AWACC
ANNUAL WORKSHOP ON ADVANCED CLINICAL CARE - AIDS

Mindful Medication

Rational prescribing for the mental health comorbidities of HIV



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HEALTH
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Outline

- Recognise the scale and impact of mental illness in people living with HIV (PLWH)
- Work condition by condition: depression, anxiety, PTSD, psychosis, bipolar, dementia, insomnia, ADHD
- Prescribe psychotropics rationally in the patient who is also on antiretroviral therapy
- Navigate drug–drug interactions with confidence — the efavirenz and dolutegravir eras
- Knowing when to refer

The case for integration



Why mental health is core HIV care — the scale, the loop, and the gap.

Mental illness in PLWH: common, and more common than you think

~1 in 3

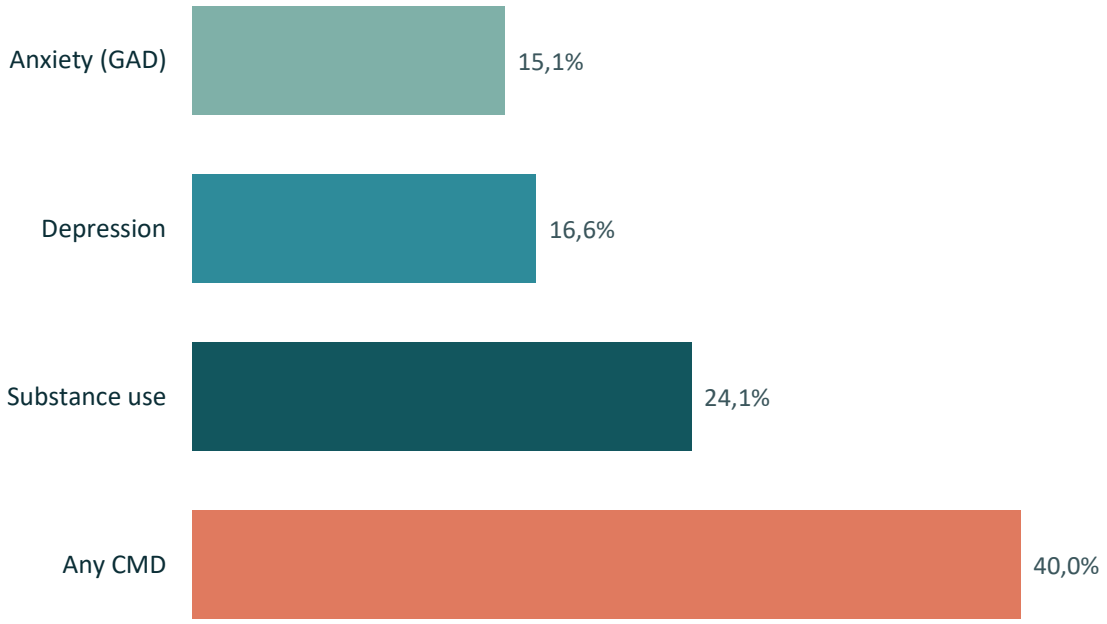
PLWH in South Africa screen positive for mental distress

2–3×

higher prevalence of common mental disorders than the general population

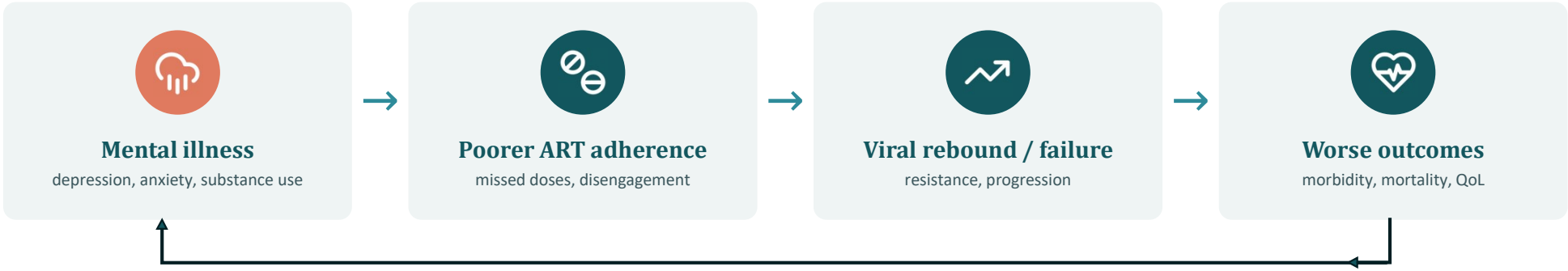
*Depression in PLWH runs **20-32%** vs 10-15% in the general population*

