



Mental Health and HIV

Alex Young PsyD

Conflict of Interest Disclosure Statement

- The presenter has no conflicts to declare.

This program is 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 \$3,132,205, with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement of, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.



Learning Objectives

1. Learn about the unique behavioral health challenges that patients with HIV face.
2. Discuss what we can do as a patient's treatment team to empower and support them.
3. Discuss the future of HIV care from a BH perspective using integration.

Stigma

- HIV stigma are the building blocks for maladjustment eventually leading to poor mental health.
 - Individuals diagnosed with HIV often experience increased stigma and limited support from their community. These changes can cause further distress and may require adjustment that includes new routines and relationships (Flowers et al., 2011).
- Distress occurs very quick usually within the the day or same week as the diagnosis. This can come in the form of increased anxiety and unwanted or unpleasant thoughts
 - Research shows that post-diagnosis or post-testing is a critical time for patients diagnosed as positive, because of depression, suicidal ideation, and other psychological effects occurring at this time (Flowers et al., 2011; Smit et al., 2012). This crucial time should be met with intensive post-diagnosis counseling and support.
 - However, Eichler, Ray, & del Rio (2002) found that post-test counseling is not routine and, in most cases, lacks specific guidelines and structure. Additionally, these researchers found that because of the variety of HIV testing sites, if post-test counseling is performed it may be done with physicians or nurses who are not specifically trained to perform these tasks.
- Post-test individuals were up to 12 times more likely to seek follow-up care for HIV intervention if counseled by mental health providers versus medical staff (Eichler, Ray, & del Rio, 2002).

HIV and Behavioral Health

- How common is co-occurrence?
 - Up to 50% of all people with HIV (PWH) have one or more psychiatric disorders.
 - These can include diagnoses such as anxiety, depression, substance misuse, and bipolar disorder.
 - Do these occur before, at time of HIV diagnosis, or life afterwards?
 - Its complicated!
 - SES/Country are variables
 - Prevalence is higher in lower SES and low resource countries
 - Having mental illness increases your risk of acquiring HIV between 4-10x.
 - Individuals with SMI are at an even higher risk compared to the general population which currently sits at .5%
- The global estimate of people with HIV is 36.9 million.
 - Predictors indicate that HIV/AIDS and depression will be the two leading causes of disability globally by 2030.

HIV and Behavioral Health Cont.

- What is the most common psychiatric disorder?
 - In a study of 2800 of PWH:
 - 36% had Major Depression
 - 15.8% had Generalized Anxiety Disorder
- Depression and HIV Theories
 - Biological Model
 - HIV causes neurobiological changes to the brain and body leading to depression
 - Psychosocial Model
 - Burden of managing a chronic condition may impact daily living, interpersonal relationships, and other aspects of an individual's life.
 - Additional impacts include: loss of support, increases in stigma from community, and identity changes.

Bipolar Disorder

- How does Bipolar disorder factor into HIV acquisition?
 - A recent study found that participants diagnosed with Bipolar disorder, on average were diagnosed 9.8 years prior to developing HIV.
 - Risk factors include MSM and drug use.
- This same study found that only 85% of those with BD/HIV were taking ART compared to the general population which is closer to 98%. This lack of adherence is well documented in other studies looking at these variables.
 - Interestingly! This group is more likely to fill their ART medication compared to their BH medication.
- Possible intervention:
 - Those within this group that attended 6 or more BH visits per year were more likely to adhere to ART.

