AN INTEGRATED APPROACH TO THE MANAGEMENT OF SUBSTANCE USE DISORDERS AND PLHIV

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CONTENT

1. INTRODUCTION

- According to the World Drug Report: 2016).
- “‘The abuse of substances is a major cause of social, economic and health problems such as crime, poverty, reduced productivity, unemployment, dysfunctional family life, escalation of chronic diseases such as HIV/AIDS, hepatitis and TB, injuries and premature deaths”.
- Drug related deaths included the following:
  - -fatal drug overdoses;
  - - deaths due to AIDS acquired through injecting drug use;
  - -intentional self-poisoning by exposure to psychotropic substances (suicide);
  - -unintentional deaths
  - -trauma (motor vehicle accidents and other forms of accidental death) due to drug use.

2. THE RELATIONSHIP BETWEEN SUD AND HIV

Drug and alcohol use complicate both the prevention and treatment of human immunodeficiency virus (HIV) infection.

Substance use is one of the major engines driving HIV transmission:

- directly, through the sharing of injection drug use equipment
- indirectly, through increasing risky sexual behaviors.
- compromise effective HIV treatment by influencing both access and adherence to antiretroviral therapy.
- immunosuppressive effects independent of their impact on access and adherence to treatment

- Alcohol = poor HIV medication adherence and is associated with lower CD4 counts.
- Methamphetamine and other amphetamine type stimulant use = HIV transmission.

3. WHO ARE OUR VULNERABLE POPULATIONS??

Examines the links between drug use and high-risk sexual practices and HIV in vulnerable drug-using populations in South Africa, including

- commercial sex workers (CSWs),
- men who have sex with men (MSM),
- injecting drug users (IDUs) and
- non-injecting drug users who are not CSWs or MSM (NIDUs).

3.1 PEOPLE WHO INJECT DRUGS(PWID)

- In 2012, an estimated 16.2% of PWID in South Africa were living with HIV.
- PWID account for a comparatively low 1.3% of new HIV infections. 86% of South Africans who inject drugs share injection equipment such as syringes and other drug paraphernalia.
- PWID re-use equipment between 2 and 15 times.
- high-risk behaviours such as sex work and unsafe sexual practices.
- up to 65% of PWID in South Africa thought to practice unsafe sex.

3.2 COMMERCIAL SEX WORKERS(CSWs)

- In a **Rapid assessment of HIV risk behavior in drug using sex workers in three cities in South Africa.**Parry CD, et al. identified that Cocaine, Ecstasy, heroin and methaqualone are used by CSWs prior to, during and after sex.
- Drugs enhance the sexual experience and prolong sex sessions.
- inconsistent condom use among CSWs together with other risky sexual practices such as needle sharing.
- Among CSWs who agreed to HIV testing, 34% tested positive.
- Barriers to accessing drug treatment and HIV treatment and preventive services were identified.
- Interventions recognizing the role of drug abuse in HIV transmission should be prioritized
- issues of access to services, stigma and power relations must be considered

3.3 NON-INJECTING DRUG USERS(NIDUs)

- Many people at **risk for or already infected with HIV** abuse alcohol, contributing to the difficulties in preventing the spread of the infection and treating infected patients.
- alcohol-abusing patients may delay testing for HIV,
- accessing appropriate medical care, and initiating antiretroviral therapy (ART), which may hasten disease progression to full-blown AIDS.
- increases the risk of HIV infection by promoting risky behaviors and counteracting efforts to minimize the risk of infection, prevent transmission of the virus to others once exposure has occurred.