Screen-positive rates in PLWH at SA primary care



Ekurhuleni PHC cohort, PLWH, n=403 (Edet et al., Afr J Prim Health Care Fam Med, 2024).

Why it matters: the vicious cycle



2.19×

more likely to miss ART with mental illness

4–10×

more likely to default with heavy/hazardous alcohol use

Mental illness is never a reason to delay or withhold ART — treat both in parallel, rather than making one a prerequisite for the other.

(*HSRC)*

The gap: under-recognised, under-treated

~16%

of PLWH recall being screened for depression…

~1%

…and only this had it documented in the file

What the SA guidelines ask of us

- Screen ALL clients on ART for depression and anxiety — at least annually
- And at any red-flag visit:
  - re-engaging,
  - elevated viral load,
  - or possible treatment failure

Screening tools that fit routine care

- PHQ-9 — depression. ≥10 = clinically significant; item 9 flags suicidality
- GAD-7 — anxiety. ≥8–10 = screen positive
- Both free, brief, and validated in South Africa (including isiZulu)
- Substance: WebASSIST: https://assistscreening.com
- BMH (KZN)

National Consolidated Guidelines (2026), Mental Health Assessment, p.179.

Edet et al., 2024 — screening for common mental disorders in PLWH at SA primary care.

Psychiatry Crash Course

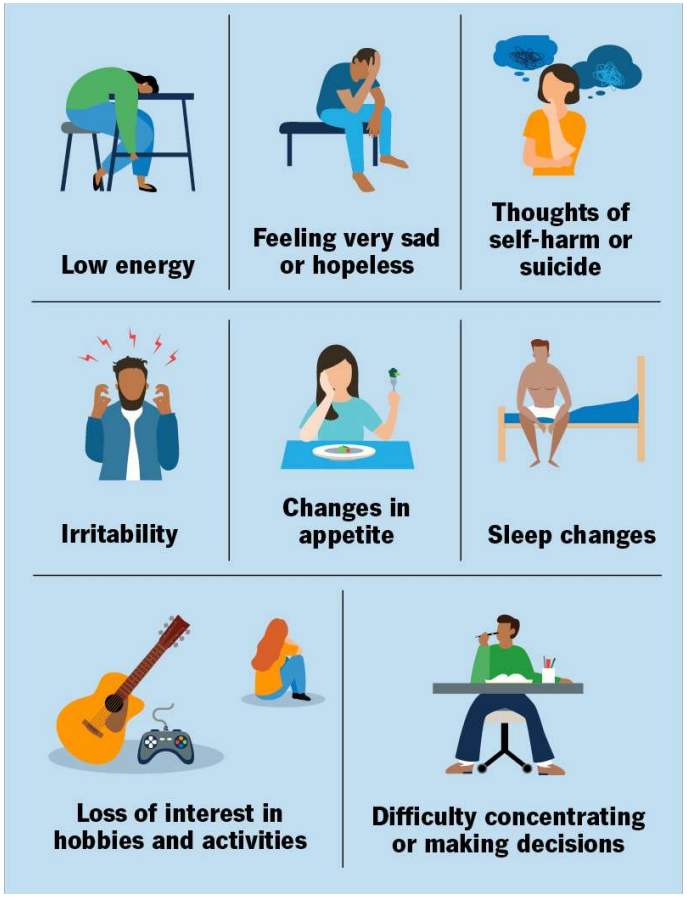
Common mental disorders (CMD)

vs

Severe mental illness (SMI)



