

CHAPTER 1

THE ROLE OF THE PRIMARY CARE PRACTITIONER IN ASSESSING AND TREATING MENTAL HEALTH IN PERSONS WITH HIV

The importance of primary care practitioners to the mental health of persons who live with HIV cannot be overemphasized. Because of the unique role of such practitioners in the health care system, they can help prevent or treat psychiatric illness and maximize patients' psychological health.

GENERAL RECOMMENDATIONS:

Mental health care for the person with HIV infection should be a collaborative effort involving primary care practitioners, patients, mental health clinicians, case managers, and also, when appropriate, substance abuse counselors or domestic violence service providers.

The stage of HIV infection and the severity of the psychiatric disorder should determine whether the medical practitioner or the psychiatrist should be the primary care practitioner.

Care should be coordinated between medical and psychiatric practitioners, and primary care practitioners should assist mental health clinicians in coordinating ongoing care when patients are referred to a mental health treatment program.

Practitioners should develop and maintain the necessary skills to recognize and address the psychiatric disorders commonly associated with HIV and the factors that may trigger distress in persons living with HIV.

Primary care practitioners should have heightened acumen with respect to mental health conditions so that they will be able to determine whether patients may be developing more serious conditions (e.g., suicidal ideation, depression, or anxiety disorder) and will be able to judge whether a patient's needs can be adequately treated by the primary care and case management team or whether the patient will need to be referred to a mental health professional.

I. PSYCHOLOGICAL IMPACT OF HIV

RECOMMENDATION:

Practitioners should be aware of specific and general factors that may trigger or exacerbate mental distress or psychological disorders in HIV-infected persons and their families.

HIV is a chronic stressor that places HIV-infected persons as well as their immediate and extended families at risk for psychological distress and psychiatric disorders. Because patients and their families may have histories of substance use, chronic mental illness, poverty, physical abuse, violence, and isolation, they may have limited coping skills. Specific crisis points and psychosocial factors can precipitate mental distress in HIV-infected persons and their families (see Table 1-1).

TABLE 1-1
CRISIS POINTS FOR HIV-INFECTED PERSONS

- Learning of HIV-positive status
- Disclosure of HIV status to family and friends
- Introduction of medication
- Occurrence of any physical illness
- Recognition of new symptoms/progression of disease (e.g., major drop in CD4 cells, rise in viral load)
- Necessity of hospitalization (particularly the first hospitalization)
- Death of a significant other
- Diagnosis of AIDS
- Changes in major aspects of lifestyle (e.g., loss of job, end of relationship, relocation)
- Necessity of making end-of-life and permanency planning decisions

Adapted with permission from Duffy V. The 14 crisis points of AIDS. *AIDS Patient Care STDs* 1994;8:28-32. Copyright 1994, Mary Ann Liebert, Inc.

II. MENTALLY ILL SUBSTANCE USERS

RECOMMENDATIONS:

Primary care practitioners should provide their substance-using patients with information about appropriate substance use-related services and, if necessary, make referrals (see Appendix IV).

For patients who are enrolled in a methadone treatment program and complain of drug withdrawal symptoms after starting HAART or other medications, coordination of care with their methadone program should be maintained so that dosage adjustments can be considered.

A high rate of HIV infection is found among persons with serious mental illness who are also substance users. Patients who are substance users and have mental illness are generally called “dually diagnosed” or mentally ill, chemical-abusing (MICA) patients. Mentally ill substance users are an especially challenging group of patients to treat, displaying a variety of behaviors that can range from erratic to enraging. Practitioners should provide information about the availability of sterile syringes through referral

to syringe exchange programs or pharmacies participating in the Expanded Syringe Access Program (ESAP) (see Appendix V).

A. General Issues

While the bizarre or combative behaviors of the HIV-infected MICA patient can be mistaken for psychiatric illness, substance users are often in some form of intoxication, withdrawal, and/or delirium from another cause (see Table 1-2). If these medical problems are treated, behavior often begins to move toward a more agreeable, manageable form. Even after treatment, a return to baseline behavior may take days to weeks to become evident.

Many substance-using patients use a combination of drugs and alcohol and are often in a state of mixed intoxication/withdrawal, which can have behavioral and physiologic manifestations. Withdrawal is best handled by detoxification in a hospital setting.

