

# Letters to the Editor

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## Tuberculosis and HIV among Mentally Ill Men in a New York City Shelter

The current spread of tuberculosis in New York City has been linked to both the human immunodeficiency virus (HIV) epidemic and homelessness.<sup>1,2</sup> Recent reports indicate that homeless mentally ill individuals, particularly men, are at high risk for HIV.<sup>3-5</sup> Effective tuberculosis control will require specifically targeting hard-to-reach groups, such as these men, that otherwise may remain a focus for its spread. However, no study has reported on the prevalence of tuberculosis or its relationship to HIV in this population. Therefore, we extended our previous investigation reported in this journal, which established a 19% HIV prevalence in a sample of mentally ill shelter users, to address this issue.

The present investigation was conducted at a shelter that accommodated

**TABLE 1—Tuberculosis Prevalence among HIV-Positive Men (n = 12) Discharged from a New York City Shelter to Community Living: 1990 through 1992**

Tuberculosis Test	Total	Positive		Negative		Inconclusive	
		No.	%	No.	%	No.	%
Purified protein derivative test	12	9	75	0	0	3	25
Chest x-ray	12	6 <sup>a</sup>	50	6	50	0	0

<sup>a</sup>One case of extrapulmonary tuberculosis.

between 600 and 1000 men. It involved all 90 men discharged to community living by the on-site mental health program between 1990 and 1992. They were offered purified protein derivative testing, and all of those tested (85) were referred for chest radiographs and accompanied to their appointments.

We systematically reviewed their charts. Tuberculosis data were rated by a medical doctor not involved in the patients' treatment. The vast majority of the men were African American and Latino (77% and 16%, respectively) and were younger than 40 (85.5%). The predominant diagnosis was schizophrenia (65.6%). Most of the patients had a comorbid diagnosis of drug (66.6%) or alcohol (53.3%) abuse. In terms of purified protein derivative testing, 33 men (36.7%) were positive (indurations of 10 mm or greater), 42 (46.6%) were negative, 10 had (11.1%) inconclusive results (indurations between 5 mm and 10 mm), and 5 refused (5.5%). Radiographs completed by 77 men, including all patients with positive and inconclusive purified protein derivative tests, documented six cases of active tuberculosis (6.7%), including one in a patient whose purified protein derivative test had been interpreted as inconclusive.

(All of these men were referred for tuberculosis treatment.)

As previously reported, 12 individuals tested positive for HIV; none had an acquired immunodeficiency syndrome (AIDS) diagnosis at the time.<sup>1</sup> Nine of these men (75%) had positive purified protein derivative test results, and 3 had inconclusive results (25%). On radiographs, 6 showed active tuberculosis (50%), representing all active tuberculosis cases in this sample. One was an extrapulmonary tuberculosis case.

In summary, there was a high prevalence of tuberculosis infection among these men (36.7%). All 12 HIV-positive men were positive or inconclusive on purified protein derivative testing, and 6 had active tuberculosis, accounting for all cases in the study. These data suggest that crowded shelter living puts HIV-infected mentally ill men at a particularly high risk for tuberculosis.

Our field experience and recent reports<sup>6</sup> indicate that active tuberculosis has decreased in this population since the time of the study. However, overall tuberculosis infection and HIV prevalence remain high among these men,<sup>4</sup> and the potential for the resurgence of active tuberculosis remains. Our findings argue

for the rapid development and implementation of tuberculosis and HIV preventive interventions targeted to these men. □

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## Needle Exchange Programs: New Zealand's Experience

In his annotation "Needle Exchange Programs—Do They Work?," Coutinho tested the "efficacy" thesis and found it wanting; he wrote that an Amsterdam study "yielded no evidence overall that the syringe exchange program was protective [in the case of the human immunodeficiency virus—HIV—and other diseases]."<sup>1(p1491)</sup> Contrary to Coutinho's equivocal conclusion about the efficacy of needle exchange programs in Amsterdam

and one in Tacoma, Wash, my assessment is that needle exchange programs work if there is sufficient conceptual clarity and political will.

A compelling example is New Zealand, where a nationwide needle exchange program was implemented in 1988. New Zealand's rate of HIV seropositivity among injection drug users is low; a national study found that 3 of the 393 (0.8%) men and none of the 190 women using the needle and syringe exchange scheme in New Zealand were infected.<sup>2</sup> The researchers for this sentinel study did not rely on self-report procedures. Rather, they tested saliva samples obtained from each exchange site.<sup>3</sup> In addition to negligible rates among individuals who anonymously volunteered saliva samples for testing at exchange sites, official health statistics indicate low infection rates among a broader population of injection drug users. Twelve injection drug users have been diagnosed with the acquired immunodeficiency syndrome (AIDS) since 1987.<sup>4,5</sup> HIV seropositivity for injection drug users has been listed at around four to six cases a year since the first case was notified in 1987.

The figures do not suggest a decline in the protective qualities of needle exchange programs, as suggested by Coutinho.<sup>1</sup> Rather, the data indicate that needle and syringe exchange programs work when (1) there is active government and intersectoral support for such programs; (2) coverage is extensive; (3) nonjudgmental services and referrals are offered by peers; (4) there is a holistic approach to disease prevention; and (5) police activity around needle exchange sites is kept to a minimum.

These data also suggest that needle exchange has become a harm-reduction "habit" for many of New Zealand's injection drug users. Coutinho wrote that the Amsterdam program was "introduced without any political interference and discussion, probably because it fitted well within Amsterdam's public health-oriented drug policy and the concept of harm reduction."<sup>1(p1490)</sup> New Zealand's response to HIV in general was enacted after public and parliamentary debate, but needle exchange was similarly aligned to harm-reduction (known locally as "health promotion") policies. Evaluations of needle exchange have not been sought, undertaken, or proposed. The public has not expressed concern about the effects of needle exchange, nor have politicians, moralists, or antidrug campaigners raised objections in any significant way since the

issue was first raised in 1986. Media coverage of injection drug use is rare; more attention is given to the existence of juvenile glue-sniffers and marijuana users. In the absence of the familiar US "war against drugs" rhetoric, the program is judged to work because it provides injection drug users with the means (and encouragement) to keep disease at bay. □

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## The Important Contribution of Community Mental Health Workers

In their recent commentary, Witmer et al. called attention to the role and usefulness of the community mental health worker in a health care system.<sup>1</sup> The extensive bibliography dating to 1970 lists one reference to mental health.<sup>2</sup> In 1972, the Journal published an article<sup>3</sup> describing the roles and advantages of using community workers in mental health that are very similar to those proposed by Witmer. In the early 1960s, the National Institute of Mental Health funded a training program for nonprofessional workers (counselors).<sup>4</sup>

The community mental health profession of the past 25 years has had much experience with using community workers and can contribute to promoting their use. Also, this letter may serve as a reminder that mental health is an integral part of