HEALTH OUTCOMES IN NIDUs

In **HIV-infected people undergoing treatment**, concurrent alcohol abuse often renders treatment ineffective because:

- patients frequently fail to adhere to the strict treatment regimens necessary to achieve control of the infection.
- Moreover, alcohol may interact with ART medications and exacerbate adverse effects of these medications.
- Future research needs to better integrate behavioral and biological research to identify strategies to prevent the spread of HIV infection in alcohol-abusing populations. Byrant,K 2010

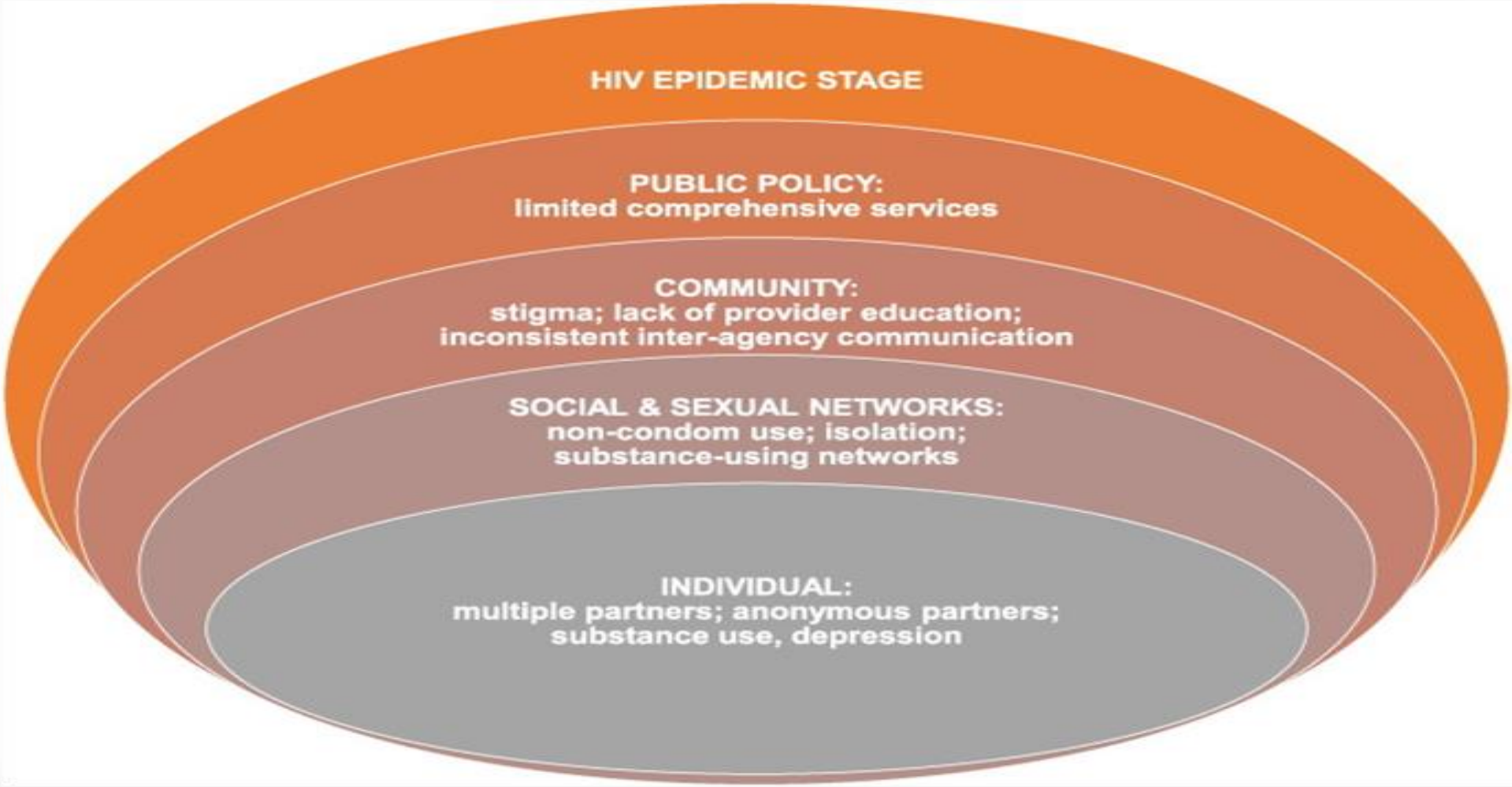