Risk factors for BD

- If you have a patient that is diagnosed with Bipolar disorder, please assess suicide risk. Individuals with this condition are almost 15x more likely to attempt suicide compared to the general population.
- Family Genetics
- Substance use
 - Stimulants- Methamphetamine
- Environmental factors such as income (more common in higher income vs lower income individuals)

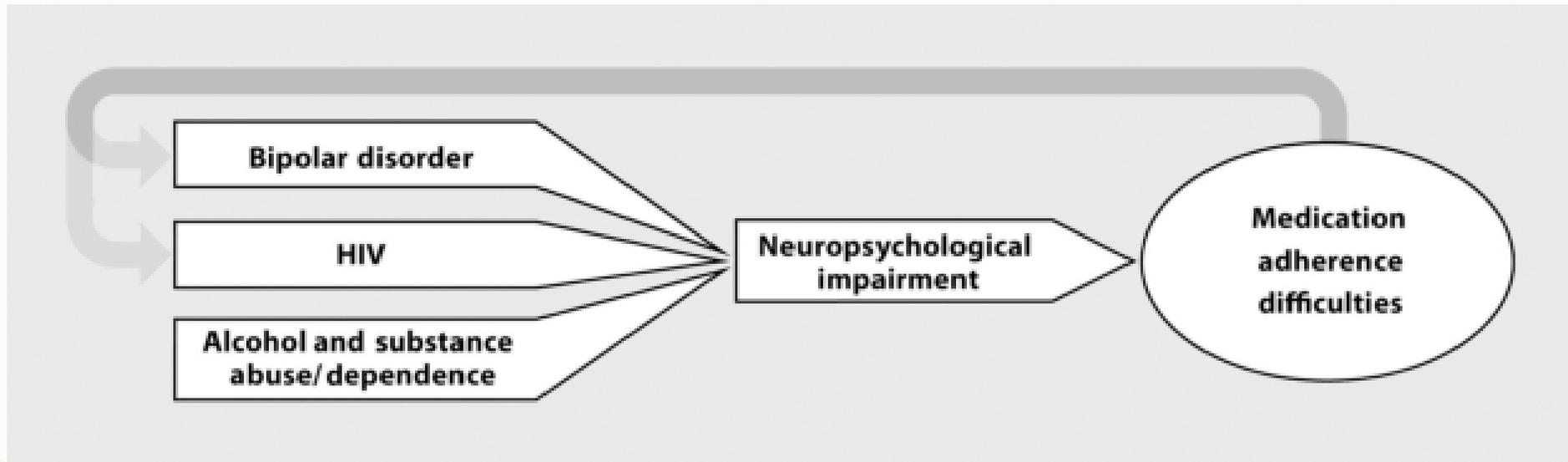
Bipolar Disorder

- Bipolar I
 - Mania or history of mania
- Bipolar II
 - Hypomania with no history of mania
- Cyclothymia
 - Episodic symptoms of hypomania and depression that are not severe enough to meet the above diagnoses.

Treatment implications

- How does mental illness affect treatment?
 - Antiretroviral Therapy (ART) adherence has been shown to be reduced when a mental illness is present.
- What is the most impactful mental diagnosis?
 - Depression is one of the strongest predictors of poor ART adherence. Adherence is cut in half for those with active depressive symptoms compared to those without depressive symptoms. This finding is consistent across income levels. Depression effects the management of other chronic issues such as diabetes, high blood pressure, and heart disease.
 - A longitudinal study following nearly 800 HIV positive women over 7 years found that those with chronic depressive symptoms were 2x more likely to die compared to those without depressive symptoms even when accounting for other predictors such as age, CD4 count, and ART duration.
- 50% of PWH develop neurocognitive impairments even those that are virally suppressed.

