


HIV Disease & Substance Abuse



**Presented by
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Presenter Information

- LMSW, LCDC, SAP
- Worked in the Addiction Field for about 10 years
- Experience in working with Incarcerated person, Drug Court participants, HIV+ clients, and specialized female clients
- Currently employed at a in-patient psychiatric care hospital as Therapist/Social Worker
- Worked in the HIV field for over 20 years

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The History

June 5, 1981

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The History

- First appearance of symptoms of HIV disease in CDC Morbidity and Mortality Weekly Report (MMWR)
- 5 cases of men with *Pneumocystis carinii* pneumonia (PCP) a very rare disease.
 - Patient 1 - 33 y/o Male
 - Patient 2 - 30 y/o Male
 - Patient 3 - 30 y/o Male
 - Patient 4 - 29 y/o Male
 - Patient 5 - 36 y/o Male

→ **This is the beginning of the AIDS Epidemic.**

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The History

- * 1981 - First cases were identified to gay men
- * 1981 - Epidemic spread to Haitians and IV drug users
- * 1982 - Disease is given the name AIDS
- * 1983 - Disease identified in heterosexuals
- * 1984 - First blood test for the disease
- * 1985 - Rock Hudson dies, Reagan first mentions AIDS
- * 1986 - New treatment discovered - AZT
- * 1990 - Pres. Bush signs Ryan White Care Act

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The History

- * 1991 - First Red Ribbon worn on Tony Awards
 - * "Even though AIDS-phobia was at its height, red ribbons began sprouting from lapels, hat brims, purse flaps -- anything that could take a safety pin. Over the next few years, the ribbons became part of the dress code for the glitterati at not only the Tonys but the Oscars and the Emmys too." L. Engle, thebody.com
- * 1991 - Magic Johnson announces his infection
- * 1992 - Definition of HIV vs AIDS, Arthur Ashe announces infection
- * 1994 - MTV cast member is HIV+
- * 1995 - Eazy E dies from AIDS
- * 1996 - Dr. David Ho discovers new treatment

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The History

- * 1997 – Deaths from AIDS decreases
- * 1998 – Pres. Clinton refuses to fund Needle Exchange
- * 1999 – AIDS becomes Africa’s number one killer
- * 2001 – Bono lobbies Sen. Jesse Helms
 - * "We've got to have some common sense about a disease transmitted by people deliberately engaging in unnatural acts," Helms told the Times.
- * 2004 – HIV hits the porn industry
- * 2009 – Pres. Obama lifts HIV travel and immigration law

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The Disease

- HIV Disease
 - a retrovirus that attacks T cells and takes over their “machinery” to produce more HIV. Infection results when the virus binds to the CD4 receptors along with a co-receptor, allowing the virus to attach to and enter the T cell. Over time, repeated infection of T cells leads to progressive loss of immune function

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The Disease

- HIV – Human Immunodeficiency Virus – the virus that causes AIDS
 - A test is conducted and determined if HIV antibodies is present, thus HIV+
 - Disease can exist in a person for up to 10 + years before advanced symptoms present
 - Once tested positive for HIV, the person will always be HIV+
 - HIV+ persons can infect another person through unprotected sex, sharing needles, through breast milk (Mother-Child)
 - HIV+ person is reported in Texas, Lab must report name, DOB, etc.

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The Disease

- Symptoms of HIV Infection
 - Most people don't have symptoms
 - Swollen lymph glands in the neck and underarm
 - Fever
 - "night sweats"
 - Rapid weight loss for no apparent reason
 - Constant tiredness
 - Diarrhea and decreased appetite
 - White spots or unusual blemishes in the mouth
 - Coughing
 - Vision and/or hearing problems
- The only true way to tell is by getting a test

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The Disease

- AIDS – Acquired Immune Deficiency Syndrome
 - Person must have a Positive test result for HIV
 - Have had at least one of the 20 opportunistic infections
 - Have less than 200 CD-4s
- Once a diagnosis of AIDS, always defined, not able to go back to being HIV+
- Immune system can be improved

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Transmission

- HIV is transmitted through the following body fluids
 - Blood
 - Semen
 - Vaginal Fluids
 - Breast Milk

