



# HIV MENTAL HEALTH TREATMENT ISSUES

## HIV and People with Severe Mental Illness (SMI)

### Serious mental illness among HIV+ patients

The prevalence of psychiatric disorders is relatively high among adults receiving care for HIV disease in the United States. “Severe Mental Illness” (SMI) refers to a wide range of psychiatric diagnoses that have common psychiatric symptoms which persist over time and are functionally disabling. They can affect daily living skills, family relations, educational attainment, work productivity, and social role. SMI includes schizophrenia, schizoaffective disorder, bipolar disorder, major depression, autism, and obsessive compulsive disorder. These disorders affect at least 2.8% of the U.S. population. No program for people with SMI can be considered comprehensive unless it incorporates services aimed at detecting and preventing HIV, and provides links to medical assessment and treatment for patients who are already infected.

### How widespread is SMI among HIV+ patients?

Epidemiological trends in the HIV epidemic indicate the SMI may be the most vulnerable, disenfranchised subpopulation at risk for HIV infection. Rates of HIV infection and transmission among those with SMI are as much as 76 times higher than in the general population.

Studies of inpatient (residential) psychiatric patients in the Northeast have shown rates of HIV infection ranging from 4% among long-stay state hospital patients to 23% among those on an acute dual diagnosis unit for people with combined mental illness and alcohol/substance use disorders. Women were as likely to be infected as men. Unfortunately, the peer-reviewed literature contains little information about outpatients, and is silent on epidemiology in other U.S. regions.

One of the few non-hospital based studies found that 19% of men attending a psychiatric program located within a homeless shelter in New York City were HIV+. Advanced HIV disease (AIDS) was the leading cause of death in a sample of 320 patients between 20 and 40 years of age in a longitudinal study of individuals experiencing their first psychiatric hospitalization for a psychotic episode. This study, conducted in suburban and semi-rural Suffolk County, New York, suggested that HIV is a major issue even for psychiatric patients outside of cities known to have high HIV rates.

### Why are people with SMI at increased risk?

**Drug Use.** Studies indicate that patients with SMI have lifetime rates of alcohol or substance use disorders of between 20% and 75%, depending on the sample studied. Studies focused on patients with SMI have found recent injection drug use in 1% to 8% of patients and past injection

drug use in 5-20% of patients. Seroprevalence studies support the powerful link between HIV and injection drug use in this population. One study demonstrated that psychiatric patients with any alcohol or drug use diagnosis had elevated rates of sexually transmitted diseases, which are both co-factors in HIV transmission and markers of unprotected sex.

**Sexual Behavior.** Studies show that a majority of patients with SMI have been sexually active in the past year. Providers and policymakers often don’t recognize patients’ sexual activity despite its links to HIV risk behaviors, including:

- Low rates of condom use;
- Buying and selling sex;
- Poorly known partners of undetermined HIV status;
- Partners who have been identified as injection drug users or as having HIV;
- Multiple partners;
- Coerced sexual encounters;
- For women: partners who are bisexual men; partners who are violent and/or have alcohol/substance use disorders; and;
- For men: rates of same-sex sexual activity exceeds rate in the general population.

**Environmental factors.** Circumstances known to be common among people with severe mental illness that increase the risk of acquiring HIV infection include:

- Residing in urban areas with a generalized HIV epidemic;
- Being institutionalized in shelters, prisons, and hospitals where HIV is prevalent, rates of same-sex sexual activity are high, and condoms are usually unavailable;
- Poverty due to limited entitlements, which makes it hard to purchase condoms and access family planning services, and promotes exchanging sexual favors for shelter, food, etc; and;
- stigma, which, along with poverty, interferes with access to medical and family planning services.

### Risk assessment and HIV testing

Many at-risk patients have never been tested for HIV. Four New York-based studies found that rates of detection varied from 12% in a state hospital setting to 68% on an acute psychiatric unit in a general hospital setting. Detection may vary with the intensity of medical oversight, and is clearly quite low in certain settings.

