How Change Happens:
Substance Use Disorders and HIV/AIDS

What challenges are present in enhancing behavior change?

A multitude of interacting and interrelated factors result in diminished motivation and desire to successfully engage in behavior change for people living with HIV/AIDS (PLWHA) and individuals experiencing difficulties as a result of substance use disorders (SUD). At a societal level, there is a belief that these indiviuals are unsympathetic victims and are subject to direct and indirect social and cultural scorn, discrimination, and (often) traumas. In order to understand the best way to engage and retain individuals in treatment in the hopes of maximizing health behavior change, providers should familiarize themselves with this complex interaction and develop a system for assessing and discusssing these challenges with clients. These combined stressors produce effects that can jeapordize access to even the most basic needs an individual may have. This concept, called "intersectionality," aims to reconceptualize and challenge "single category thinking about identity and group status and emphasizes approaches that interrogate how race, class, gender, sexuality, and other social locations operate simultaneously in social life." [1]

Of particular focus in assessing intersectional aspects of an individual's functioning include: race, sexual orientation, socioeconomic class, gender, social oppression, and substance use. Related to HIV/AIDS, researchers have found that men who have sex with men (MSM) are disproportionately affected by risk of contracting HIV/AIDS. While just 4% of the population of the United States, MSM account for 78% of all new HIV infections among males[1]. If current diagnosis rates persist, 1 in 4 Latino MSM will be diagnosed with HIV in their lifetime and 1 in 2 Black MSM will be diagnosed with HIV in their lifetime[2]. The discrimination, homophobia, and racism that LGBTQ+ people of color face result in riskier sexual behaviors such as unprotected sex. Additionally, intravenous drug use plays a role in increasing HIV risk in additiona to substance use associated impairments. While only 5% of all new cases of HIV in 2014 resulted from drug use, 3% of all new cases were of gay/bisexual men who injected drugs[3].

Recommendations to address these larger societal issues include: (1) challenging an overemphasis on biomedical and individualized behavioral approaches; (2) enhancing intersectional approaches to care; and (3) focusing research on behaviors that fall outside the perceived traditional norms. In order to enhance intersectional approaches to engagement in care, providers should consider the ways in which basic needs are met or not met with clients. In an intersectional approach, individuals may experience financial hardships or inconsitent housing that can affect medication adherence among other treatment expectations. When combined with food insecurity, housing insecurity has a negative relationship with antiretroviral (ART) treatment adherence[4]. Social support can have a positive impact and considering ways to integrate effective case maangement to outreach to the community in order to reduce barriers presented by lack of transportation or access to food may increase treatment engagement.

Reducing Stigma

Stigma is a complex and confounding aspect of treatment in that, even if the practitioner is careful not to perpetuate stigma, it may still affect the engagement and willingness of the client to participate as fully as the practitioner may want. Stigma also impacts the experience of stress and can affect an individual's health either directly by preventing an individual from access care at a certain location; or indirectly through the stress response produced by having to confront devaluation. This stress response can push individuals in the direction of riskier coping mechanisms such as substance use. Education and employment stigmatization can lead to health disparities, as well, as limited opportunities in these areas can exacerbate devaluation or, more practically, deny the individual access to needed resources related to healthcare and well-being. One study of students on college campuses found attitudes toward HIV testing revolved around stigma and secrets. Only 35% of people aged 18-24 have ever had an HIV test and only 25% of sexually experienced youth have ever had an HIV test[5].

Counteracting stigma requires providers to recognize messages that are perpetuated about risk and correct misinformation that is presented. Language also matters when discussing stigma – how we talk about HIV and substance use can powerfully impact impressions and perceptions. Studies show that referring to an individual as a "substance abuser" carries a connotation that the individual is significantly less likely to benefit from treatment or engage in changing behaviors[6]. This bias can impact treatment. The use of person-first language that seeks to identify less stigmatizing terms for substance use and HIV can help make the topic of change easier to discuss.

Correcting Language to be Less Stigmatizing[6, 7]

Shifting from stigmatized to corrected, less judgmental terms is beneficial for engagement. For substance use, this may look like:

- "abuser, addict, alcoholic" to "a person with a substance use disorder"
- "clean" to "a state of a person being in recovery"
- "substance abuse" to "substance use disorder"
- "relapse" to "a recurrence of symptoms"

For HIV/AIDS, this may look like:

- "HIV/AIDS patient" to "person living with HIV/AIDS"
- "to catch HIV/to pass on HIV" to "to acquire HIV/to transmit HIV"
- "to battle HIV/AIDS" to "response to HIV/AIDS"