Cycle of non-compliance



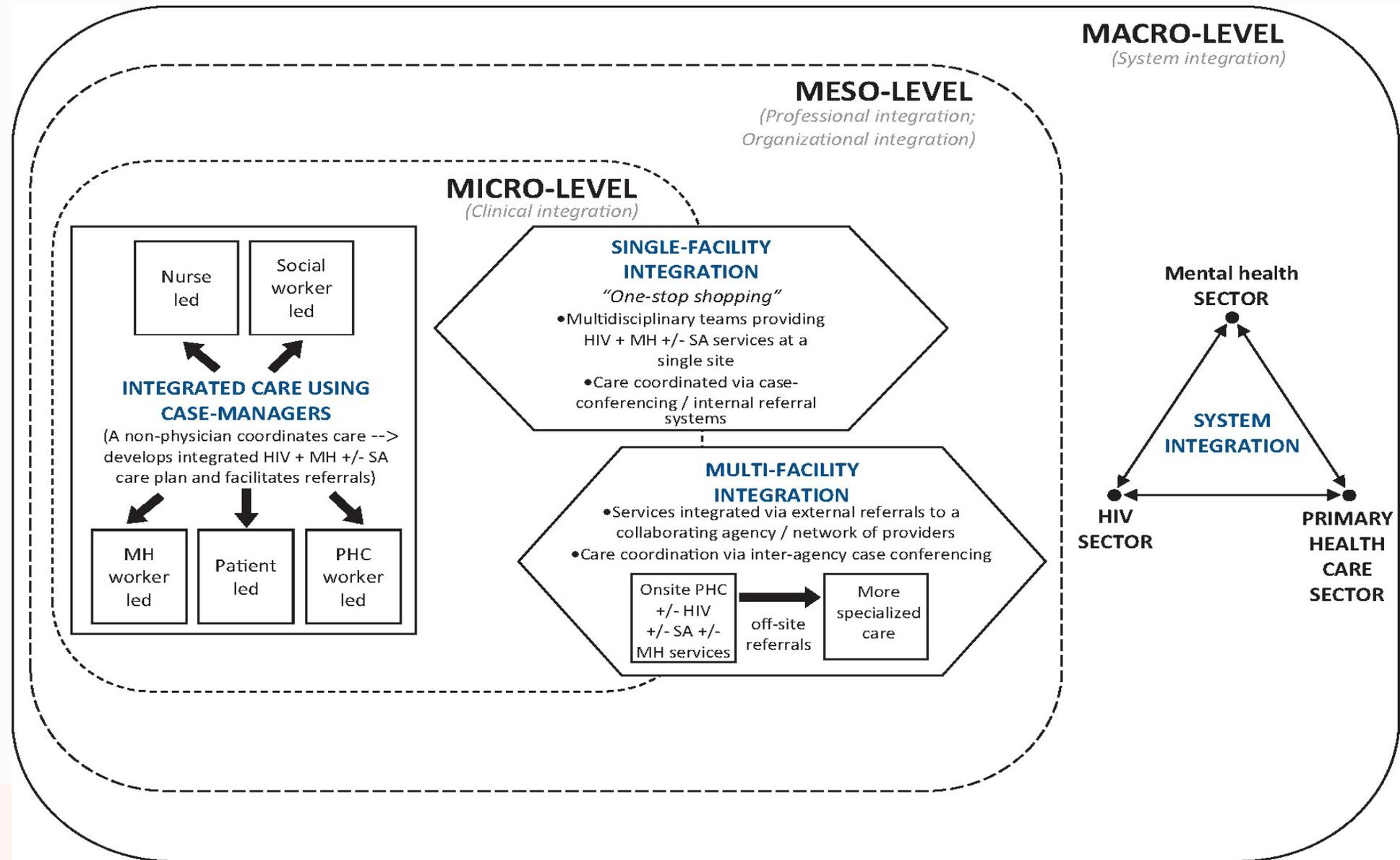
Moore et al., (2008)

How can we help?

Integration!!!

- Single-site integration: Different providers under one roof (ideally in the same office). This model can reduce costs and barriers to patient access. This type of integration might not be feasible for super complex patients.
- Multi-facility integration: A collaborative network of agencies that specialize in aspects of care. Might be beneficial to super complex patients. Utilizing rapid referrals might be effective to assist with care. However, a larger work force is needed to ensure coordination and continuity.
- Self-care model: utilizing the patient to coordinate service components through intensive education. This could be accomplished by using their own treatment plan and tools to assist in tracking.

