HIV Mental Health Update

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Advances in HIV/AIDS Care: Challenges for HIV+ People with Mental Illness

Advances:

- HIV/AIDS is now a treatable chronic illness
- Antiretroviral medications keep expanding, creating new options for patients with rx failure.
- Antiretroviral rx is simpler and less toxic.

Challenge: HIV+ people with mental illness are overrepresented among those who are not on treatment.
Advances in HIV/AIDS Care: Challenges for People with Mental Illness

**Advance:** We are treating HIV infection much earlier. This is associated with improved medical outcomes and reduced HIV transmission.

**Challenge:** Most people are diagnosed with HIV infection too late, after HIV has already caused advanced immunosuppression. Both medical and mental health programs need to routinely offer HIV testing.

Advances in HIV/AIDS Care: Challenges for HIV+ People with Mental Illness

**Advance:** Much discussion is taking place about the appropriate use of PrEP (pre-exposure prophylaxis) as a prevention intervention among sexually active people with risk behavior.

**Challenge:** People with severe mental illness are often not included in the roll out of new approaches, although those who are sexually active are often exposed to unsafe sex.
Advances in HIV/AIDS Care: Challenges for HIV+ People with Mental Illness

• **Advance:** Cure of Hepatitis C (HCV), a common HIV-related co-morbidity and cause of death, is dramatically improving as new medications come on board (2 protease inhibitors in 2011, other medications on the way).

• **Challenges:** Studies are ongoing to clarify use of new HCV treatments in HIV+ people; Treatment of HCV still requires interferon, which can have severe psychiatric morbidity; Psychiatric patients are often discriminated against by HCV treatment providers.

Advances in HIV/AIDS Care: Challenges for HIV+ People with Mental Illness

• **Advance:** Many HIV programs increasingly strive to accommodate patients with severe psychiatric and substance use disorders.

• **Challenges:** Mental health services are often not sufficient; Health care reform may dismantle integrated disease-specific programs such as those for HIV; The mental health care system is ill equipped to handle HIV+ people.
Advances in HIV/AIDS Care: Challenges for HIV+ People with Mental Illness

- **Advance:** Very effective short-term psychotherapies are now available to treat anxiety disorders and mild-moderate depression (e.g. CBT, IPT).

- **Challenge:** These therapies are often not available in settings where HIV care takes place; problems include cost of training, poor reimbursement, poor dissemination, lack of priority.

Why Are Psychiatric Disorders Such an Important Concern among People with HIV/AIDS

Psychiatric Disorders Often Precede HIV Infection
Concentrated HIV Epidemics

- Subpopulations involved
  - Injection drug users (IDU)
  - Men who have sex with men (MSM)
  - Sex workers (SW)
  - Partners of the above three groups

Psychiatric Disorders Among Injection Drug Users (IDU)

Multiple studies of injection drug users demonstrate:

- Nearly universal opioid dependence
- Dependence on multiple other non-opioid substances (including alcohol) exceeding 50%
- Elevated rates of mood and personality disorders
Most studies of MSM show higher rates of the following disorders when compared to their heterosexual counterparts:

- Depression
- Anxiety disorders
- Alcohol and other substance disorders
- Suicide risk/Attempts

Sex-workers have elevated rates of physical and sexual traumas both during childhood and in the context of sex-workers. Physical and sexual traumas are risk factors for mental disorders.

Elevated rates of psychiatric disorders among sex-workers include:
- Substance abuse and dependence
- Suicide risk/Attempts
- PTSD and other anxiety disorders
- Mood disorders
Overlap among Vulnerable Populations
Example: Substance Use and Prostitution

• Burnett, et al studied 1,606 women and 3001 men entering substance use treatment across the U.S.

