**Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's telephone and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to the authors for possible reply. Send letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.**

## Rates of HIV Infection Among Probationers and Parolees With Mental Illness

***To the Editor:*** Rates of HIV infection among people with severe mental illness have been found to range from 4 percent to 23 percent, with an average rate of 8 percent (1,2). The highest rates in this population were found among those in inpatient settings for the treatment of comorbid psychiatric and substance use disorders (18.4 percent) and among those in homeless shelters (19.4 percent) (3). We examined rates of HIV infection among probationers and parolees with severe mental illness, most of whom were serving all or part of their sentence under community supervision.

During eligibility screening for a study to examine reincarceration of probationers and parolees with severe mental illness, participants were asked if they had ever been tested for HIV. Participants who had been tested were asked about their test results. Of those screened, 254 met diagnostic criteria for schizophrenia and major affective disorders as assessed by the Quick Diagnostic Interview Schedule (4). Two-thirds of these participants (163, or 64 percent) were African American, 59 (23 percent) were white, and the remaining 32 (13 percent) were Hispanic, Asian, mixed, or other. A total of 186 (73 percent) were men. The mean±SD age of the sample was 34.7±9.1 years. More than half (150 participants, or 59 percent) had never married. The mean±SD number of years of education was 11±2.4. The median lifetime number of lifetime arrests was four.

Eighty-three percent (N=212) knew their HIV status, and 11 of these participants (5 percent) reported being HIV positive. Among the 23 participants who were homeless, four (17 percent) reported being HIV positive. Women had the lowest rate of infection; only one of 56 women who knew their HIV status (less than 2 percent) reported positive test results. The infection rate among the 55 men and women who reported exchanging sex for money or substances —four persons, or 7 percent—was slightly higher than the rate for the overall sample.

These findings provide further evidence for the validity of current estimates of high rates of HIV infection among persons with severe mental illness. This population is at a particularly high risk of infection because of its high rates of comorbid substance abuse, homelessness, and sexual risk behaviors. More efforts are needed to implement HIV prevention education. Probationers and parolees with severe mental illness are frequently mandated to receive treatment from mental health agencies in lieu of incarceration. Unfortunately, most mental health agencies do not actively address HIV issues (5). Mental health providers need training and education in HIV prevention to increase their skills and comfort in dealing with HIV issues and to help prevent transmission.

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## Insight and Disability

***To the Editor:*** In "Mental Illness and Changing Definitions of Disability Under the Americans With Disabilities Act" in the May issue (1), attorneys Petrila and Brink illustrate well how the U.S. Supreme Court's 1999 amendment to the Americans With Disabilities Act (ADA) has affected the ability of persons with disabilities to meet criteria for protection under this act. The amendment required that illnesses contributing to disabilities be evaluated in their "corrected state." The authors not only provided an excellent synopsis of the ADA and its history but also described important issues raised for persons whose disabilities are the result of mental illness.

However, the authors failed to comment on the unique contribution of insight—and lack thereof—in the treatment and management of mental illness. They point out that persons with mental illness may refuse to take medications because of actual or perceived adverse effects. Individuals who refuse medications may fail to experience the corrected state of their illness. They may therefore continue to be disabled yet be denied ADA protection. However, a

primary reason for refusing to take medications is the patient's denial of illness and lack of insight into the need for medication and treatment. This aspect of mental illness makes the recent amendments to the ADA most discriminatory to the mentally ill population.

***Judy Sigmund, M.D.***

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### *Reference*

1. Petrila J, Brink T: Mental illness and changing definitions of disability under the Americans With Disabilities Act. Psychiatric Services 52:626–630, 2001

***In Reply:*** Dr. Sigmund makes an excellent point. If a person with mental illness declines to take medication because of a lack of insight into the illness, the person may not qualify for ADA protection because he or she has not taken corrective action. Thus the illness itself may lead to behavior that disqualifies the person from the ADA's coverage. This is a paradoxical result, to say the least, given the intent of the ADA and, as a practical matter, penalizes the person for having a mental illness.

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## Telepsychiatry in a Rural Inpatient Setting

***To the Editor:*** The treatment of psychiatric patients in rural areas has benefited from the improvement of telepsychiatric services (1,2). Many factors make psychiatry and telemedicine a successful marriage, including the ability to assess mental status, symptoms, and most side effects effectively by listening to, talking to, and observing the patient (3,4).

Although telepsychiatry is becoming more established and accepted in the treatment community (5), it has generally been used with patients who are stable and relatively asymptomatic. Telepsychiatry could bring additional benefits to treatment if it could be used more widely to provide services to those who are unstable or in distress. Patients who are experiencing an exacerbation of symptoms or changes in their mental status could use this technology to communicate with their physician to discuss treatment options or changes in their medication regimen. Because few studies have included mentally ill patients with active and severe symptoms, we wanted to investigate attitudes toward telepsychiatry in a group of patients served in a rural acute care psychiatric facility.