Effective Interventions to Promote Change

The Centers for Disease Control and Prevention *Compendium for Evidence-Based Interventions for HIV Prevention* is a list of behavioral interventions for individuals who are using illicit drugs[8]. This Compendium has demonstrated efficacy in reducing the risk of acquiring HIV or other STDs. The resource is divided into three chapters that focus on different practice areas: (1) Linkage to, Retention in, and Re-engagement in Care; (2) Medication Adherence; and (3) Risk Reduction. Recommended interventions include focusing on cognitive-behavioral based interventions and focusing on Motivational Interviewing approaches to enhance engagement through recognition of client strengths and development of an approach of acceptance. Motivational interviewing is effective alone and in combination with other interventions and has been demonstrated to improve CD4 counts and medication adherence in as little as 8 sessions[9, 10]. Similarly, linkage to 12-step groups to supplement ongoing treatment has been found to enhance abstinence self-efficacy related to substance use which may assist in enacting change related to other health impairments such as HIV[11].

HIV/Substance Abuse Websites Focused on Enhancing Engagement

- NIATx Promising Practices Database: https://niatx.net/promisingpractices/Search.aspx?SPNID=19
- CDC's HIV Treatment Works: http://www.cdc.gov/actagainstaids/campaigns/hivtreatmentworks/index.html
- Act Against AIDS – Partnering and Communicating Together: https://www.cdc.gov/actagainstaids/partnerships/pact.html

Keep a list of your local referral resources and update it regularly. Write down referral information you can share with your patient!

Need a local substance abuse treatment referral? Phone: 1-800-662-HELP (SAMHSA National Helpline); Website: http://findtreatment.samhsa.gov

Need a local 12-Step meeting? Alcoholics Anonymous: http://www.aa.org (On the home page, click on the "How to Find A.A. Meetings" tab and then click on either the "*Click Here*" link [for A.A. Meetings in the U.S. or Canada] or "international General Services Office" link [for meetings located outside the U.S. or Canada])

REFERENCES

1. Watkins-Hayes, C. (2014). Intersectionality and the Sociology of HIV/AIDS: Past, Present, and Future Research Directions. *The Annual Review of Sociology, 40*, 431-457.
2. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Diseases Control and Prevention. (2016). *NCHHSTP Newsroom: Lifetime Risk of HIV Diagnosis.* Retrieved from: http://www.cdc.gov/nchhstp/newsroom/2016/croi-press-release-risk.html.
3. Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. (2018). *HIV/AIDS: HIV among African Americans.* Retrieved from: https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html.
4. Cornelius, T., et al. (2017). Impact of food, housing, and transportation insecurity on ART adherence: A hierarchical resources approach. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 29*(4), 449-457.
5. Edwards, L.V., Lindong, I., Brown, L., Hawkins, A.S., Dennis, S., Fajobi, O., Rowel, R., Braithwaite, R., & Sydnor, K.D. (2017). None of us will get out of here alive: The intersection of perceived risk for HIV, risk behaviors and survival expectations among African American emerging adults. *Journal of Health care for the Poor and Underserved, 28*(2), 48-68.
6. Facing Addiction with NCADD. (2018). Presentation credit to Facing Addiction with the National Council on Alcoholism and Drug Dependence.
7. Centers for Disease Control and Prevention. (n.d.) *A Guide to Talking About HIV*. Retrieved from: https://www.cdc.gov/actagainstaids/pdf/campaigns/lsht/cdc-hiv-together-stigma-talking-guide.pdf.
8. Centers for Disease Control and Prevention. (2017). *Compendium of Evidence-Based Interventions and Best Practices in HIV Prevention*. Retrieved from: http://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html.
9. Dillard, P.K., Zuniga, J.A., & Holstad, M.M. (2016). An integrative review of the efficacy of motivational interviewing in HIV management. *Patient Education and Counseling, 100,* 636-646.
10. Palacio, A., Garay, D., Langer, B., Taylor, J., Wood, B.A., & Tamariz, L. (2016). Motivational interviewing improved medication adherence: A systematic review and meta-analysis. *The Journal of General Internal Medicine, 31*(8), 929-940.
11. Majer, J.M., Glanstman, O., Palmer, J.S., & Jason, L.A. (2015). Predictors of abstinence self-efficacy: Examining the role of HIV-risk sexual behavior. *Journal of Social Service Research, 41*(1), 39-48.

This fact sheet was prepared and reviewed by: Andrew Kurtz, LMFT – Pacific Southwest Addiction Technology Transfer Center/UCLA Integrated Substance Abuse Programs; and Phil Meyer, LCSW, Maya Talisa Gil-Cantu, MPH, and Tom Donohoe, MBA – Pacific AIDS Education and Training Center/Charles Drew University of Medicine and Science/UCLA Department of Family Medicine.

Final Draft, 7/18/2018