• Rates of self reported prostitution were:
  • Past year: 41% of women and 11% of men
  • Lifetime: 51% of women and 19% of men

• In both men and women, prostitution was associated with higher levels of mental health symptoms, injection drug use, and HIV infection


HIV Among People with Severe Mental Illness: Summary of U.S. Studies

◆ Rates of HIV Infection (2%-23%) > general population
◆ ↑ Rates of unsafe sexual behavior
◆ ↑ Rates of co-morbid alcohol/drug use
◆ Intermittent IDU:
  – 1%-8% recent
  – 4%-26% lifetime
◆ HIV Infection Rates by Type of Drug Use
  – Injected drugs 33.8%
  – Non-Injected drugs 15.4%
  – Alcohol only 10.9%
Prevention Opportunity?


Psychiatric Disorders are Common Among People Who Have HIV Infection
Neuropsychiatric Problems Are Common among HIV+ People

- Mood disorders
- Anxiety disorders
- Alcohol/Substance use disorders
- Psychotic illnesses
- Somatic problems: insomnia, pain, fatigue, sexual dysfunction, body habitus changes
- Neuropsychiatric disorders due to opportunistic diseases, medication side effects, HIV itself (neurocognitive disorders)

RAND HCSUS Study: 2,864 HIV+ Medical Patients in U.S.

- Probable Psychiatric Disorder: 48%
- Major depression 36%
- Dysthymia 27%
- Generalized anxiety disorder 16%
- Panic attack 11%
- Drug dependence 13%
- Problematic alcohol use 19%

Assessing Mental Status Changes in HIV + People

Look for underlying biological cause

1. Medications: HIV, psychiatric, other
2. Substances: Alcohol, drugs, herbal, other
3. Non-HIV medical problems
4. HIV-related illnesses:
   • CNS lesions, infections
   • Non-CNS medical problems

Psychiatric Syndromes

• HIV-associated Neurocognitive Disorders (HAND)

HIV Associated Neurocognitive Disorders

NIMH working group, Neurology 2007

♦ Asymptomatic neurocognitive impairment (ANI),
♦ HIV-associated mild neurocognitive disorder (MND)
♦ HIV-associated dementia (HAD)
♦ Milder impairment is under-diagnosed and may be present even when patients are otherwise well controlled (e.g., stable ARV regimen, undetectable viral load): To date, no consistent diagnostics or therapeutics are available for this problem.
Screening for Mental Disorders

Some Easy to Use Screening Tools: PHQ-2, PHQ-9 and GAD-7

- Readily available online at no charge
- Already translated into multiple languages
- Well studied in general medical populations
- Easy to administer or self administer
- Can be used to screen and/or make a diagnosis
- Can be used to follow patient’s progress
Over the last two weeks how often have you been bothered by any of the following problems:

- Little interest or pleasure in doing things.
  - 0 = Not at all
  - 1 = Several days
  - 2 = More than half the days
  - 3 = Nearly every day

- Feeling down, depressed or hopeless
  - 0 = Not at all
  - 1 = Several days
  - 2 = More than half the days
  - 3 = Nearly every day

If the score is 3 or more, move to the PHQ9.

Diagnostic Instrument for Depression:
PHQ9 – Items Rated from 0-3

- 1. Little interest or pleasure in doing things
- 2. Feeling down, depressed, or hopeless
- 3. Trouble falling or staying asleep, or sleeping too much
- 4. Feeling tired or having little energy
- 5. Poor appetite or overeating
- 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
- Trouble concentrating on things, such as reading the newspaper or watching television
- 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
- 9. Thoughts that you would be better off dead or of hurting yourself in some way
Diagnostic Instrument for Generalized Anxiety Disorder:
GAD-7 – Items Rated from 0-3

- 1. Feeling nervous, anxious or on edge
- 2. Not being able to stop or control worrying
- 3. Worrying too much about different things
- 4. Trouble relaxing
- 5. Being so restless that it is hard to sit still
- 6. Becoming easily annoyed or irritable
- 7. Feeling afraid as if something awful might happen

Questions to Identify PTSD

In your life, have you ever had any experience that was so upsetting, frightening, or horrible that you:

- Have nightmares about it or think about it when you do not want to?
- Try hard not to think about it or go out of your way to avoid situations that remind you of it?
- Are constantly on guard, watchful, or easily startled?
- Feel numb or detached from others, activities, or your surroundings?

