

# HIV and Addictions: From Separated Treatments to Ideal Single Provider

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## Abstract

Although the relationship between HIV/AIDS risk and alcohol and other drug (AOD) use is well documented, individuals living with both HIV/AIDS and AOD addictions present health and social service providers and funders with unique challenges. Historically, clients diagnosed with HIV and AOD addictions have been treated at either a medical facility that had few addiction professionals or an addiction treatment facility that had few medical professionals sensitive to the needs of the HIV-positive individual. This paper examines the histories of HIV/AIDS and AOD treatment as separate services, followed by recent approaches to blend treatments. Finally, considerations regarding funding policies for agencies interested in rendering services to people living with both HIV and AOD diagnoses will be discussed, in the context of professional social work ethics.

*Keywords:* HIV/AIDS; alcohol and other drugs; addictions; social work ethics

## 1. Introduction

Recent estimates indicate that 33.4 million people are living with HIV infection worldwide (Joint United Nations Programme on HIV/

AIDS, 2009). The pandemic continues to infect approximately 2.7 million people each year (2009). The burden of disease in this pandemic is disproportionately high among women and people living in poverty. The proportion of infected women to men has increased steadily so that females make up more than 50% of the people living with HIV. Individuals aged 15–24 account for half of all new infections worldwide, and girls and young women are particularly vulnerable (2009).

Approximately 1.2 million Americans are living with HIV/AIDS (UNAIDS, 2008). Although HIV has historically been most prevalent among men who have sex with men (MSM) (Bacon et al., 2006; Celentano et al., 2006) and intravenous drug users, the proportion of HIV cases acquired through heterosexual contact has also increased and is equal to the proportion of cases attributed to injection drug users (CDC, 2002; Karon, Fleming, Steketee, & De Cock, 2001). In the United States, a large proportion of HIV-infected adults are women, who according to data collected in 2004 (the most recent year for which data are available), now account for 25% of all HIV infections (CDC, 2004a; CDC, 2004b; Kaiser Family Foundation, 2004). This amount is three times the rate established in the mid-1980s,

and resulted primarily from heterosexual exposure and secondarily from injection drug use (CDC, 2002). Other minority groups in the United States are also disproportionately affected, particularly African Americans and Hispanics, who make up 12.3% and 13% of the population respectively but account for approximately 50% of new cases (Kentucky HIV/AIDS Surveillance Report, 2004; Zaidi et al., 2005).

The National Institute of Alcohol Abuse and Alcoholism (NIAAA) classifies alcohol abuse as an ongoing pattern of drinking that causes harm for the drinker, others, or society. NIAAA characterizes alcohol dependence as a complex disease noted for continuous and intense alcohol-seeking behaviors that lead to loss of control over drinking and the eventual development of dependence (NIAAA, 2008). According to the Centers for Disease Control and Prevention (2010), 79,000 Americans die because of excessive alcohol use each year. Kohnke (2008), who conducted an exhaustive review of family, twin, and adoption studies, concluded that between 50% and 60% of the individuals who participated in those studies had family histories of alcoholism. Others concluded that as many as 7 million children live with an alcoholic parent and are at risk for developing AOD problems in the future (NIAAA, 2001; The Teacher's Spot, 2009).

The National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009a) reported that 51.6% of Americans aged 12 or older (129 million Americans) reported that they consume alcohol. In fact, the rates of alcohol use continue to rise among all age groups from 12 to 25. The rates decline beginning at age 26. It should be noted, however, that more than one fifth (23.3%) of individuals 12 years of age and older (58.1 million people) reported that they participated in binge drinking within the past month.

Many people who have addictions use several additional substances, such as marijuana, cocaine, and heroin. Marijuana was reported to be the most commonly used illicit drug

(6.7%), followed by nonmedical prescription-type psychotherapeutic drugs (2.9%), inhalants (1.1%), hallucinogens (1.0%), and cocaine (0.4%) (SAMHSA, 2009a).

Research has also shown that people who use alcohol are likely to abuse intravenous drugs (Conner, Piquart, & Holbrook, 2008; Metzger, Navaline, & Woody, 1998; Walley et al. 2008) and to engage in behaviors that place them at higher risk for contracting HIV/AIDS (Metzger et al., 1998; Stein et al., 2000; Walley et al. 2008). Moreover, drug-related risk behaviors including needle sharing and unprotected sex correspondingly increase with alcohol use (Stein et al., 2000; Surratt, Inciardi, Kurtz, & Kiley, 2004; Walley et al. 2008).

