



# The Intersection of Substance Abuse, Depression, Violence and HIV: Implications for Ending the HIV Epidemic

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Program

# Disclosures

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- ❑ Ms. Ramroop has no disclosures

# Objectives

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At the conclusion of this activity, the participant will be able to:

- ❑ Recognize the inter-relationship of HIV, substance abuse, depression and violence
- ❑ Describe the effect of substance abuse, depression, and violence on the course of HIV
- ❑ Identify challenges and potential strategies to address this syndemic

# Importance of Viral Suppression

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Maximal and durable viral suppression:

- Prevents/delays selection of drug resistance
- Preserves or improves CD4 cell count
- Reduces HIV-associated morbidity and prolongs duration and quality of survival
- Prevents HIV transmission

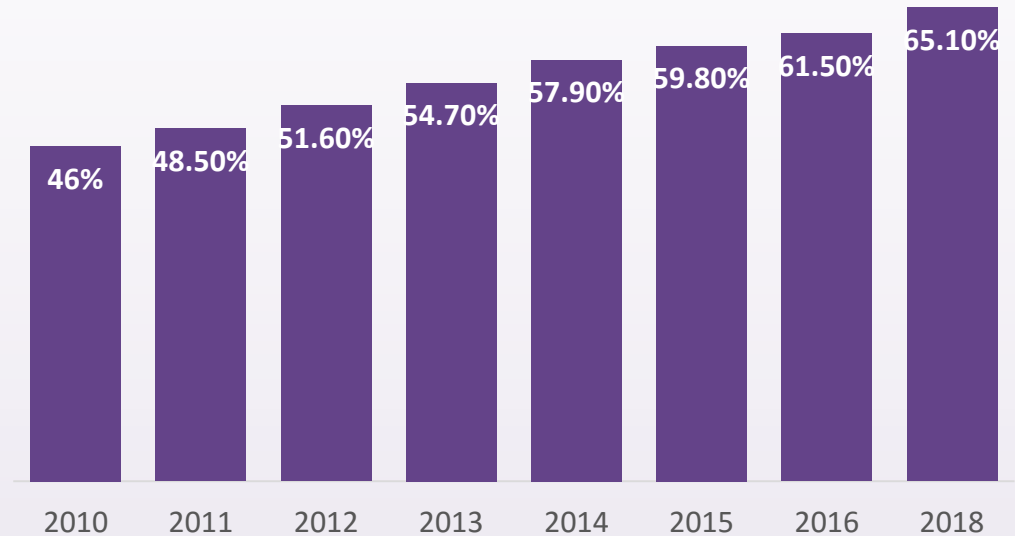
HRSA/CDC: PLWHA who take HIV meds daily as prescribed and who achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner

- U=U
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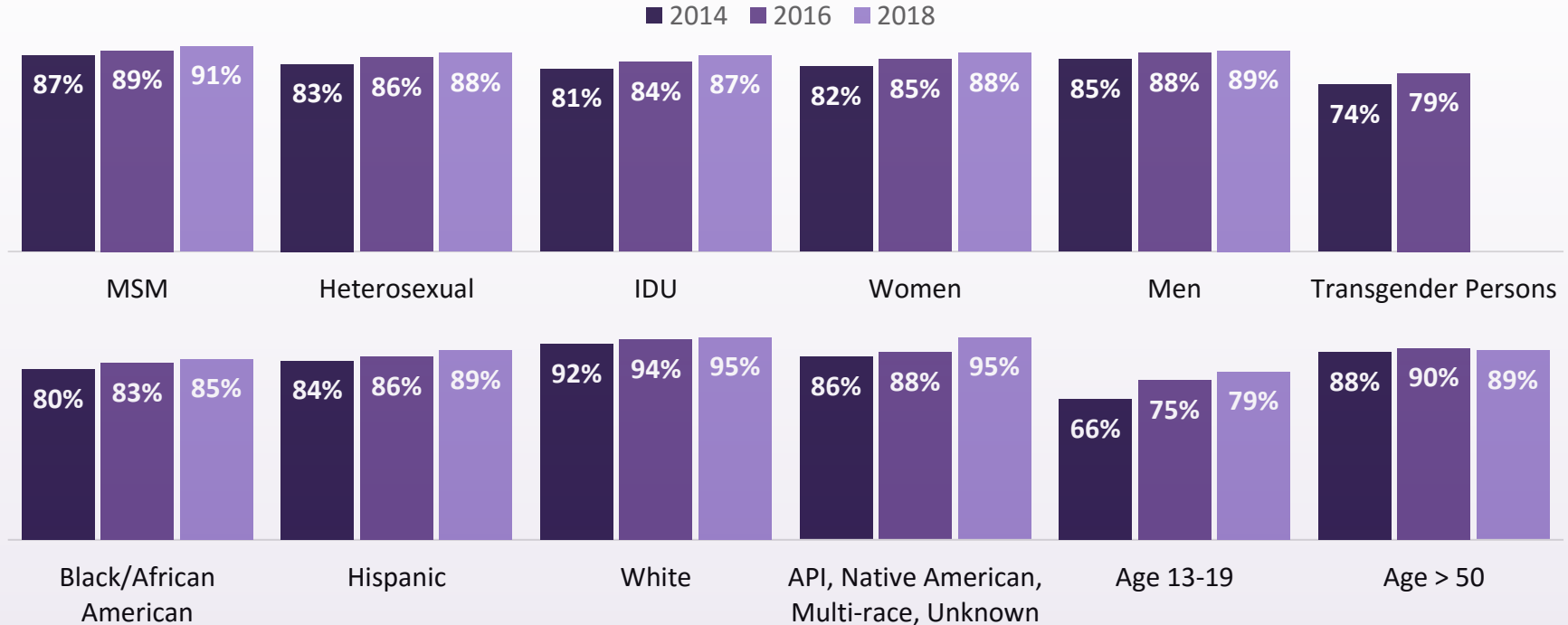
# HIV Monitoring Report: HIV Viral Suppression Increasing

- 85.8% of persons with HIV knew their status (2017)
- 80.2% of newly diagnosed linked to medical care (2018)
- Included data from 40 jurisdictions

