Complete Summary

GUIDELINE TITLE

Mental health disorders among substance-using HIV-infected patients.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Mental health disorders among substance-using HIV-infected patients. New York (NY): New York State Department of Health; 2008 Mar. 19 p. [8 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Substance-use disorders
- Mental health disorders, including
  - Depression
  - Mania
  - Anxiety
  - Psychosis
  - Cognitive disorders

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management

Screening
Treatment

CLINICAL SPECIALTY

Allergy and Immunology
Emergency Medicine
Family Practice
Infectious Diseases
Internal Medicine
Psychiatry

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Physician Assistants
Physicians
Public Health Departments
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To provide guidelines for diagnosis and treatment of mental health disorders in substance-using human immunodeficiency virus (HIV)-infected patients in primary care settings

TARGET POPULATION

Human immunodeficiency virus (HIV)-infected substance users with mental health disorders

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Screening human immunodeficiency virus (HIV)-infected patients who use alcohol or other substances for mental health disorders
2. Distinguishing between substance-induced and independent presentations of mental health disorders and excluding medical causes of mental health symptoms
3. Mental health assessment including evaluation for cognitive impairment; depression; anxiety; post-traumatic stress disorder; history of all prescribed, over-the-counter, and herbal medications; psychiatric history; etc.
4. Assessment for suicidality and potential for violence including emergency evaluation if indicated

Management/Treatment

1. Referring patients for emergency mental health evaluation if there is a risk of violence toward self or others

2. Pharmacotherapy including benzodiazepines
3. Coordination of care among multiple providers and development of treatment plan
4. Using appropriate treatment model (sequential, parallel, or integrated)
5. Referring patients to specific treatment programs such as inpatient, outpatient, community support, residential rehabilitation, and HIV-specific skilled nursing facility programs
6. Nonpharmacologic treatment including individual psychotherapy, group and family therapy, and self-help groups

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

AIDS Institute clinical guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to people with HIV infection. Committees* meet regularly to assess current recommendations and to write and update guidelines in accordance with newly emerging clinical and research developments.

The Committees* rely on evidence to the extent possible in formulating recommendations. When data from randomized clinical trials are not available, Committees rely on developing guidelines based on consensus, balancing the use of new information with sound clinical judgment that results in recommendations that are in the best interest of patients.

* Current committees include:

- Medical Care Criteria Committee
- Committee for the Care of Children and Adolescents with HIV Infection
- Dental Standards of Care Committee
- Mental Health Committee
- Women's Health Committee
- Substance Use Committee
- Physician's Prevention Advisory Committee
- Pharmacy Committee

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All guidelines developed by the Committee are externally peer reviewed by at least two experts in that particular area of patient care, which ensures depth and quality of the guidelines.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Key Point:

For human immunodeficiency virus (HIV)-infected patients with co-occurring substance use and mental health disorders, services that successfully combine substance use and mental health treatment with HIV care may positively affect the patient's overall medical care.

Screening for Mental Health Disorders

Clinicians should screen HIV-infected patients who are actively using alcohol or other substances for mental health disorders at baseline and at least every 4 months thereafter while the patient is actively using. Patients with a history of substance use should be screened for mental health disorders at baseline and at least annually.

Key Point:

Screening instruments are designed to complement, not replace, face-to-face evaluation.

Assessment and Diagnosis of Triply Diagnosed Patients*

*See Table 1 in the original guideline document for a glossary of mental health terms, including dually diagnosed, triply diagnosed, primary mental health disorder, substance-induced disorders, and severe and persistent mental illness (SPMI).

Although the diagnostic accuracy of many mental health disorders among substance users is improved following a period of sustained abstinence, clinicians should not delay treatment of mental health symptoms that cause significant functional impairment while awaiting abstinence.

Differential diagnosis of acute change in mental status with psychiatric/behavioral symptoms and concurrent substance use should include:

- HIV-related or other systemic disease
- HIV-related or other medications
- Substance use disorders
- Substance-induced disorders, including intoxication and/or withdrawal
- Primary mental health disorders
- Delirium of any etiology

Exclusion of Medical Causes of Mental Health Symptoms

Clinicians should include HIV-related or other medical causes, including medications, in the differential diagnosis of aberrant behavior or acute change in mental status in patients with concurrent substance use.