Although these studies demonstrate the overlap between HIV and AOD addiction, the funding for services to treat these problems and the research on the effectiveness of those services remain separate. We argue that funding sources have an ethical obligation to fund treatment that is integrated and service providers have an ethical obligation to become competent in rendering services to individuals living with HIV and AOD addictions.

## **2. Alcohol and Drugs**

The National Institute on Drug Abuse (NIDA) and SAMHSA have sponsored several national surveys to track drug use trends since the 1970s. One of the most widely known is the National Household Survey on Drug Abuse (2004), which surveyed persons age 12 and older. Between 1999 and 2001 the survey respondents who reported using illicit drugs in the past month increased from 6.3% to 7.1%.

The National Survey on Drug Use and Health reported in 2007 that 21.1% of young adults (an estimated 6.9 million persons) needed treatment for alcohol or illicit drug use in the past year. Nearly one fifth (17.2%) needed treatment for alcohol abuse and dependence, 8.4% needed treatment for illicit drug use, and 4.4% needed treatment for both alcohol and illicit drug use (SAMHSA, 2009b).

### **3. The History of HIV/AIDS Treatments**

Although the virus that causes AIDS was initially identified in the early 1980s, it likely infected humans as early as the 1950s, and became an epidemic in the 1970s (Worobey et al., 2008; Zhu et al., 1998). There are many theories concerning the exact origin of HIV. Gao et al. (1999) discovered a subspecies of chimpanzees in Africa carrying the Simian Immunodeficiency Virus (SIV-1) virus, which was introduced to humans and became known as Human Immunodeficiency Virus (HIV-1) and is responsible for the current pandemic. The first cases of AIDS reported during the 1980s puzzled physicians because healthy young gay men were showing up in hospitals with rare infections (including *Pneumocystis carinii*, an ordinary organism rarely causing infection, and Kaposi sarcoma, a strange cancer that was usually localized), which historically had been found only in severely immunocompromised people (Treisman & Angelino, 2004).

In the early years of HIV, the treatment focused mainly on palliative care. In the early 1990s, antiretroviral drugs were developed and later prescribed. One of the first drugs, Azidothymidine (AZT), was thought to add about 18 months to the lives of HIV-infected individuals (Treisman & Angelino, 2004). As research progressed, new combinations of drugs referred to as the “HIV/AIDS cocktail” were developed. To be effective, this highly active antiretroviral therapy (HAART) had to have 90% compliance (Treisman & Angelino, 2004). Since then, new questions have emerged, such as when to begin treatment (Hammer et al., 2010) and whether the benefits of intermittent treatment surpass those of ongoing or continuous treatment (Leibowitch, Mathez, de Truchis, Peronne, & Melchior, 2010).

### **4. The History of Addiction Treatments**

Practitioners and researchers in the addiction treatment field have long disagreed about the best model for treating the addicted

individual. Early research has concluded that the causes of alcoholism have been rooted in personal choice (Fingarette, 1988), sociocultural influences (Cahalan, 1987), family-of-origin pathologies (Steiner, 1971), social learning (Peele, 1985), and biochemical dysfunctions (Milam & Ketcham, 1981).

Just as the problems connected to drinking alcohol have a long history, so do the proposed solutions. One of the oldest solutions has been to modify individuals’ behavior and moral codes. The “moral perspective” sees drinking as a willful act that violates socially acceptable norms that can be controlled by individual choice (Connors & Rychtarik, 1989).

Following the moral perspective of addiction was the “temperance movement,” which emphasized controlled use of alcohol. As the use of alcohol began to spread, however, and people in the late 18th century and into the early 19th century died from alcoholism, the temperance movement changed from moderation of consumption to “total abstinence” (Maxwell, 1950). The natural progression from this perspective was to ban the manufacture, sale, transportation, and importation of alcohol, under the 18th Amendment to the U.S. Constitution, better known as “Prohibition.” While alcohol consumption decreased under Prohibition, the law was difficult to enforce, widely unpopular, and frequently ignored.