Percentage of Persons with Diagnosed HIV Who Are Virally Suppressed



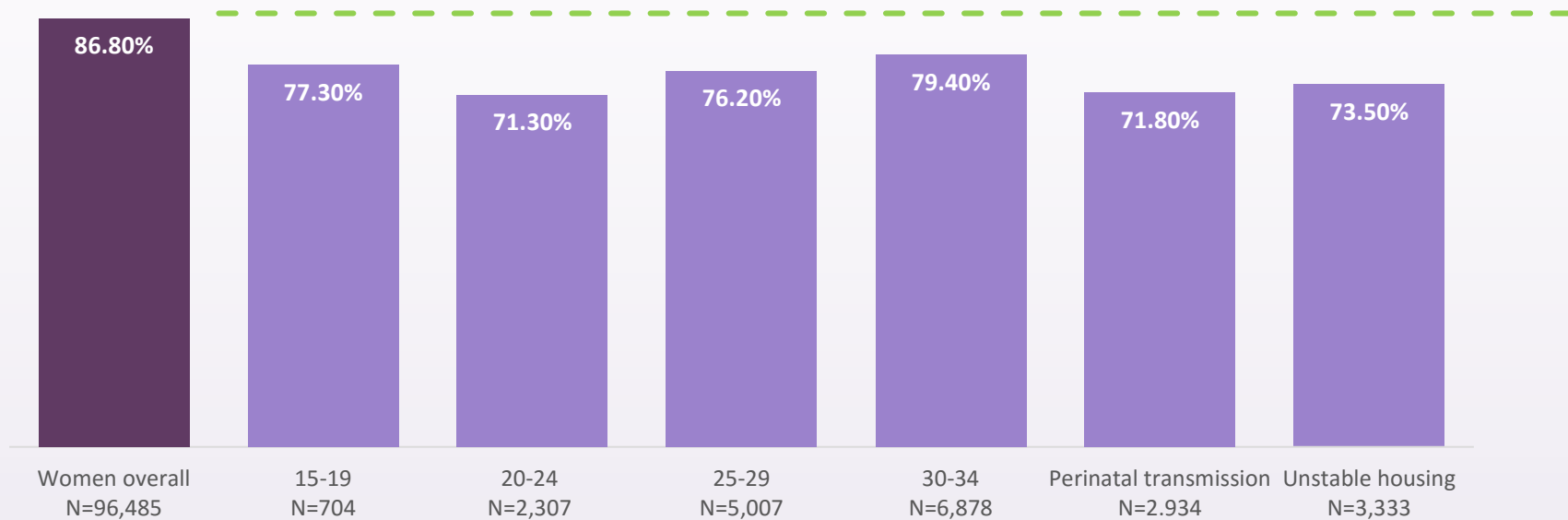
# Viral Suppression\* Among In-Care PLWDHI by Demographics (NY State)



\* Nondetectable or <200 copies/ml at test closest to end-of-year among PLWDHI

1. New York Department of Health.

# Viral Suppression among Women Served by the RWHAP, 2018 – United States and Territories



N represents the total number of clients in the specific population.

Includes women aged 13 years and older.

Viral suppression: >OAHs visit during the calendar year and >1 viral load reported, with the last viral load result <200 copies/mL.

Source: HRSA, Ryan White HIV/AIDS Program Services Report(PSR) 201.

# Substance Abuse, Violence, and HIV/AIDS = SAVA

- Conceptualized in 1994 as “set of closely intertwined and mutually enhancing epidemics” that are fueled and sustained by social and economic inequities<sup>1</sup>
- HIV, substance abuse, and violence each contribute independently to the collective health burden on women
- But they act synergistically to negatively affect health outcomes
- The co-occurrence of these factors is termed the *SAVA syndemic*

## Plus Depression

1. Gilbert L, Goddard-eckrich D, Hunt T, et al. Efficacy of a Computerized Intervention on HIV and Intimate Partner Violence Among Substance-Using Women in Community Corrections: A Randomized Controlled Trial. *Am J Public Health.* 2016;106(7):1278-86.



# Substance Abuse: A National Public Health Crisis

- 21.2 million Americans needed treatment for a substance use disorder in 2018.<sup>1</sup>
  - ❖ Only 3.7 million of those Americans received treatment<sup>1</sup>
- In 2018, 31.9 million Americans aged 12 or older were current illicit drug users.<sup>1</sup>
- Drug overdose is the number one cause of injury related deaths in the US.<sup>2</sup>

1. Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health.

2. [https://www.cdc.gov/injury/wisqars/pdf/leading\\_causes\\_of\\_injury\\_deaths\\_highlighting\\_unintentional\\_2018-508.pdf](https://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_injury_deaths_highlighting_unintentional_2018-508.pdf)

# Intimate Partner Violence (IPV) and Depression

- 31% of U.S. women will experience physical violence by an intimate partner (IPV) during their lifetimes
- 47% will experience psychological aggression<sup>1</sup>
- 50% to 60% of women on public assistance have been victims of domestic violence as adults<sup>2</sup>
- Costs of IPV exceed \$5.8 billion each year<sup>3</sup>
- Approximately 7% of US adults have had at least one major depression episode in past year and lifetime prevalence much higher

1. Breiding MJ, et al. MMWR Surveill Summ. 2014;63(8):1-18.

2. Violence Against Welfare Recipients: Domestic & Sexual Abuse." 2007. Legal Momentum)

3. <https://www.cdc.gov/violenceprevention/pdf/IPVBook-a.pdf>

4. Center for Behavioral Health Statistics and Quality 2016

# IPV and Mental Health and Substance Abuse

- Higher rates of trauma-related mental health conditions among IPV survivors<sup>1,2</sup>
- Nearly three times the risk for developing major depressive disorder<sup>3</sup> or PTSD<sup>4</sup>
- Women with a recent history of experiencing IPV had nearly six times the risk of problematic alcohol use<sup>5</sup>
- Prevalence rates of substance use/abuse among IPV survivors vary from 18%-72%
- Prevalence rates of IPV among people using substances vary from 31%-90%<sup>6</sup>

1. Nathanson AM, et al. Partner Abuse. 2012;3(1):59-75.

2. Phillips et al., 2014

3. Beydoun HA, et al. Soc Sci Med. 2012;75(6):959-75.

4. Fedovskiy K, et al. J Immigr Minor Health. 2008;10(1):45-51.

5. La flair LN, et al. J Stud Alcohol Drugs. 2012;73(3):351-60.

6. Rivera E.A., et al. . National Center on Domestic Violence, Trauma & Mental Health. <http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/09/IPV-SAB-Final202.29.1620NO20LOGO-1.pdf>

