



Mental Health Issues and HIV/AIDS: HIV-specific Screening and Treatment Tools for Mood Disorders



Question

Are there HIV-specific screening tools for the mood disorders including Depression, Anxiety disorders, Adjustment Disorder or Substance Abuse Disorders?

Are there specific recommendations on appropriate treatment or treatment tools of mood disorders and substance abuse disorders in people with HIV, in general, prescribing medication and/or physical therapy?

Key Take-Home Messages

- HIV-specific screening and treatment tools for substance abuse and mood disorders have not been developed. The following are primarily recommendations from experts in the HIV field.
- Physical symptoms of depression are difficult to distinguish from the physical manifestations of HIV, except perhaps to physicians with a particular expertise in serving people with HIV. Following an initial screen, using the PHQ-9 noted above, physicians and professionals without an expertise in HIV infection should consider seeking consultation or referring to a specialist.
- With the exception of depression, mood disorders and substance abuse disorders among people with HIV are poorly addressed in the literature.
- Significant additional research is necessary to investigate the interactions of psychopharmacology and HAART

EVIDENCE INTO ACTION

The OHTN Rapid Response Service offers HIV/AIDS programs and services in Ontario quick access to research evidence to help inform decision making, service delivery and advocacy.

In response to a question from the field, the Rapid Response Team reviews the scientific and grey literature, consults with experts, and prepares a brief fact sheet summarizing the current evidence and its implications for policy and practice.

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Prepared by:

D. Nico Baker
Michael G. Wilson, PhD

Program Leads / Editors:

Michael G. Wilson, PhD
Jean Bacon
Sean B. Rourke, PhD

Contact:

rapidresponse@ohntn.on.ca

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The Issue and Why It's Important

As treatment protocols for people with HIV become increasingly sophisticated, clinicians and medical professionals are seeking guidance in identifying and addressing concurrent diagnoses such as mood disorders and substance abuse disorders. Distinguishing between physical manifestations of HIV infection and physical symptoms of mental health challenges can be difficult as can simultaneously treating multiple physical and mental health concerns. A primary care physician has requested assistance reviewing the literature for screening tools, treatment protocols and best practices for people with HIV who also have mood or substance abuse disorders.

What We Found

Depression

Screening

- It has been noted that physical symptoms of depression can be challenging to distinguish from symptoms of HIV so a focus on cognitive and affective symptoms is advocated.¹ Loss of libido, fatigue, hypochondriasis and weight loss have been found to be poor discriminators between depressed and not depressed people with HIV.¹
- The Adding Life to Years project advocates using the Patient Health Questionnaire (PHQ-9) as an initial screen for depressive symptoms, especially useful for frontline workers.²
- Experts in the field additionally support use of the Montgomery-Asberg Depression Scale (MADRS) as it does not rely on physical symptoms (as do other instruments such as the Beck Depression Inventory and HDMA).⁴

Treatment

- The Standards of Care do not include mental health interventions for people with HIV beyond counseling after HIV testing.⁵
- Psychopharmacological (medication) and psychotherapeutic (i.e. talk therapy) interventions for people with HIV and depressive symptoms are similar to those recommended for those without HIV.
- Meta-analysis of double blind randomized control trials reveal that antidepressant medications are effective for people with HIV, particularly SSRI's (fluoxetine and paroxetine) and TCA's (imipramine). A majority of the studies reviewed, however, were completed before the HAART era and could not account for potential interactions.^{6,7,8}
 - ◇ Care should be taken when prescribing anti-depressants and HIV medications as they use similar metabolic pathways and protease inhibitors may inhibit the metabolism of SSRI's.⁹ The literature, however, reports relatively few serious interactions.⁷
 - ◇ Alternately, SSRI's appear to be as effective or superior to TCA's, and are favored by many clinicians, based on a balance of efficacy and tolerability. Further research is necessary.^{7,8,9} Caution is also advised when prescribing fluoxetine for people with HIV as it inhibits Cytochrome P450 isoforms 2D6 and 3A4. Further research is necessary.⁷

