at least from US studies, between methamphetamine use and HIV infection. A study from San Francisco in 2005<sup>6</sup> estimated that the annual HIV incidence rate amongst gay men testing for HIV was 2.5%, but was 8% amongst meth users – explained by the fact that meth users were 2.3 times more likely to have unprotected anal sex.

Studies have found much higher HIV treatment failure rates in methamphetamine users: one study in 2007 found that less than 40% of meth users on HIV treatment had an undetectable viral load compared with over 60% of non-users.<sup>7</sup> But people not on HIV treatment had similar viral loads regardless of meth use, showing that the difference in treatment success was due to meth causing adherence problems rather than to any direct effect on HIV.

The key problem with meth use for the gay community is the length of its effect and its comedown. People may take too much of other drugs, such as alcohol or cocaine, (and this will eventually tell on their health), but generally they can still hold down a job and have the basics of a structured life. But a drug that keeps you up for days, followed by an equally lengthy period of major depression, is much more difficult to reconcile with a normal lifestyle.

David explains: "Meth is not a drug men use to deal with shyness or social unease, as they might with cocaine. It's all about gay men's feelings of sexual inadequacy." The 'benefit trap' generation of HIV-positive gay men, dealing with unprocessed grief, deskilling, lost opportunities and stigma, is particularly vulnerable.

Antidote thinks there's room for differing, harm reduction messages in meth education and doesn't support the 'total abstinence and nothing but' line.

"You need information on meth for people contemplating its use, not glamorising it or frightening people, but emphasising its dangers. But once someone has started using, no amount of horror stories in themselves will stop people using it. Users will feel it doesn't apply to them. They'll think 'I know more about this drug than any pharmacist'. In

gay society there's a stigma about not being able to 'handle your drugs', and they'll just think 'No way am I one of those sad losers'."

The method Antidote has adopted so far is essentially a slow process of socialisation.

David says: "Gay men take it initially so they can lose their inhibitions about connecting with other gay men and yet ironically, more than any other drug, meth isolates its users. Our users usually turn up sober – and devastated. Shame is a major barrier."

Monty says: "What we do is provide a space where they can experience being normal and calm again. We offer support groups, massage so they can experience non-sexual touch, just a space for people to be. At first many users are paranoid and don't want to

socialise. Gradually they'll start talking about their experiences. There will likely be many relapses... We help them plan for trigger times like public holidays."

Learning to have non-drug-fuelled sex is the worst problem facing many users, because sexual attraction will set off cravings. "Many people abstain and only slowly learn about being able to combine sex with an intimacy they might never have had," says David.

They don't see shortcuts. "Ultimately, the only answer is to have a more esteemed and confident gay community." ■

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Antidote @ The Hungerford (London)  
020 7437 3523  
www.thehungerford.org/antidote.asp

## I hated it

**Stewart Who** is a DJ and former editor of QX Magazine.

*I first came across crystal in San Francisco in the mid-90s. I just bought some because everyone else did. I assumed it was like coke.*

*I had a horrible time. It's a really boring drug. There's no buzz on it – you just can't blink. You could be on other drugs and it kind of flatlines their effect.*

*You become hyperaware, and slightly dissatisfied with whatever is going on. ... You think the next thing is going to satisfy you and it doesn't. That applies to the sex too. After two hours you want to cum and you can't. It becomes mechanical.*

*The comedown was monstrous. I thought I'd be OK after the first day, but every day was a new level of awfulness. The despair and hollowness is just unparalleled.*

*It's got this bad-boy reputation – how close to the fire can you go?*

*I've known successful people who've lost their jobs, lost their money – real junkie behaviour – stealing and lying. You may think you can manage it but sooner or later you'll end up living in your car.*

*How do people get over it? You have to value a normal life again. Take pleasure in having food in the fridge, a tidy flat, and a walk in the park on a summer's day.*

*But it's hard to sell that till you've lost it.*

## I loved it – too much

**Pete** is an ex-escort who used crystal for ten years and now helps other gay men with meth problems.

*I became an escort because I wanted to be like the popular, sexy, interesting people I met in gay clubs. I was soon diagnosed with HIV at 21.*

*I had a very repressed upbringing. Sex was just currency to me, I couldn't ask for pleasure.*