TABLE 1-2
ORGANIC CONTRIBUTIONS TO ABERRANT BEHAVIOR

- **Direct drug influence:** drug intoxication; drug withdrawal (or a combination*); drug-related delirium.
- **HIV-related central nervous system (CNS) disorders:** toxomoplasmosis; cryptococcosis; progressive multifocal leukoencephalopathy (PML); lymphoma; HIV dementia.
- **Underlying chronic brain disorders or developmental disorders** (sometimes secondary to fetal alcohol syndrome or malnutrition): mental retardation; minimal brain dysfunction; dementia.
- **Psychiatric illness:** psychotic disorders; affective disorders; anxiety disorders; personality disorders.
- **Other:** infection; fever; hypoxia; anemia; subdural hematoma; delirium of any etiology (e.g., electrolyte imbalance, glucose imbalance); hepatic encephalopathy.

* Because cocaine intoxication and sedative withdrawal are often hard to differentiate, cocaine users are often at risk for undiagnosed sedative withdrawal due to the use of sedatives in heavy doses to “come down” from cocaine.

B. Management Issues

RECOMMENDATIONS:

HIV-infected MICA patients with insomnia, low energy, anxiety, and pain (which can be primary symptoms or symptoms of drug withdrawal) should be referred to an addiction specialist or psychiatrist for assessment and treatment.

Prescriptions for a controlled substance can be written by a primary care practitioner unless the prescriptions are part of a coordinated plan of care agreed upon by the medical practitioner and the psychiatrist.

Practitioners should realize that drug users, because of their high tolerance, often require larger doses of sedatives and opioids for treatment purposes than other patients.

Differentiating legitimate need from the desire for mood-altering medications in HIV-infected MICA patients, even in the context of bona fide need, is extremely difficult. Thus, coordination and consultation with relevant addiction or mental health specialists are extremely helpful, especially because the pain of drug users is as undertreated, if not more so, than that of other patients. Patients who are actively using substances or who are homeless may find the demands of a medication schedule more challenging, while those on methadone may fear the interaction of HAART or other medications with their methadone, leading to symptoms of withdrawal (see Table 1-3).

**TABLE 1-3
MEDICATIONS KNOWN TO INDUCE ENZYMES AND
DECREASE METHADONE LEVELS**

- Carbamazepine
- Nelfinavir
- Pentazocine
- Phenobarbital
- Phenytoin
- Rifabutin
- Rifampin
- Rifapentine

Adapted from *Gen Hosp Psychiatry*, Volume 22, Adler Cohen MA, Jacobson JM, Maximizing life's potentials in AIDS: A psychopharmacologic update, pp 375-388, 2000 with permission from Elsevier Science.

III. PSYCHIATRIC DISORDERS

RECOMMENDATIONS:

Primary care practitioners should have sufficient expertise to recognize and to treat appropriately the psychiatric disorders commonly associated with HIV and AIDS.

For patients with more severe mental illness, services based in the mental health system may be necessary.

Because most patients with HIV and mental illness are seen in primary care settings, primary care practitioners are often the first to assess the risk of mental distress and to observe its signs and symptoms.

These psychiatric disorders include:

- Mood disorders
- Substance use
- Personality disorders
- Adjustment disorders
- Cognitive disorders
- Depression
- Suicide risk
- Anxiety disorders

A. Psychotropic Medications

RECOMMENDATIONS:

To provide comprehensive care, primary care professionals should be familiar with the commonly prescribed psychotropic medications and should be confident in their use of these medications. Specifically, primary care practitioners should understand how these agents work, their side effects, and for whom they work best.

Primary care practitioners, in addition, should be aware of how these medications may interact with HIV-related drugs (see Appendix I).

B. Adherence

Adherence to HAART regimens by people with HIV and mental health conditions requires extra attention and involvement of the care team. When patients are also taking psychotropic medications, adherence may be even more difficult. Referral to specialized adherence services should be made.

RECOMMENDATIONS:

Practitioners should carefully assess adherence and reasons for non-adherence on a case-by-case basis.

For patients with HIV and mental illness who do not adhere fully or who refuse treatment, close coordination between the primary care practitioner and psychiatrist should be maintained.

An important consideration for patients who are mentally ill is adherence to both HIV and psychotropic medication regimens. Fluctuations in mental status or impairments in cognitive function may interfere with patients' ability to follow directions. Adherence to medication regimens, including HAART, has been shown to be affected by psychosocial, cultural, and substance use factors. Psychotic disorders, affective disorders, or personality characteristics, such as pessimism, apathy, and poor coping styles, can decrease adherence. Lack of social support, poor self-image, and fears of stigma can also make the initiation of treatment more difficult.