# Interrelationship of IPV, Depression, and Substance Abuse with HIV in Women

- Physical IPV alone increases risk for HIV in women by 28%–52%<sup>1,2</sup>
  - ❖ Women in relationships with violence have 4x greater risk for contracting STIs than women in relationships without violence<sup>3</sup>
- Substance abuse is a major risk factor for HIV transmission
  - ❖ Injection drug use: transmission category for 7%-28% of women with newly diagnosed HIV<sup>2</sup>
  - ❖ Noninjection drug use/alcohol increase risk through impaired judgment, disinhibition
- The syndemic effect of living with all three SAVA factors is associated with increased risk of depression among women.<sup>3</sup>
  - ❖ Study: 445 urban women who had experienced all three SAVA factors were 6.8 times more likely than women with no SAVA factors to have depressive symptoms<sup>4</sup>

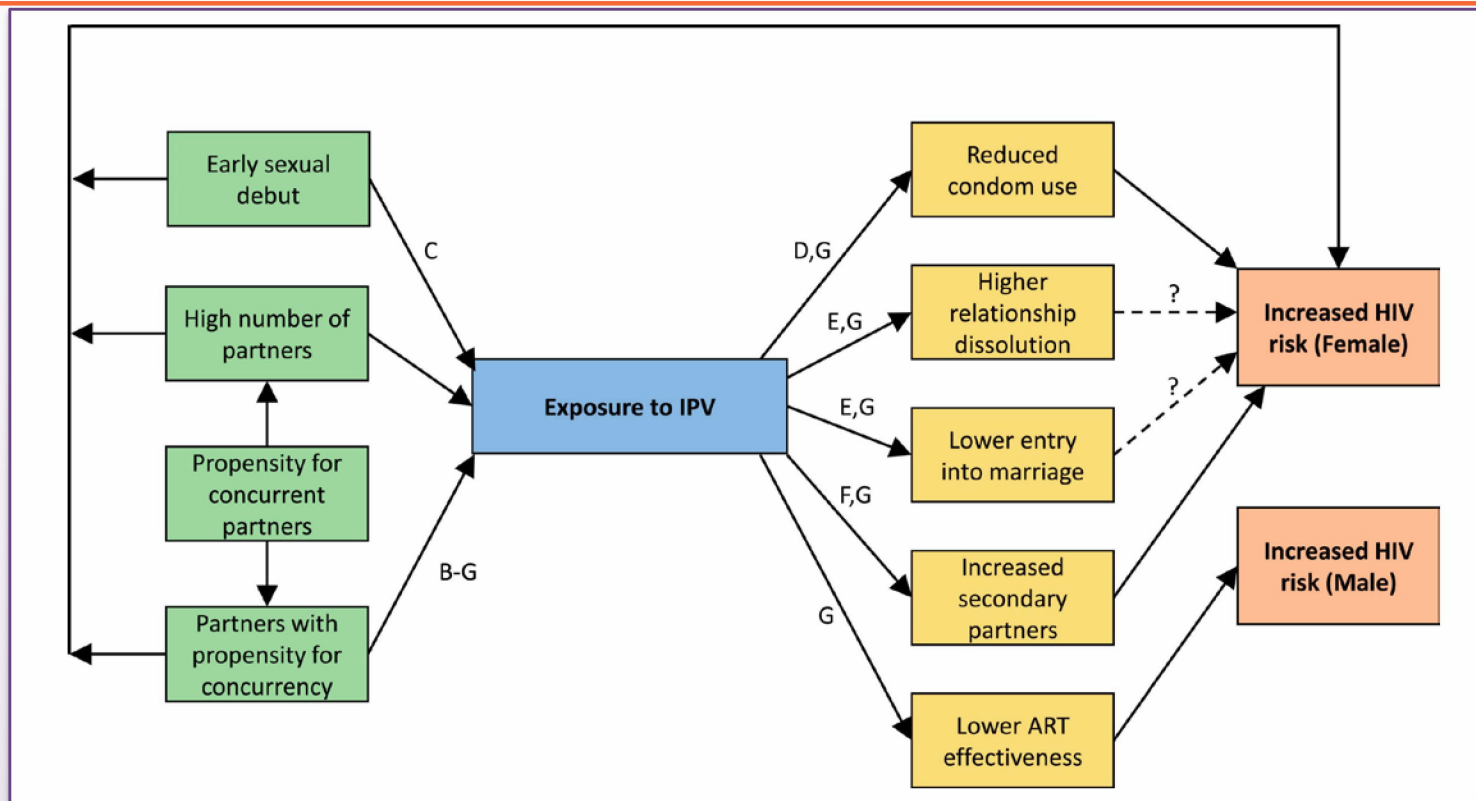
1. HIV and substance use in the United States. Accessed 21 November 2017at: <https://www.cdc.gov/hiv/risk/substanceuse.html>.

2. Li Y, et al. J Int AIDS Soc 2014;17:18845

3. Illangasekare S, et al. J Urban Health. 2013;90(5):934-47.

4. Betancur MN, et al. Braz J Infect Dis. 2017;21(5):507-514.

# Relationship Between IPV and HIV



# Risk for IPV, Substance Abuse, and Depression Among HIV Infected Women

- Women with HIV experience more frequent and *more severe* IPV than HIV-negative women<sup>1</sup>
  - ❖ 55.3% of HIV-positive women experience IPV (>2x national rate)<sup>2</sup>
- One-third of the 1.2 million people living with HIV (PLWH) in the United States drink alcohol in unhealthy amounts or use illicit drugs<sup>3</sup>
- Depression is the most common psychiatric comorbidity among PLWH
  - ❖ Affects 30%-40% of infected adults<sup>4,5</sup>; 3x greater than among general population<sup>6</sup>
  - ❖ Women with HIV 2x more likely than men to have depression<sup>7</sup>
  - ❖ Approximately 50% with depression go unrecognized
  - ❖ 50% of those recognized go untreated<sup>8,9</sup>

1. Gielen AC, et al. Trauma Violence Abuse. 2007;8:178-98

2. Machtinger EL, et al. AIDS Behav. 2012;16(8):2091-100

3. Substance Abuse and Mental Health Services Administration, 2010.

4. Pence BW, et al. J Acquir Immune Defic Syndr. 2006;42(3):298-306.

5. Schumacher JE, et al. AIDS Behav. 2013;17(8):2781-91.

6. Cook JA, et al. Drug Alcohol Depend. 2007;89(1):74-81.

7. Simoni JM, et al. AIDS Behav. 2011;15(2):376-88.

8. Pence BW, et al. AIDS. 2012;26(5):656-8.

9. O'cleirigh C, et al. Psychosomatics. 2015;56(5):470-8.

# Substance Use Disorders (SUDs) are Common in PLHIV

	Total (10,652) (%)
Any SUD	48
Alcohol UD	19
Opioid UD	4
Cocaine UD	11
Marijuana UD	31
Methamphetamine UD	13