3.4 *MSM*

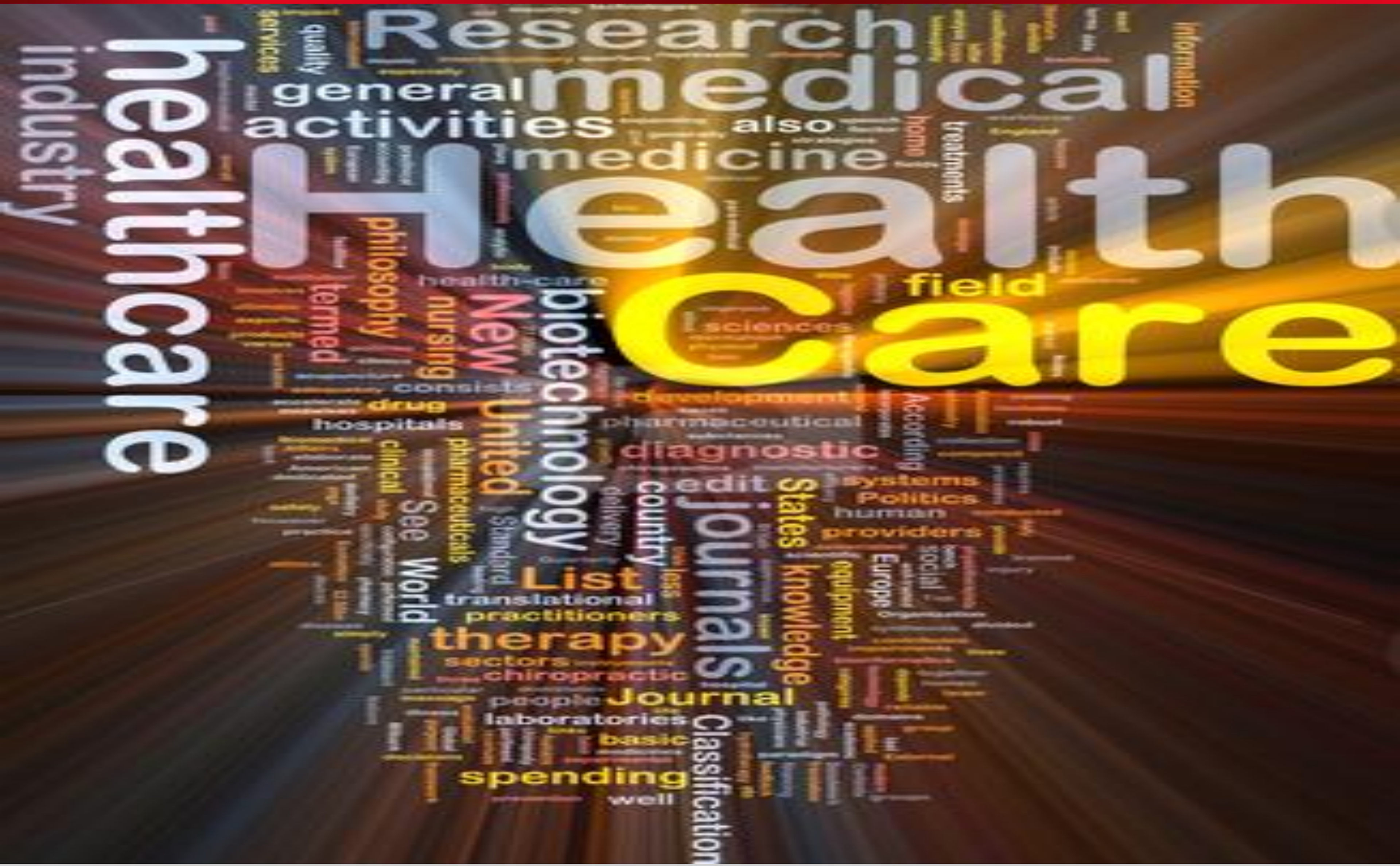
- This MSM explicitly linked his HIV diagnosis to suicidality, social isolation, and subsequent substance use:
- *I've always thought about [suicide]. Always thinking of a way to do it… I'm scared to do anything because I'd rather be here and try to deal with it. And my way of dealing with it is isolate myself, just stay to myself. And that's what I've meant to do after the shock of finding out I have HIV. I started] isolating myself. . . I think that's when my alcohol problem and drug problem accelerated*.