Alcoholics Anonymous (AA) was founded a few years after the repeal of Prohibition, in 1935, by two alcoholics who were attempting to use spiritual principles to recover. One of the founders, Bill Wilson, experienced a spiritual awakening resulting from his encounter with the Oxford Group fellowship, a religious movement that thrived briefly in the 1930s. The Oxford Group meetings consisted of small-group discussions where people confessed to one another their alcohol use, talked out their emotional problems, and prayed to God (Trice, 1958). While the Oxford movement focused on religious conversion, the AA movement focused on illness (www.aa.org, n.d.).

The medical community quickly became interested in the topic of alcoholism. In its attempt to study alcohol problems through scientific inquiry, the Research Council on Problems of Alcohol was established in New York in 1936 (Keller, 1976; Keller, 1990). Although the research council did not receive any funds to study the problems associated with alcohol, the council did result in focusing less attention on the moral aspects of the problem and setting the stage for the federal government to create a bureaucracy around the problem of alcoholism. The first federal fund established to deal with alcohol problems was the NIAAA, which after a short period of time led to federal funding directed toward combating alcoholism.

## **5. Levels of Treatment for AOD Disorders**

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000), the criteria for diagnosing alcoholism requires the presence of three or more of the following: increased tolerance, consumption, and time invested in obtaining or using alcohol; greater withdrawal and desire to cut down the amount of alcohol used; reduced social activities that include drinking alcohol; and continued use despite physical or psychological problems.

Addiction treatment is currently designed to begin with medically supervised detoxification, followed by rehabilitation services lasting from a few weeks to more than one year. The three levels of care for the treatment of addiction are inpatient services, which is the highest level of care and includes residential services lasting approximately one month; intensive outpatient services (IOP), which may include daily and possibly weekend services lasting several hours per day over a period of many months; and standard outpatient treatment, which is the lowest level of care and is designed for those who are well into recovery and who work and have stable employment and social supports. All three levels include activities

such as group and individual counseling, addiction education sessions, basic life skills education, and participation in ongoing 12-step meetings.

## **6. The Importance of Studying Addiction & HIV/AIDS Together**

The relationship between alcohol use and HIV/AIDS risk has been documented among various groups including men who have sex with men (Bacon et al., 2006; Celentano et al., 2006; Mansergh et al., 2008), urban minority groups (Operario, Smith, Arnold, & Kegeles, 2010), adolescents (Kerr & Matlak, 1998; O'Donnell, Myint-U, Duran, & Stueve, 2010; Subramaniam, Stitzer, Woody, Fishman, & Kolodner, 2009), HIV-seropositive individuals (Carey et al., 2009; Marks, Crepaz, Senterfitt, & Janssen, 2005; Van Kesteren, Hospers, & Kok, 2007), and people living with serious and persistent mental illness (Collins, von Unger, & Armbrister, 2008; Senn & Carey, 2009; Tucker, Burnam, Sherbourne, Kung, & Gifford, 2003).

The incidence of AOD addiction among HIV-infected individuals has been reported to be significantly higher than that of the U.S. population that does not have HIV (Bernard et al., 2007). The Center for Substance Abuse Treatment (2002) has identified five important issues related to AOD and HIV/AIDS: (a) substance abuse increases the risk of contracting HIV due to the association between the use of dirty needles and engaging in risky sexual behaviors in exchange for drugs and/or money, (b) substance abuse increases risks for obtaining substances while under the influence or while under coercion, (c) substance abuse and HIV/AIDS both serve as potential catalysts or obstacles in the treatment of the other, (d) substance users who inject drugs represent the largest HIV-infected population in the United States, and (e) substance abuse treatment, along with a continuum of care, minimizes the risk of substance abuse and HIV infection. In order to stop the spread of HIV/AIDS without a vaccine, people who are infected with the disease must stop engaging in high-risk sexual behaviors. One of the best ways to stop the spread

of the disease is for patients to enter and engage in treatment that lowers the risks for exposing others.

## **7. Current Addiction and HIV/AIDS Treatment**

In 2006, SAMHSA announced that it awarded 16 grants totaling \$42 million over five years to enhance and expand the provision of effective and culturally competent HIV/AIDS-related mental health services in minority communities (SAMHSA News, 2006). In 2006, SAMHSA's Center for Substance Abuse Treatment (CSAT) awarded 65 grants for a total of \$32.1 million to improve and increase all forms of treatment services in combination with HIV/AIDS services in racially or ethnically diverse communities affected by AOD abuse and HIV/AIDS. These funds are geared toward addiction treatment programs and HIV/AIDS service organizations with a history of serving chronic drug users and their sex or needle-sharing partners.