# PTSD and HIV

- 10%-20% prevalence in general population<sup>1</sup>
- Prevalence/incidence of PTSD higher in HIV patients<sup>2</sup>
  - ❖ Lifetime PTSD in HIV: 54%
  - ❖ PTSD related to HIV: 40%
- Women with HIV 2x more likely to have PTSD than men<sup>3</sup>
- Patients with PTSD 2-3x more likely to have substance use disorder<sup>4</sup>

1. Brunello N, et al. Neuropsychobiology. 2001;43(3):150-62.

2. Martin L and Kagee A. AIDS Behav. 2011;15:125-131

3. Hilerio CM, et al. Ethn Dis. 2005;15(4 Suppl 5):S5-47-50.

4. Kessler RC, et al. Arch Gen Psychiatry. 1995;52(12):1048-60.



# High rates of Traumatic Events/PTSD in HIV-positive Women

**Table 3** Meta-analytic prevalence rates of traumatic events and PTSD in HIV-positive women

Categories	Number of studies	Pooled <i>n</i>	Prevalence <sup>a</sup> (%)	95% confidence interval	Reference prevalence <sup>b</sup> (%)
Recent PTSD	6	499	30.0	18.8–42.7	5.2
Intimate partner violence	8	2285	55.3	36.1–73.8	24.8
Adult sexual abuse	8	2237	35.2	20.1–51.4	– <sup>c</sup>
Adult physical abuse	5	1791	53.9	30.2–76.8	– <sup>c</sup>
Adult abuse unspecified	2	532	65.0	58.9–70.8	– <sup>c</sup>
Childhood sexual abuse	7	3013	39.3	33.9–44.8	16.2
Childhood physical abuse	6	1582	42.7	31.5–54.4	22.9
Childhood abuse unspecified	2	232	58.2	36.0–78.8	31.9
Lifetime sexual abuse	8	1182	61.1	47.7–73.8	12.0
Lifetime physical abuse	6	878	72.1	60.1–82.1	– <sup>c</sup>
Lifetime abuse unspecified	6	1065	71.6	61.0–81.1	39.0

<sup>a</sup> Pooled prevalence from random-effects model (DerSimonian-Laird)

<sup>b</sup> National samples of US women (citations in text)

<sup>c</sup> Data from a national sample not available or national samples report conflicting rates

# Relationship Between Psychosocial Factors Associated with SAVA

- Study of 563 HIV-positive women of color (67% Black, 26% Hispanic/Latina) at 9 sites examined relationships of 5 psychosocial factors associated with SAVA: poor mental health, substance use, binge drinking, IPV and sexual risk-taking
- As the number of psychosocial problems increased, likelihood of viral suppression decreased<sup>1</sup>
- Additive effect plateaus with  $\geq 3$  psychosocial problems
  - ❖ Suggests a threshold beyond which an increasing proportion of women have poor clinical outcomes

Sullivan KA, Messer LC, Quinlivan EB. AIDS Patient Care STDS. 2015;29 Suppl 1:S42-8.

# Impact of Substance Abuse, IPV and Depression on HIV Outcomes

- Depression in PLWH is associated with negative health behaviors and outcomes
  - ❖ reduced antiretroviral (ART) adherence<sup>1,2</sup>
  - ❖ missed HIV primary care appointments<sup>3</sup> reduced viral suppression<sup>2,4</sup>
  - ❖ higher rates of AIDS-related morbidity and mortality<sup>5,6</sup>
- Women with history of violence less likely to have viral suppression (76.4% vs 93.3%)<sup>7</sup>
- Experiencing physical and other types of IPV increases the likelihood of not getting tested for HIV as well as not accessing and staying in HIV care and poor ARV medication adherence among women who use drugs.<sup>8,9</sup>
  - ❖ Childhood sexual abuse is a strong risk factor for substance use, particularly injection drug use, engaging in risky sex, and failing to engage in HIV care and medication adherence.<sup>8,9</sup>

1. Mugavero M, et al. AIDS Patient Care STDS. 2006;20(6):418-28.
2. Gonzalez JS, et al. J Acquir Immune Defic Syndr. 2011;58(2):181-7.
3. Zuniga JA, et al. AIDS Patient Care STDS. 2016;30(1):34-8.
4. Pence BW, et al. J Acquir Immune Defic Syndr. 2007;44(2):159-66.
5. Todd JV, et al. Am J Epidemiol. 2017;185(10):869-878.
6. Mugavero MJ, et al. AIDS Patient Care STDS. 2007;21(9):681-90.
7. Espino, SR, et al. AIDS Patient Care and STDs 2015;29(Suppl 1), S36–S41
8. Meyer JP, et al. J Womens Health (Larchmt). 2011;20(7):991-1006.
9. Schwartz RM, et al. AIDS Patient Care STDS. 2014;28(5):260-7.

# Impact of Substance Abuse, IPV and Depression on HIV Outcomes

- Several studies have shown an association between specific substance use and a detectable HIV VL<sup>1,2</sup>
- Relationship of contextual, psychological, and environmental factors with adherence to ART:<sup>3</sup>
  - ❖ Depression and adherence self-efficacy were significant predictors of adherence, and fewer depression symptoms predict higher self-reported ARV adherence
  - ❖ Depression is associated with lower adherence and quality of life.<sup>4</sup>

1. Baum et al. 2009, Journal of Acquired Immune Deficiency Syndromes (JAIDS)  
2. Bonn-miller MO, et Al. J Behav Med. 2014;37(1):1-10.  
3. Tyer-Viola LA, et al. J Obstet Gynecol Neonatal Nurs. 2014;43(2):168-78  
4. Betancur MN, et al. Braz J Infect Dis. 2017;21(5):507-514.

