

HIV/AIDS and mental health

Report by the Secretariat

1. HIV/AIDS is a significant cause of death and disability, especially in low- and middle-income countries. UNAIDS estimates that in 2007, 33 million people were living with HIV. Mental health and HIV/AIDS are closely interlinked; mental health problems, including substance-use disorders, are associated with increased risk of HIV infection and AIDS and interfere with their treatment, and conversely some mental disorders occur as a direct result of HIV infection.

2. Studies have demonstrated a high seroprevalence of HIV infection in people with serious chronic mental illnesses. Prevalence rates in mentally ill inpatients and outpatients have been reported to be between 5% and 23%, compared with a range of 0.3% to 0.4% in the general population in the United States of America over comparable time periods. Some studies have reported behavioural risk factors for transmission of HIV in between 30% and 60% of people with severe mental illnesses. These risks include high rates of sexual contact with multiple partners, injecting drug use, sexual contact with injecting drug users, sexual abuse (in which women are particularly vulnerable to HIV infection), unprotected sex between men and low use of condoms. Besides these behavioural risks, mental disorders may also interfere with the ability to acquire and/or use information about HIV/AIDS and thus to practise safer behaviours or increase the likelihood of situations occurring in which risk behaviours are more common.

3. The Reference Group to the United Nations on HIV and Injecting Drug Use recently estimated that worldwide about three million injecting drug users might be infected with HIV. About 10% of HIV cases worldwide are attributable to injecting drug use (mostly with opioids, although the use of other substances, including stimulants, has been associated with unsafe injecting practices and sexual risk behaviours). Injecting drug users principally acquire HIV through sharing injection equipment, whereas non-injecting use of drugs, such as cocaine or amphetamine-type stimulants, is associated with transmission of HIV through high-risk sexual behaviours. Some drug users practise unsafe sex with multiple partners in exchange for drugs or money, providing a bridge for HIV to spread from populations with high HIV prevalence to the general population. Interventions that reduce the spread of HIV in injecting drug users include, among others, HIV testing and counselling, needle and syringe programmes, opioid substitution therapy and other drug dependence treatment.¹

¹ Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector. Geneva, World Health Organization, 2005.

4. Drug dependence is associated with particularly high-risk patterns of drug use and related risks of HIV transmission for the following reasons: drug users experience difficulties in controlling drug-taking behaviours and frequent episodes of intoxication and withdrawal (often accompanied by a strong desire to take drugs); furthermore, they persist with drug use despite clear evidence of harmful consequences or high risk of such consequences. Effective and ethical prevention and treatment at the early stages of drug use and dependence can reduce the drug-related risks of HIV transmission. A recent WHO collaborative study on drug dependence treatment and HIV/AIDS found that substitution therapy of opioid dependence significantly reduced risks of HIV transmission in opioid-dependent individuals in low- and middle-income countries, consistent with the findings in high-income countries.

5. The use of alcohol is known to be associated with an increased risk of unsafe sexual behaviour. Given the widespread harmful use of alcohol in many countries with a high incidence and prevalence of HIV, levels and patterns of alcohol consumption may substantially influence HIV spread in populations. Several studies, including those conducted in African countries with high prevalence of HIV, have shown a positive association between HIV and alcohol consumption, with a prevalence of HIV infection among people with alcohol-use disorders higher than in the general population.

6. The prevalence of mental illnesses in HIV-infected individuals is substantially higher than in the general population. Furthermore, HIV tends to be concentrated in highly vulnerable, marginalized and stigmatized populations; in particular, sex workers, men who have sex with men, drug users and prisoners have higher levels of mental health disorders than the general population. Increased psychological distress among people with HIV infection is common. Studies in both low- and high-income countries have reported higher rates of depression in HIV-positive people compared with HIV-negative control groups. The level of distress often seems to be related to the severity of symptoms of HIV infection. Coping styles and learnt resourcefulness may shape the experience of depressive symptoms and the ability to care for oneself. Family relationships and the support of a partner can also influence mental health consequences.

7. HIV/AIDS imposes a significant psychological burden. People with HIV often suffer from depression and anxiety as they adjust to the impact of the diagnosis of being infected and face the difficulties of living with a chronic life-threatening illness, for instance shortened life expectancy, complicated therapeutic regimens, stigmatization, and loss of social support, family or friends. HIV infection can be associated with high risk of suicide or attempted suicide. The psychological predictors of suicidal ideation in HIV-infected individuals include concurrent substance-use disorders, past history of depression and presence of hopelessness.

8. Apart from psychological impact, HIV infection has direct effects on the central nervous system, and causes neuropsychiatric complications including HIV encephalopathy, depression, mania, cognitive disorder, and frank dementia, often in combination. Infants and children with HIV infection are more likely to experience deficits in motor and cognitive development compared with HIV-negative children.

9. Cognitive impairment in HIV/AIDS has been associated with greatly increased mortality, independent of other factors such as baseline clinical stage, CD4+ cell count, serum haemoglobin concentration, antiretroviral treatment, and social and demographic characteristics. The incidence of AIDS-defining illness in patients receiving highly active antiretroviral therapy has been reported to be especially high in injecting drug users. In a study conducted in HIV-positive women in the United States of America, chronic depressive symptoms were associated with increased AIDS-related mortality and rapid disease progression independent of treatment and comorbid substance use.