Depression



(Moosa et al.); Diagram: Reproduced from my.clevelandclinic.org

Recognising it

~1 in 3-5

- Most common psychiatric comorbidity in HIV
- Symptom overlap — fatigue, sleep, appetite — can be HIV or ART; look for anhedonia, hopelessness, guilt, worthlessness
- Always ask about suicidality

An approach to deciding between depression and grief / sadness

- Mild: transient, low distress, often tied to diagnosis or starting ART → adherence counsellor and education
- Moderate–severe (will require psychotropic medication):
  - persistent symptoms, that are not reactive
  - high distress, suicidality → start pharmacotherapy
  - Self-deprecatory thoughts, worthless, hopeless
  - Effective treatment improves adherence and viral suppression

Depression

56% in♀ vs 51% in ♂(Kalafong Hosp)



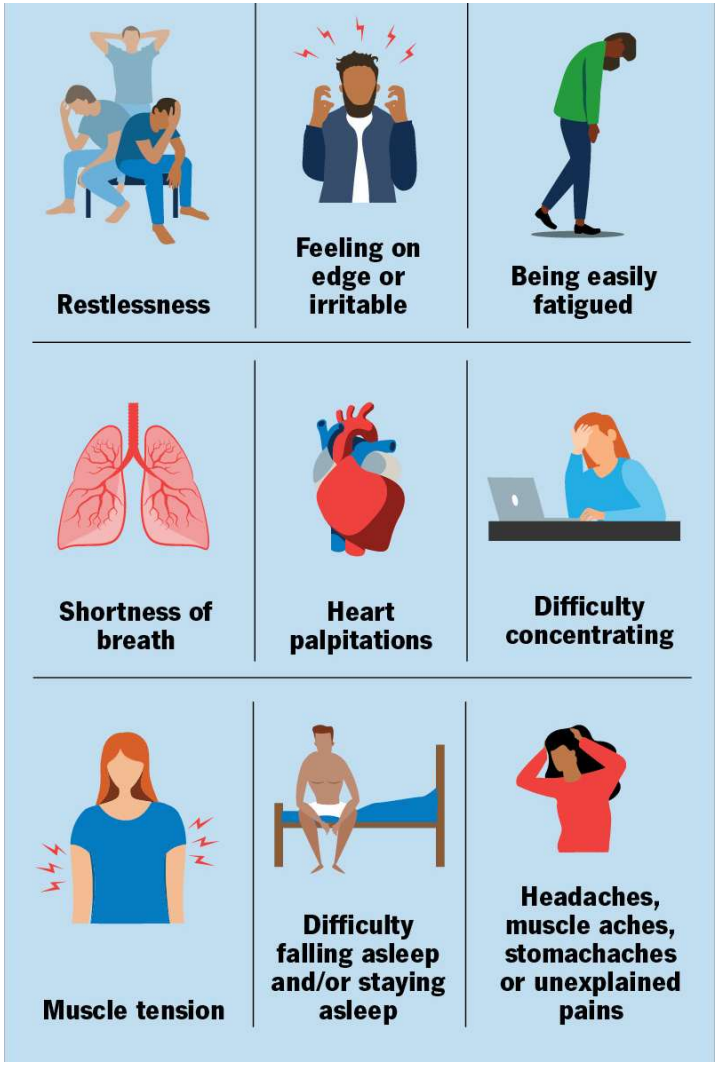
Gender differences in depression presentation	
Females	Males
Blames themselves	Blame others
Feel sad and apathetic	Feel angry, irritable
Feel anxious and scared	Feel suspicious and guarded
Avoid conflicts at all costs	Create conflict
Feel slowed down and nervous	Feel restless and agitated
Have trouble setting boundaries	Need to feel control at all costs
Find it easy to talk about self-doubt and despair	Find it weak to talk about self-doubt or despair
Use food, friends, and love to self-medicate	Use alcohol, TV and sex to self-medicate

Jed Diamond: Male Menopause (1997); van Coppenhagen: Prevalence of depression in people living with HIV and AIDS at the Kalafong Provincial Tertiary Hospital Antiretroviral Clinic (2019)