*I came across crystal when I was 28. Someone noticed I was twitchy and said "Take this, you'll feel more confident." Well I did! I could finally say to guys "Do this to me, I like it".*

*I was on it for ten years. I was getting really lonely going from one sexual encounter to another, but the solution to loneliness was to go out and find more.*

*Eventually lack of sleep and isolation led to psychosis. I thought people were watching me and insects crawling under my skin. I realised I had to get help.*

*It took me two years to get sober; two years to get that much of a rush out of life.*

*Today I have amazing sex because I date people! I get to know them. I say "I want to feel really safe and intimate and familiar before we have sex". I don't have the fear of being judged – are my muscles good enough, will I lose my erection? – that I did before.*

*My goal is to nurture this work, have a busy life, a relationship, and a pension. Normal stuff I never had before.*

# whoever you vote for, the government gets in

*Lisa Power* of the Terrence Higgins Trust (THT) looks at what voting for the three main political parties in the UK might bring for people with HIV and those who serve them.

There are two things about the forthcoming general election that make it special for anyone interested in politics. One is the economic situation of the UK and the other is the massive influx of new, inexperienced MPs, with so many retiring or fatally damaged by the expenses scandals of the past two years.

Though the recession may officially be over, that's not true for public services, where the worst impacts are yet to be felt. Local authorities and NHS trusts (or health boards, if you're in Scotland or Wales) are only just beginning to feel the impact of the collapse of their investments, the strain on their pension schemes and the imminent reduction of some of their central-government funding. Essentially, whatever promises any of the political parties are making, they will be subject to complete revision once the winning party gets a good look at the state of the Treasury. This lack of money will distort, if not simply negate, any election promises.

Whoever takes the reins of power in Westminster this year will have to manage their way through a serious level of cutbacks in public service for at least the next two years – and that will likely mean reductions in both statutory and community services for people with HIV. Not just national government but also primary care trusts (PCTs), health boards and local authorities will be looking to prioritise what they – and local residents – see as must-do services, and we all know how low down that list HIV and sexual health services can come, despite the best efforts of both THT and NAT (National AIDS Trust) in lobbying.

Because health is a devolved responsibility, with the Scottish

Parliament and the Welsh Assembly making decisions in those countries, some (though far from all) of what follows relates specifically to the English NHS. But it's worth remembering that all MPs at Westminster have a vote on English health matters, and many of the things that affect people with HIV are not in the health brief.

In particular, the AIDS Support Grant, which comes up for scrutiny again in 2011 after a three-year renewal by Labour, is at serious risk. Without it, many local authorities in England will cease to fund any HIV social care at all. If you want those services now or in the future, then it's a point worth making to any candidate that you want the AIDS Support Grant renewed. That decision will be centrally made by the Treasury and the Department of Health.

Money will be scarce throughout the NHS, and managers will be looking to make changes to how care is delivered in order to use their scarce resources to best advantage. HIV services won't be exempt from this, but currently all three parties are keen to show that the broader NHS is safe with them and so are not really tackling the issue convincingly. Whoever gets in will be keen to devolve decision-making to local level, and then disclaim responsibility for those decisions. Local MPs, however, have local influence so it will be important that yours understands HIV, whichever country you're in.

Whatever the party in power, there will be many shiny new MPs with, to be tactful, variable levels of experience of the practicalities of government. The election of 2010 is expected to see more new MPs than any since 1945. That's

not necessarily a bad thing, but it does mean that they'll start out with more enthusiasm than experience. It's going to be up to all of us, as their constituents, to train them about issues dear to us.

Health, as said, is a devolved responsibility nationally but one thing all three main parties agree on is that even more decision-making ought to be devolved, with health funding and prioritisation done at PCT level or lower. All three parties want to see the NHS and local authorities working together better, particularly in managing public health and social care. The Conservatives are flirting with abolishing primary care trusts, the Liberal Democrats want to abolish strategic health authorities and all three (particularly the Tories) are keen on using GPs to commission services on an ever smaller and more parochial basis. Would you want your GP commissioning your HIV services?

