HIV and substance use are intimately connected, making it particularly important to develop ways of integrating an understanding of each into both types of services. The research on this reciprocal sensibility, however, is surprisingly scarce: it focuses primarily on HIV education for injection drug users. By focusing solely on injection drug use, current integration efforts exclude the complex and crucial connections between a range of substances—some of which are increasing dramatically in use—and HIV risk and HIV care and substance abuse treatment.

For the HIV service provider, integration may involve talking with a client about the ways recreational drug use—for example, methamphetamine or cocaine use—impacts the ability to practice safer sex. Or it may relate to problem-solving about the effects of alcohol use on a client’s ability to adhere to an HIV antiviral medication regimen.

For the drug treatment counselor, integration may mean working with a female client whose recovery is motivated by her desire to have children and whose discovery that she’s HIV-positive jeopardizes her plans. For the alcohol counselor, it may mean challenging a client to consider the ways in which alcohol use increases the risk for sexual transmission of HIV.

Both worlds—HIV prevention and care services and drug and alcohol treatment—perceive the conversation of the “other” world as a Pandora’s Box of unrelated problems that will adversely affect outcomes for clients and reveal counselor inadequacies. Each views the other as a vastly different entity, whose approaches, resource capacities, and mandates are unknown, strange, contradictory, or potentially harmful. This article explores the connections between drug and alcohol treatment and HIV prevention and care, the barriers to their integration, and the methods that can be applied to get beyond these barriers.

Making the Connections

The Statewide Partnership for HIV Education in Recovery Environments (SPHERE) is a Massachusetts-based program that promotes HIV and substance use integration and helps health and human service programs develop and implement site-sensitive integration plans. In doing so, SPHERE operationalizes the connections between substance use and HIV. Among these connections are: substance users may barter risky sexual activities for drugs; an individual's commitment to his or her health—and health-seeking behaviors such as HIV antiviral treatment adherence—may be diminished by substance use; substance use can undermine condom use; and the route of drug administration—primarily, the sharing of injection equipment—can increase HIV risk.

Despite these connections, drug and alcohol treatment providers often remain silent on the subject of sex and HIV, and HIV service providers are often mute on the topic of substance use. While the resulting silence may make a provider's job easier in the short term, it can undermine the basic goals of care, the capacity of clients to address their concerns, and the trust and credibility that is the foundation of the counselor-client relationship. Likewise, clients may not be forthcoming about their HIV status when seeking drug treatment or about their drug use when seeking HIV-related services. To achieve successful integration, provider-client communication is crucial.

Barriers to Integration

In general, providers working in drug and alcohol treatment programs and HIV service organizations are not knowledgeable enough about each other's services or capacities. Myths about how each type of
I like to imagine HIV counseling and substance abuse treatment programs as places that bathe themselves and their clients in the warmth of acceptance, an atmosphere in which no secrets seem too cruel to disclose and no response is less than empathic and supportive. But, of course, the taboos that immerse our culture are as present in these places as in any other.

There is at least one crucial difference between these programs and the rest of the world. There is usually a commitment by providers to confront their values and fears in order to avoid undermining their relationships with their clients. That is the foothold for the approaches set out in Mindy Domb’s article in this issue of FOCUS. Her discussion of how to integrate the topic of HIV into substance abuse treatment and the topic of substance use into HIV prevention offers a view of the barriers to this goal and the strategies to overcome these barriers.

This perspective is especially important now that research confirms the significance of non-injection drug use in fueling dramatic increases in HIV incidence. In the United States, in particular, the use of methamphetamine and “party drugs” such as Ecstasy is combined with behaviors that greatly magnify the likelihood of HIV transmission. In their article, Michael Gorman and Perry Halkitis offer a snapshot of this situation and insight into how to respond to it.