MSM

- Also making an argument for causation, this PLHIV described how his HIV diagnosis increased his need for external validation through substance use and sex:
- *I think that because I knew that I had AIDS, I was HIV +, I thought that maybe someone could look at me and tell, from the outside, so I had to make myself feel, like, desirable, in a flipped crazy way, and part of doing that was that I had to make sure that I was drunk before I even went out. . . Once I found out I was HIV, that made me, believe it or not, even more reckless. . . It made me even more sexually reckless and sexually irresponsible than I had ever been in my entire life.*

4.MODEL FOR FACTORS IMPACTING HEALTH AND HIV TRANSMISSION AMONG HIV-INFECTED.

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5. WHERE AND BY WHOM SHOULD INTOXICATION AND WITHDRAWAL BE MANAGED?

- Substance intoxication and withdrawal are medical problems and should be treated at an appropriate medical centre.

5.1GENERAL PRINCIPLES

- Start with medical stabilisation of the patient for intoxication, withdrawal and medical complications
- Follow with intervention to prevent relapse back to substance use.
- Brief interventions may be used in cases of misuse or abuse
- If fulfil criteria for dependence - refer to a specialist addiction treatment service ,
- This does not “cure” the patient, but provides tools and the support necessary to maintain sobriety
- Relapses and lapses (short periods of relapse) may still happen - learning opportunity

5.2 SCREENING AND BRIEF INTERVENTIONS

Two rapid screening instruments:

1. CAGE
2. AUDIT

AUDIT (Alcohol Use Disorders Identification Test)

- screening instrument
- hazardous and harmful alcohol consumption
- part of a six-country WHO study of brief alcohol interventions
- measures alcohol consumption, drinking behavior and alcohol-related problems during the past year
- emphasizes the detection of current disorders
- The CRAFFT and AUDIT tools currently have the most evidence for validity among adolescents. other widely used tools such as DAST-10, ASSIST (Alcohol, Smoking and Substance Involvement Screening Test),

