10 - Substance use disorders

Substance use disorders

806 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 10 SSRIs being the first-line options. Benzodiazepines may have some utility in the acute treatment of anxiety but require caution because of potential misuse, possible drug interactions and a higher risk of sedative and neurocognitive adverse effects in PLWH.33 Lorazepam is metabolised by non-CYP pathways, and so has a lower risk of interactions. Clonazepam has no active metabolites and so it may be a preferred short-term option for PLWH.34,35 Buspirone may also be helpful.34 HIV-associated neurocognitive disorders (HAND) HAND encompasses three sub-disorders, ranging from the more common asymptomatic neurocognitive impairment (ANI) to a mild neurocognitive disorder (MND) and the more severe but less common HIV-associated dementia (HAD). Screening for cognitive impairment is recommended in PLWH using scales such as the MoCA or the three-item Cognitive Concerns Questionnaire.36 In 2023, the International HIV-Cognition Working Group published recommendations to better define the cognitive impairment in HIV.37 Treatment involves the use of ART with high CNS penetration effectiveness (e.g. raltegravir), aiming to achieve therapeutic levels in the CNS with minimal drug-related neurotoxicity. Cognitive rehabilitation is an essential treatment component. Effective treatment of depression is essential as is management of substance use disorders and physical health comorbidities. Psychostimulants, modafinil, memantine, lithium and valproate have been studied but there is currently no licensed treatment for HAND.38 Delirium Delirium in HIV can be difficult to differentiate from HAND, although onset of delirium is more acute and its severity may fluctuate. Organic causes should be identified and treated. Antipsychotics are probably not effective in treating delirium and so should only be used as a last resort in severe cases and when non-pharmacological measures fail.27 Early studies document the efficacy of haloperidol, but the lowest possible dose should be used given the high incidence of EPSEs, particularly in those with advanced HIV (e.g. doses used in delirium in palliative care may be considered).27 Benzodiazepines should be used cautiously as they may worsen delirium except when alcohol or benzodiazepine withdrawal is the precipitating factor.27 Substance use disorders Substance use disorders are highly prevalent in PLWH. Commonly used substances include alcohol, stimulants (including cocaine and methamfetamine), benzodiazepines, opioids and cannabinoids. The potential for interactions between drug use and prescribed medicines should be considered. Treatment should be offered to PLWH with comorbid substance use disorders. Naltrexone is safe and effective for alcohol relapse prevention in PLWH,39 while acamprosate has not been studied in this population and has a high tablet burden. Methadone and buprenorphine are possible evidence-based options for opioid use disorder but care is required with ART drug interactions.27,40

Revision #1
Created 2026-01-04 20:17:40 UTC by Omar Ayman

Updated 2026-01-04 20:17:40 UTC by Omar Ayman