References and more tools: www.hivguidelines.org
Screening for Hazardous Alcohol Use:
Audit-C Questionnaire

- There are 3 questions:
  - How often do you have a drink containing alcohol?
  - How many standard drinks containing alcohol do you have on a typical day?
  - How often do you have six or more drinks on one occasion?
- Each item is rated on a five-point scale used to identify hazardous alcohol use.
- The Audit-C is easily accessed online at no charge.

Screening for Substance Use:
Cage-AID (CAGE Adapted to Include Drugs)

Target Population: Adults and Adolescents > 16

- Have you ever felt the need to cut down on your use of alcohol or drugs?
- Has anyone annoyed you by criticizing your use of alcohol or drugs?
- Have you ever felt guilty because of something you’ve done while drinking or using drugs?
- Have you ever taken a drink or used drugs to steady your nerves or get over a hangover (eye-opener)?

A total of ≥ 2 may be suggestive of a problem
References and more tools: www.hivguidelines.org
Treatment of Mental Disorders is Associated with Better Outcomes Among People with HIV/AIDS

Untreated Mental Illness is Associated with Poorer HIV/AIDS Outcomes

- **Multiple studies worldwide show that depression is associated with**
  - Increased morbidity and mortality in its own right (HIV+ women with chronic depression twice as likely to die)
  - Failure to initiate antiretroviral treatment (ART)
  - Failure to adhere to ART once initiated
  - Slower virologic suppression
  - Increased sexual risk behavior

- **Hazardous alcohol/substance use is associated with**
  - Failure to initiate ART treatment
  - Failure to adhere to ART once initiated
  - Faster virologic failure
  - Increased sexual risk behavior
Associations Between Treatment for Mental Disorders and HAART Use and Outcomes

HIV Research Network study: Five U.S. sites, 4989 HIV+ people, predominantly minority men. Patients classified as severe mental illness, depression, no mental illness. (Himelhoch, AIDS, 2009)

Odds of discontinuing HAART by mental health visits/year

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Using Psychotropic Medication with HIV+ People: Key Points

Medically asymptomatic and not on antiretroviral treatment

- Most psychotropics can be used as usual
- Monitor use of typical antipsychotics for increased incidence of extrapyramidal side effects
- Evaluate for testosterone deficiency if depressed or fatigued
Using Psychotropic Medication with HIV+ People: Brief Summary

Medically ill and/or on antiretroviral treatment

- For most psychotropics, start with low doses and increase slowly
- Check for interactions and overlapping toxicities between psychotropics and antiretrovirals
- Protease inhibitors are especially potent inhibitors of cytochrome P450 enzymes—use caution

Treating Depression
Agents Used for Depression in Patients with HIV

- **Antidepressants**
  - SSRIs
  - SNRIs
  - TCA (tricyclic antidepressants)
  - Other antidepressants

- **Psychostimulants**

- **Hormonal treatment**—check for/treat testosterone levels in men and women

Antidepressants: SSRIs Have Been the Most Studied

- In general, SSRIs are well tolerated, safe, and have lower rates of drug discontinuation in studies with HIV-infected patients—all have equal efficacy

- SSRIs have proven efficacy in clinical trials with HIV+ depressed patients

- Drug interactions need to be considered with fluoxetine and paroxetine
Associations Between Depression Treatment and HAART Use and Outcomes

• Use of antidepressants + MH therapy, or MH therapy alone, associated with increased HAART utilization (N = 1,371; Cook, AIDS Care, 2006)

• Compliant SSRI use is associated with improved HIV adherence and laboratory parameters (CD4 cell count and viral load). (Horberg, JAIDS, 2008)

• Community-based prospective cohort study

• 158 HIV+ homeless/marginally housed people followed every 3 months between 2002-2007

• Antidepressant treatment associated with
  – 4 times the likelihood of accepting HAART
  – 2 times the likelihood of achieving viral suppression

Tsai et al. Arch Gen Psych, 2010
What are the Causes and Approaches to Anxiety Among HIV+ People?