### Confronting Taboos

It is clear that clients are well-served in some cases by systems of care that have different emphases, that is, substance abuse treatment for people whose main concern is responding to addiction or HIV care and prevention for people whose main concern is dealing with HIV disease or avoiding infection. But the traditional separation of these services undermines quality if providers in both venues are not able to help their clients confront taboo topics that can have a critical impact on care.

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**References**


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Robert Marks, Editor

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clients who use drugs or alcohol may need to prove that they are not using in order to get HIV services. They may also fear law enforcement as a result of disclosure.

Finally, the fear of being perceived as "other" may be affirmed as rational by a range of provider attitudes and approaches. In the HIV world, substance use is often viewed only as an obstacle to prevention and care, for example, as undermining both safer sex behaviors and adherence. Here, also, it may be seen as a significant contributing factor to the creation of "noncooperative" clients. In the recovery world, HIV is seen as an obstacle to treatment and recovery. Drug and alcohol treatment providers fear that the discovery of HIV status may prompt relapse, and many drug and alcohol treatment providers believe sexual activity threatens or distracts a person’s recovery, in response making sexual abstinence a program requirement. This, coupled with provider discomfort around discussing sex, may lead to a reluctance to raise the topic of sexuality at all, including discussing sexual health, sexual decision making, and sexual orientation.

A provider’s words or body language concerning HIV or substance use may subtly convey attitudes that lead clients to believe that they are “other” and that their safety depends on silence. Provider judgment may communicate impatience and rejection; provider silence may reveal discomfort or disinterest.

All of these barriers to integration relate to the interaction between providers and clients. Providers can uncover other potential barriers by considering the following question: what does the client risk by disclosing HIV status or drug use to you? Once answered, providers can use counseling interventions to minimize that risk. By being informed, honest, and open, providers can create a safe place for disclosure and acknowledgement. It is also useful for providers to consider a range of responses to client disclosure in order to minimize their own negative reactions when disclosure occurs, although it is important not to craft specific or “canned” replies that undermine client-centered counseling. Further, it is helpful for providers to define, in advance, the areas in which they can offer the most support.

In addition, making active referrals is essential, and identifying local referral sources is the first step in this process. Following up on a client’s use of these referrals to see if the referral was helpful is essential to ensuring and maintaining an effective referral capacity.

Steps Toward Integration

The first step towards integration is for programs to conduct assessments of the efforts they have already made toward integrating either HIV- or substance use-related issues into their services and to spotlight ideas for new approaches. The next step is to develop policies to support integration. The third step is professional development: staff needs to start talking.

All HIV service organizations and drug and alcohol treatment programs need to communicate awareness, knowledge, respect for confidentiality, and acceptance in proactive and concrete ways to combat the reluctance their clients have to talk about what they perceive to be taboo topics. To ensure that these qualities are present in all areas of service, it is important to implement broad policies that: protect client confidentiality, particularly in the context of risk assessment and disclosure discussions; prioritize staff training; and support “universal education,” that is, conduct HIV risk assessment, risk reduction planning, and client education with all clients in drug and alcohol treatment programs and substance use assessment and education with all clients in HIV prevention and care programs.

In addition, it is useful to develop a policy about environmental measures that support communication. For example, ensure that educational posters are on the walls of offices and bathrooms and that culturally and language-appropriate brochures are in waiting rooms and offices. Posters and brochures should be written in plain language. They should communicate specific educational messages and clarify the significance of the service about to be offered. These materials add another voice to the

Words or body language about HIV or substance use may convey attitudes that lead clients to believe that they are “other” and that safety depends on silence.


discussion, and can act to introduce difficult topics so clients feel safer raising these topics during sessions. The materials can also reinforce counselors’ statements.

Provider Training

Provider training is vital to undertaking integration. Training increases knowledge, fosters discussion, increases comfort in talking about both HIV and substance use, affords an opportunity to practice skills, and improves counseling techniques. In both cases, training needs to go beyond information and skills-building; it also needs to address provider attitudes and increase staff willingness and motivation to implement integration. To bolster motivation, training needs to convince participants that integration is going to help them and their clients and that integration can be rooted in the reality of the provider-client relationship.