Mental Health Assessment

Primary care clinicians should consult a psychiatrist, preferably someone with experience working with substance users, to assist in the assessment of mental health symptoms in individuals who are actively using alcohol and/or other substances.

The mental health assessment should include evaluation for each of the following:

- Cognitive impairment
- Depression
- Anxiety
- Post-traumatic stress disorder
- Substances used and relationship between substances used and mental health symptoms
- A history of all prescribed, over-the-counter, and herbal medications used, because they may all have central nervous system (CNS) effects
- Psychiatric history, including psychotropic medications
- Suicidal/violent ideation
- Psychosocial status (e.g., housing, employment, family and social support)
- Sleep habits and appetite

Assessment for Suicidality and Potential for Violence

Clinicians should:

- Assess for suicidal and violent behavior at baseline and at least annually as part of the mental health assessment; suicidal behavior should be assessed more frequently in patients who present with increased somatic complaints, changes in mental health or medical status, or changes in significant relationships (e.g., loss of a partner or other significant person in the patient's life).
- Assess for depression among HIV-infected patients to ensure early detection and treatment of patients who may be at increased risk of suicide due to depressive symptoms.
- Obtain an emergency evaluation if a patient is at imminent risk of harm to self or others; patients who are not at immediate risk should be referred to outpatient mental health services when mental health treatment by the primary care clinician does not successfully stabilize symptoms.
- Clearly instruct medical support staff about how to manage emergencies involving patients with suicidal or violent behavior, such as contacting emergency services or isolating the patient from other patients.

Key Points:

- Patients with co-occurring substance use and mental health disorders have elevated rates of suicide and potential for physical violence.
- A significant percentage of patients who commit suicide will have seen their primary care clinician in the month prior to their suicide.
- Signs of suicide may be overlooked when the focus of treatment is directed at other symptoms.

Indications for a Mental Health Evaluation in Patients Expressing Suicidality

An immediate mental health evaluation is indicated when there is:
 	
• Acute intoxication and/or withdrawal from substances, particularly alcohol
• An untreated or undertreated mood disorder, particularly symptoms of depression, hopelessness and despair, and/or mania
• Significant cognitive impairment, particularly impulse control, judgment and/or reality testing, or presence of perceptual disturbance
• Psychosis, particularly with persecutory or paranoid delusional ideation and/or command hallucinations
• Significant anxiety symptoms, particularly panic
 	
Referral for a mental health evaluation should be considered when there is:
 	
• Active alcohol use
  • Alcohol may increase the likelihood of suicidal behavior through its effect on impulse control and judgment
• Active use of other substances such as heroin and other opioids, barbiturates, and cocaine
• Use of certain prescription medications
  • Tricyclic antidepressants (e.g., amitriptyline), lithium, and monoamine oxidase inhibitors (MAOIs) can be lethal in overdose

Assessment for suicidality in triply diagnosed patients should proceed as described in the National Guideline Clearinghouse (NGC) summary of the New York State Department of Health Mental Health Guidelines Suicidality and Violence in Patients with HIV/AIDS.

Determination of Substance Use-Induced Versus Primary Mental Health Disorders

Clinicians should attempt to distinguish between substance-induced and independent presentations of the following mental health disorders:

- Depression and mania
- Anxiety disorders
- Psychotic disorders
- Cognitive disorders

Substance-Induced Mental Health Disorders

Clinicians treating HIV-infected substance users should be familiar with the psychiatric manifestations of commonly used substances (see Table 3 in the original guideline document).

Management of Triply Diagnosed Patients

Urgent Treatment

Clinicians should immediately refer patients experiencing psychosis, mania, severe depression, or significant cognitive impairment for psychiatric evaluation and care.

Clinicians should have patients escorted for emergency mental health evaluation when:

- They pose significant risk of violence toward self or others.
- They are actively withdrawing from substance(s) or withdrawal is imminent, particularly from alcohol, benzodiazepines, or other sedatives.
- They develop an acute change in mental status that is not readily attributable to intoxication, particularly when judgment and/or capacity for self-care is significantly impaired.
- They develop acute psychotic symptoms, particularly when the diagnosis is unclear and the differential includes withdrawal and/or intoxication.

Supportive care should be provided for patients requiring urgent treatment, and the disposition plan should be explained in simple, clear, specific, and concrete terms.