# Alcohol and Illicit Drug Use and Virologic Suppression<sup>1</sup>

- Cross-sectional study 2012-2014: HIV+ on ART, current substance use/disorder
  - ❖ Number of drug dependence criteria associated with <90% ART adherence and lack of viral suppression
    - Past 30 days specific substance use/heavy drinking days ( $\geq 4$  drinks/d women,  $\geq 5$  drinks/d men)
    - Severity of drug/alcohol dependence in preceding 12 mos. (DSM IV criteria)
  - ❖ Approx. 75% of substance-using cohort receiving ART achieved virologic control
  - ❖ Criteria for drug dependence, rather than specific substance use, associated with detectable VL

- Treatment for depression can improve outcomes among PLWH
  - ❖ Reduced depressive symptoms<sup>1</sup> (Pence et al. AIDS 2012; Pence et al. AIDS 2015)
  - ❖ Improved ART adherence and viral suppression<sup>2-4</sup>
- Drug use independently associated with poorer outcomes along depression treatment cascade
  - ❖ Current drug users are most likely to need depression treatment
    - Least likely to receive treatment or to have depression remission<sup>5</sup>

1. Schumacher JE, et al. AIDS Behav. 2013;17(8):2781-91.

2. Himelhoch et al. AIDS Patient Care STDs 2005

3. Himelhoch et al. AIDS Patient Care STDs 2007

4. Sin et al. Ann Behav Med 2014; Springer et al. AIDS Behav 2012

5. DiPrete et al. AIDS Behav 2018

# Treatment with SSRIs Improves HAART Adherence

- Retrospective cohort study-3359 patients were evaluated
  - 42% had a depression diagnosis
  - 15% used SSRIs during HAART
- With continuous outcomes and with likelihood of  $\geq 90\%$  adherence: patients with depression adherent to SSRIs had significantly greater mean ART adherence compared to patients with depression not on SSRIs
- Similarly, the likelihood of have HIV-RNA  $<500$  c/ml at 12 mo and improvement in CD4 count significantly greater with patients with depression adherence to SSRIs compared to those with depression not on SSRIs

Horberg et al, JAIDS. 2008

# Treating depression improves viral suppression

- Retrospective chart review: patients referred to on-location therapy services for depression had significant decreases in depression scores and HIV RNA with increases in CD4.<sup>1</sup>
- Viral suppression and CD4 count increased and PHQ-9 improved after initiating antidepressants in a study comparing effectiveness of single vs dual-action antidepressants.<sup>2</sup> No significant difference observed in effectiveness of single vs dual-action medications.

1. Coleman SM et al. Psychosomatics. 2012;53(1):51-7; 2. Mills JC et al. AIDS. 2017;31(18):2515-2524.



# Treating Substance Use

At SF methadone clinic, records of HIV patients (n = 65) reviewed for retention in care and viral suppression:<sup>1</sup>

- Women more likely to attain suppression (96% vs 71%)
- Viral suppression 14% higher for those who receive HIV care onsite vs at HIV clinic nearby
- 31% higher compared to community clinics

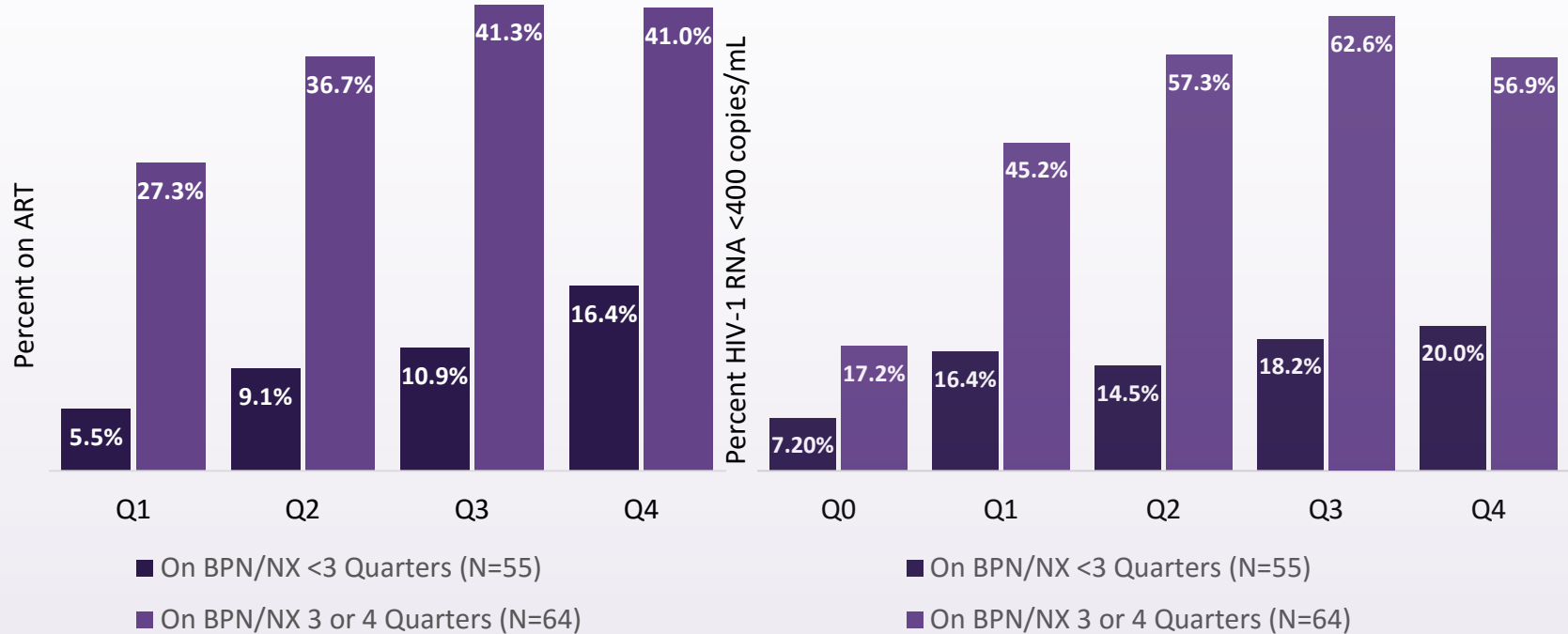
**France:** 2-3 times better adherence to ART among those who had stopped injecting drugs while prescribed methadone or buprenorphine:<sup>2</sup>

- Duration of opioid-agonist therapy significantly associated with viral suppression

**Canada:** Methadone treatment associated with improved adherence, viral suppression, and CD4 count<sup>3</sup>

1. Simeone C, et al. Addict Sci Clin Pract. 2017;12(1):19; 2. Roux P et al. Addiction. 2008;103(11):1828-36; 3. Palepu A et al. Drug Alcohol Depend. 2006;84(2):188-94.