Unfortunately, we know from experience under Labour how poorly this localism works for HIV. Stigmatised, unpopular conditions lose out in local 'democratic' prioritisation of scarce funds unless they have a local 'champion' – all too uncommon with HIV. Sexual health funds have notoriously been plundered in the past few years to make up deficits; and only unpopular national targets seem to have any leverage in getting most trusts to do the right thing by any area of sexual health. Local election of members of the public onto PCT boards, as suggested by the Liberal Democrats, sounds great – but will those members of the public be sympathetic to the issues of people with HIV? Sadly, so far they've often not been unless people living with HIV are prepared to get involved.





candidates  
health board MPs  
NHS trust

general election

money standards

localism sex education

recession Labour  
Conservative  
testing rates Liberal Democrats

funding

local level

charges

policies

issues prescription

sexual health lobby

AIDS Support Grant primary care trust

constituents



Localism, so popular with politicians, also increases the postcode lottery of variable health care – an evil which all parties are stoutly against. ‘Doublethink’, as George Orwell defined it, “the power of holding two contradictory beliefs in one’s mind simultaneously, and accepting both of them”, is alive and well across all the main British political parties.

As a lay person trying to find out what the parties officially think should be done about HIV from their policies, you’d have a hard time. Though over 90,000 people in the UK are currently infected and numbers continue to rise, domestic HIV is not a big ticket item for any of the parties. Labour’s website has their policy on public health, but neither HIV nor wider sexual health figure in it. The LibDems have a handy pocket guide to their policies, but neither this nor the health page on their website mention HIV or sexual health. Interestingly, both parties find time to mention other public health threats like obesity, alcohol and smoking. The Tories follow the same format, although they do link to their overarching health policy document, which talks about HIV and sexually transmitted infections under public health. They also have a newer public health policy, ‘A Healthier Nation’, which talks a lot more about HIV.

If you cast your net a little wider, there are some interesting ideas about, which will have an impact on people with HIV, or on its continuing spread. The Liberal Democrats, for example, want to abolish prescription charging, which impacts increasingly on people with HIV as cost pressures force specialist clinics to push patients back to their GPs for everything bar prescriptions for antiretrovirals. Labour has also promised to remove prescription charges for long-term conditions, but have failed so far to do this for anything except cancer – because of the costs involved.

Of course, this reflects the reality of being in government as much as anything else. It’s much easier to promise things when you’re not the one currently having to balance the books though, to be fair, the LibDems are also the only party prepared to admit they are in favour of increasing taxation to pay the bill for their promises.

## It is vital that newly elected MPs appreciate that some of their constituents really care about HIV.

With the outcome of the election on a knife edge, it’s tempting for politicians to worry as much about not saying things that might alienate people, as putting forward positive policies. That means that HIV and sexual health, as ‘tricky’ subjects, are likely to get little attention unless interested parties ensure they are raised.

Of the three main UK-wide parties, the Conservatives have undoubtedly published the most detailed plans for health (and a number of other areas). This isn’t surprising, since they have a serious shot at power but no recent government record to stand on (and in some areas probably wouldn’t want to be remembered for their previous history anyway – Section 28, I’m looking at you). Interestingly, on HIV itself they do have a strong record due to their response in the 1980s which, under Norman (now Lord) Fowler, was swifter and more pragmatic than many other European countries despite wider Conservative policies inimical to discussing sex, and homosexuality in particular.

Though they regularly attack the current Labour Government on sexual health issues, even the Conservatives don’t have many concrete answers on HIV. Their latest policy green paper sets out the problems well, but doesn’t offer the detailed strategies for change that they do for smoking, drinking and obesity. But they do offer increasing emphasis on public health including ring-fenced public health funding, slanting that funding towards the most deprived areas of the country, a linking of funding to results and a more “mixed economy of care” involving private and voluntary sector groups as well as the NHS. The latter is in clear contrast to the current Health Secretary, Andy Burnham’s, off-the-cuff promise that NHS service providers would always be favoured.

However, all too frequently the parties use jargon to sound more different than they are. Both the LibDems and the Tories berate Labour for their use of targets, much hated by PCTs, and claim they wouldn’t use them. But the LibDems would have “patient entitlements” and the Tories would have “standards”. Is there a difference?

The relevant question is, how enforceable will any of these be? For HIV, targets and ring-fencing and directives are often the only way we get anything done – everyone knows, for example, that we desperately need to increase testing rates for HIV and they know how it could be done, but without central government diktats, everyone’s just milling around saying what a good idea it is. Many people hated the national target of 48-hour access to GUM (sexual health) clinics, yet it undoubtedly led to major improvements in access and services.