Figure 3. Integration models for HIV, mental health and substance abuse services at the macro, meso, and micro-level.



The future of care and integration cont.

- Task shifting: Utilizing other individuals to assist in treatment such as screening and providing treatment with specific protocols.
- Stepped Care: Utilizing steps to move patients up and down the care continuum as needs present.
- Transdiagnostic care: Utilizing interventions like Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), Behavioral Activation (BA), Problem solving therapy, or other interventions that might assist with over lapping conditions.
- Utilizing technology: telephone, computer, or app-based interventions such as medication reminders or modules for CBT.

Here and now interventions!

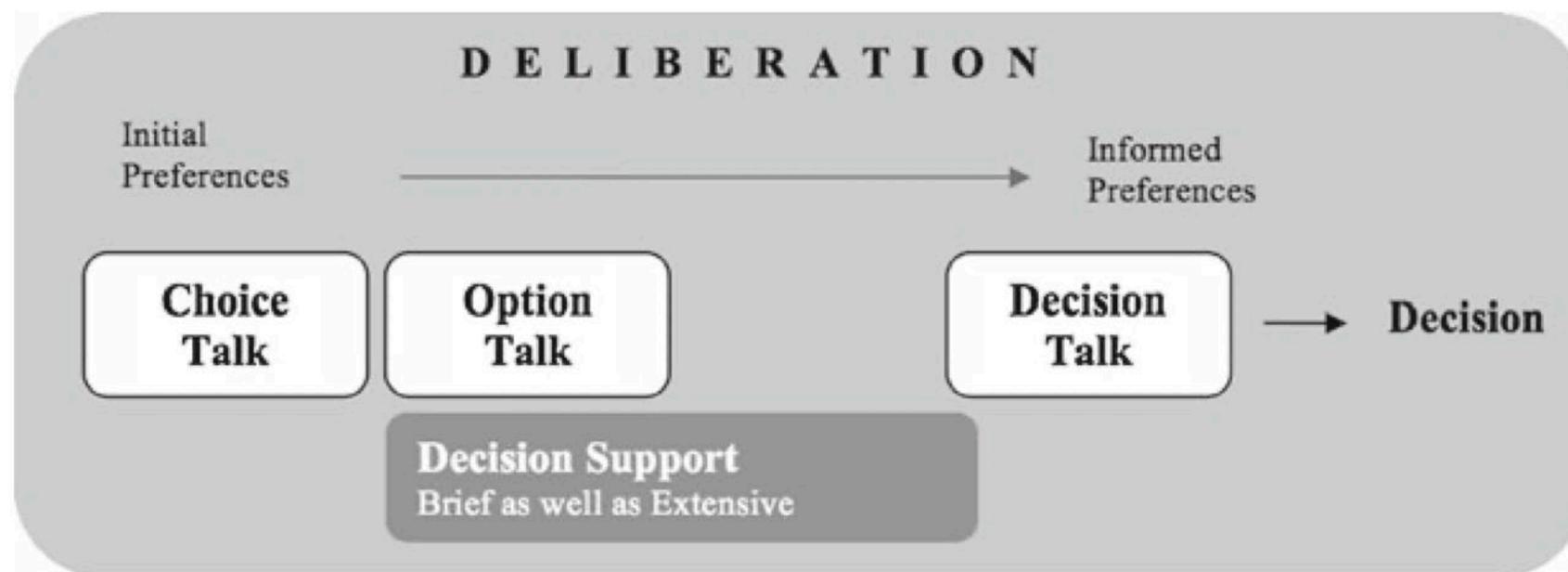
Motivational Interviewing



Shared-decision Making

- Choice Talk- making sure patients know that reasonable options exist.
- Option Talk- providing more detailed information about options.
- Decision Talk- supporting the work of patient preferences and the determined intervention.