# Buprenorphine, Naloxone, and HIV Clinical Outcomes



- Brief behavioral interventions can reduce syndemic risks for IPV and HIV among women who use drugs
- Meta-analytic reviews and recent studies suggest that trauma-focused interventions that address substance abuse disorders, IPV, PTSD associated with IPV-related trauma, and HIV/ AIDS in an integrated, concurrent approach are more likely to succeed, to be more cost-effective, to increase medication adherence, and to reduce symptoms of PTSD<sup>1</sup>
- Other trauma-informed interventions for those who are HIV + have revealed significant effects in reducing substance use, decreasing PTSD symptoms and unprotected sex as well as improving medication adherence<sup>2</sup>

Wyatt et al. Women's Health Iss. 2011; Wyatt et al. AIDS and Behavior. 2004; Ironson et al. J Consult Clin Psych. 2013; Meade et al. Addiction. 2010.

# Screening for Substance Abuse and Depression

Screening for substance use and depression is effective in identifying affected patients and introducing support (n=1398):<sup>1</sup>

- In the waiting room at each visit, HIV+ patients completed PHQ-9, Substance Abuse and Mental Illness Symptoms Screener (SAMISS), and questions about adherence
- 12.2% had indications of moderate/severe depression
- Associated with decreased adherence
- 19.1% had indications of problematic drinking
- 8.2% had indications of problematic drug use

*“Patients were willing to disclose mental health distress, substance use and sub-optimal medication adherence to providers, highlighting the importance of routinely assessing these behaviors during clinic visits.”*

1. Skalski LM, Watt MH, Macfarlane JC, et al. Mental Health and Substance Use Among Patients in a North Carolina HIV Clinic. N C Med J. 2015;76(3):148-55.

## HIV clinic in Alberta, Canada (n = 1721)<sup>1</sup>

- 46% of women in HIV care had experienced IPV
- Only 22% of patients had been asked about violence in any other health care setting
- Patients were responsive to routine violence screening, *but referral services need to be easily accessible*
- 23% of patients disclosing IPV were connected to resources after screening

*“We recommend that universal IPV screening be incorporated within regular HIV clinic care. The IPV survey should be given after trust has been established with regular follow-up every 6-12 months. A referral process to local agencies dealing with IPV must be in place for patients disclosing abuses.”*

1. Raissi SE, Krentz HB, Siemieniuk RA, Gill MJ. Implementing an intimate partner violence (IPV) screening protocol in HIV care. AIDS Patient Care STDS. 2015;29:133-41.

# Screening for Violence

**Chicago HIV clinic** (n = 102 women of color) tested novel approach to screening:<sup>1</sup>

## At Baseline:

- Women's Experience of Battering Scale
- Three-question ER screening for IPV
- One question measuring fear of partner as barrier to care
- Asked to identify level of safety in relationship (acuity assessment)

## At Follow-up visits:

- At 3 months, asked “How likely is it that you became infected with HIV as a result of being forced to have sex with someone who may have been infected?”
- Repeat acuity assessment every 6 months

1. Espino SR, Fletcher J, Gonzalez M, et al. Violence screening and viral load suppression among HIV-positive women of color. *AIDS Patient Care and STDs*. 2015;29(Suppl 1), S36–S41.

## Results of the Chicago study:

- Women reporting IPV were *~8 times less likely* to be virally suppressed
- 70.6% indicated a history of violence using the composite measure (ie, positive on at least one screening tool).
- 35% identified history of sexual assault
- Acuity assessment identified 41% of participants as having a history of IPV
- Baseline ER screening Qs identified 37% of participants as having a history of IPV

*“Asking questions multiple times in a variety of ways may be key to identifying women who may not disclose violence when first asked.”*

1. Espino SR, Fletcher J, Gonzalez M, et al. Violence screening and viral load suppression among HIV-positive women of color. AIDS Patient Care and STDs. 2015;29(Suppl 1), S36–S41.

# Select IPV Screening Tools:

For all tools, a single “yes” response constitutes a positive screen for IPV.

All tools include questions about physical and psychological violence.

Optimizing Disease Management



Abuse Assessment Screen (AAS) Laughon et al. 2008	Sensitivity: 32%-93% Specificity: 55%-99% Positive predictive value: 33% Negative predictive value: 97%	<u>Pro</u> : 4 questions Assesses sexual violence Assesses nonfatal strangulation Developed for and tested in pregnant women <u>Con</u> : Inconsistent psychometrics
Humiliation, Afraid, Rape, Kick (HARK) Sohal et al. 2007	Sensitivity: 81% Specificity: 95% Positive predictive value: 83% Negative predictive value: 94%	<u>Pro</u> : 4 questions Assesses sexual violence High sensitivity and specificity <u>Con</u> : Since it is a relatively newer tool, less research supports its use
Partner Violence Screen (PVS) Feldhaus et al. 1997	Sensitivity: 64.5%-71.4% Specificity: 80.3%-84.4% Positive predictive value: 51.3%-63.4% Negative predictive value: 87.6%-88.7%	<u>Pro</u> : 3 questions <u>Con</u> : Does not assess sexual violence
Slapped, Threatened, and Throw (Things) (STaT) Paranjape et al. 2003	Sensitivity: 64%-96% Specificity: 75%-100%	<u>Pro</u> : 3 questions High sensitivity and specificity <u>Con</u> : Does not assess sexual violence Some articles report 2 yes responses yields higher sensitivity and specificity



# Barriers to IPV Screening Identified by Providers

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- Lack of awareness of the problem and its prevalence
- Discomfort with topic
- Tendency to blame the victim
- Lack of training
- Inadequate resources or lack of knowledge of available resources
- Not knowing how to respond to + screen
- Lack of time
- Lack of privacy to screen
- Fear of offending patients
- Perception that screening is not clinician's role

## Possible Clues to IPV

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- Evidence of physical trauma (bruising, abrasions, etc), especially if repeated over time, with vague/implausible explanations
- Unexplained chronic GI/GU sx (chronic pain, frequent UTIs)
- Unexplained reproductive tract sx (chronic pelvic pain, sexual dysfunction, repeated STIs, unexplained genital/anal injury)
- Multiple unintended pregnancies and/or terminations
- Other unexplained chronic pain
- Repeated health consultations with no clear diagnosis
- Intrusive partner who insists on being present in consultations
- Sx depression, anxiety, PTSD, sleep disorders
- Suicidal ideation and/or behaviors or other self-harm

## Potential Clues to IPV (continued)

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- Shows discomfort when discussing possibility of abuse
- Seems fearful of partner
- Patient appears to be embarrassed, ashamed, frightened, disoriented, or depressed
- Excessive distress over a minor injury or little emotion over a serious injury
- Is unusually quiet, jumpy, or nervous
- Has a limited attention span during assessment
- Hyper-vigilance among victim or abusive partner

# Potential Clues to Depression and Substance Abuse

## DEPRESSION

Chronic fatigue      Low self esteem  
Sleeping difficulties      Hx major losses  
Chronic pain      Loss of libido  
Emotional lability  
Chronic missed visits  
Weight changes

## SUBSTANCE ABUSE

Chronic pain  
Chronic missed visits  
Skin changes  
Weight changes  
Changes in hygiene  
Emotional lability

# Screening for Depression

U.S. Preventive Services Task Force recommends screening in adolescents and adults in clinical practices that have systems in place to ensure accurate diagnosis, effective treatment, and follow-up.