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Transmission

- Mother to child transmission
 - With modern treatments, the rate has dropped to only 2%. Without treatment, HIV infected mothers pass the virus on at the rate of 25%
- Most women report transmission via heterosexual contact
- Most men report transmission through male to male contact

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Transmission

There must be one of the above present and a portal for it to be transmitted



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Prevention

- HIV infection is completely preventable
 - Practice abstinence – No sex is the safest
 - Practice “Safer Sex” – ALWAYS
 - Don’t share needles – getting tattoos, shooting up
 - Limit your sex partners
 - Know your partner’s HIV status, and other STDs
 - Don’t mix sex and alcohol or other drugs

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Prevention

→ Universal precautions

- " as defined by CDC", are a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other blood borne pathogens when providing first aid or health care.
- involve the use of protective barriers such as gloves, gowns, aprons, masks, or protective eyewear, which can reduce the risk of exposure of the health care worker's skin or mucous membranes to potentially infective materials.

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Prevention

Universal precautions apply to:

- blood
- other body fluids containing visible blood
- semen
- and vaginal secretions
- Also apply to tissues and to the following fluids: cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids

→ In addition, under universal precautions, it is recommended that all health care workers take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices.

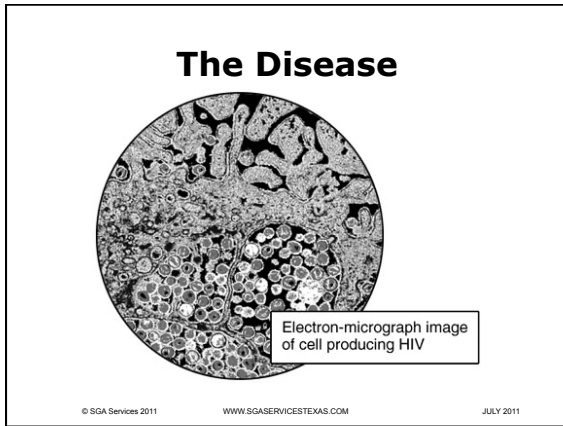
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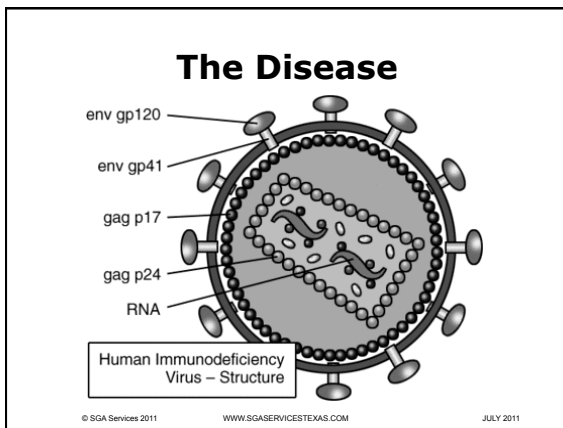
Prevention

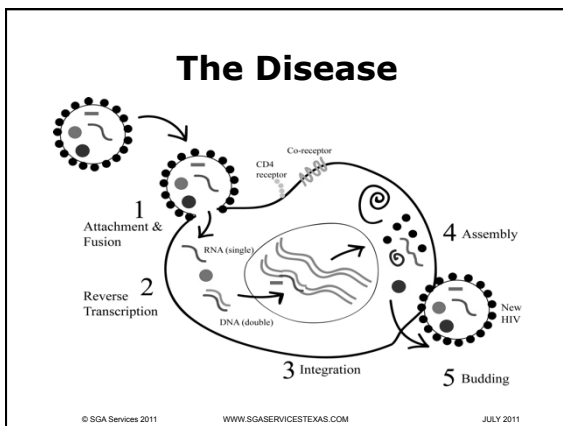
→ Universal precautions do **not** apply to:

- feces
- nasal secretions
- sputum
- sweat
- tears
- urine
- Saliva
- and vomitus unless they contain visible blood

