Current Mental Health and Addiction Treatment for People Living with HIV/AIDS

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Disclosures

Kevin Moore is AETC Faculty and some of the following slides were originally created for AETC in-services. Thus, this presentation was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $3,960,119 with zero percentage financed with nongovernmental sources. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

Introduction and Notifications

- Executive Director of Courage Medicine
- Adjunct Professor at Widener University's Institute for Graduate Clinical Psychology
- When I was at Philadelphia FIGHT and AIDS Care Group, I was Principle Investigator on multiple HRSA grants, including Special Projects of National Significance, that supported work with patients like those described today.
- I will use brand names like Suboxone, but I have no affiliation with any pharmaceutical manufacturer or company.

What percentage of people living with HIV/AIDS are depressed and/or anxious?

A. Less than 40%
B. Between 40-60%
C. Between 60-80%
D. More than 80%

Mental health issues are very common

- An estimated 20% to 40% of people living with HIV suffer from depression.
- Approximately 16% of people living with HIV suffer from anxiety.

American Psychiatric Association (APA). HIV mental health treatment issues. www. psychiatry.org/practice/professional-interests/hiv-psychiatry/ physician-resources-publications.

- 50% screened positive for depression at Philadelphia FIGHT
- 55% screened positive for depression at AIDS Care Group

ICQI data from the respective agencies.

What percentage of people living with HIV/AIDS have a history of addiction?

A. Less than 60%
B. 60-75%
C. 75-90%
D. More than 90%

Addictions are very common

- Of the 1.2 million Americans living with HIV, 1 in 3 persons is a current drug user or binges on alcohol.
- 24% of people with HIV are in need of substance abuse treatment.

CDC - https://www.cdc.gov/hiv/risk/substanceuse.html

- 80% screened positive for previous substance abuse at Philadelphia FIGHT
- 75% screened positive for history of addiction at AIDS Care Group

CQI data from the respective agencies.

Main three mental illnesses (+)

1) Depression – remit spontaneously, if chronic- need treatment
2) Anxiety (and trauma)- often chronic without treatment
3) Substance Abuse – recovery equality likely with or without treatment, if chronic- need treatment

- Psychotic disorders like Schizophrenia and Bipolar

HIV interacts with mental illness

- HIV in the brain causes depression, likely due to viral inflammation
- worrying about one's CD4 count or fear others will stigmatize them increases anxiety
- substance use increases the likelihood of HIV transmission

Current Treatment Thinking

Harm Reduction

Instead of emphasizing abstinence-only goals for substance use treatment, current treatment thinking looks to increase knowledge and options to reduce harm of drug use.

Harm Reduction also applies to approaching mental health issues, condom use, and many other public health activities.

Bessie

43-year-old Black woman, diagnosed with HIV in jail, came to our clinic and said she:

- Needed help with her heroin addiction but wanted to keep drinking alcohol and smoking marijuana

We prescribed buprenorphine on the agreement she would decrease her alcohol use

- She said she felt her feelings for the first time in a long time and she wanted “clean up,” take her HIV meds and “live life”

Bessie – 3 months later

Bessie quickly got control of her heroin and alcohol addictions but found she:

- Can't get out of bed
- Feels terrible all the time
- Can't sleep
- Has no appetite
- Thinks about dying every day

She saw me twice a week, was prescribed anti-depressants. She initially felt much better.

Bessie – six months later

As her depression subsided, she became flooded with traumatic memories of having been stabbed, she:

- Was scared to leave her apartment
- Had panic attacks
- Woke up every night from nightmares
- Worried “all day long”

We worked on anxiety management tools including breath training, muscle tension training, and using her thoughts to “put her problems to size”/not catastrophize

Bessie – one year later

Through working very hard in therapy and working with the medical providers in our clinic on her HIV, depression, anxiety, and addictions, Bessie felt “good.”

These are conditions she will need to work against for the rest of her life, but she has the skills and the motivation to manage them. (more on motivation later)

Reactions about Bessie?

Question: Which of these people likely has trauma?

A. Complains loudly at the front desk
B. Often no-shows for appointments
C. Has poor adherence to medications
D. Expresses paranoid thoughts about their medical provider

Trauma-informed Care

Trauma can take many forms:

- Fear-based re-experiencing like “flashbacks”
- Negative mood and thoughts
- Highly aroused and watching everything
- Being “out of it” and not remembering many things
- Complex combinations of the above

Current Treatment Thinking

- Trauma-informed care provides:
  - Anxiety management skills
  - Coping strategies
  - Depression treatment
  - Trauma processing for people who are in a good place in their lives
- Trauma psychotherapy is available and effective
- Trauma psychotherapy is typically long-term over many years

Question: Are psychotic people more dangerous than others?

A. Yes, they are unpredictable and violent
B. Yes, make elaborate plans to kill people
C. No, they are 100% harmless
D. No, they are no more likely to be dangerous than anyone else

Schizophrenia and Bipolar Disorder

- Less common than depression, anxiety, and substance abuse
- Most people with these diagnoses and an addiction history were misdiagnosed, i.e. over-diagnosed
- Those who have it need long-term mental health treatment including both therapy and medication
- Are no more dangerous than anyone else

Current Treatment: Motivational Interviewing

Assist people in identifying their own motivations to change a health behavior

- Active listening
- Not offering advice, only information
- Assume ambivalence to change
- Ask “if you do change this, what would be better?”
- Ask “if you don’t change this, what will stay bad?”

Thank you!

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