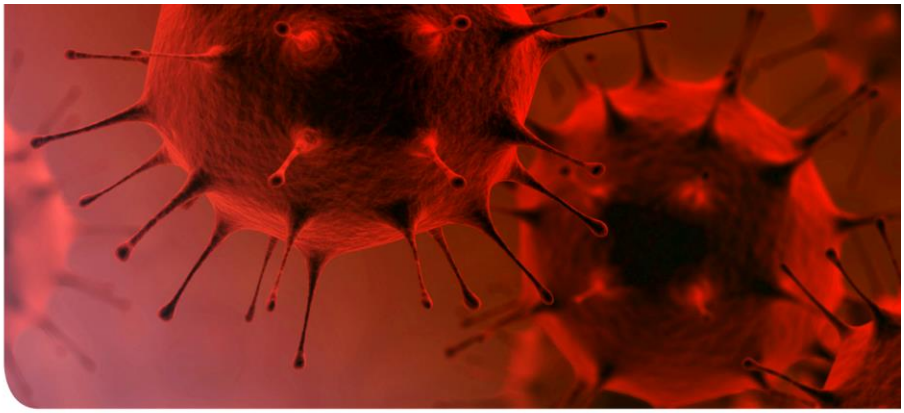

HIV in Aboriginal Community: a case study

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Introducing Cheryl

- 48yo urban Aboriginal woman diagnosed with HIV 12 years ago in context of IVDU, on treatment for past 8 years, generally undetectable viral load
- Significant comorbidities: diabetes, (pseudo)psychotic episodes/PD/PTSD, long history of HCV
- Admissions to hospital for mental health respite & acute episodes, diabetic management, sepsis
- Well connected in local Aboriginal community although not close family
- Minimal resource security – housing, food, transport, etc
- Intellectual impairment ?ABI ?FASD - State Trustees appointed
- Three adult children all removed as infants, minimal contact with one daughter

Clinical

HIV
- on ART, daily pickup from ACCHO pharmacy
- primary care team - GP, BBV Nurse, AHW
- hospital-based HIV specialist service
- HIV Physician available for secondary consult anytime
- attends hospital review 6/12ly with ACCHO support

Diabetes
- daily insulin, BSL range 12-30, has been resistant to administering her own insulin & monitoring BSL
- insulin administered by AHW/RN
- regular review & monitoring by DNE & GP
- also podiatrist, optometrist/ophthalmologist, dietician

Mental health/social & emotional wellbeing
- psychotic episodes in context of trauma/BPD/PTSD ?schizophrenia
- 2/52ly depot antipsychotic
- has periods of deterioration in mental state and general functioning, becomes intensely agitated, often loses housing during these times due to property damage, behaviours of people who visit, etc
- intermittent IVDU and other poly-substance use (amphetamines, benzos, benztropine, opiates)
- irregular admissions to Mental Health Unit x2-3/year, early in deterioration phase when possible

Other
- recently successfully-treated HCV, needs long-term HCC surveillance
- serious intercurrent illness eg pneumonia
- routine general health care including contraception, immunization, screening, dental care, etc

Who is involved in care?

Primary clinical team
- GP, BBV RN, AHW, DNE, case manager, pharmacist, mental health workers
- HIV specialist service
- Range of allied health

Key partners
- RDNS, homeless/housing services, AOD services
- Others eg justice system, financial services

What does it take to be effective?

- Engagement & trust - flexibility/accommodate preferences & messiness, case management/coordination, kindness, considering who else needs to be involved (family/significant others)
- Collaboration – client/patient, multidisciplinary team & partners
- Acknowledging competing priorities, often complex needs with limited stable resources
  - Environmental factors; housing/homelessness, poverty, social isolation, incarceration
  - Risk behaviours; sharing injecting equipment, sexual contact
  - Comorbidities
- Planning – to support agency, flexibility & continuity of care
- Care with privacy & confidentiality – transparency about who is involved
- Challenge of holding the *whole person* in sight and *hearing* them – needs, priorities, preferences

Other GP/primary care issues

- screening/testing
- initial notification
- contact tracing
- cluster/outbreak