- Noting the HIV-associated reductions in testosterone levels and their correlation with changes in mood, appetite and energy levels, several studies have found hormone therapy effective for treating symptoms of depression and fatigue.⁸
- Meta-analysis of double blind randomized control trials document that group and individual psychotherapy are both effective for reducing depressive symptoms in people with HIV. Particularly robust are the findings for group and individual Cognitive-Behavioral Therapy (CBT) or CBT delivered in conjunction with another intervention.^{10,11} Studies that excluded participants diagnosed with Major Depression reported less significance in effect size, indicating that there could be a limit as to how much improvement can be seen through these interventions.¹¹
 - ◇ Stress management interventions delivered individually or in small groups decreased anxiety and depressive symptoms with effect sizes in the small to medium range. These findings are consistent with effects found for similar interventions with patients with cancer, heart-disease and other chronic illnesses.¹²
- St. John's Wort, often cited as useful for decreasing depressive symptoms, should not be taken with protease inhibitors according to a panel of HIV experts.¹³ This has not been verified through randomized control trials.
- Some discourage concurrent prescription of bupropion and ritonavir¹³ while others cite their metabolism through different isoforms, which should prevent substantial interaction between the medications.⁷

Anxiety

Screening

- Experts in the field recommend use of the Hamilton Anxiety Scale (HAM-A) to assess anxiety symptoms in persons with HIV.⁴

Treatment

- SSRI's are indicated in the treatment of chronic anxiety disorders.⁷ (Note cautions cited above)
 - ◇ 10-60 mg/d doses of Buspirone has been shown to be effective with a sample of asymptomatic gay men and intravenous drug users with HIV.⁷
- Researchers recommend that benzodiazepines be started at half the usual dose and slowly increased as BZ blood levels can be elevated in people with HIV. This is particularly true of alprazolam, triazolam and clonazepam.^{7,13}
- Several benzodiazepines (clorazepate, diazepam, estazolam, flurazepam, midazolam, triazolam, and zolpidem) are contraindicated with ritonavir to avoid increased serum levels of the sedative.⁷
- While not as robust as findings for depression, Cognitive Behavioral Therapy has been found effective for the treatment of anxiety in persons with HIV. Results are best when the therapy includes a stress management component.¹¹

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Adjustment Disorders

Screening and Treatment

- Neither the literature nor our consultations with experts in the field revealed screening tools or treatment protocols for adjustment disorders particular to persons with HIV.

Substance Abuse

Screening

- Experts in the field recommend using the Drug Abuse Screening Tool (DAST-20) to screen for substance abuse in people with HIV.³ The test can be self administered or structured as an interview.
- For alcohol abuse, the Alcohol Use Disorders Identification Test (WHO-AUDIT) developed by the World Health Organization, is recommended.^{3,14}
- While neither of these tools was developed specifically for people with HIV, professionals have found them useful in clinical practice.

Treatment

- The sparse literature addressing substance abuse treatment for people with HIV advocate an integrated approach of coordinated care.^{15,16,17} Treatment teams including medical professionals, case managers and mental health clinicians were found to be effective in addressing both HAART adherence and substance abuse issues. One program also included an outreach component where individuals were visited in their homes to ensure proper adherence to medication regimens.
- A pilot program conducted in the Southern United States found that a similar integrated model of care, incorporating individual therapy, group therapy and medication management, returned successful outcomes for individuals with HIV who were dually diagnosed with major mental illness and substance abuse. This program relied heavily on the transtheoretical model of behavior change and tenets of Motivational Interviewing.¹⁶

Factors that May Impact Local Applicability

- Most studies reviewed contain an overrepresentation of men and an under representation of women, visible minorities, and intravenous drug users (IDUs). Visible minorities were better represented in the meta-analysis of psychotherapeutic group interventions for depressive symptoms. African-Americans were overrepresented in studies pertaining to substance abuse among persons with HIV.
- Research has not sufficiently addressed interactions of pharmacological responses to mood disorders and HAART. Nor have they considered adherence to HAART regimens as a factor.
- Studies rarely accounted for difference in severity of infection or CD4 counts.
- With the exception of the Adding Life to Years Project, based in Toronto, and a comparative study of depression rating scales completed in Australia, all mood disorder literature reviewed was from the United States.
- All the studies addressing treatment of HIV and Substance Abuse were completed in the United States.

What We Did

We located the studies used in this summary through electronic database searches and by contacting experts in the field to obtain their recommendations. We searched the Cochrane Library and PubMed by combining HIV with four different terms – depression, anxiety, adjustment disorder, and substance abuse disorders and reviewed the results for relevant systematic reviews and studies. We also contact three researchers working in the field of HIV and mental health and addictions (Dr. Sean B. Rourke, Dr. Adriana Carvalhal and Sergio Rueda).