Anxiety disorders

Approach

- Common (GAD ~15% of PLWH)
- Exclude medical mimics: thyroid, cardiac, substance withdrawal
- Treatment – the same as for depression
- But start LOWER than for depression



(Diagram: Reproduced from my.clevelandclinic.org)

PTSD

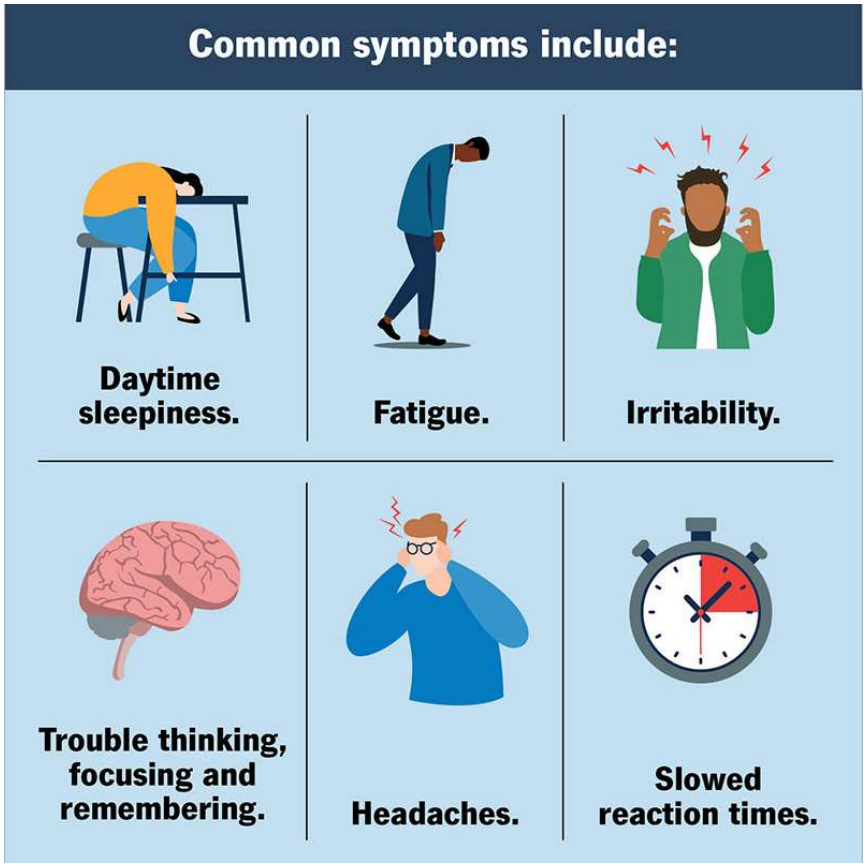
Highly relevant in local setting:
trauma, interpersonal violence and GBV are common

Management

- Trauma-focused psychotherapy is the core treatment.
- Medical treatment is the same as for depression
- Benzodiazepines — do not treat PTSD, may worsen it in the acute phase, and carry dependence risk



Insomnia in HIV



Treat the cause before the symptom

- Screen for reversible drivers:
  - depression,
  - mania,
  - pain,
  - substances (including alcohol and cannabis),
  - medication (efavirenz, steroids, antihypertensives)
  - poor sleep hygiene
- Check medication timing (stimulating drugs in the morning, sedating at night)
- Set realistic expectations about sleep, and advocate sleep hygiene