6.GUIDELINES FOR THE MANAGEMENT OF ACUTE INTOXICATION AND WITHDRWAL

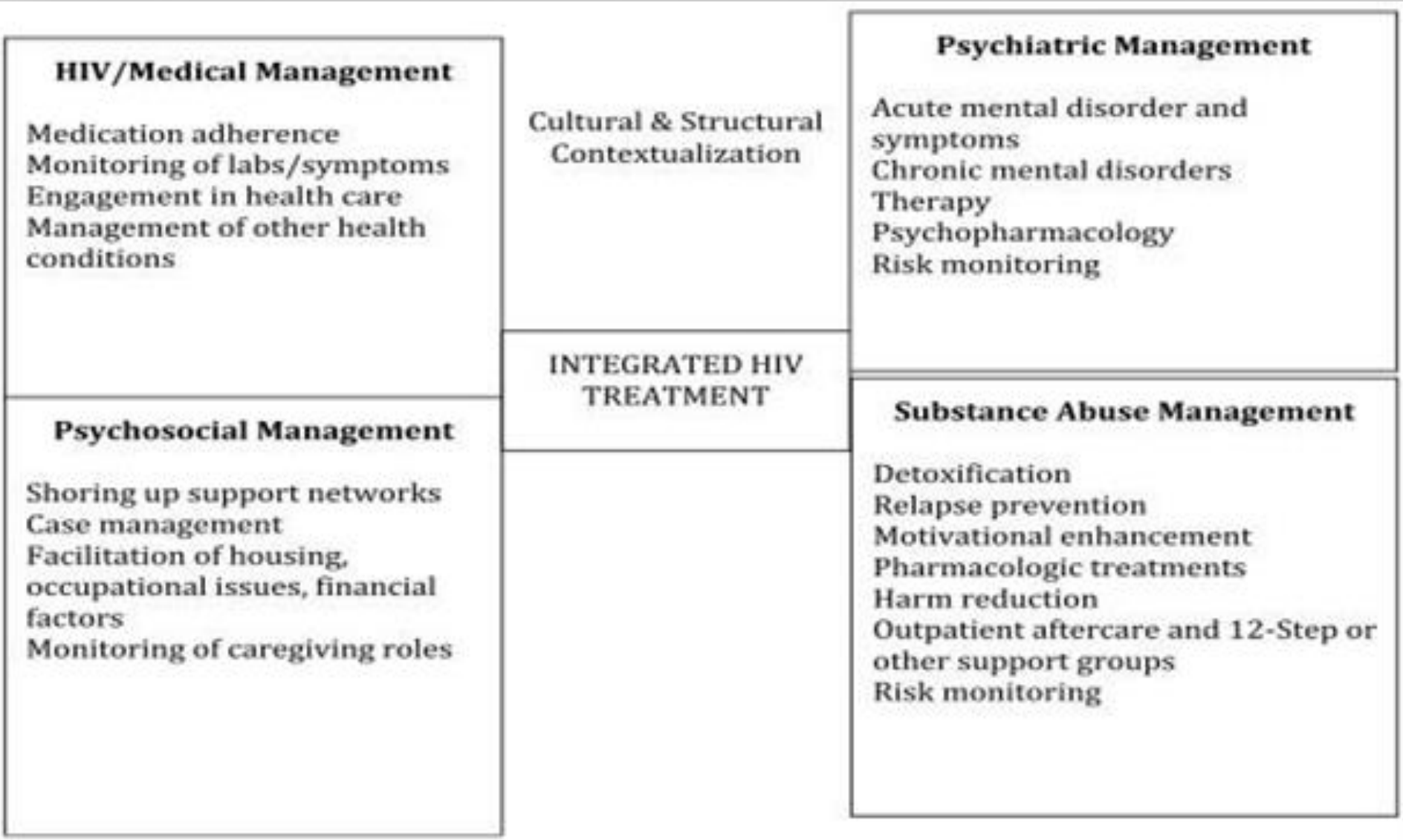
- Severe alcohol dependence - tolerance or withdrawal symptoms
- Past history of convulsions during detoxification
- Past history of Delirium Tremens
- Older age (>60 years)
- Pregnancy
- Significant medical co-morbidity (e.g. liver disease, cardiac disease, severe infections etc.)
- Significant psychiatric co-morbidity (e.g. psychosis, suicidal ideation)
- Lack of support at home, unless access to inpatient rehabilitation facility
- Previous failed outpatient detoxification attempts
- Special arrangement apply for opioid detoxification – see opioid section

Admit to a district or regional hospital, or a tertiary hospital (only if secondary level is not available).

GUIDELINES FOR OUTPATIENT/COMMUNITY WITHDRAWALS

- Someone available to monitor and supervise the withdrawal process.
- Discuss treatment plan with both the patient and the person providing supervision
- Write out the regime and keep a copy in the notes.
- Arrange for the patient to be seen daily where appropriate, especially initially.
- If the patient resumes drinking or drug use, the regime needs to be stopped.
- Ensure patient and carer has contact details so that they can contact the health facility if there are any problems.

7.MODEL OF INTEGRATED HIV TREATMENT



THE CONTINUIM OF CARE

Substance abuse treatment of HIV positive persons occurs on a continuum

- individuals becoming aware of their HIV status,
- engaging in HIV, psychiatric and substance abuse related care, and
- avoidance of relapse and continued adherence to treatment; with the recognition that these steps can be bidirectional.
- Lapses and setbacks in psychiatric symptomatology, drug use and adherence behaviours should not only be expected but also planned for.

8. CONCLUSION

Measures effective at minimizing HIV transmission attributable to drug and alcohol use include

- HIV testing and referral to treatment,
- HARM REDUCTION education programs, detoxification, and
- behavioral interventions targeting HIV risk behaviors among both HIV-infected and HIV-uninfected people.

Measures effective at optimizing HIV treatment among alcohol and drug-dependent patients include:

- HIV testing with referral to treatment and
- substance use treatment that is linked to or integrated into HIV treatment.
- Due to the intertwining problems of substance use and HIV infection, physicians and other health care workers must address the issues of illicit drugs and alcohol use as mainstream medical problems in order to provide optimal care for HIV-infected patients.

THANK YOU!!

Ro Livhuwa!

Hasante sana!

Danke schön!

Kealeboga!

Merci!

Inkoma!

Shukaraya!

Dankie!

Ndiyabulela

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