10. Mental and substance-use disorders affect help-seeking behaviour or uptake of diagnostic and treatment services for HIV/AIDS. Mental illnesses have been associated with lower likelihood of receiving antiretroviral medication. In a study of women who were medically eligible to receive highly active antiretroviral therapy, its non-receipt was associated with substance use and with a history of childhood sexual abuse. Among people with HIV/AIDS, those with drug-use disorders typically experience the greatest barriers in accessing treatment because of negative societal attitudes and reluctance to seek any kind of treatment. Injection drug use has consistently been shown to be associated with low uptake of highly active antiretroviral therapy. Inadequate provision of integrated services for people with mental-health and substance-use disorders, HIV/AIDS and related physical, psychological and social problems creates an additional serious barrier to treatment and care for HIV/AIDS.

11. For sustained suppression of HIV, the highly active antiretroviral therapy regimen must be adhered to. Moreover, adherence of less than 95% is associated with development of viral resistance. Drug-resistant viruses can be transmitted to other people, thereby limiting their treatment options. There is consistently strong evidence from high-income countries that adherence to highly active antiretroviral therapy is lowered by depression, cognitive impairment, alcohol use and substance-use disorders. Furthermore, such therapy, especially with efavirenz, can be associated with a range of side-effects on the central nervous system, including depression, nervousness, euphoria, hallucination and psychosis. Little evidence is available from low- and middle-income countries, although one study from Uganda reported no association of these conditions with adherence, whereas in Ethiopia depression was associated with less than 95% self-reported adherence.

12. Substance-use disorders affect both the progression of HIV disease and the response to treatment. In untreated comorbid drug dependence, rates of adherence to highly active antiretroviral therapy are low, and rates of coinfection with hepatitis B and C viruses are high. Several randomized controlled trials have indicated that, with integrated treatment of both drug dependence and HIV/AIDS, rates of adherence approach the rate for the non-drug-dependent population. Recent research suggests that harmful patterns of alcohol use are associated with higher mortality in patients with HIV/AIDS. Several mechanisms appear to be responsible, including a direct effect of alcohol on HIV disease progression, probably mediated through the immune system, and the undermining of adherence to treatment. Even relatively low levels of alcohol consumption, such as one standard drink per day, have been associated with a reduction in adherence to treatment regimens.

ISSUES

13. Mental disorders, including substance use disorders, are risk factors for contracting HIV, and the presence of HIV/AIDS increases the risk of development of mental disorders. The resulting comorbidity complicates help-seeking, diagnosis, quality of care provided, treatment and its outcomes, and adherence.

14. The diagnosis of mental health problems in HIV-infected individuals faces several barriers. Patients often do not reveal their psychological state to health-care professionals for fear of being stigmatized further. Also, health-care professionals are often not skilled in detecting psychological symptoms and, even when they do, they often fail to take the necessary action for further assessment, management and referral.

15. Effective and readily available treatment and preventive measures for injecting drug users can prevent HIV epidemics among such groups if they reach sufficient proportions of the target populations. Appropriate policies and programmes should ensure that prevention and treatment services meet the needs of clients and include a combination of interventions for substance-use disorders and HIV/AIDS. Treatment of substance-use disorders should be integrated with HIV prevention and treatment interventions.

Priorities for action

16. Integration of mental health into HIV/AIDS initiatives and programmes in countries presents an opportunity to improve the health of people with HIV/AIDS. WHO has produced a series of modules and training material for integration of mental health interventions into antiretroviral therapy programmes.¹ HIV/AIDS programmes in countries need to include assessment of mental and substance-use disorders and their appropriate management. Primary health-care providers, including HIV counsellors, can be trained to recognize and treat common mental and substance-use disorders and refer patients to specialized services when warranted. Such providers need to be properly trained and supported by adequate supervision, and the process of referral to mental health services needs to be an integral part of the health infrastructure. The services for mental health and substance-use disorders need to collaborate closely with HIV/AIDS services at all levels in order to facilitate coordinated action involving other relevant community-based resources.

17. Integration of HIV into mental health services provides opportunities for identifying individuals at risk of HIV infection, introducing HIV prevention and detecting those who are infected and providing them with appropriate HIV treatment and care. Mental health services should ensure access to voluntary and confidential HIV testing and counselling for those at risk.

18. Where HIV is transmitted predominantly through injecting drug use and behaviour related to alcohol consumption and other drug use, a major challenge is insufficient coverage of measures aimed at reducing the risk of HIV transmission related to substance use, including prevention and treatment of substance-use disorders, effective harm-reduction interventions and provision of antiretroviral treatment to people living with substance-use disorders and HIV/AIDS.

¹ World Health Organization. *Mental health & HIV/AIDS therapy series*. Geneva, World Health Organization, 2005.

19. There is a need for relevant normative guidance, continued advocacy, and monitoring of the actual levels of coverage of interventions for mental health, including substance use disorders, and HIV/AIDS in different countries. Furthermore, the formulation and implementation of effective policies, strategies and programmes need supportive environments if their coverage is to be adequate.

20. Despite the fact that developing countries carry more than 90% of the burden of HIV/AIDS, little information about the interaction between HIV/AIDS and mental health is available from low- and middle-income countries. Support is needed for research in those countries on that interaction, including the relationships between mental-health and substance-use disorders and HIV/AIDS, between levels and patterns of alcohol consumption and HIV/AIDS. Further research should investigate service delivery, cost-effective models of service provision and the impact of interventions for mental disorders and substance use on the outcomes of HIV disease.

ACTION BY EXECUTIVE BOARD

21. The Executive Board is invited to note the report.

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