Pharmacotherapy for Triply Diagnosed Patients

Clinicians should consult with a psychiatrist with expertise in substance use when pharmacotherapy is indicated for patients with comorbid substance use and mental health disorders.

Clinicians should carefully consider potential drug-drug interactions when developing a treatment plan for triply diagnosed patients.

Patients should receive behavioral therapy in conjunction with pharmacotherapy whenever possible.

For information regarding psychotropic drug-drug interactions, refer to the Mental Health Guidelines *Appendix II: Interactions between HIV-Related Medications and Psychotropic Medications: Indications and Contraindications* available from the New York State Department of Health Web site.

Treatment with Benzodiazepines in Triply Diagnosed Patients

Clinicians should:

- Perform a mental health evaluation and physical examination of patients who request or who may already be taking benzodiazepines to determine whether

the patient has an underlying mental health disorder, such as an anxiety disorder, or an underlying medical condition, such as peripheral neuropathy.
- Consider the potential for benzodiazepine dependence if benzodiazepines are prescribed for treatment of anxiety disorder(s) in triply diagnosed patients.
- Explore alternative therapies to benzodiazepines, such as pharmacologic and nonpharmacologic therapies including behavioral treatment.
- Exercise care when prescribing benzodiazepines because the medications can interact dangerously with alcohol and other CNS medications and contribute to cognitive impairment, falls, motor vehicle accidents, or overdose.

Chronic treatment with benzodiazepines should be decided upon and managed in consultation with a psychiatrist.

Key Points:

The risk of benzodiazepine dependence is greater when:

- Patients have a previous history of a substance use disorder
- Benzodiazepines with a more rapid onset of action are used
    - Rapid onset of action: alprazolam, lorazepam, diazepam
    - Slower onset of action: clonazepam, chlordiazepoxide, oxazepam

Benzodiazepine Withdrawal

Clinicians should:

- Refer patients for evaluation by a clinician who is familiar with substance use when benzodiazepine withdrawal is a concern.
- Refer patients for an emergency evaluation if they are actively withdrawing from benzodiazepines or withdrawal is imminent.

Benzodiazepine detoxification should be managed by a clinician experienced in treating substance use disorders.

Coordination of Care

Primary care clinicians should collaborate with substance use and mental health care providers to ensure adequate provision of services to patients with dual or triple diagnoses.

Clinicians should provide triply diagnosed patients with information about available substance use- and mental health-related services and, if necessary, should make referrals.

Clinicians should ensure that triply diagnosed patients receive coordinated healthcare treatment, whether care is provided from one source treating the three disorders or from three separate sources. When multiple providers are caring for a patient, a plan of care should be developed to avoid duplication of prescription medications and other care.

If integrated treatment is not available, primary care clinicians should consult a mental health care provider to develop a treatment plan.

Programs that frequently provide referrals to each other should develop written, working interagency agreements.

Adherence to confidentiality regulations must be observed when exchanging information among providers and programs.

Key Points:

- Care of HIV-infected substance users with mental health disorders in optimal when treatment for HIV infection, substance use, and mental health disorders is closely coordinated.
- Patients with severe and persistent mental illness (SPMI) and those who are homeless often require more intensive and specialized services.

Models of Treatment and Treatment Programs

Treatment Models for Co-Occurring Mental Health Disorders and Substance Use

Treatment Model	Description	Patients Who May Benefit From This Type of Treatment
Sequential treatment	• Acute disorder is treated first. After stabilization, other disorder(s) is addressed. • Treatment of acute disorder should not exacerbate milder disorder.	• Appropriate for patients who have one disorder that is mild and does not contribute significantly to or interfere with acute disorder

Parallel treatment	• Provides simultaneous treatment of both disorders but in different settings and by different providers. • Necessitates ongoing and effective communication among providers to avoid potential conflicts among different treatment approaches. • Requires aggressive case management, preferably by a single case manager who can assist patients across settings. • May be the only option available in areas with limited resources.	• Effective for patients who are motivated and able to navigate multiple systems
Integrated treatment	• Substance use and mental health treatments occur in the same location. • Providers are trained in both fields and have regularly scheduled meetings to discuss treatment progress and planning. • Optimal treatment includes HIV care at the same location. • Truly integrated models of treatment for co-occurring disorders are not commonly available in many communities.	• May be the preferred treatment strategy for SPMI patients with active comorbid substance use. • May be effective for patients who require careful monitoring of HIV-related medications and psychotropic medications

Treatment Programs

Refer to Table 6 in the original guideline document for treatment programs for triply diagnosed patients, including inpatient programs, outpatient programs, community support programs, residential rehabilitation, and HIV-specific skilled nursing facilities.