- PHQ-2 has a 97 percent sensitivity and 67 percent specificity in adults
- PHQ-9 has a 61 percent sensitivity and 94 percent specificity in adults
- If the PHQ-2 is positive for depression, the PHQ-9 should be administered

## PHQ 2

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- Over the last 2 weeks, how often have you been bothered by any of the following problems? (score 0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day)
  - Little interest or pleasure in doing things
  - Feeling down, depressed, or hopeless
- Score > 2 defaults to PHQ-9

Over the last 2 weeks, how often have you been bothered by the following problems?  
(same scoring system)

- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless
- Trouble falling asleep, staying asleep, or sleeping too much
- Feeling tired or having little energy
- Poor appetite or overeating
- Feeling bad about yourself or that you're a failure or have let yourself or your family down
- Trouble concentrating on things, such as reading the newspaper or watching TV
- Moving or speaking so slowly that other people could have noticed or the opposite: being so fidgety or restless that you have been moving around a lot more than usual
- Thoughts that you would be better off dead or of hurting yourself in some way



**Screening:** The application of a simple test to determine if a patient is at risk for or may have an alcohol or substance use disorder

**Brief Intervention:** The explanation of screening results, information on safe use, assessment of readiness to change, and advice on change

**Referral to Treatment:** Patients with positive results on screening are referred for in depth assessment and/or treatment



# Alcohol Screen (AUDIT-C)

Q1: How often did you have a drink containing alcohol in the past year?	
	Points
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4
Q2: How many drinks did you have on a typical day when you were drinking in the past year?	
	Points
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4
Q3: How often did you have six or more drinks on one occasion in the past year?	
	Points
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

# Drug Use Screen

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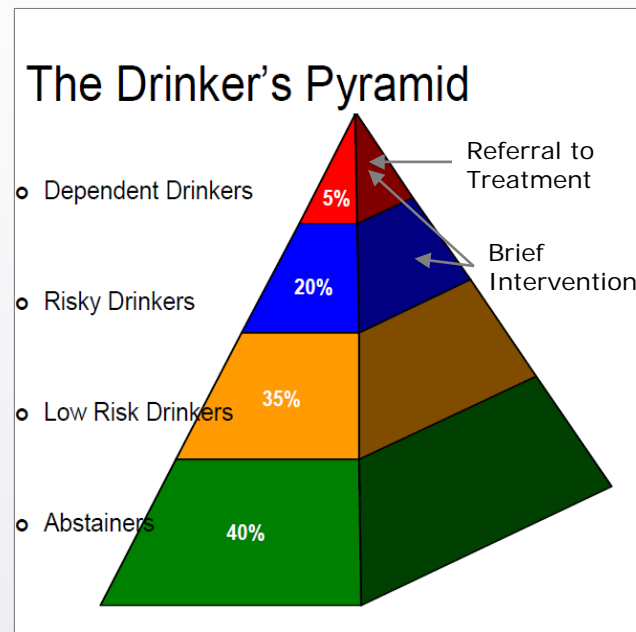
- In the past 12 months, have you used any illegal/street drug, including marijuana?
- In the past 12 months, have you used a prescription drug for non-medical reasons or more often and/or at higher doses than prescribed?

Positive responses prompt additional questions/brief intervention or referral

# Rationale for SBIRT

Screening, Brief Intervention, and Referral to Treatment (SBIRT) aims to:

- Identify persons with substance use disorders.
- Identify persons who are at high risk for developing a substance use disorder.
- Help patients reduce or eliminate alcohol or other drug consumption and thereby minimize or avoid associated problems.
- Motivate patients to accept referrals for more specialized assessment and treatment services.



# SBIRT: Results

Using Cochrane methodology, 69 primary care brief intervention trials for 33,642 participants:<sup>1</sup>

- Significantly reduced alcohol consumption compared to controls

SBIRT demonstration projects: cross-site evaluation:<sup>2</sup>

- 11 programs funded for 5 years to promote the adoption and sustained implementation of SBIRT
- Pre/post differences were clinically meaningful and statistically significant for almost every measure of substance use
- Greater intervention intensity was associated with larger decreases in substance use
- Brief intervention was more cost-effective for most substances

SBIRT associated with reduced health care costs, ED visits, and hospitalizations<sup>3</sup>

1. Beyer et al. *Curr Addict Rep*. 2018;5:265; 2. Babor et al. *Addiction* 2017; 112 Suppl 2:110; 3. SAMHSA-HRSA. Center for Integrated Health Solutions.

# How Often to Screen

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## IPV

- Maryland Health Care Coalition Against Domestic Violence: Screen every patient.  
Every visit

## Depression and Substance Abuse

- No formal evidence-based screening guidelines
- Screening every patient at every visit for both depression and substance abuse may help identify patients in need