Risk assessment should always be incorporated into the psychiatric assessment of patients with



SMI. Forming an adequate therapeutic alliance between provider and patient—ensuring confidentiality and using language comprehensible and comfortable for the patient—is needed to obtain accurate and candid information about sexual activity or drug use. HIV testing should be offered routinely to patients who are pregnant, have risk histories or medical findings that suggest HIV infection, or are being admitted to hospitals with more than a 1% HIV seroprevalence. Careful pre- and post-test counseling is important, and when appropriate, providers who know the patient well should be involved.

### **Access to medical care/reproductive services**

Patients with SMI often find it hard to access adequate medical care. It is well known that this population has higher morbidity and mortality with common medical illnesses. With respect to HIV/AIDS, it is important to ensure access and integration of medical, mental health, alcohol/substance use, and reproductive/family planning services. Changes in HIV+ patients' mental states require medical assessment to rule out organic causes.

### **Adherence**

Adherence has long been a focus in treating people with SMI. The medical literature does not support the common assumption that this population is less likely than the general population to properly take prescribed medication. Psychiatric patients are familiar with stigma as well as the emphasis on maintenance medication, so it may be easier for them to accept having a second stigmatizing illness that requires ongoing medication management. Even patients in homeless shelters can follow antiretroviral regimens when all the necessary supports are in place. A 2009 study found that HIV+ patients with psychiatric disorders were more likely to adhere to HIV treatment when they had regular mental health care visits.

Patients with SMI need to be assessed individually and without preconceived bias regarding their ability to follow an antiretroviral regimen. It is essential first to stabilize their psychiatric condition before starting an antiretroviral regime. Involving significant others and using directly observed therapy (DOT) are useful adherence strategies. As with other populations, only patients who are ready to adhere should be started on antiretrovirals, since intermittent use leads to the dangerous problem of viral resistance.

### **Education and training**

Both patients and providers need continuous updates about HIV. Educational materials can be provided to patients easily and inexpensively, but knowledge must be paired with skills training. It is also essential to have administrative support for education, adequate risk assessment, and preventive interventions.

### **Prevention**

Primary prevention efforts—including skills-building and rehearsal of safer strategies such as correct condom use—

are effective for people with SMI. These skills must be reviewed repeatedly with patients to maintain gains. It is important to provide condoms in both institutional settings and for the majority of outpatients who live well below the poverty level. Access to clean needles and syringes is important for those who inject drugs. Secondary prevention efforts aimed at decreasing the morbidity and mortality associated with HIV must include risk assessment and HIV antibody testing to identify infected patients, better access to medical care, and efforts to promote adherence to antiretroviral treatment.

### **Psychopharmacology**

The combined medical treatment of HIV infection and severe mental illness raises concerns about the psychopharmacologic management of patients. The literature suggests that most psychotropic drugs can be used safely, though the dosage may need to be adjusted depending on the stage of HIV disease, the presence of neurocognitive impairment, and drug-drug interactions caused by competitive metabolism in the liver's cytochrome P-450 system. Of note in the treatment of patients with combined psychotic illness and late-stage HIV disease (AIDS) is that standard neuroleptics, particularly such high-potency medications as haloperidol, can be associated with severe side-effects, especially extrapyramidal symptoms (movement disorders). These include parkinsonism that is unresponsive to usual treatments, and the rapid onset of neuroleptic malignant syndrome or tardive dyskinesia. It is helpful to use the lowest possible doses and select the newer "atypical" antipsychotic medications.

### **References**

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### **About this Fact Sheet**

This fact sheet was updated by John-Manuel Andriote, based on an earlier version written by Francine Courmos, M.D., in collaboration with the APA Commission on AIDS. For more information contact American Psychiatric Association, Office of HIV Psychiatry, 1000 Wilson Blvd., Suite 1825, Arlington, VA 22209; phone: 703.907.8668; fax: 703.907.1089; or e-mail AIDS@psychiatry.org. Visit our web site at [www.psych.org/AIDS](http://www.psych.org/AIDS).