Purpose

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recognises that people who have human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS) can have unique mental health needs both due to the infection itself and the experience of anxiety and depression that can be associated with the condition. It is essential that people who have HIV/AIDS, or who may be at risk of contracting HIV, are able to access appropriate, respectful and confidential mental health support when required.

Key messages

- People living with HIV/AIDS have higher rates of mental illness than the general population.
- Psychiatrists should consider screening their patients for sexual and drug use risks during psychiatric assessments and HIV testing should be offered where indicated.
- Some medications used to treat HIV can have side effects including anxiety, depression and other psychological symptoms. Psychotropic medications can also interact with HIV anti-retroviral medications including potentially severe interactions.
- It is important to consider neuropsychiatric conditions when assessing the health needs of people living with HIV/AIDS, particularly HIV-associated neurocognitive disorders.

Background

Medical advances in HIV treatment have increased life expectancy and quality of life for people living with HIV/AIDS. Anti-retroviral therapies not only present clinical benefits for people living with HIV/AIDS but also significant benefits for public health, with treatment reducing the risk of transmission by more than 90% (Cohen et al., 2016). There are now also pre- and post-exposure prophylaxes which can further reduce the risk of transmission when administered. However, there are now different challenges for people living with HIV/AIDS in Australia and New Zealand; people must now focus on managing a life-long illness rather than a necessarily terminal one.

Advances in treatment options may also have led to public complacency about the risk and seriousness of HIV infection. In 2016, there were an estimated 26,444 people living with HIV/AIDS in Australia and an estimated 3500 people living with HIV/AIDS in New Zealand (The Kirby Institute, 2017; New Zealand AIDS Foundation, 2017). Compared to many other countries, Australia and New Zealand have relatively low prevalence rates of HIV/AIDS following their strong focus on primary prevention activities in the 1990s. However, in recent years there has been an increase in the number of new HIV diagnoses through sexual transmission and in particular as a result of sexual contact between men (The Kirby Institute, 2016; Ministry of Health, 2014).
Mental health of people living with HIV/AIDS

People living with HIV/AIDS have higher rates of mental illness than the general population (de Hert, 2011). Contributing factors can be: anxiety and depression associated with the HIV diagnosis as well as resulting from possible stigma in their everyday lives (Judd and Millich, 1996; Judd et al., 1997; Judd et al., 2000). Relationship difficulties, issues with self-esteem and anxiety disorders can present at key moments during the course of HIV disease including at the time of diagnosis with an opportunistic infection, a declining CD4 count or transient viral increase (‘blip’) or any other reminder of ongoing HIV infection (American Psychiatric Association, 2012a).

Some medications used to treat HIV can have side effects that cause anxiety, depression and other psychological symptoms (American Psychiatric Association, 2012a; American Psychiatric Association, 2012b). There are potentially severe pharmacokinetic and pharmacodynamic interactions between HIV anti-retroviral medication and psychotropic medications. There are specific contraindications to the use of some antipsychotic medications when protease inhibitors are prescribed as treatment for HIV. Drug interactions must be considered and monitored when using psychopharmacotherapy in people living with HIV (American Psychiatric Association, 2012b). More information about interactions can be found through the HEP Drug Interaction Checker.

It is also important to consider neuropsychiatric conditions when assessing anxiety and depression in people living with HIV/AIDS, particularly HIV-associated neurocognitive disorders (American Psychiatric Association, 2012a; American Psychiatric Association, 2012b; Alzheimer’s Australia 2016). Since the advent of highly active anti-retroviral therapy, the incidence of HIV-associated dementia has fallen; however, its prevalence has increased (‘What once was old is new again’, 2009). In Australia, an estimated 7% of people living with HIV/AIDS are affected by HIV-associated dementia (the most severe of the HIV-associated neurocognitive disorders) while 30% are affected by an HIV-associated neurocognitive disorder (Alzheimer’s Australia, 2016). Age, co-infection with hepatitis, methamphetamine use and a family history of dementia all increase the risk of a person living with HIV/AIDS developing a neurocognitive disorder (American Psychiatric Association, 2012c).

At risk populations: people living with mental illness

People living with serious mental illness and/or addictions experience much higher rates of physical ill health than the general population (RANZCP, 2016). Of particular relevance to people living with a serious mental illness and HIV/AIDS is the influence psychiatric illness may have on risk behaviours, medication adherence and clinical course (Andersson-Noorgard, 2010). Psychiatrists treating people living with HIV/AIDS should ensure adequate support is provided either through up-skilling or appropriate referrals.

Despite a higher incidence of HIV-related risk behaviours among people living with mental illness, attention to HIV education and prevention for this group of people has been limited to date (Thompson et al., 1997; Andersson-Noorgard, 2010). People with serious mental illness should be identified as a health priority population group. Psychiatrists should consider screening their patients for sexual and drug use risks during routine psychiatric assessments. HIV testing should be offered where indicated by risk histories or other relevant medical findings. Further guidance on how to conduct HIV/AIDS risk assessments may be found in the Mountain Plains AIDS Education and Training Center’s HIV Risk Assessment and HIV Risk Reduction reference guide.

Confidentiality and public health

Confidentiality is an essential part of the doctor–patient relationship. The RANZCP believes that at the time of the initial consultation, psychiatrists should make it clear that confidentiality is an ethical obligation and the right of all patients but there are limits to patient confidentiality.

Psychiatrists in all settings should be aware of relevant public health concerns. Of particular relevance when treating people living with HIV/AIDS may be if the psychiatrist suspects/knows the person living with HIV/AIDS is behaving in a manner which places others at risk of infection. In
such circumstances, the psychiatrist should contact the relevant public health service for assistance. Public health management processes are very effective at achieving sustained behaviour change through counselling, education and addressing the underlying causes of risk behaviour and public health officials can provide as much support, direction or restriction as required to prevent individuals putting others at risk of HIV infection (Boyd et al., 2016).

Recommendations

The RANZCP recommends that:

- the training of mental health care workers includes promoting awareness of HIV, HIV risk reduction strategies and the interactions between HIV and psychiatric medications
- HIV and mental health services develop formal relationships to assist with addressing the mental health needs of people living with HIV/AIDS and with identifying people living with HIV/AIDS who may benefit from receiving appropriate mental health care and treatment
- psychiatrists screen their patients for any sexual and drug use risks during psychiatric assessments with HIV testing offered where indicated
- targeted screening and HIV prevention and education programs are made available in all specialist mental health settings.

References


Royal Australian and New Zealand College of Psychiatrists (2015) *Keeping body and mind together: Improving the physical health and life expectancy of people with serious mental illness*. Melbourne, Australia: RANZCP.


What once was old is new again: the re-emergence of HIV-associated dementia (2009) *HIV Australia* 7: 20–2.

**Disclaimer**

This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

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