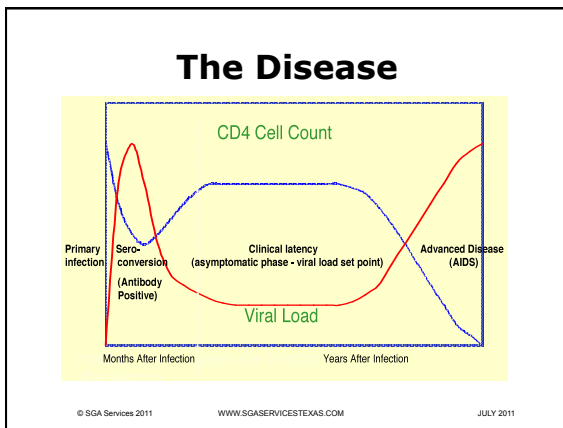
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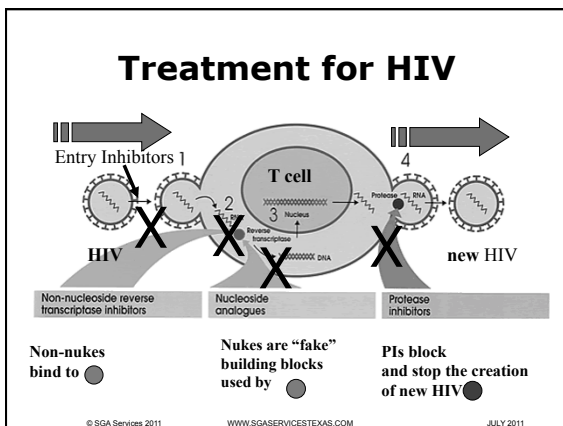












Treatment for HIV

- Protease Inhibitors (Pis)
 - Aptivus
 - Crixivan
 - Invirase
 - Kaletra
 - Lexiva
 - Norvir
 - Prezista
 - Reyataz
 - Viracept

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Treatment for HIV

Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)

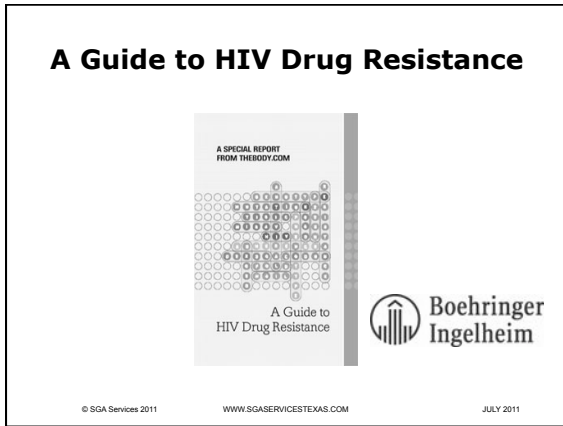
- Atripla
- Combivir
- Emtriva
- Efavirenz
- Epzicom
- Retrovir
- Trizivir
- Videx EC
- Viread
- Zerit
- Ziagen
- Racivir
- amdoxovir
- Apricitabine
- Elvucitabine

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Treatment for HIV

- Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)
 - Atripla
 - Intelence
 - Rescriptor
 - Sustiva
 - Viramune
- Entry Inhibitors (including Fusion Inhibitors)
 - Fuzeon
 - Selzentry
- Integrase Inhibitors
 - Isentress

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Drug Resistance

→ How Drug Resistance Occurs

- Not taking medications on time, mutated HIV can make up a larger and larger percentage of the HIV in your body, and the odds of developing drug resistance will greatly increase.
- Using a resistance test, your doctor can take a closer look at the HIV in your body to see whether it's developed mutations that will make it resistant to one or more HIV meds.
- In the United States, an average of 7% to 19% of newly infected people have mutations that are associated with drug resistance to at least one drug -- and, in some cases, to a whole class of medications.

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Drug Resistance

→ How Drug Resistance Occurs (cont'd)

- The virus received may have been receiving HIV treatment, and the virus became resistant to one or more medications.
- Transmitted along with HIV was their resistance to certain drugs
- If infected within the last several years, taking a resistance test before beginning HIV treatment will reveal resistance to any HIV medications.