Insomnia in HIV

If medication is needed — short-term, lowest dose

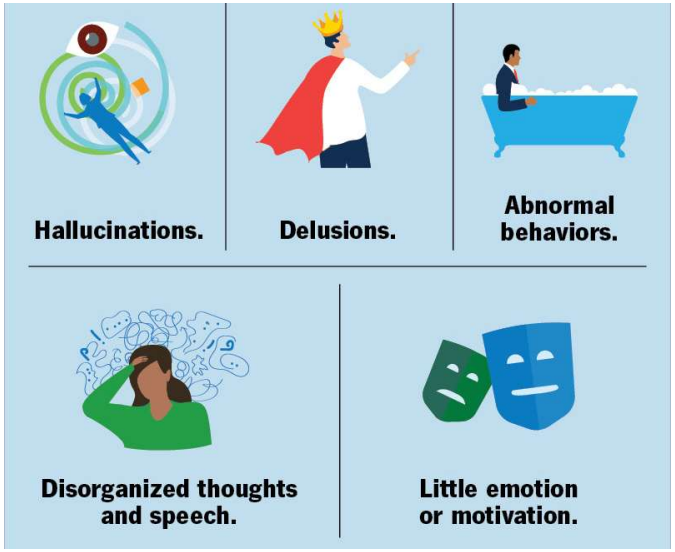
- Promethazine — sedating antihistamine (dry mouth, 'hangover')
- Low-dose amitriptyline — especially with neuropathic pain
- Oxazepam — short-term only, ≤14 days; dependence risk
- Avoid long-term benzodiazepines and Z-drugs (zolpidem, zopiclone)

Sleep Hygiene Checklist

- ✓ Stick to a **consistent bedtime** and wake-up time.
- ✓ Wind down with a **relaxing nightly routine**.
- ✓ **Dim the lights**, and use blackout curtains to block out light.
- ✓ **Lower the temperature** in your bedroom.
- ✓ Use a sound or **white noise machine** to reduce disruptions.
- ✓ **Exercise regularly** in the morning or afternoon.
- ✓ Get plenty of **natural light** in the morning.
- ✓ **Keep a sleep diary** to track factors that affect your rest.
- ✓ Use **comfortable bedding** that suits your needs.
- ✓ Use a **pillow that keeps your neck aligned** and supported.
- ✓ **Invest in a mattress** that relieves pressure and supports spinal alignment.

Psychosis

1–15%



Exclude secondary causes FIRST

- Delirium: fluctuating attention, disturbed sleep-wake cycle, disorientation = a medical emergency
- In advanced HIV / low CD4, consider CNS disease: cryptococcal meningitis, TB meningitis, toxoplasmosis, neurosyphilis, PML
- Also substances, steroids, and medications (efavirenz)

Red flags → urgent medical work-up:

- Rapid onset
- fever
- headache, meningism, focal signs, seizures
- reduced consciousness
- rapid progression
- low CD4

- Get a psychiatric opinion, at some stage
- But commence medication earlier rather than later
- atypical antipsychotics preferred

Bipolar disorder & mania



± 4 ×

higher prevalence of bipolar disorder than the general population

Mania in the HIV patient

- Can be primary bipolar - or organic (HIV encephalopathy)
- “Manic overlay” in psychotic patients (up to 80%)
- Multiple mechanisms: predisposition, neuropathology, unmasking
- Treat mania with: antipsychotic ± short-term benzodiazepine, plus a mood stabilizer
- Get psychiatric opinion regarding diagnosis and treatment

Neurocognitive disorder (HAND) & dementia

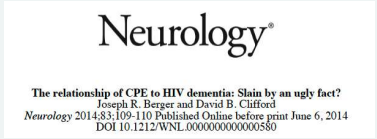
An ageing HIV population means more cognitive impairment, frailty and polypharmacy - PLWH get age-related disease earlier.

Clinical Approach

- Screen with the IHDS (HIV-specific) or MoCA
- Treat reversible contributors FIRST:
  - depression ('pseudodementia')
  - B12/thyroid
  - Substances
  - Neuroimaging
- Optimise ART and viral suppression
- Review polypharmacy — deprescribe anticholinergic and sedating drugs

Medications

- Cholinesterase inhibitors / memantine: limited evidence (except for comorbid Alzheimer's in the ageing patient)
- Stimulants (e.g. methylphenidate) can improve HIV-associated cognitive slowing
- Don't change ART just to chase a CNS-penetration (CPE) score
- **viral suppression comes first**


Neurology®

The relationship of CPE to HIV dementia: Slain by an ugly fact?
Joseph R. Berger and David B. Clifford
Neurology 2014;83:109-110 Published Online before print June 6, 2014
DOI 10.1212/WNL.0000000000000580

- Build cognitive reserve in younger patients

Ageing / healthspan: SA HIV Clinicians Society older-PLWH guidelines; Lancet HIV commission (2026).