Elwyn et al. (2012)



SDM Preferences

- Interestingly SDM preference from patients is not equal across the board.
- Younger aged patients prefer SDM compared to adults 60+.
- Physicians are often not the best judge of who wants SDM in visits.
- Patients often believe that the “treatment” being presented is the only or best treatment for their condition.
- Research shows that the more invasive or demanding an intervention the more SDM preference there is.

Frosch & Kaplan (1999)

SDM Snapshot

Choice Talk

- Stepping back: Reflecting on previous interventions
- Offer choices: Higher level of care options

Option Talk

- Check Knowledge: What does the patient understand about offered options?
- Discuss: What are the positives and negatives of each choice?
- Summarize: What did the patient choose and how might that help them?

Decision Talk

- Focus on preferences: What preferences do they have for treatment? (e.g., brief, long, evidence-based, process-focused, etc.)
- Move toward a decision: Set up a plan for the decision to be followed. Possibly utilize Motivational Interviewing/Brief Motivational Interviewing
- Offer review: Review and reflect the SDM visit to ensure all questions are answered and motivation is present for the patient to access a higher level of care

Other interventions

- Develop mood charting with the patient
- Have daily reminders sent to the patient
- Engage in cognitive as well as affective rapport building
- Utilize screeners on a regular basis (memory, executive functioning, mood, SUD) (MOOD Questionnaire)
- Encourage collaboration with MH providers
- Engage the patients with options (Shared Decision Making-SDM) and support to promote resilience formation post diagnosis and throughout care.