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Resistance Tests

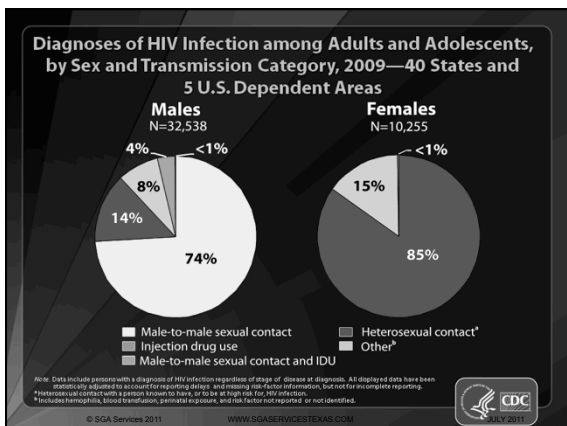
- Genotypic Tests
 - A blood sample is examined to see if there are any mutations.
 - The test results will pinpoint the exact HIV genes where the mutation or mutations occur.
 - Once mutations are found, they are compared to a long list of mutations known to cause resistance to HIV medications.

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Resistance Tests

- Phenotypic Tests
 - Blood samples are divided into many test tubes, each of which includes increasing doses of a given HIV medication.
 - Lab tech carefully study the samples to see how HIV reacts. They can calculate how much of each HIV medication would be needed to keep your HIV from reproducing.
 - The lab workers then compare these amounts to the amount of each drug needed to stop wild-type HIV from reproducing.

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Treating the HIV+ Client

- Staff attitudes
- Staff cultural sensitivity awareness and training
- Counter-transference issues
 - Fear of unknown, dying, loss
 - Shame and guilt
 - Stigmatization
 - Fear of infection
 - Staff burnout
 - Staff retreats
 - Build in 'mental health' days
 - Vary task and duties

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Treating the HIV+ Client

Client Specific Needs

- Substance abuse treatment
- Medical care
- Housing – Housing Opportunities for People With AIDS
- Mental health care
- Nutritional care
- Dental care
- Eye care
- Transportation
- Disclosure issues
- HIV/AIDS knowledge and educational needs
- Additional STI testing and treatment

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Treating the HIV+ Client

- Child care services
- Stigma issues – HIV+, addict, 'crazy', etc.
- Denial – to the deepest level
- Support services
 - Spiritual
 - Peer support groups
 - Family support
- Transgender issues
 - Cultural awareness
 - Specific issues related to Transgender clients
 - M→F, F→M, transition process, pre-surgery, sexual reassignment surgery
 - Gender identity vs sexual orientation

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Treating the HIV+ Client

- Continuum of Care
 - Working with the medical care provider
 - Referral to mental health provider
 - Referrals to ancillary services and follow up
 - Need for continuum of care
- Appropriate treatment for client
 - Residential care
 - Outpatient care
- Conflict of ancillary appointments with treatment sessions

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Mental Health Issues

- Mental Health has affects to the progression of the disease.
- Some factors include:
 - Fear of death
 - Stigma/disclosure
 - Changes in sexual behavior
 - Management of substance use
 - Uncertainty of treatment
 - Lifetime medication
 - Decline of quality of life, and Physical changes

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Triggers

Possible relapse "triggers" or increase use

- Experiencing the first symptoms
- Experiencing the first opportunistic infection
- Experiencing the first AIDS-related hospitalization
- Being diagnosed with AIDS
- Losing a friend, or significant other who dies from AIDS

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Triggers

- Beginning the medication regimen
- Experiencing little or no response to various medication regimens
- Decreasing CD4+ T cell count or increasing viral load
- Dating
- Having sex for first time
- Disclosure to family or friends
- Employment, hiring, firing, etc.
- Successes

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Challenges

- Clients are very knowledgeable of the "system"
- Client's not compliant with HIV medications when using alcohol and drugs
- Client's present with "pain" that needs treatment
 - Prescription of narcotic medications that client's can become addicted to
 - Client's do not inform their medical doctor about their addiction, therefore they get prescription with no problems

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Challenges

- Primary Care doctors are not educated on addiction and enable the client to remain dependent upon narcotic medications
- Patient's co-occurring disorders
 - Client's not wanting to attend psychiatrist due to further stigmatism
 - Un-diagnosed Mental Health issues
 - Non-compliance with psychiatric medications which complicates addictions

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Case Study #1

- HIV + AA Female, 36 y/o
 - On probation due to prostitution charges
 - Relapse prone
 - Living at transitional housing
 - Childless
 - Mother was killed by HS boyfriend after 30 year reunion
 - Has not informed boyfriend of HIV status
 - Presents angry, depressed, anxious, paranoid, denies any AH, VH, SI, SA, HI or HA
 - Is receiving care at local hospital district, reports compliance on meds only when not using