A total of 35 patients—16 women and 19 men—who were involuntarily committed were seen by their treating physician over Mountaineer Doctor Television (MDTV), a telemedicine service provided jointly by the West Virginia University School of Medicine and the state of West Virginia. The patients were usually seen face-to-face by their physician. Immediately after the telecommunication session, they were asked their opinions of the experience in a series of questions.

Twenty-seven patients (77 percent) felt that the physician understood them as well as or better than usual through MDTV. Twenty-two (63 percent) felt that the MDTV system was the same as or better than having their physician in the room. Only five (14 percent) stated that they would be generally unwilling to use the MDTV system again.

An interesting finding was that patients who had mania or hypomania were significantly more likely than those who had psychotic or depressive disorders to report a positive experience with MDTV. Wilcoxon Mann- Whitney exact tests revealed that patients who had mania were more likely to feel that their physician understood their needs better using MDTV ($S=201$; $z=2.37$; $p=.014$). The patients with mania were also more likely to state that the MDTV experience was better than having a physician in the room, but this difference was not significant.

These initial findings in an acutely ill psychiatric population are encouraging for two reasons. First, the findings indicate that inpatients are willing to use the technology with their treatment providers. Its use allows treatment providers to be in contact with patients even when the providers are required to be away from the hospital. Thus providers can serve in a number of different settings more effectively. Second, the findings have many implications for monitoring patients in an outpatient setting and for use in emergency care. The results suggest that patients may be willing to use this technology when they are entering an active phase of their illness and when their symptoms are worsening. Given these findings, we recommend that rural clinics take greater advantage of telepsychiatry with patients who have acute symptoms and that they explore ways of using this technology for early detection of psychiatric distress.

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## Recognizing and Managing "Illy" Intoxication

***To the Editor:*** "Illy" or "fry," a combination of marijuana, phencyclidine (PCP), and embalming fluid, is portrayed on the streets as super-marijuana. Although the prevalence of marijuana use is stabilizing, it is frequently used in combination with other drugs (1). A significant increase in the use of PCP and PCP-combination products has been noted in emergency departments (2). Several states, such as Connecticut (3) and Texas (4), have initiated studies of illy use and have formed task forces to curtail its spread. In this letter we describe the pharmacology, presenting symptoms, and management of illy intoxication.

Four pharmacological agents may be active in illy: tetrahydrocannabinol (THC), PCP, formaldehyde, and embalming fluid. (Embalming fluid is composed of formaldehyde, methanol, ethyl alcohol or ethanol, and other solvents.) Other relatively inert agents like mint or parsley may be added to improve taste. Both PCP and THC have reinforcing effects, and embalming fluid may enhance their absorption by slowing the rate at which the marijuana burns (3). Whether the substances interact or have synergistic or addictive effects is unclear.

The clinical picture of illy intoxication is derived primarily from observations in emergency settings. Like PCP, illy induces hallucinations, psychomotor agitation, impaired judgment, and intermittent violence. Cognitive deficits, such as an inability to recall violent acts, may also be noted. Physical symptoms may include autonomic arousal, dry mouth, ataxia, and numbness (3).

The acute symptoms of illy intoxication usually subside in 24 to 36 hours, but the course may vary, depending on the half-lives of the drugs used in a particular illy mixture. Both PCP and THC can be stored in fats and then released, causing recurrence of symptoms. Although the long-term effects of illy are unknown, cognitive deficits may persist (4).

Because multiple drug use and psychopathology are common among substance abusers, diagnosis of illy intoxication can be challenging. Blood or urine specimens may confirm use of THC and PCP, but they do not detect all components of illy. Therefore, the diagnosis is based on self-report of illy consumption, a consistent clinical presentation, and exclusion of intoxication from other drugs and psychiatric disorders.

Treatment should focus on minimizing aggressive behaviors and monitoring medical complications. Illy users seem to be particularly susceptible to environmental stimuli, a factor that may pose significant challenges in busy emergency departments or in jail settings.

Short-term pharmacological treatment strategies include use of benzodiazepines and antipsychotics (3). Although benzodiazepines lower the seizure threshold and may prevent PCP-induced musculoskeletal complications, they may also exacerbate behavioral disinhibition. Antipsychotics, in addition to their standard adverse effects, may also cause rhabdomyolysis, which is also associated with PCP use. Nevertheless, haloperidol and droperidol have been used to manage aggression among users of illy.

Use of illy appears to be a growing public health concern. No empirically based guidelines for managing illy intoxication are available, but both benzodiazepines and antipsychotics may be helpful as long as the patient is monitored for potential drug interactions and medical complications.

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## Submissions Invited for Frontline Reports Column

*Psychiatric Services* invites contributions for Frontline Reports, a column featuring short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings.

Text should be 350 to 750 words. A maximum of three authors, including the contact person, can be listed; one author is preferred. References, tables, and figures are not used. Any statements about program effectiveness must be accompanied by supporting data within the text.

Material to be considered for Frontline Reports should be sent to the column editor, Francine Cournos, M.D., at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032. Dr. Cournos is director of the institute's Washington Heights Community Service.