

Recognition and Management of Substance Use Disorders and Other Mental Illnesses Comorbid with HIV

POSITION STATEMENT

Approved by the Assembly, November 2004
Approved by the Board of Trustees, December 2004

"Policy documents are approved by the APA Assembly and Board of Trustees...These are ... position statements that define APA official policy on specific subjects..." -- *APA Operations Manual*.

Background

In the United States substance use disorders and other mental illnesses are closely linked to the acquisition and transmission of HIV infection. Injection drug use accounts for approximately 30% of AIDS cases to date and a greater percentage of recent cases of HIV infection. A substantial proportion of cases of heterosexual transmission are linked to having injection drug-using partners. Moreover, many substance use disorders alone or in combination with other psychiatric illnesses are associated with increased risk for acquiring HIV. Patients with severe mental illnesses have rates of HIV infection that exceed the general population and, in this group, women are as likely as men to be infected. Men who have sex with men and transgendered individuals at risk for HIV infection have higher lifetime prevalence rates of major depression and non-opiate substance use disorders. Latinos and African Americans are overrepresented among patients with substance use disorders, other mental illnesses, and HIV, and they may have problems with access to the most expert care. In recognizing these links, psychiatrists have an important opportunity to implement primary and secondary prevention efforts in their work with patients.

In addition the course of HIV infection is complicated by the neuropsychiatric manifestations of the disease. HIV invades the brain at the time of initial infection. It may cause neuropsychiatric symptoms at any point in the infection but more likely with advanced illness (see *Position Statement on Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments*). Many of the treatments for HIV infection, and their associated complications, can have neuropsychiatric implications. The picture may be further complicated by comorbid HCV infection (see *Position Statement on Psychiatric Implications of HIV/ HCV Coinfection*). Psychiatrists have an important role to play in the differential diagnosis of mental status changes in HIV-positive patients.

Many HIV-infected patients seen in medical settings are taking psychotropic medication. In a nation-wide study of randomly-selected patients receiving HIV medical care, 27% of patients were receiving psychotropic medication (21% antidepressants, 17% anti-anxiety drugs, 5% antipsychotics, and 3% stimulants). In this study, only about half of patients meeting criteria for major depression were receiving antidepressant medication, and African-Americans were over-represented in those not receiving treatment. At present, many barriers exist to integrating substance use and psychiatric services into routine HIV medical care. Conflicting models of treatment can compound logistical problems in integrating care (e.g., abstinence only vs harm-reduction models of substance abuse treatment).

Adherence to HIV medication regimens is associated with longer life and improved outcome. It should be noted that substance use problems, cognitive impairment, and depression have been associated with decreased adherence to antiretroviral medication. Psychiatric and substance use disorders may also increase the risk for secondary transmission of HIV.

Recommendations

1. Psychiatrists should attend to the HIV-related prevention and psychiatric and substance use treatment needs of their patients (see position statements for specific settings and patient groups). Psychiatrists treating patients with substance use disorders are encouraged to stay abreast of psychosocial and somatic interventions with proven efficacy for these problems and their negative consequences (e.g., antabuse, naltrexone, buprenorphine, motivational enhancement therapy, cognitive behavioral therapy, needle exchange programs, methadone maintenance).
2. Psychiatrists are encouraged to collaborate with their medical colleagues (physicians and others) to provide comprehensive and integrated care for HIV-infected patients. This can include collaboration with the treatment of substance use, psychiatric, pain, sleep, and sexual disorders. Coordination is essential to maximize adherence and minimize drug-drug interactions and overlapping medication toxicities. Such coordination may also need to take into account the treatment of medical disorders commonly associated with HIV, such as Hep C, Hep B, and TB. For psychiatrists who regularly evaluate and treat HIV-positive patients, staying knowledgeable about current HIV-related medical care will enhance their abilities to meaningfully engage in these collaborations.
3. When a psychiatrist evaluates a change of mental status in an HIV-infected patient, consideration should always be given to disorders due to general medical conditions and substance-induced disorders as possible underlying causes.