Anxiety and Milestones of HIV Disease / Progression

Anxiety may be related to milestones:

- HIV testing
- News of HIV positive status
- Appearance of first illness symptoms
- Changes in CD4 count & viral load
- Onset of AIDS-defining illness
Anxiety May be Caused by Substance Use / Withdrawal

**USE:**
- Amphetamines
- Ecstasy
- Caffeine
- Cocaine
- Nicotine

**WITHDRAWAL:**
- Alcohol
- Benzodiazepines
- Opiates

Management of Anxiety

◆ Try non-pharmacological strategies first—stress reduction techniques, psychosocial support, etc.

◆ Reduce / discontinue anxiety-provoking substances

◆ Consider CBT, IPT and other EBT interventions if available
Pharmacotherapy of Anxiety Disorders in HIV+ Patients

- **SSRI’s**
  - Helpful for many anxiety disorders:
    - Social phobia, panic disorder, OCD, PTSD, GAD

- **Venlafaxine (Effexor)**
  - Approved for treatment of GAD
  - Few drug-drug interactions
  - No abuse potential
  - May decrease indinavir levels-significance unknown

- **Buspirone (Buspar)**
  - Levels may be increased by protease inhibitors

Pharmacotherapy of Anxiety

- **Benzodiazepines**
  - Often used for time-limited treatment
  - Dependence/withdrawal possible
  - Low doses are often adequate
  - Drug-drug interactions possible, especially Cytochrome P450 inhibition by protease inhibitors
  - Fewer P450 interactions with lorazepam (Ativan), oxazepam (Serax), temazepam (Restoril)-metabolized by glucuronidation
Other Medications

Antipsychotics and Mood Stabilizers: Some Key Points

Antipsychotics

- Older neuroleptics - high rates of extrapyramidal side effects
- Newer "atypical" antipsychotics – easier to use, but have metabolic complications

Mood stabilizers

- Avoid carbamazepine – lowers ARV levels
- Avoid lithium with HIV-associated nephropathy
Use of Psychotropic Medications: Other Key Points

- Protease inhibitors increase the levels of newer sleep medications (zolpidem/Ambien, zaleplon/Sonata, eszopindone/Lunesta) and most benzodiazepines.

- Do not use benzodiazepines to treat delirium in medically ill HIV+ patients.

Interactions Between Antiretrovirals and Alternative / Recreational Drugs

- Interactions can occur -- much is unknown

- Concerns about the interaction between ritonavir and ecstasy

- Methadone dose may need to increase (or, less often, decrease) depending on the antiretroviral regimen

- St. John’s Wort may lower levels of NNRTIs and protease inhibitors
Hepatitis C: A Comorbidity of HIV, Mental Illness and Substance Use

- HCV is over-represented among people with HIV/mental illness/substance use
- In the U.S., HCV infection is a leading cause of death among HIV-infected people
- HCV is neurotropic and replicates in the CNS
- HCV is associated with cognitive impairment even in the absence of liver failure
Approaches to HCV in Mental Health Settings

- Psychiatric programs should test patients for hepatitis A, B, C.
- Patients testing positive for HCV should be referred for evaluation, immunization as needed (A and B) and potential treatment.
- Avoid psychotropic medications with liver toxicity
- Follow liver enzymes
- Advocate for/assist with HCV assessment and treatment
- Monitor for depression and worsening of psychotic symptoms while on antiviral therapy; treat as necessary

Common Treatment Dilemmas in Patients with HIV, Mental Illness and Substance Use

- Adequate access to and integration of mental health and substance use services.
- Maintaining adherence in patients with three chronic relapsing disorders.
- Provider countertransference to “self-destructive” and “manipulative” patient behaviors.
- Balancing harm reduction approaches with sensible limit-setting.
- Adequate differential diagnosis.
To schedule a Psychiatric Consultation please contact James Satriano, PhD, at
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