SPHERE has developed a collection of tools for counselors to use with clients. We recommend facilitating multiple opportunities for clients to characterize the extent of the “problem.” Giving clients a chance to describe or rate their self-defined problem can be a powerful experience. Using a self-assessment tool—like a ruler—can help clients describe on a scale from 1 to 5 any dissatisfaction they have with substance use, HIV-related risks, or other aspects of their lives. This gives providers a chance to follow-up with some key open-ended questions designed to give the client control over defining goals, problems, solutions, and the ways in which a provider can help.

For example, a provider might ask: “On a scale from 1 to 5—1 being a small problem and 5 being a huge problem—where would you place your concern?” Then, “Using the scale, what number describes where you would like your concern to be? What can I do to support you in moving from the first place to the second?” When a client responds “I don’t know,” a counselor can use this opportunity to explore the harms associated with various activities in order to help the client examine risk. A good open-ended question might be “What have you heard about the connections between HIV and your substance use?” This question allows the client to tell his or her “story” and offers the counselor a chance to assess the client’s knowledge level about HIV risk.

Finally, training should emphasize the importance of offering referrals. Not only do referrals facilitate access to services, they also help counselors participate in difficult conversations. Knowing that discussion might raise an issue that exceeds a counselor’s professional capacity or personal comfort can undermine a counselor’s openness to broaching that topic. Having a referral in hand in advance prepares the counselor for the topic, increases his or her confidence to respond to the client’s concerns, helps him or her remain open to anywhere the conversation may lead, and better supports the client. Providers do not have to fear a topic of discussion if they know they can refer clients to an appropriate resource. SPHERE trainings teach participants how to develop a listing of the categories of referrals they anticipate needing and strategies for identifying specific resources. The trainings also offer participants an opportunity to describe and create tools that would help facilitate the active referral process.

Conclusion

As health care resources diminish, integration may be one way to achieve more with less. Integration, however, is more than a route to potential savings. Acknowledging the “other” in both substance use and HIV-related counseling and treatment venues leads to more comprehensive and meaningful services, better care, more effective programs, and better outcomes for society.

Clearinghouse: Substance Use and HIV

References


Methamphetamine and Club Drug Use and HIV

Michael Gorman, PhD, MPH, MSW and Perry Halkitis, PhD

The use of “club drugs”—methamphetamine, Ecstasy (MDMA), gamma hydroxybutyrate (GHB), ketamine, and poppers (amyl nitrites)—has increased dramatically since the early 1990s with the spread of circuit parties and raves, and the re-emergence of sex clubs. The use of these substances in sexually charged environments creates a psychological, sociological, and biological environment that threatens individual and public health.

Physical Effect of Substances

The 1996 National Household Survey on Drug Abuse estimated that 4.8 million people used methamphetamine in their lifetime. Amphetamine treatment admission rates have increased dramatically since 1993, by at least 100 percent in 24 states. Methamphetamine—known as speed, crank, ice, glass, or crystal meth—is the primary form of amphetamine in the United States and can be smoked, injected, inhaled, or ingested. In addition to psychological manifestations, prolonged use of club drugs may lead to damage to skin integrity (especially among injection users), oral health, and heart and respiratory rates, and to electrolyte imbalances (related to dehydration) and malnutrition (related to appetite suppression).

Club drugs commonly place gay and bisexual men at greater risk for HIV seroconversion by increasing the likelihood of unprotected anal intercourse. In a New York sample, participants reporting more substance use were more likely to engage in unprotected oral and anal sex—both insertive and receptive—than those reporting less substance use. Gay men consistently reporting unprotected anal sex also reported a higher frequency of drug use during sex than those who always reported protected anal intercourse. Finally, the relationship between drug use and risky sexual behaviors is mediated by partner type—for example, primary or anonymous partner, and HIV-positive or HIV-negative partner—which may increase or reduce the risk of HIV transmission and the frequency of unprotected sex.