ADHD

~1 in 4-5

children with HIV are affected by ADHD

30% of HIV mums have kids with ADHD

Treatment

- Methylphenidate is effective; also helps HIV-related fatigue and cognitive slowing
- Atomoxetine is a non-stimulant alternative

Caution

- Cardiovascular caution - HIV already raises CV risk; check BP/HR
- Seizure risk with CNS involvement - titrate slowly
- Watch appetite, sleep, and growth in children
- CYP2D6 interaction with ritonavir/cobicistat is more theoretical - monitor



Principles of rational prescribing



how to prescribe safely in the patient on ART.

Principles for prescribing psychotropics in HIV

Primary vs secondary

exclude ARV effects, medical causes, delirium, substances first

Keep it simple

minimise pill burden; prefer once-daily; fewer moving parts

Start low, go slow

↑ sensitivity, less lean mass, altered BBB

Anticipate interactions

both ARVs and psychotropics run through CYP450

Mind overlapping toxicity

QTc, sedation, metabolic, hepatic toxicity

Address adherence & stigma

the point of treating is to keep them in care

Primary vs Secondary: Exclude ARV-induced mental symptoms

Before you start a psychotropic, check the ARV regimen

New low mood or insomnia on efavirenz may be the drug, not a depressive disorder.

Switching the ARV may resolve; however, very individualized

Symptoms are too often misattributed between mental illness and treatment side-effects — in both directions.

Efavirenz

- Vivid dreams, insomnia, dizziness, impaired concentration
- Low mood, anxiety — and, less commonly, psychosis or suicidality
- Typically early (first weeks); often settle by 6–8 weeks

Dolutegravir

- insomnia, occasional neuropsychiatric effects

Non-ART medications

- Steroids, isoniazid, co-trimoxazole, metronidazole

  can all mimic psychiatric illness

Anticipating interactions

ARVs and most psychotropics are metabolised by cytochrome P450 — so the ARV changes how your psychotropic behaves. (The other way is rarer)

Efavirenz (EFV) era

- An inducer — speeds metabolism, LOWERS levels of some psychotropics
- Its OWN neuropsychiatric effects (see next slide)
- No longer first-line

Dolutegravir (DTG) now

- First-line: TLD = TDF + 3TC + DTG
- Minimal CYP interactions → far more prescribing freedom

Boosted PIs (2nd line)

- Ritonavir = potent CYP3A4 inhibitor (+2D6)
- RAISES levels of many psychotropics → toxicity

TB co-treatment: rifampicin is a potent inducer — it lowers many psychotropics; the induction lingers for weeks after it stops.

SA first-line regimen, DTG & rifampicin interactions: National Consolidated Guidelines (2026), pp. 31–35.

Psychotropic medication

Antidepressants

- SSRIs
  - Citalopram
  - Escitalopram
  - Sertraline
  - Fluoxetine
- Tricyclic antidepressants
  - Amitriptyline (75 mg +)
- Other:
  - Venlafaxine
  - Duloxetine
  - Bupropion
  - Mirtazapine

Antipsychotics

- Typical
  - Haloperidol
  - Chlorpromazine
- Atypical
  - Risperidone
  - Ziprasidone
  - Paliperidone
  - Olanzapine
  - Quetiapine
  - Clozapine
  - Amisulpride
  - Aripiprazole

Mood stabiliser

- Atypical antipsychotics
- Lithium carbonate
- Antiepileptics:
  - Lamotrigine,
  - Valproate,
  - Carbamazepine

Antidepressants - first-line: the SSRIs

Indicated in depression, anxiety, PTSD, impulsivity

Citalopram / Escitalopram

PREFERRED

- Few CYP interactions — safest with PIs
- QTc: cap citalopram ≤40 mg (≤20 mg if elderly)
- Escitalopram: faster response; scored tablet eases low starts

Fluoxetine

- Cheap, widely available at PHC
- Long half-life — forgiving of missed doses
- Activating (early anxiety/insomnia); more P450 interactions