Many, if not most, of these agencies do not appear to provide services to individuals with HIV/AIDS and addictions. The federal funds seem to favor existing treatment infrastructure rather than specialized, recommended approaches to treating the dual problem. Unfortunately, current funders must rely on these existing programs to carry out services without any cross-training. Although the programs are carried out with good intentions, until programs are designed and developed offering integrated services, people living with HIV/AIDS and addictions will have to be treated by a single-trained provider.

## **8. Combining Addiction and HIV/AIDS Treatment**

Because both of these conditions are complex and chronic, it is important to have experienced AOD practitioners on staff to treat AOD-addicted HIV-infected individuals. Connections must be made among the providers who often disagree on which chronic disease has priority (Patterson et al., 2004) so as to enhance access to care and expand integrated services to

provide quality integrated care (Kalichman, 2008).

Alcohol and drug treatment providers should be able to conduct HIV risk assessments, provide basic HIV education and counseling, and provide HIV testing with pre- and post-test counseling (CDC, 2004b). The staff within the primary medical care facility should ask questions regarding alcohol and drug use, have cultural competence training, and reinforce the message to patients that any AOD use damages overall health and is a cause for referral for AOD treatment (Patterson, 2004). One of the services that both AOD and HIV/AIDS providers have in common is case management services. Due to the long histories of providing case management within these services, combining this aspect of treatment would be fairly simple and straightforward—requiring case managers to become cross-trained in each area.

## **9. Conclusion, Recommendations, & Value/Ethics**

Once HIV/AIDS and AOD treatment programs have been successfully integrated, SAMHSA should dedicate funds directed at agencies to reach specific benchmarks, including training and skill-building needs. The Center for Substance Abuse Treatment Improvement Protocols manuals provide an excellent design for training practitioners and programs interested in treating HIV/AIDS and addiction. These guidelines are extensively researched, enabling health-care providers as well as federal funders with specific training standards to achieve them before being awarded treatment grants.

Specific, planned, and documented linkages with services would need to be established before federal funds would be offered. For instance, addiction treatment providers would need to plan how they would provide and ensure explicit client assistance such as medical care, mental health services, case management, ongoing risk-reduction education, legal services, and addiction and HIV/AIDS self-help groups. Agency administrators must clarify how their training and limited staff skills will be addressed.

Addiction treatment providers who work with the HIV-positive client would need to address issues concerning staff who may have disapproving attitudes and beliefs that emerge when accommodating the first HIV-infected addict who may be gay or transsexual. Many residential treatment agencies will have to edit their policies and procedures around client chores and other client activities that place HIV-infected and non HIV-infected clients at risk of exposure to harmful diseases if these activities could result in possible exchanges of bodily fluids. There are also many faith-based agencies that could run into moral or other program-mission issues that result in clients rejecting their services. A community task force should be created to look at agency policy and staff needs with detailed plans on how to accommodate and treat HIV-positive clients as part of the application process.

While both standalone agencies (e.g., medical and addiction treatments) have limitations that the above recommendations could address, there are also strengths. Because these two services have existing infrastructures and established resources, collaborations will likely help to develop best practice treatment models. Both services have specialized technologies that when united could prove to be vital in treating the AOD-addicted HIV/AIDS-infected person. For instance, monitoring a client's viral load during addiction treatment is impossible without access to medical care facilities. The side effects of some HIV/AIDS medications could prove to be a barrier to regular addiction-focused therapeutic group sessions that last one hour or longer. Integrating both medical and addiction treatment services to treat the HIV/AIDS AOD-addicted person, while currently separated, will greatly enhance the quality of health care for this population.

While a number of social work values and ethics could come into play related to this topic, the one that seems most applicable is the value of social justice. The ethical principle stating that "social workers pursue social change, particularly with and on behalf of vulnerable

and oppressed individuals and groups of people" (NASW, 2008) calls for specific attention given to those individuals suffering from and seeking treatment for the combined impact of HIV/AIDS and addiction. This population of sufferers can be considered extremely vulnerable as well as easily labeled as nondeserving of health care services (Patterson & Keefe, 2008). Promoting sensitivities toward this population and their special treatment needs ensures the essential information, services, and equity of resources (NASW, 2008).

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