But the issues that relate to HIV go a lot wider than the health brief. Social care, benefits, employment and legal protection are all relevant and for some people, gay issues, immigration, ageing and overseas aid are policy areas that we care deeply about, whether it’s for ourselves or others.

Social care is undoubtedly going to take a battering in the current economic situation, and there’s little to choose between the three main parties. All of them are in favour of better

co-ordination between health and local authorities, and all three are pushing personal care budgets, an idea that's been around for more than a decade without anyone working out how to do it well and efficiently. The Conservatives are keen on ways of increasing self-reliance through new technologies, such as the greater use of new technology to allow people to live independently.

Education shows more differences, with the Conservatives visibly unwilling to support compulsory sex and relationships education (SRE), illustrated by their current opposition to lowering the age at which compulsory SRE would start to 15 (as the Government wants, in order to ensure every pupil gets at least one year of it) or even lower (as the LibDems want). Though the Tories have moved a long way from their 1980s attitudes to sex education, they still show a reluctance to enforce teaching of the basic sexual life skills. On the other hand, they are keen on increasing numbers of school nurses able to give advice on sexual health.

LGBT (lesbian, gay, bisexual and transgender) issues are an area where the past shows clear differences, but future promises are less distinctive. Labour are extremely proud of their equalities record, having presided over a lot of change for LGBT people, from equalisation of the age of consent to civil partnership, equal rights to goods and services and the repeal of Section 28. Their anti-discrimination measures have also been important to disabled people of all sexualities.

Many Labour politicians of my acquaintance are completely bewildered as to why so many gay men are

therefore ungrateful enough to vote Tory, given the party's poor past record on gay issues. But times, and parties, change and there are increasing numbers of openly gay people within the Tory party. Undoubtedly many old-timers within the party are holding their tongues in hopes of being elected, but the same could be said of many to the left in Labour who 'behaved' in order to get Blair elected – and then found themselves unable to backtrack.

Conservative public health policy talks clearly about individual and social responsibility and about making funding more dependent on results. If they win, there will be a strong focus on these issues and it will be interesting to see how that translates into HIV. There may well be challenges to how current services, including health promotion, are focused, but don't expect a return to eighties-style 'Just Say No' campaigns; their policies are about 'nudging' people into social norms. Payment by results will take the foreground, though.

Migration and border controls are a difficult area and one whose interaction with HIV can be volatile. Shortly before the last election, Michael Howard, for the Tories, made a sudden proposal to introduce border controls based on health and, when this proved less popular than hoped, linked it explicitly to people with HIV. Hopefully, now even the US has admitted this is an unworkable policy, that won't happen again – but I'm willing to bet someone will try and suggest it. Both the Tories and Labour are big on policing our borders and managing immigration, whereas the LibDems have taken on board the pragmatism of allowing asylum seekers to work instead of relying on handouts.

People with HIV are living longer and are increasingly likely to need care services in their old age. At time of writing, this is a battleground between Labour and the Conservatives, with accusations of false accounting, scaremongering and unrealistic plans. Again, the bottom line will be – whatever they promise, the economy will come first. Money will have to be found to pay for elder care and some will come through charges in one form or another.

The other big area for people with HIV, given that 47% are unemployed, is benefits and support to work. Labour's review of Special Needs and recent proposals to change some benefits have not endeared them to many people who are (or were) dependent on these, but it is unlikely that the other parties would act substantially differently if in power. Traditionally, Labour have offered more schemes to enable people to get back into work, but these have not always proved the success hoped for. The LibDems want to simplify the benefits system – something I think we'd all agree on – and to give debt advice to the unemployed through Jobcentres.

That's only a brief overview of some of the policies currently being promoted by Labour, Conservatives and the Liberal Democrats. As said at the start, whoever wins the election – and that includes the possibility of a hung Parliament with the LibDems holding power – the economy will take precedence and could well throw many plans and promises straight out of the window. In a situation where only the highest priorities will get attention, it is vital that newly elected MPs appreciate that some of their constituents really care about HIV. ■

THT, NAT and other groups are working hard to influence the future of HIV with parliamentarians, but it takes constituents to make an issue stick. If you want inspiration about what to talk about with candidates, THT and NAT have agreed some main priorities they'll both work on (see [www.tht.org.uk](http://www.tht.org.uk) and [www.nat.org.uk](http://www.nat.org.uk)) and there are lots of tips about tackling candidates on the ShoutLoud website ([www.shoutloud.org.uk](http://www.shoutloud.org.uk)), put together by all the main sexual health organisations. You can also get campaign updates, including tipsheets and information on your local candidates, from [guy.slade@tht.org.uk](mailto:guy.slade@tht.org.uk).