Sertraline

- A safe all-round choice
- Boosted PIs can lower levels (~40–55%)

Tricyclics — amitriptyline

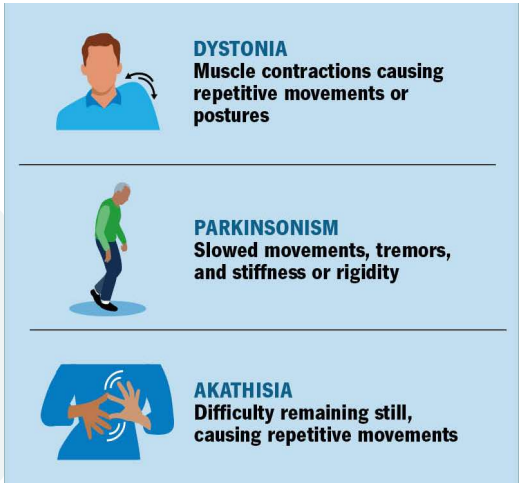
- Useful for comorbid neuropathic pain or insomnia
- LETHAL in overdose — avoid if suicidal
- Anticholinergic; ritonavir raises levels (reduce dose)

St John's wort — CONTRAINDICATED.
A potent inducer; lowers ARV levels → virological failure

Psychosis — choosing an antipsychotic

Principle

Match to the patient's risk profile.
Antipsychotics add little CYP burden themselves
(except the ritonavir–risperidone/quetiapine effects)

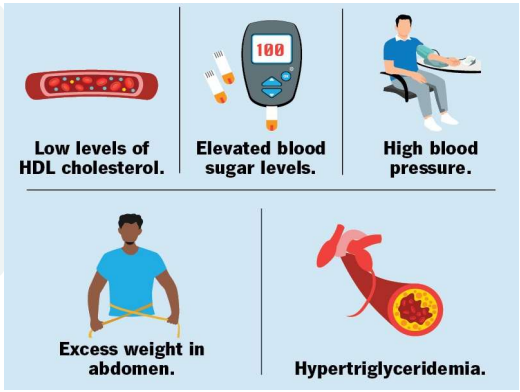


Higher-risk medical profile → risperidone (low-dose)

- Haloperidol has a high burden of EPSE esp in HIV
- Most-studied atypical; raises prolactin; EPSE is dose-dependent
- Levels rise with ritonavir

Lower-risk medical profile → chlorpromazine, "pines"

- Chlorpromazine – anticholinergic, epileptogenic, cardiotoxic
- Metabolic syndrome
- Quetiapine: level rises with ritonavir → reduce to ±1/6 dose



Other medications

Valproate and Carbamazepine

- Carbamazepine lowers DTG & PI levels → virological failure
- TERATOGENIC - avoided

Lamotrigine

- Good for bipolar depression
- Ritonavir LOWERS it ~50% - may need ↑ dose
- Slow titration (Stevens–Johnson)

Lithium

- Narrow therapeutic index
- Dehydration risk: ARV GI effects, night sweats
- Renal monitoring; DTG/cobicistat

Benzodiazepines — handle with care

- Short-term only (<2–3 weeks); dependence & abuse, especially with substance use
- Lorazepam & oxazepam are SAFEST, no significant CYP interaction
- Avoid alprazolam & diazepam with boosted PIs
- Oral midazolam & triazolam are CONTRAINDICATED with ritonavir / cobicistat

Overlapping toxicity: QTc

Psychotropics that prolong QTc

- Citalopram & escitalopram (dose-dependent)
- Tricyclic antidepressants
- Antipsychotics (varies by agent)
- Methadone

ARVs with QTc warnings

- Efavirenz
- Boosted saquinavir & lopinavir/ritonavir (older PIs)
- Risk is additive when stacked together
- Dolutegravir: not a QTc concern

Principles:

Don't stack QT-prolongers.
Cap citalopram at 40 mg (20 mg with a CYP2C19 inhibitor or in the elderly).
Routine ECG for everyone on an SSRI is not needed.
Get a baseline and periodic ECG where risk is high: older age, cardiac disease, methadone, or multiple QT drugs.