C. Referral or Consultation

RECOMMENDATIONS:

The practitioner should familiarize him/herself with the resources available in the community to make the most appropriate referral (see Appendix IV).

Consultation with a psychiatrist, psychologist, nurse practitioner, or certified social worker is appropriate when the patient refuses treatment, when advice is needed in regard to the patient's needs for psychotherapy, or if the patient needs a complete psychiatric evaluation or assessment in regard to his/her risk of suicide. When the practitioner is in need of information concerning psychotropic medications, a psychiatrist or nurse practitioner with expertise in psychiatry should be consulted.

When there is a concern about the presence of serious mental illness in a patient, the most appropriate referral is to a psychiatrist.

Practitioners should contact a psychiatric service to establish intensive case management for mentally ill patients requiring such care, particularly if the patient uses substances.

Practitioners should opt for referral or consultation when unfamiliar with the patient's needs for prescription of psychotropic medications, assessment of mental status, or further management of the mental condition.

The primary care practitioner should routinely consider mental health aspects of care when treating patients who are also being cared for by a mental health provider (see Table 1-4).

Practitioners should maintain ongoing communication with psychiatric personnel to provide optimal care.

TABLE 1-4
THE ROLE OF THE PRIMARY CARE PRACTITIONER WHEN WORKING
IN COORDINATION WITH THE MENTAL HEALTH PROVIDER

- Ask follow-up questions of patients regarding mental health and treatment progress as a routine part of office visits.
- Include mental health issues in medical problem lists and progress notes and in corresponding medical assessments and plans.
- Consider patients' mental status, particularly suicidal ideas and alcohol use or other substance use, before prescribing medications.
- Monitor interactions between patients' physical and mental conditions and the effects of psychotropic and other medications.
- Maintain follow-up phone contact with patients' mental health treatment programs, including notifying programs of medication changes.
- Monitor patients' attendance and missed appointments.
- Consider substance use as a factor in the above recommendations when appropriate.
- Consider mental illness and/or substance use as possible underlying causes when unexplained signs (e.g., weight loss), symptoms, or laboratory abnormalities become apparent or when there are changes in behavior or adherence with medical treatment.

Some primary care practitioners may not be fully aware of the many psychological symptoms and disorders commonly noted in people who live with HIV. The medications used to treat these problems also may be unfamiliar. In such cases, referral or consultation may be the "treatment of choice." Knowing the roles of the various mental health professionals and when to consult with and refer patients to them is as important as any other treatment that can be provided. It is also advisable to ascertain from a particular individual whether he/she has the necessary professional training and experience to deliver mental health services.

- Psychiatrists are licensed physicians with graduate training at the doctoral level who have completed 4 years of post-graduate internship and residency. They should have familiarity with medical illnesses and their treatment, as well as an ability to diagnose and treat any psychiatric disorder with medication and/or psychotherapy.
- Psychologists are licensed professionals with graduate training at the doctoral level who have completed a 1-year internship. They are able to diagnose psychiatric disorders but only treat patients with psychotherapy. They also have expertise in intellectual/academic testing and assessment.

- Nurse practitioners and social workers are licensed professionals who have completed graduate level training and have developed expertise or concentrated their work in mental health.

When there is a concern about the presence of serious mental illness in a patient, the most appropriate referral is to a psychiatrist who is qualified by training and experience to 1) make a full diagnostic evaluation, 2) consider all the organic, psychological, environmental, and psychosocial factors, 3) prescribe medication as needed, and 4) make the appropriate referrals, if necessary, to other mental health professionals.

Serious mental illness usually refers to schizophrenia, schizoaffective disorder, and other mental illnesses, such as bipolar disorder and depression, that can have psychotic features. Persons with pre-existing serious mental illness (i.e., psychotic disorders) are substantially more likely to become infected with HIV than those in the general population. Patients with such serious mental illnesses pose challenges for all health care providers, but improving their medical and psychiatric care may greatly enhance their quality of life. Since people with mental illness are likely to be part of the primary care patient population, primary care practitioners should be aware of their special needs.