And, after the election, if your MP only does one thing about HIV, it should be to join the All-Party Parliamentary Group on HIV/AIDS ([www.appg-aids.org.uk](http://www.appg-aids.org.uk)) because that will keep them updated about developments. So if you want any of the things above to happen (or some of the bad things not to), get stuck in – talk to your local candidates, tell them what you care about and tell them your vote may depend upon it. And hold them to it later.

# news from the 17th conference on retroviruses and opportunistic infections

## Anti-HIV drugs

### Tenofovir and atazanavir associated with kidney disease

The most widely used nucleoside reverse transcriptase inhibitor (NRTI) and the most widely used protease inhibitor (PI) are both associated with chronic kidney disease, the conference heard.<sup>1</sup>

Investigators from the EuroSIDA cohort looked at creatinine measurements from the blood of 6843 patients (creatinine is a waste product, high levels of which in the blood indicate kidney dysfunction).

More than one high measurement of creatinine, more than three months apart, was defined as chronic kidney disease. During the study, 225 participants progressed to chronic kidney disease, an incidence rate of 1.1% a year. This increased over time, from 0.5% after the first year to 4.5% after four years.

Patients taking tenofovir had a 16% higher risk of developing chronic kidney disease than other patients, and patients taking atazanavir a 21% higher rate.

## Anti-HIV drugs

### 'Quad pill' may outclass *Atripla*

A four-drug combination pill manufactured by the pharmaceutical company Gilead performed at least as well against HIV as the three-drug pill *Atripla* (tenofovir/FTC/efavirenz), the conference heard. As well as tenofovir and FTC, the pill contains two new drugs: a new integrase inhibitor, elvitegravir, and a new booster drug, cobicistat, which is used to raise the levels of elvitegravir in the blood to therapeutic levels. The protease inhibitor (PI) ritonavir is already

used this way, but cobicistat is the first drug designed specifically as a booster, with no anti-HIV activity of its own.

In a trial, 90% of patients taking the four-drug combination achieved a viral load under 50 copies/ml, compared with 83% taking *Atripla*. This result doesn't prove the elvitegravir combination is better than *Atripla*, but it's certainly not worse. The difference in performance appeared mainly to be due to the side-effects of the efavirenz in *Atripla*, with 57% of people taking it reporting side-effects versus 35% on the quad pill.<sup>1</sup>

In a separate study, cobicistat performed as well as ritonavir when combined with the PI drug atazanavir.

## HIV testing

### Frequent testing may be bringing down HIV rates in San Francisco

San Francisco has promoted HIV testing so well that only one in seven people with HIV are undiagnosed. The conference heard that the number of HIV diagnoses nearly halved between 2004 and 2008, and it is estimated that the number of new infections declined by a third between 2006 and 2008.<sup>1</sup>

More than half of all people in the city who have HIV, including the undiagnosed, now have a viral load under 75 copies/ml, and the mean viral load in the HIV-positive population declined from 23,000 in 2005 to 15,000 copies/ml in 2008.

This has been achieved because nearly three-quarters of San Franciscans who have tested for HIV do so at least annually, and over half every six months.

Dr Julio Montaner from British Columbia in Canada told the conference that there were early signs that more testing was producing falls in so-called 'community viral load' there too. He estimated that the proportion of HIV-positive people in the province with a viral load over 500 copies/ml fell from 65% in 2003 to 41% in 2008. This had primarily been achieved amongst a particular population of injecting drug users in Vancouver.<sup>2</sup>

## Treatment access

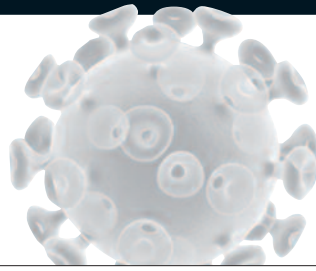
### Late starting leads to deaths in Africa