Demographics of Meth and Club Drug Use

Findings from studies on both the East and West coasts of the United States demonstrate the multifaceted nature of the club drug epidemic. Project SURE, a University of Washington and San Jose State University study, found a high prevalence of club drug use in tandem with unsafe sexual practices in Seattle and San Jose, California. Project SURE conducted 215 interviews over the course of four years, 132 of which were with gay or bisexual men. Demographically, this was diverse in terms of race and ethnicity, wealth and education, socioeconomic class, and geography. It also included men with concurrent mental health diagnoses such as bipolar disorder or schizo-affective disorder, a number of whom were homeless or experienced bouts of transiency.

Many Project SURE respondents reported that they “medicated” their HIV symptoms through substance use. Many said that club drug use reduced sexual inhibitions and found that 55 percent of a sample of 202 men who have sex with men reported the use of substances other than alcohol.

Gay men often identify substance use as a major cause of unprotected sex and as an important element of their lives. In a New York sample, participants reporting more substance use were more likely to engage in unprotected oral and anal sex—both insertive and receptive—than those reporting less substance use. Gay men consistently reporting unprotected anal sex also reported a higher frequency of drug use during sex than those who always reported protected anal intercourse. Finally, the relationship between drug use and risky sexual behaviors is mediated by partner type—for example, primary or anonymous partner, and HIV-positive or HIV-negative partner—which may increase or reduce the risk of HIV transmission and the frequency of unprotected sex.

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See also references cited in articles in this issue.

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allowed them to engage in activities in which they would not otherwise engage. Respondents reported frequent sex with multiple partners, widespread drug injection, and virtually nonexistent communication between anonymous participants, particularly at clubs and baths.

Studies in the New York metropolitan area uncovered similar findings. In 1999–2000, data from New York University’s Project Tina suggested that methamphetamine use crossed racial and economic strata, and was present in both the HIV-negative and HIV-positive gay and bisexual male communities. Further, use appeared to happen primarily on weekends. Users said that the drug use enhanced socialization with others, reduced social stress, and enhanced physical and sexual sensations. Methamphetamine was often used in combination with other substances, including Viagra. HIV-positive men and older respondents indicated significantly greater use of methamphetamine for sexual reasons than did HIV-negative men or respondents in their twenties. HIV-negative participants and younger men reported significantly greater use of the drug for social reasons. White participants were significantly more likely to use the drug to enhance physical energy and stamina compared to other men.

Preliminary data from NYU’s Project BUMPS—a cohort of 450 club drug-using men who have sex with men—echo these results. The data suggest that club drug use for coping as well as for ameliorating feelings of depression and loneliness appears closely linked to sexual risk taking.

**Addressing Club Drug Use**

Club drug use among men who have sex with men and the complex interaction between use of these substances and physical and mental health require programs that holistically address the user. Further, culturally sensitive programs must link clients to HIV screening and treatment, substance abuse treatment, including relapse prevention and harm reduction programs, and mental health treatment.

New York’s Project Tina users identified six areas that they believed should be addressed in treatment programs for methamphetamine: the physiological aspects of use, risk reduction strategies, methods for coping with cravings while seeking to stop use of the substance, methods for increasing social support, motivational strategies for non-use, and abstinence-related strategies. In addition, five recommendations made by Project SURE staff may help enhance program efficacy.

First, club drug use is not an isolated fad, but a serious public health threat. Train staff and develop targeted programs and consider developing partnerships with agencies and individuals where expertise in these areas already exists.

Second, ask clients about club drug use and further assess clients for club drug use and effects, noting physical and psychological signs, and undertaking a short drug and alcohol history, and brief, periodic mental status exams, paying particular attention to alterations in thought processes and speech patterns.