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Case Study #1

- Treatment Planning
 - Discharge plan
 - Medical Care
 - Client will increase health status; Maintain compliance with appts and medication; Client will be monitored for medical care, labs, doctors
 - Substance abuse
 - Client will identify how continued use of mood-altering substances negatively affects client's HIV status
 - Mental health issues
 - Client will participate in MH program and identify how HIV+ status has affected MH status
 - Drug court/probation
 - Housing
 - Disclosure
 - Client will identify how lack of disclosure to partners affects continued use of alcohol or drugs and MH status

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Case Study #1

- Client asked for help after relapse on Probation sent to residential facility, when asked for help
- Client discusses Mother's death, maintains psychotropic medication compliance, willing to process issues that are intense and never wanted to process before
- Maintains medication compliance, attends all ancillary medical appointments
- Housing in transitional living facility for HIV affected women after residential treatment
- Has actively engaged in recovery program; Working on healthy boundaries
- Progressing well on probation, has maintained abstinence from prostitution, no further arrests made

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Case Study #2

- HIV+ AA Male, 36 y/o
- Participating in STAR Court, Drug Court program
- Living in transitional housing facility paid by Court
- Unable to read or write, lacks HS/GED education
- Lived drug dealer lifestyle most of his life
- Unemployed
- Mother is alcoholic
- Has never received any medical care treatment, not registered with local system for HIV expenditure

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Case Study #2

- Treatment Planning
- Discharge plan
- Medical Care
 - Participate in medical care treatment; increase knowledge of HIV; Maintain compliance with appts and medication; Monitored for medical care, labs, doctors
- Substance abuse
 - Client will identify how continued use of mood-altering substances negatively affects client's HIV status and drug resistance possibilities
- Drug court/probation
- Housing
- Education

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Case Study #2

- Did not complete STAR court, served time after relapse and other charges
- Reports sobriety
- Attended medical care = CD4s 120 to 345
- Reported back to agency after being released from TDCJ
- Increased reading skills after CM worked with him on basic level

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Case Study #3

- HIV+ C, Male, 33 y/o, Homosexual
- Living in transitional housing facility, HOPWA funded
- Employed
- Mother kept in his room most of his life; moved with father who taught him about drugs
- Reports compliance with medication, unhappy about provider
- Had 14 y/o daughter that lives with him, unaware of his status
- Substance use – Crystal meth, hydrocodone, oxycotton, crack/crack cocaine, cannabis & alcohol
- Numerous sex partners
- Presents depressed, anxious, paranoid, emotionally unstable

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Case Study #3

Treatment Planning

- Discharge plan
 - Medical Care
 - Participate in medical care tx; Maintain compliance with appts and medication – non narcotic tx; Monitored for medical care, labs, doctors & prescription medications
 - Substance abuse
 - Identify how continued use of mood-altering substances negatively affects client's HIV status
 - Identify how use affects client's sexual activity
 - Identify how use affects relationship with daughter
 - Housing
 - Mental Health
 - Maintain emotional stability, discuss h/o emotional abuse, HIV status, disclosure

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Case Study #3

- Client actively engaged in recovery, sponsor, working steps, participates in IOP as self referral
- Has disclosed to daughter
- Reports 60+ days of sobriety
- Still homeless, but working on residence
- Has maintained medical care
- Participates in psych and mental health services
- Resilient, resilient, resilient

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Program Success

- HIV+ Client Program Success
- Referral to Support Services
- Cultural sensitivity/population specific services
- Integrated Service delivery models
- Staff skills, sensitivity and attitudes
- Use of harm reduction philosophy and tolerance for relapse
- 'Shame free' support
- A well informed Counselor/Therapist of HIV services
- Lots of patience

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Other Issues

- Beware of clients working the system
 - Addicts will be addicts
- "Pain" treatment
 - Non-narcotic prescriptions
- Working the providers
 - Medical care, Psych, Substance Abuse providers
- Client denial issues
- Client anger about HIV infection

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Websites

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- www.projectinform.org
- www.aegis.org
- www.thebody.com
- www.aidsmeds.com
- www.aidsinfo.nih.gov
- www.aidsinfonet.org

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Questions

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