People starting HIV therapy in Africa are still at a very high risk of death because they often start treatment too late, the conference heard. In a presentation from Free State Province in South Africa, the conference heard that nearly a quarter of patients eligible for HIV therapy died while on the waiting list. Half of the 15% who had a CD4 count below 50 cells/mm<sup>3</sup> when enrolled died while waiting.<sup>1</sup>

The study called current treatment criteria into question. Currently patients have to have a CD4 count under 200 cells/mm<sup>3</sup> to be entitled to HIV therapy. The conference heard that the CD4 count in a group of patients with an average count of 260 cells/mm<sup>3</sup> had fallen to 101 cells/mm<sup>3</sup> when measured again six months later, putting them in considerable danger.

In a separate study,<sup>2</sup> researchers from the DART trial in Uganda and Zimbabwe found that within a year of starting treatment, 78% of patients had not achieved a CD4 count over 350 cells/mm<sup>3</sup> and nearly half had not reached 200 cells/mm<sup>3</sup>. The average CD4 count in patients starting therapy was 86 cells/mm<sup>3</sup>. Five years later, only one in five patients had achieved a CD4 count over 500 cells/mm<sup>3</sup>. DART is a large trial investigating the benefits of putting

For more coverage see  
[aidsmap.com/croi2010](http://aidsmap.com/croi2010)



patients on standard drug regimens with minimal monitoring. Its usual regimen is tenofovir/AZT/3TC, but patients are only switched from this when they develop an AIDS-defining illness or a CD4 count below 100 cells/mm<sup>3</sup>.

### Treatment as prevention

## HIV treatment could prevent nine in ten infections

The efficacy of HIV treatment in preventing infection between long-term, serodiscordant heterosexual partners is at least 90%, the conference heard.<sup>1</sup>

The Partners in Prevention study in Africa tried to see if HIV transmission in long-term heterosexual relationships could be prevented by treating herpes. This did not work, but during the trial 10% of the HIV-positive partners started HIV treatment.

There were 152 new infections in the HIV-negative partners in the study, of which 108 came from their primary partner. Only one of these infections came from someone on treatment, and he had only started HIV drugs 18 days before his partner tested HIV-positive.

This result implied that the rate of transmission from an HIV-positive partner was reduced from 2.25% a year to 0.39% a year when they started treatment: a 92% fall in the likelihood of infection.

Another important finding from this study was that partners with CD4 counts under 200 cells/mm<sup>3</sup> were five times more likely to transmit HIV than others.

Presenter Deborah Donnell said that trials were ongoing which should be able to establish whether HIV treatment can also reduce infection between gay couples.

### Brain impairment

## Drugs that penetrate brain help with dementia

HIV drugs that penetrate the brain more efficiently produce superior results both in reducing neurocognitive impairment symptoms and by reducing the amount of HIV in the brain and cerebrospinal fluid (CSF).

Researchers from the large CHARTER study of brain impairment told the conference that symptoms of neurocognitive malfunction such as memory loss, poor concentration and slowed reactions were detectable in psychological tests in the majority of patients (52%), and 15% had symptoms that interfered with daily life. Impairment was more likely in patients who had had very low CD4 counts in the past.<sup>1</sup>

The absolute CSF viral load was not associated with having brain impairment symptoms, but having a CSF viral load higher than in blood was.

In another study from Italy, doctors found that patients on drugs that penetrated the blood-brain barrier had fewer impairments of verbal skills and symbolic thought.<sup>2</sup>

The drugs with the highest brain penetration include AZT (zidovudine, *Retrovir*) and nevirapine (*Viramune*); amongst those with the lowest is one of the most commonly used, tenofovir (*Viread*). However in a test-tube study in which rat nerve cells were cultured with HIV drugs, researchers found that some of the drugs that penetrated the brain well were also amongst the most toxic to nerve cells.

This may explain why treating HIV in the brain does not produce more dramatic reductions in brain impairment symptoms.

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# too much pressure: the *HIV in Mind* survey

According to a survey recently conducted on our website, [aidsmap.com](http://aidsmap.com), four out of five people with HIV have suffered from depression. *Gus Cairns* reports.

