Aims and Background

**Aim:** To describe the cohort of people accessing a community mental health service for patients with HIV and mental illness in South East London.

**Background:** We have developed a strong multidisciplinary collaborative team to explore the important but neglected area of the interface between mental health and HIV.

CASCAID is a unique community-based service in South East London, which provides care for people with HIV who have mental health issues. They receive referrals from medical teams, inpatient and community mental health teams. It does not accept referrals for patients who are homeless.

Our team has access to a new and extensive database of anonymised patient records, and to start our research we have selected the CASCAID cohort from these records and present their demographics.

**Method**

Clinical Record Interactive Search (CRIS) provides authorised researchers with regulated access to anonymised information extracted from the South London and Maudsley NHS Foundation Trust (SLaM) electronic clinical records. Data presented here describes adult CASCAID patients accessing CASCAID from January 2007 to May 2015. These patients are a subset of those accessing services for HIV and mental illness in South-East London, which has the highest rates of HIV infection in the UK (Public Health England 2014).

Where data was not available for a specific criterion, the patient was excluded from that analysis.

**Results**

We found 1696 adult patients who had been seen by CASCAID over this time. 1035 had a diagnosis coded by the CASCAID team. The primary diagnosis was a psychiatric diagnosis in 611 patients.

**Conclusions**

Baseline analysis of coded diagnoses in the CASCAID HIV/mentally ill population showed a largely male (67%), and predominately black or African population. Most males were white, and most females were black.

There was a large variety of coded ICD-10 diagnoses, however, this data was in general poorly recorded in the coded information. Depressive and adjustment disorders were the most commonly coded diagnoses.

**Discussion**

Coding was only available for limited demographic information, and this was incomplete in some cases. Information on sexual orientation was, for example, not collected.

For this reason our group intends to interrogate the “free text” data on CRIS of patient encounters using Natural Language Programming techniques to gain diagnostic, demographic, and comorbidity data. We believe that working with CRIS data will enable us to construct a large cohort of people living with HIV and SMI and will therefore provide an important contribution to the evidence base of this uncommon but potentially burdensome comorbidity.