# Considerations in Screening

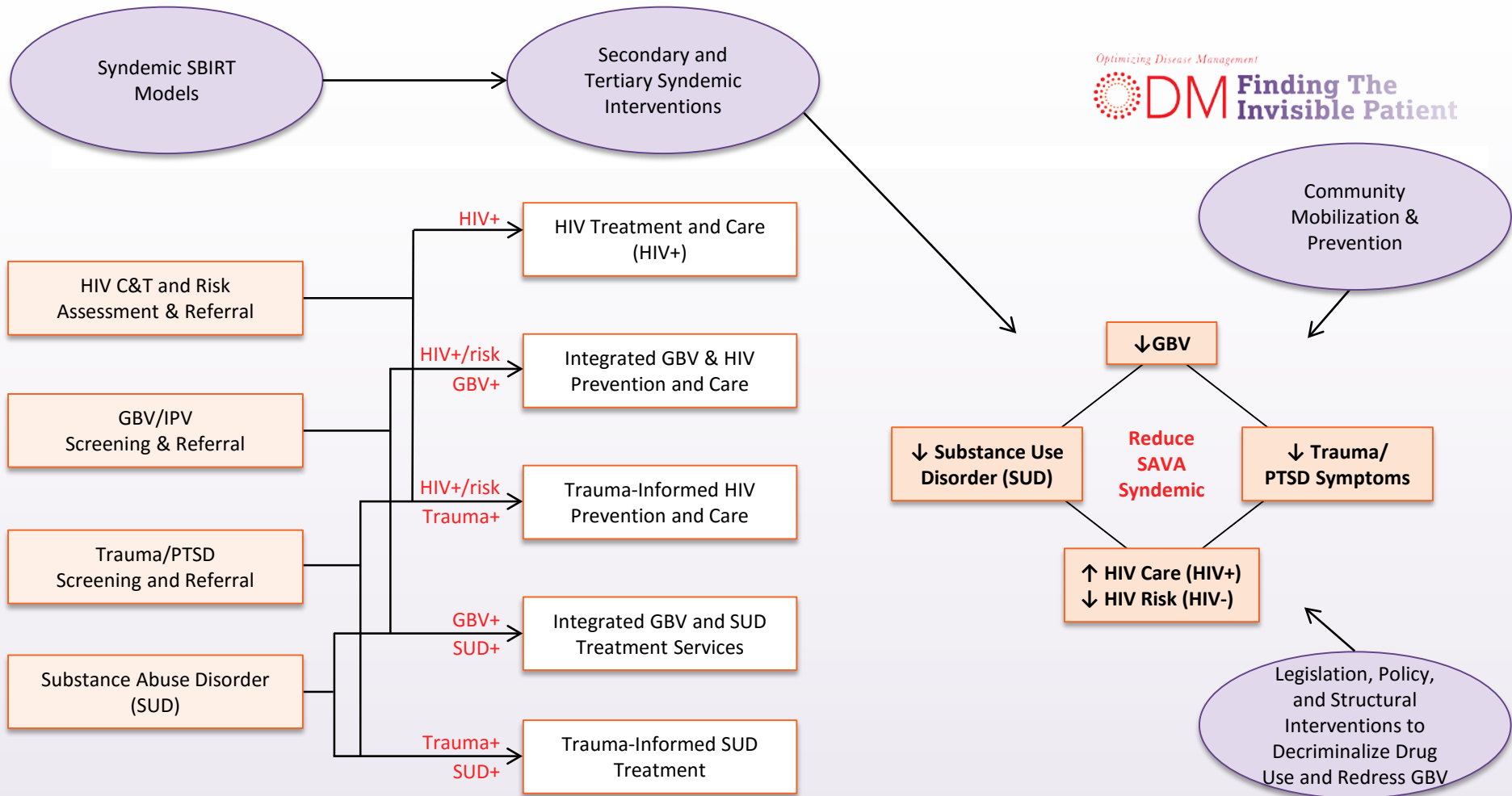
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- Privacy
- Confidentiality
- Brochures/other materials in waiting rooms and bathrooms
- Systematic protocol
- Screening script
- Validated screening tool(s)
- Mandatory reporting issues
- Referral needs

### **DO NOT CONTACT THE POLICE WITHOUT THE ADULT VICTIM'S CONSENT:\***

- Contacting the police without the victim's consent may place the patient in a higher level of danger.
- Inform patients that they can contact the local police or state attorney general's office to request that charges be filed against the abuser.
- Victims may also file for a protective order.

\*Refer to specific state laws regarding confidentiality and reporting.





## Responding to a Positive Screen

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- Acknowledge
- Ask if she wants help
- Offer support and referrals
- Encourage safety planning if IPV
- Additional assessments to determine level of danger or suicidal ideation, as appropriate
- Identify relevant comorbidities

# Services/Interventions: General Considerations

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- Ensure that services are culturally relevant and trauma-informed
- Incorporate gender-responsive coordinated, collaborative, and integrated services
- Use peer supports
- Understand specific factors that influence access to and adherence to care
- Need for privacy and confidentiality
- HIV disclosure considerations
- Need to establish referral pathways

# COVID 19 Considerations

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There are reports of increases in IPV, depression and substance abuse during “stay at home” orders for the COVID 19 pandemic

- may be “locked down” with their abuser

- access to medications/insurance issues

- fewer in-person medical/psychiatric or SUDS treatment visits

Providers should have low threshold for considering these problems

- Screening critical but special confidentiality issues

- Extended medication refills/home delivery

- Consider in-person visits if needed

## Conclusion

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Substance abuse, depression, IPV and HIV are closely intertwined and mutually enhancing epidemics (or syndemic)

These factors act synergistically and are associated with negative HIV outcomes

Identification and treatment of depression, substance abuse, and IPV can improve ART adherence and viral suppression

Screening for the components of this syndemic should be routine in the context of HIV care

# Resources for Referral

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## Violence

- **Futures Without Violence ([www.endabuse.org](http://www.endabuse.org))**
- **National Coalition Against Domestic Violence ([www.ncadv.org](http://www.ncadv.org))**
- **National Network to End Domestic Violence ([www.nnedv.org](http://www.nnedv.org))**
- **National Resource Center on Domestic Violence ([www.nrcdv.org](http://www.nrcdv.org))**

## Mental Health

- **National Council for Behavioral Health: [www.thenationalcouncil.org](http://www.thenationalcouncil.org)**
- **Black Mental Health Alliance: [info@blackmentalhealth.com](mailto:info@blackmentalhealth.com) (410-338-2642)**
- **Mental Health America: [www.mhanational.org](http://www.mhanational.org)**
- **SAMHSA: [www.samhsa.gov](http://www.samhsa.gov)**

## Resources for Referral (cont)

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### Mental Health

- **NAMI: National Alliance on Mental Illness: [info@nami.org](mailto:info@nami.org) or 1-800-950-NAMI**

### Addiction/SUD

- **NAADAC: the Association for Addiction Professionals; [naadac@naadac.org](mailto:naadac@naadac.org)**
  - **All Treatment: [www.alltreatment.com](http://www.alltreatment.com)**
  - **NIDA: National Institute on Drug Abuse: SAMHSA Treatment Locator: 1-800-662-HELP**
  - **Narcotics Anonymous 1-800-317-3222**
  - **Alcoholics Anonymous: [aa.org](http://aa.org)**
  - **American Society of Addiction Medicine: [www.asam.org](http://www.asam.org) 301-656-3920**
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