When we agreed to host a survey, *HIV in Mind*, sponsored by the drug company Boehringer Ingelheim and the consultancy Huntsworth Health last year, we knew we'd get results that should be of concern to healthcare workers. Other UK surveys such as *What do you Need?*<sup>1</sup> have found that people with HIV had very high rates of emotional problems.

We weren't expecting how common they would prove to be, however. The survey showed that the vast majority – 87% of the sample – considered themselves to be suffering or have suffered from one of a list of pre-defined mental health problems.

By far the most common of these were depression, experienced by three-quarters of all respondents, and anxiety, suffered by two-thirds. Sixty per cent of all respondents had at some point had suicidal thoughts, and startlingly, 23% had actually attempted suicide at some time in the past, though – in one of the few positive findings – only a handful felt actively suicidal now.

These are even higher figures than reported from other surveys, and might be because people with mental health issues were more interested in answering it.

It was also asking people to self-diagnose. However, although the survey asked about respondents' own view of their mental state, 88% of those with depression and three-quarters of those with anxiety problems had had their condition formally diagnosed by a doctor or psychiatrist.

The reason for these states of distress? Although bereavement, relationship break-up, rejection, stigma and poverty all played their part, the most common

reasons cited for feeling depressed and/or anxious were loneliness and isolation.

This is despite the fact that half the respondents were in a relationship, and that most had disclosed their condition to family and friends. (In one intriguing finding, a high proportion said that disclosing to family and friends had contributed to depression and anxiety – while even more said *not* disclosing had.) It appears that for a lot of people with HIV, being 'lonely in the crowd' is a big issue.

## The people

The survey was a relatively small one, answered by 318 people, so fine analysis of subgroups is not possible. A link to the 20-minute survey was put up on [aidsmap](http://aidsmap.com) between June and October last year.

Most of the people who replied were male (87%), white (86%) and gay (76%). Sixty-three per cent were employed; 21% said they were either unemployed or "could not work due to health issues".

Half of them were in a relationship, including 7% married and 10% in a civil partnership. The mean age was 40, ranging from 18 to 70, with one in five respondents under 30.

Although a quarter of the male respondents had had no sexual partners last year and a third only one, a sizeable majority (11%) had eleven or more partners. Two-thirds of the minority of female respondents had had no sexual partner last year, and none had more than one partner.

This was a quite recently diagnosed group. The majority of respondents had been diagnosed since 2000, and a quarter

in the last two years (11% in 2009 alone). Three-quarters of them were on HIV treatment. Two-thirds had changed treatment at least once. By far the most common reason for changing treatment was drug side-effects: two-thirds said they'd changed for this reason, and 42% said drug side-effects had contributed to poor mental health. Much less important were treatment failure (19%), drug interactions (9%) and adherence problems (5%).

## The conditions

Depression and/or anxiety were experienced by a large majority of the respondents. Other conditions people were asked if they had suffered from included post-traumatic stress disorder (PTSD). One in six respondents considered they had this, of whom less than half had a formal diagnosis. Fourteen per cent thought they had bipolar disorder ('manic depression') of whom half had been diagnosed; 11% said they self-harmed, of whom 64% had been diagnosed. Some people also had rarer conditions like schizophrenia.

People could self-diagnose with more than one condition and indeed the majority had two (41%) or more than two (27%) conditions. People with only one condition were more likely to see their condition as liveable with and less likely to have sought help.

For the most common conditions, patients related their depression or anxiety strongly to HIV diagnosis and even more strongly to starting treatment. For instance, a quarter of those with depression said they had had it before their diagnosis; just under a third said it was set off by diagnosis; and 45% said it didn't start till they started treatment. Results for anxiety were the same.

Being diagnosed was cited as the most common contributor to mental ill-health by respondents, with 70% saying it had set off problems or made them worse. Forty-two per cent cited coping with side-effects as a contributor, sexual problems were also mentioned and, as we said above, there were contradictory results about whether disclosing or not disclosing was more stressful.

In fact only 6% of the group had told no-one at all about their HIV. Half had told close family and friends, and 15% had told 'everyone'. People who said they'd told everyone were mainly in the older age group.

### Quality of life and stressors

People were asked if they had experienced a number of stressful life situations and events and whether this was just in the past, or currently. These included loneliness, relationship break-up, bereavement, illness, discrimination, housing problems, violence, sexual abuse, drink and drugs, and immigration problems. Most of these issues were much more likely to be experienced by people with a greater number of mental health problems.