Third, recognize and treat dual diagnosis (substance use and psychiatric disorders): clients with undiagnosed psychiatric problems are vulnerable to substance use and addiction, either because of impaired judgment or as a means to self-medicate psychological symptoms. Be alert to emotional reactions to changes in HIV status or HIV disease progression and to the potential for clients to use methamphetamines to block these reactions. Finally, to avoid self-medication with methamphetamines, monitor prescription drug use for effectiveness in the treatment of fatigue, pain, and psychological symptoms.

Fourth, educate clients about the health effects of all medications and drugs, including behavioral disinhibition that may lead to HIV transmission. Explore with clients the ways in which recreational drug use may increase risks to individual and community health, and undermine physical and mental health. Screen clients on HIV medications about substance use and its impact on treatment adherence.

Finally, maintain a focus on the whole person—if possible, including members of his or her support system in care—and offer clients appropriate and culturally sensitive referrals. All of these approaches are crucial to employ at a time when recreational drug use and sexual risk characterize the lives of many gay and bisexual men.

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**Comments and Submissions**

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rmarks@itsa.ucsf.edu or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.
Substance Treatment as HIV Prevention
Shoptaw S, Frosch D. Substance abuse treatment as HIV prevention for men who have sex with men. AIDS and Behavior. 2000; 4(2): 193–203. (Los Angeles Addiction Treatment Research Center.)

Treatment for substance abuse can be a powerful component of HIV prevention, often leading to a reduction in sexual risk behavior, according to a recent review of the literature on substance treatment and HIV risk among men who have sex with men.

Many men who have sex with men report strong associations between drug use—particularly with methamphetamine (speed) use—and sexual risk. Various studies have found that the heightened sensations of sex and prolonged ability to have sex reported by methamphetamine users result in conditioned associations between sex and speed. Individuals are also less likely to take precautions when under the influence of drugs, and substance use often alters their perceptions of risk.

Substance abuse treatment programs affect the spread of HIV by removing significant triggers for unsafe sexual behaviors and removing the inhibition-lowering effects of substances. For example, a 1997 study found a significant reduction of HIV-related risk behaviors among heterosexual cocaine abusers receiving substance abuse counseling, and a 1995 study of gay men recovering from substance use problems reported reductions in unsafe sexual practices. Even when treatment is not entirely successful, it provides a leverage point for delivering interventions that can guide sexual decision making.

Many gay men and women have reported biases from clinicians and health workers at mainstream treatment centers, and feelings of alienation in treatment programs where clinicians focus on homosexuality as the root problem of addiction or fail to recognize that sexuality is a part of the client's identity. Clinicians should receive training in these areas in order to assist clients in HIV-related risk reduction and prevention.

Even when drug abuse treatment is not entirely successful, it provides a leverage point for delivering interventions that can guide sexual decision making.

Continued Crack Use After HIV Diagnosis

A study of 10,415 HIV-positive people found that the majority of the 34 percent who had ever smoked crack continued using crack after being diagnosed with HIV. Post-HIV crack use was significantly associated with sexual risk behavior such as unprotected sex with multiple partners and the exchange of sex for money or drugs.

Researchers analyzed three years of data collected using the Supplement to HIV/AIDS Surveillance (SHAS), a survey of adults with HIV or AIDS in 12 U.S. cities. The cohort was 76 percent male and 24 percent female; 48 percent African American, 32 percent White, and 20 percent of other ethnicities; and 50 percent men who have sex with men, 26 percent male heterosexuals, and 24 percent female heterosexuals.

Twenty-seven percent of the men who have sex with men, 42 percent of the male heterosexuals, and 37 percent of the female heterosexuals reported some lifetime history of using crack. Sixty-nine percent of these respondents reported using crack since their HIV-diagnosis. Crack use after an HIV-diagnosis was associated with being African American, a heterosexual woman, 30 to 49 years of age, having injected drugs, and having been diagnosed with HIV more than two years prior to the questionnaire. Those who had used crack since diagnosis were more likely to report sexual risk behavior than those who had used crack before, but not after, diagnosis.