The easiest way to find out if patients have, or have had, serious mental illness is to ask them about past psychiatric treatments and/or hospitalizations. In talking with patients, practitioners may discover mental illness exhibited by patients' bizarre ideas or delusions or by their disorganized thinking and language. The hallucinations of mentally ill patients are usually auditory. Patients may hear voices telling them to harm themselves or others. Such episodes are considered psychiatric emergencies and will require immediate referral of the patients for psychiatric evaluation and treatment. Similarly, if a patient is suspected to suffer from a serious mental illness but is not currently receiving mental health care, he or she should be referred for psychiatric evaluation.

If a patient needs ongoing psychotherapy, other licensed mental health professionals (e.g., psychiatrist, psychologist, social worker) should also be able to provide this treatment. Because some individual mental health professionals may have more specific expertise or interest in working with special populations (e.g., couples, families, adolescents, children, substance users, or victims of domestic violence), the practitioner should familiarize him/herself with the resources available in the community to make the most appropriate referral (see Appendix IV).

D. Treatment Programs

Many HIV/AIDS clinics offer mental health services or work closely with specially trained professionals who can counsel patients or provide information.

Various mental health programs exist that attend to patients' different psychiatric conditions and needs. Such programs are categorized into four general areas: outpatient mental health services, community support programs, emergency services, and inpatient psychiatric programs. HIV/AIDS-specific mental health programs are funded by the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services and by the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act. Summaries of the general types of programs follow. Referrals to these programs are usually made by mental health clinicians following their evaluation of patients. Availability of the programs varies regionally.

1. Outpatient Mental Health Programs

Outpatient mental health programs are designed to meet the needs of patients who require psychiatric care and who can participate on an ambulatory basis. There are four categories of outpatient mental health programs:

- **Outpatient treatment**

Outpatient treatment includes a variety of services, such as assessment, medication, and psychotherapy. This treatment, offered both by clinics and in private mental health settings by practitioners in their own offices, can reduce symptoms in, improve daily functioning of, and provide ongoing support to patients.

- **Partial hospitalization**

These programs provide active treatment within a medically supervised environment and are designed to stabilize and ameliorate acute symptoms. These programs offer an alternative to inpatient hospitalization and, while primarily serving as a means to reduce the length of hospital stays, they also provide patients with a transitional therapeutic environment.

- **Intensive psychiatric rehabilitative treatment (IPRT) programs**

These are time-limited programs with active psychiatric rehabilitation and are designed to assist more seriously ill patients to reach goals.

- **Continuing day treatment programs**

These programs provide mental health treatment and rehabilitation to more chronically mentally ill patients who benefit from the ongoing structure of such programs.

2. Community Support Programs

Patients with severe and persistent mental illness may benefit from programs that provide help to enable them to live as independently as possible in the community. These programs fall into the following three broad categories:

- **Intensive Case Management program**

Managing patients with severe mental illness and HIV infection presents significant challenges. These patients require a coordinated effort, providing them with a wide range of medical, psychiatric, and social services. To accomplish this coordination, the Intensive Case Management (ICM) program was developed by the New York State Office of Mental Health. This program assigns case managers to individuals who have been identified as being in need of high levels of mental health care. Case managers then maintain contact with patients to ensure that they are receiving the benefits of all appropriate services. To participate in an ICM program, patients must be referred by a psychiatric service. Once patients are enrolled in an ICM program, ongoing communication between primary care practitioners and psychiatric personnel is key to providing them with optimal care.

- **Educational, vocational, and social rehabilitation programs**

These programs assist patients with severe mental illnesses to develop skills necessary to enable them to live more independently.

- **Mental health residential programs**

These programs include supported permanent housing, transitional housing, and family care programs.

3. Emergency Programs

These programs provide services to individuals in the community who are experiencing psychiatric crises. Services include:

- **Mobile crisis teams**
- **Emergency room intervention and observation**
- **Crisis residences**

4. Inpatient Psychiatric Programs

These programs include acute care in psychiatric units and also extended care stays at psychiatric hospitals.

IV. RISK REDUCTION

RECOMMENDATIONS:

Mentally ill patients should be counseled on how to reduce their risk of HIV infection and how to avoid infecting their partners.

Patients will benefit from education regarding safer sex practices, including how to use condoms and other barrier methods.

Demonstrating how to use condoms and other barrier methods is one counseling strategy, and provision of information about how to make sterile syringes available through referral to syringe exchange programs or pharmacies participating in the ESAP is another. Such treatment is as important as any other care for these patients. Practitioners should consult with local mental health care providers about the availability of HIV risk-reduction groups for people with mental illness who are also substance users.