Loneliness and isolation were by some way the most significant stressors, suffered by three-quarters of respondents, and even 35% of those with no mental health issues. People felt that loneliness and isolation were worse now than they had been in the past. Relationship breakdown and suicidal thoughts had been suffered by about 60% of respondents each, and bereavement by 40%. Worryingly, actual suicide attempts had been made by nearly a quarter of respondents, and even by 5% of those with no mental health issues.

But these attempts were mainly in the past: only 3% said they had attempted suicide recently.

Another worrying finding was that a third of respondents said they suffered from memory loss, and in most cases (26%) this was current, rather than in the past.

Some issues were more strongly associated with high mental ill-health scores than others. For instance loneliness was three times more likely to be experienced by people with four or more mental health problems than



## The reason for these states of distress? The most common reasons for feeling depressed or anxious were loneliness and isolation.

those with none, suicidal thoughts six times more, and suicide attempts 13 times more.

### Seeking help

Most people had sought help or information about their mental health issues: only 8% had sought no help at all and another 7% had restricted it to non-personal methods such as internet research and information leaflets. Sixty per cent had sought out a counsellor, psychotherapist or psychiatrist, 55% had consulted their HIV physician and 50% their GP. Younger people tended not to talk to medical doctors about it, and very few under 30 had approached their GP.

When healthcare workers were approached, they referred patients to a counsellor or psychotherapist 60% of the time, prescribed medication such as antidepressants 54% of the time, and referred them to their mental health hospital team in 43% of cases. Eleven per cent of respondents said their

healthcare worker had done nothing when they mentioned emotional problems.

In terms of commonly used resources, GPs were seen as amongst the least useful, with only half the respondents thinking their GP had helped. Counsellors and psychotherapists were the most useful, with 80% finding them useful. Sources of help used by fewer people that were helpful were HIV nurses and, for the 6% that used them, churches and religious resources. Mental health support groups were not felt to be useful, possibly because of stigma and minority issues.

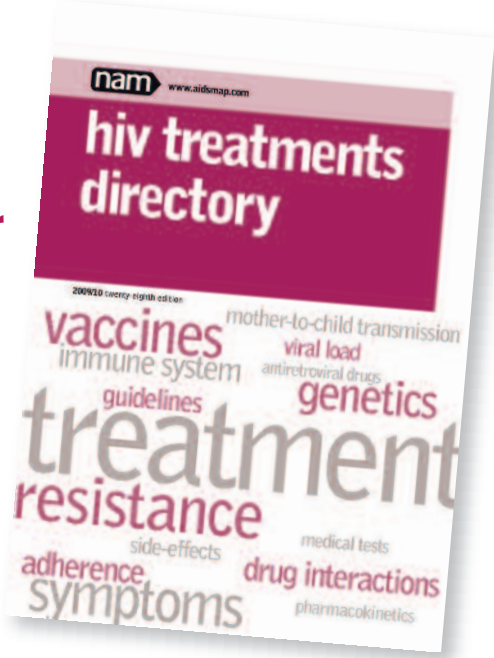
Fifty-six per cent had done some internet research or sought out online support, of which roughly two-thirds each had used the Terrence Higgins Trust and aidsmap websites (aidsmap was favoured by older people), and one-third HIV i-Base. They had also used a variety of non-HIV-related sites.

Not surprisingly, 92% of respondents said more information and support on mental health was needed, especially information on how HIV may contribute to mental health problems and general information on how to cope with mental distress.

Although depression and anxiety are very common conditions, affecting respectively one in three and one in four of the general UK population at some point in their lives,<sup>2</sup> the rates revealed in this survey are far in excess of those seen in the general population. They remind us that we have a long way to go before HIV becomes something people take in their stride. ■

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- **THT Direct**  
Offers information and advice to anyone infected, affected or concerned about issues relating to HIV and sexual health.  
**0845 1221 200**  
Mon-Fri, 10am-10pm Sat-Sun, 12pm-6pm
- **i-Base Treatment Phonenumber**  
An HIV treatment phonenumber, where you can discuss your issues with a treatment advocate.  
**0808 8006 013**  
Mon-Wed, 12pm-4pm