Lenacapavir — a new era in prevention

- 6-monthly PrEP
- SAHPRA-approved Oct 2025
- Roll-out in June 2026
- Target - 1 million by end-2027

The rule for a patient on lenacapavir

- Lenacapavir RAISES levels of midazolam, triazolam, alprazolam → more sedation
- Lorazepam and oxazepam – safer (no interaction)
- Carbamazepine; St John's wort LOWER lenacapavir → loss of PrEP protection
- Long tail: effects can persist up to 9 months after the last injection



The interaction red list — and the safe picks

Avoid / contraindicated

- Carbamazepine - lowers DTG & PIs; also lower lenacapavir
- St John's wort — lowers ARVs → failure
- Rifampicin (TB) — not avoidable, but a potent inducer: anticipate lower psychotropic levels; DTG goes 12-hourly
- Oral midazolam / triazolam with ritonavir or cobicistat
- Stacking QT-prolongers; citalopram >40 mg

Reach-for / safer picks

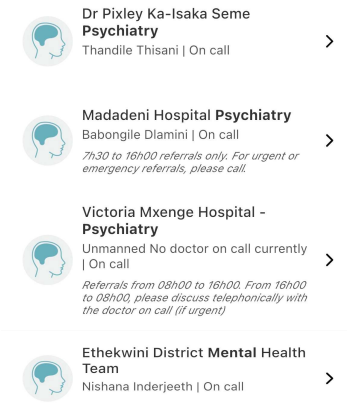
- Depression / anxiety: citalopram, escitalopram or sertraline
- Sedation / anxiety: lorazepam or oxazepam
- Mood stabilising: valproate, lamotrigine, levetiracetam
- Psychosis: low-dose risperidone (watch prolactin)

A practical framework for primary care

1	**Screen**	All PLWH with e.g. BMH
2	**Check the regimen**	TLD - safer
3	**Exclude secondary causes**	ARV effects, medical, delirium, substances
4	**Choose low-interaction, start low**	Prefer agents from the safe list; titrate
5	**Counsel adherence & stigma**	Refer to allied health workers (social worker, psychology)
6	**Review & monitor**	Response, side-effects, QTc/metabolic where relevant
7	**Refer red flags**	Consult psychiatrist

When to refer

- **Primary psychosis**
- **Bipolarity / mania**
- **Suicidality**
- **Neurocognitive disability**
- **Treatment resistance**
- **Complex polypharmacy**



Refer at any time you're uncertain.
Treat confidently within scope, and escalate without hesitation beyond it.

Case scenarios

1

New insomnia and vivid dreams two weeks after starting ART

→ Check chronology, severity, suicidality, adherence and alternative causes.
Likely efavirenz - it may settle, but persistent or severe symptoms (or any suicidality) warrant review of ARVs ± advice on sleep hygiene

2

Marked sedation after an antipsychotic is added to boosted ART

→ Likely increased psychotropic level — the classic quetiapine–ritonavir interaction.
Assess airway, vitals and ECG; check the specific interaction and adjust deliberately

3

New psychosis with headache, fever and confusion

→ **R**ed flag: urgent medical work-up for delirium / CNS disease (meningitis, toxoplasmosis),
Low dose antipsychotic if behaviourally disturbed
Treat the cause; manage agitation safely in the meantime.

References

1. Close M. Psychiatric Challenges Related to HIV for Patients and Carers. 18 June 2026.

2. Goodlet KJ, Zmarlicka MT, Peckham AM. Drug–drug interactions and clinical considerations with co-administration of antiretrovirals and psychotropic drugs. CNS Spectrums. Published online 2018.

3. Reid E, Orrell C, Stoloff K, Joska J. Psychotropic prescribing in HIV. SA J HIV Med. 2012;13(4):188–194. Supplied PDF; historical background, not current dose authority.

4. SA HIV Clinicians Society. Adult ART guidance, Module 22: Psychiatric disease.

5. SA National Department of Health. National Consolidated Guidelines. January 2026. Printed pp. 28, 31–35, 113 and 179.

THANK YOU

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