References

- Himelhoch, S., Brown, C. H., Walkup, J., Chander, G., Korthius, P. T., Afful, J., & Gebo, K. A. (2009). HIV patients with psychiatric disorders are less likely to discontinue HAART. *AIDS (London, England)*, 23(13), 1735.
- Moore, D. J., Poquette, A., Casaletto, K. B., Gouaux, B., Montoya, J. L., Posada, C., ... & Atkinson, J. H. (2015). Individualized texting for adherence building (iTAB): improving antiretroviral dose timing among HIV-infected persons with co-occurring bipolar disorder. *AIDS and behavior*, 19(3), 459-471.
- Moore, D. J., Posada, C., Parikh, M., Arce, M., Vaida, F., Riggs, P. K., ... & Atkinson, J. H. (2012). HIV-infected individuals with co-occurring bipolar disorder evidence poor antiretroviral and psychiatric medication adherence. *AIDS and Behavior*, 16(8), 2257-2266.
- Moore, D. J., Depp, C. A., Posada, C., Parikh, M., Bhatt, A., Moseley, S., ... & HNRC Group. (2008). Risk for cognitive impairment among HIV-infected persons with bipolar disorder. *Dialogues in clinical neuroscience*, 10(2), 256.
- Meade, C. S., Bevilacqua, L. A., & Key, M. D. (2012). Bipolar disorder is associated with HIV transmission risk behavior among patients in treatment for HIV. *AIDS and behavior*, 16(8), 2267-2271.
- Yalin, N., Conti, I., Bagchi, S., Essig, A., Bird, C., Adlington, K., ... & Stokes, P. R. (2021). Clinical characteristics and impacts of HIV infection in people with bipolar disorders. *Journal of Affective Disorders*, 294, 794-801.
- Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., ... & Barry, M. (2012). Shared decision making: a model for clinical practice. *Journal of general internal medicine*, 27(10), 1361-1367.
- Emanuel, E. J., & Emanuel, L. L. (1992). Four models of the physician-patient relationship. *Jama*, 267(16), 2221-2226.
- Frosch, D. L., & Kaplan, R. M. (1999). Shared decision making in clinical medicine: past research and future directions. *American journal of preventive medicine*, 17(4), 285-294.
- Légaré, F., & Thompson-Leduc, P. (2014). Twelve myths about shared decision making. *Patient education and counseling*, 96(3), 281-286.
- Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing?. *Behavioural and cognitive Psychotherapy*, 23(4), 325-334.
- Bundy, C. (2004). Changing behaviour: using motivational interviewing techniques. *Journal of the royal society of medicine*, 97(Suppl 44), 43.
- Glasgow, R. E., Goldstein, M. G., Ockene, J. K., & Pronk, N. P. (2004). Translating what we have learned into practice: principles and hypotheses for interventions addressing multiple behaviors in primary care. *American journal of preventive medicine*, 27(2), 88-101.
- Miller, W. R., & Rollnick, S. (2009). Ten things that motivational interviewing is not. *Behavioural and cognitive psychotherapy*, 37(2), 129-140.
- Chuah, F. L. H., Haldane, V. E., Cervero-Licerias, F., Ong, S. E., Sigfrid, L. A., Murphy, G., ... & Legido-Quigley, H. (2017). Interventions and approaches to integrating HIV and mental health services: a systematic review. *Health policy and planning*, 32(suppl_4), iv27-iv47.
- Himelhoch, S., Brown, C. H., Walkup, J., Chander, G., Korthius, P. T., Afful, J., & Gebo, K. A. (2009). HIV patients with psychiatric disorders are less likely to discontinue HAART. *AIDS (London, England)*, 23(13), 1735.
- Moore, D. J., Poquette, A., Casaletto, K. B., Gouaux, B., Montoya, J. L., Posada, C., ... & Atkinson, J. H. (2015). Individualized texting for adherence building (iTAB): improving antiretroviral dose timing among HIV-infected persons with co-occurring bipolar disorder. *AIDS and behavior*, 19(3), 459-471.
- Moore, D. J., Posada, C., Parikh, M., Arce, M., Vaida, F., Riggs, P. K., ... & Atkinson, J. H. (2012). HIV-infected individuals with co-occurring bipolar disorder evidence poor antiretroviral and psychiatric medication adherence. *AIDS and Behavior*, 16(8), 2257-2266.
- Moore, D. J., Depp, C. A., Posada, C., Parikh, M., Bhatt, A., Moseley, S., ... & HNRC Group. (2008). Risk for cognitive impairment among HIV-infected persons with bipolar disorder. *Dialogues in clinical neuroscience*, 10(2), 256.
- Meade, C. S., Bevilacqua, L. A., & Key, M. D. (2012). Bipolar disorder is associated with HIV transmission risk behavior among patients in treatment for HIV. *AIDS and behavior*, 16(8), 2267-2271.
- Pence, B. W., Mills, J. C., Bengtson, A. M., Gaynes, B. N., Breger, T. L., Cook, R. L., Moore, R. D., Grelotti, D. J., O'Cleirigh, C., & Mugavero, M. J. (2018). Association of Increased Chronicity of Depression With HIV Appointment Attendance, Treatment Failure, and Mortality Among HIV-Infected Adults in the United States. *JAMA psychiatry*, 75(4), 379-385. <https://doi.org/10.1001/jamapsychiatry.2017.4726>
- Remien, R. H., Stirratt, M. J., Nguyen, N., Robbins, R. N., Pala, A. N., & Mellins, C. A. (2019). Mental health and HIV/AIDS: the need for an integrated response. *AIDS (London, England)*, 33(9), 1411-1420. <https://doi.org/10.1097/QAD.0000000000002227>
- Yalin, N., Conti, I., Bagchi, S., Essig, A., Bird, C., Adlington, K., ... & Stokes, P. R. (2021). Clinical characteristics and impacts of HIV infection in people with bipolar disorders. *Journal of Affective Disorders*, 294, 794-801.
- Yehia, B. R., Stephens-Shield, A. J., Momplaisir, F., Taylor, L., Gross, R., Dubé, B., Glanz, K., & Brady, K. A. (2015). Health Outcomes of HIV-Infected People with Mental Illness. *AIDS and behavior*, 19(8), 1491-1500. <https://doi.org/10.1007/s10461-015-1080-4>