

Suicidality is common among HIV infected people in Estonia and is associated with lack of psychological help

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INTRODUCTION

In the era of antiretroviral therapy, suicide ratio for people living with HIV (PLHIV) is still more than three times higher compared to the general population¹. Suicidality is mostly associated with psychiatric disorders and history of drug abuse¹. Usually suicidal PLHIV have developed a psychiatric disorder after being diagnosed with HIV³.

Yet the lessons from general mental health on targeting and prevention of suicidality have not been fully transferred to the HIV field as to there are scarce interventions².

The aim of this study was to explore suicidality among PLHIV in Estonia. It was hypothesised that suicidal people have not got the help they had felt the need for.

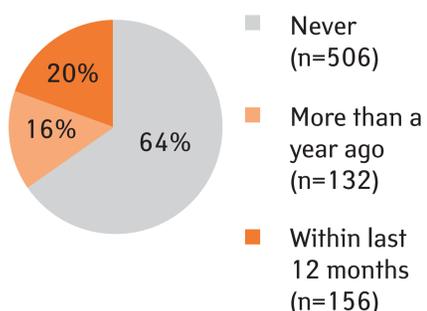
METHODS

PLHIV in care from 3 outpatient clinics (Tallinn, Ida-Viru, Narva), around which the epidemic is concentrated, participated in a cross-sectional study. Eligibility criteria were age 18+ years, speaking Estonian/Russian, aware of HIV status for at least 3 months, not pregnant, not under the influence of drugs or alcohol. A structured questionnaire filled in by the participant included questions on socio-demographic characteristics, quality of life, mental health, substance abuse, sexual behaviour, HIV treatment and usage of services aimed at PLHIV. For this poster, answers to suicidal ideation (Have you ever thought about suicide?), suicide attempt (Have you ever tried to commit suicide?), need and usage of psychological help within last 12 months were analysed.

RESULTS

800 PLHIV participated in the study (9% of people diagnosed with HIV in Estonia). Mean age of participants was 34.0 (SD=7.6), and 58.9% were male (n=471), of whom 10.2% (n=48) had had sex with a man. Mean time since contracting HIV was 8.3 (SD=3.7) years. 67.5% had a history of drug injection (n=539), and 53.3% (n=400) of alcohol abuse (CAGE≥2).

Suicidal Ideation



Suicide Attempt

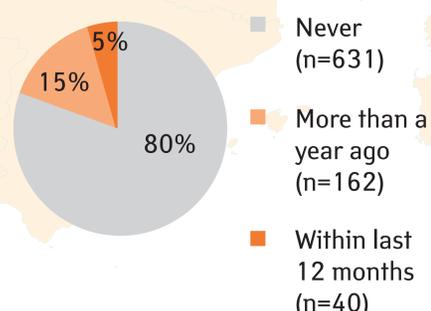


Figure 1. Suicidal ideation during lifetime among PLHIV. Figure 2. PLHIV who had ever attempted suicide.

Table 1. Need and usage of psychological help among PLHIV who have been suicidal within last 12 months compared to those who have never been suicidal.

	Never (N=485)			Suicidal ideation (N=156)			Suicide attempt (N=40)		
	n	%	χ^2	n	%	χ^2	n	%	χ^2
Psychological counselling									
Felt need, got	52	12		29	22		9	26	
Felt need, did not get	79	18		50	39		12	34	
Felt no need, got	2	1		2	2		0	0	
Felt no need, did not get	293	69		48	37		14	40	
Data missing	59			27			5		
Psychotherapy									
Felt need, got	15	4		19	15		4	12	
Felt need, did not get	35	8		32	25		9	27	
Felt no need, got	4	1		5	4		2	6	
Felt no need, did not get	366	87		74	57		18	55	
Data missing	65			26			7		

Note. ** $p < .001$, * $p < .01$

- PLHIV who felt a need for counselling but did not get it were 3.7 times more likely to have been suicidal within last year compared to those who did not need it and did not get it (OR $p < .001$, 95% CI 2.4 to 5.7).
- PLHIV who felt a need for psychotherapy but did not get it were 4.7 times more likely to have been suicidal within last year compared to those who did not need it and did not get it (OR $p < .001$, 95% CI 2.8 to 7.7).
- No significant statistical difference emerged between PLHIV who needed help and got/did not get (counselling, psychotherapy) in relation to suicidality.

DISCUSSION

Suicidality is a common problem among PLHIV in Estonia. We found that suicidality is higher among those who felt the need for psychological help but did not get it, as compared to those who felt no need and did not get it. There is still considerable proportion of suicidal people who do not feel they need psychological help. These findings accentuate the need to make psychological help better available and accessible to this highly stigmatised population.

References

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