For heterosexual women, crack use after diagnosis was a predictor of unprotected sex with a main partner, having multiple partners, and exchanging sex for money or drugs. For heterosexual men, crack use after diagnosis predicted unprotected sex with casual partners, having multiple sex partners and (for African American heterosexual men only) exchanging sex for money or drugs. For men who have sex with men, all of the risk behaviors were associated with crack use after diagnosis.

Substance Use and Sex Among Latino Men

A survey of 307 men from four Latino ethnic groups found significant rates of substance use in conjunction with sex,
both with and without condoms. Social factors such as acculturation and psychological factors such as sensation seeking may contribute to rates of drug use during sex or unprotected sex and substance use.

The cohort was divided evenly among Mexican, Dominican, Colombian, and Puerto Rican participants. Ages ranged from 18 to 55; the average was 31.

Respondents reported on a range of behaviors in the 12 months prior to the survey. Eighty-four percent of the men reported more than one partner; 92 percent of the men had engaged in anal sex (receptive or insertive), and 43 percent had not used condoms. Sixty-eight percent reported using alcohol with sex, and 45 percent reported using drugs with sex: marijuana, poppers/nitrates, and cocaine/crack were the most commonly used drugs in conjunction with sex.

Thirty-four percent reported inconsistent condom use. Substance use among these men was identical and independent of partner type (primary/lover or casual/one-night stand). Men who used alcohol with one-night stands reported significantly higher rates of unprotected anal sex than those who did not. There were no differences between users and non-users in rates of unprotected sex with a primary partner/lover.

While substance use in conjunction with sex differed among the four ethnic groups, the association between substance use and unprotected sex was similar across these groups. Levels of acculturation for members of all the groups was significantly correlated with drug use in conjunction with sex, while age, education, and income was not. Finally, sensation seeking, machismo, and low levels of self-worth were significantly correlated with higher frequency of unprotected sex and substance use, though machismo was only related to insertive anal sex.

Methamphetamines and HIV-Positive Men
Semple SJ, Patterson TL, Grant I. Motivations associated with methamphetamine use among HIV+ men who have sex with men. Journal of Substance Abuse Treatment. 2002; 22(3): 149–156. (University of California, San Diego; and Department of Veteran Affairs Medical Center, San Diego.)

High rates of methamphetamine use were associated with high rates of anal sex, low rates of condom use, and having multiple, often anonymous partners, according to a small qualitative survey of HIV-positive men who have sex with men.

San Diego researchers interviewed 25 gay and bisexual male participants. Of this sample, 56 percent were White, 24 percent were Latino, 16 percent were African American, and 4 percent were Native American. Ages ranged from 27 to 57; the average was 38.

Participants had known about their HIV status for an average of eight years. Sixty-seven percent of participants had received a psychiatric diagnosis in their lifetimes; 42 percent were currently taking psychiatric medications. The most common current psychiatric diagnoses were depression (81 percent), bipolar disorder (13 percent), and anxiety (6 percent). All participants had used methamphetamine at least twice in the past two months, and the average frequency of use was 10 times in the past month.

Ninety-seven percent of participants used methamphetamines before or during sex, and all participants reported that a primary motivation was an increase in sexual pleasure. Participants also reported that the drug enhanced sexual performance and longevity (80 percent had engaged in marathon sex) as well as diminishing the emotional connection of sex. One-quarter of participants said methamphetamine helped them cope with their HIV diagnosis; others used it to control health-related problems such as fatigue.

Fifty-five percent of participants were more likely to have anal sex without a condom while high; of these, 62 percent were more likely to be the insertive partner. Participants reported having unprotected anal sex with an average of eight partners of unknown or negative serostatus during the prior two months.
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