Nonpharmacologic Treatment Modalities

Clinicians should have a basic knowledge of the treatment modalities available to dually and triply diagnosed patients to ensure that patients will receive the most beneficial treatment.

Common Treatment Modalities Offered for Patients with Dual Diagnoses

Individual psychotherapy	• Motivational counseling, supportive counseling, and cognitive-behavioral and psychoeducational therapies. • Patients in early stages of recovery may require motivational counseling and relapse-prevention counseling. • Expressive therapy may not be indicated in early recovery because it may stimulate painful psychological conflicts that could destabilize recovery and trigger relapse. • Expressive therapy may be used later to promote insight.
Group therapy	• Most widely used modality. • Group-based cognitive-behavioral, supportive, and psychoeducational techniques are usually employed.
Family therapy	• May be used to provide added support and educate family members about substance use, mental health disorders, and their treatments.
Self-help groups	• Clinicians should advise patients to find a group that meets their needs, such as one that is comfortable with persons taking psychotropic medications, including agents such as methadone or buprenorphine. Although some self-help groups may be critical of psychoactive substance use, even prescribed psychotropic medications, other groups have been formed that are more inclusive. • Not indicated for patients who have difficulty interacting in large groups or coping with confrontation, such as patients with SPMI.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and management of mental health disorders in substance-using human immunodeficiency virus (HIV)-infected patients

Subgroups Most Likely to Benefit

Refer to Table titled Treatment Models for Co-Occurring Mental Health Disorders and Substance Use in the "Major Documentations" field for information on patients who may benefit from sequential, parallel, or integrated treatment.

POTENTIAL HARMS

- Clinicians should exercise care when prescribing benzodiazepines because the medications can interact dangerously with alcohol and other central nervous system (CNS) medications and contribute to cognitive impairment, falls, motor vehicle accidents, or overdose.
- Benzodiazepine dependence and withdrawal are also a concern.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines address the medical management of adults, adolescents and children with human immunodeficiency virus (HIV) infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public.

Guidelines Dissemination

Guidelines are disseminated to clinicians, support service providers and consumers through mass mailings and numerous AIDS Institute-sponsored educational programs. Distribution methods include the HIV Clinical Resource website, the Clinical Education Initiative, the AIDS Educational Training Centers (AETC) and the HIV/AIDS Materials Initiative. Printed copies of clinical guidelines are available for order from the New York State Department of Health (NYSDOH) Distribution Center for providers who lack internet access.

Guidelines Implementation

The HIV Clinical Guidelines Program works with other programs in the AIDS Institute to promote adoption of guidelines. Clinicians, for example, are targeted through the Clinical Education Initiative (CEI) and the AETC. The CEI provides tailored educational programming on site for health care providers on important topics in HIV care, including those addressed by the HIV Clinical Guidelines Program. The AETC provides conferences, grand rounds and other programs that cover topics contained in AIDS Institute guidelines.

Support service providers are targeted through the HIV Education and Training initiative which provides training on important HIV topics to non-physician health

and human services providers. Education is carried out across the State as well as through video conferencing and audio conferencing.

The HIV Clinical Guidelines Program also works in a coordinated manner with the HIV Quality of Care Program to promote implementation of HIV guidelines in New York State. By developing quality indicators based on the guidelines, the AIDS Institute has created a mechanism for measurement of performance that allows providers and consumers to know to what extent specific guidelines have been implemented.

Finally, best practices booklets are developed through the HIV Clinical Guidelines Program. These contain practical solutions to common problems related to access, delivery or coordination of care, in an effort to ensure that HIV guidelines are implemented and that patients receive the highest level of HIV care possible.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Mental health disorders among substance-using HIV-infected patients. New York (NY): New York State Department of Health; 2008 Mar. 19 p. [8 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Mar

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

AVAILABILITY OF COMPANION DOCUMENTS

This guideline is available as a Personal Digital Assistant (PDA) download from the New York State Department of Health AIDS Institute Web site.

PATIENT RESOURCES

None available

NGC STATUS

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