

# Providing mental health care and wellbeing in HIV: Learnings from the field

Chair:

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*This educational event is supported by*



# Recent updates in the provision of addiction treatment

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# Addictions: What is new and what can HIV clinics do?

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## Conflict of Interest

In relation to this presentation, I declare that I have no conflict of interest.

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# Content

- Drug Trends – International / National / Local
- Drug Related Deaths
- Alcohol
- Treatment Developments
- What can services do?



European Monitoring Centre  
for Drugs and Drug Addiction

EN

# European Drug Report

Trends and Developments



2022



# EMCDDA 2022 Report

- 83 million (29%) of adults (15 – 64) ever used an illicit drug
- Cannabis most common (22 million in last year)
- Stimulants second (cocaine, then MDMA, then amphetamine)
- Synthetic drug production growing (esp. metamphetamine)
- Opiates – 1 million (but 75% of all fatal overdoses)
- Polydrug use & increasing complexity: medicinal, NPS, ketamine, GHB/GBL

# EMCDDA 2022 Report

- Globalisation / International situation
- COVID-19 rebound
- Cannabis (price stable but THC content up) / synthetic cannabinoids
- Cannabis – implications of policy development
- Cocaine availability and use high (price stable)
- Increasing diversity e.g., synthetic cathinones



# Intravenous Drug Use

- Injecting associated with more damaging drug use and increased risk of BBV infections
- Injection of synthetic cathinones linked to chemsex practices and marginalised groups who inject drugs linked to outbreaks of HCV and HIV
- Injecting drug use has declined (but COVID 19 disruption of distribution and testing)
- Long term trends in new HIV infection associated with injecting falling across Europe

# Injecting and HIV

- Transmission persists where outbreaks linked to stimulant injecting has been notified in the past e.g., Athens (2011), Luxembourg (2014) and Glasgow (2015)
- Risk factors – cocaine injecting, homelessness and incarceration
- Also sexual transmission
- Late diagnosis

# Prescription drug misuse

- Opiates (POM or OTC) e.g., tramadol, codeine
- Increasing use of more potent opiates e.g., oxycodone and fentanyl
- Gabapentinoids i.e., gabapentin and pregabalin
- Benzodiazepines use (not new) – alprazolam and etizolam concerning
- Stimulants e.g., methylphenidate, ephedrine
- Antipsychotics e.g., quetiapine, olanzapine
- Antidepressants e.g., bupropion, venlafaxine

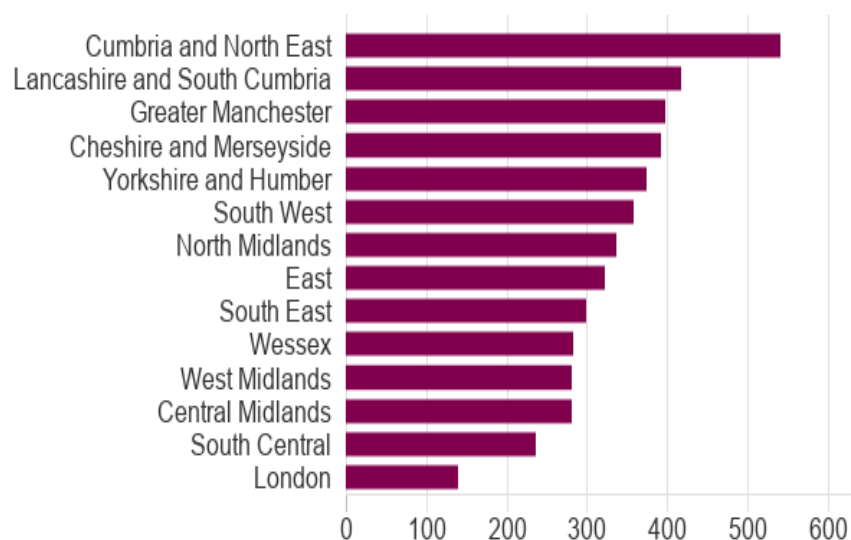
*Schifano et al., 2018; PHE - Sept 2019*

# Opiate Epidemic USA

- Global problem: 55% of premature death caused by drug abuse due to opiate addiction - *World Drug Report 2016*
- 2017 – US declared National Public Health Emergency
- Four fold increase in opiate prescriptions 1991 - 2013 - *Volkow–NIDA*
- Parallel increase in opiate related mortality rates, A/E visits - *Warner et al., 2014; SAMHSA 2011*
- Opiate abuse and overdose costing US \$56 billion annually - *Birnbaum et al., 2011*

## Opioid analgesics prescribed in 2017

Items prescribed per 1,000 residents, by NHS region



Source: NHS Digital/Openprescribing.net

BBC

## Prescription Opiates

- 2.3 million took a prescription opiate prescribed for another (2016 – 2017) – England and Wales Crime Survey
- Doubling of patients prescribed opioids by GP in last 10 years (PHRC – 2017)
- Prescription rates for in NE and Cumbria are 4 x that in London

# Chemsex (Strong et al., Lancet 2022)

- Studies show an association between drug use in sexual contexts (chemsex) and HIV among gay, bisexual, and MSM (but causal relationship contentious)
- Relationship between chemsex, HIV treatment and prevention, harm reduction, and the provision of health services is complex
- Potential harms exist beyond HIV (e.g., intoxication and overdose)
- Community responses to chemsex involve social and cultural strategies of harm reduction and sexual health promotion before, during, and after a chemsex session



# Chemsex

- Recreational drug use is associated with potentially high-risk sexual behaviours and so elevated risk of STIs and HIV

*McCarty-Caplan, Jantz, & Swartz, 2014*

- International evidence suggests, among MSM and use drugs, a preference for 'sex-drugs' e.g., alkyl nitrites ('poppers'), crystal methamphetamine ('crystal meth') and club drugs (e.g., ketamine, MDMA, GHB & GBL)

*McCarty-Caplan et al., 2014*

- New psychoactive substances (NPS), also popular with MSM, with mephedrone the sixth most used substance in gay bars /nightclubs (UK)

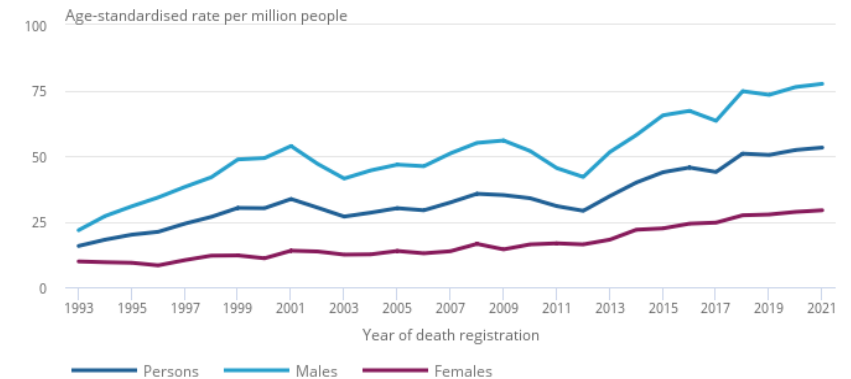
*Winstock et al., 2011*

# ONS Drug Misuse Deaths

- 63% drug poisoning deaths due to drug misuse
- Rate rose from 16 per million (1993) to 52 per million (2021)
- Rates for men 38% > than for women
- Government 10-year drugs plan for England – to prevent 1000 deaths by 2024 / 2025

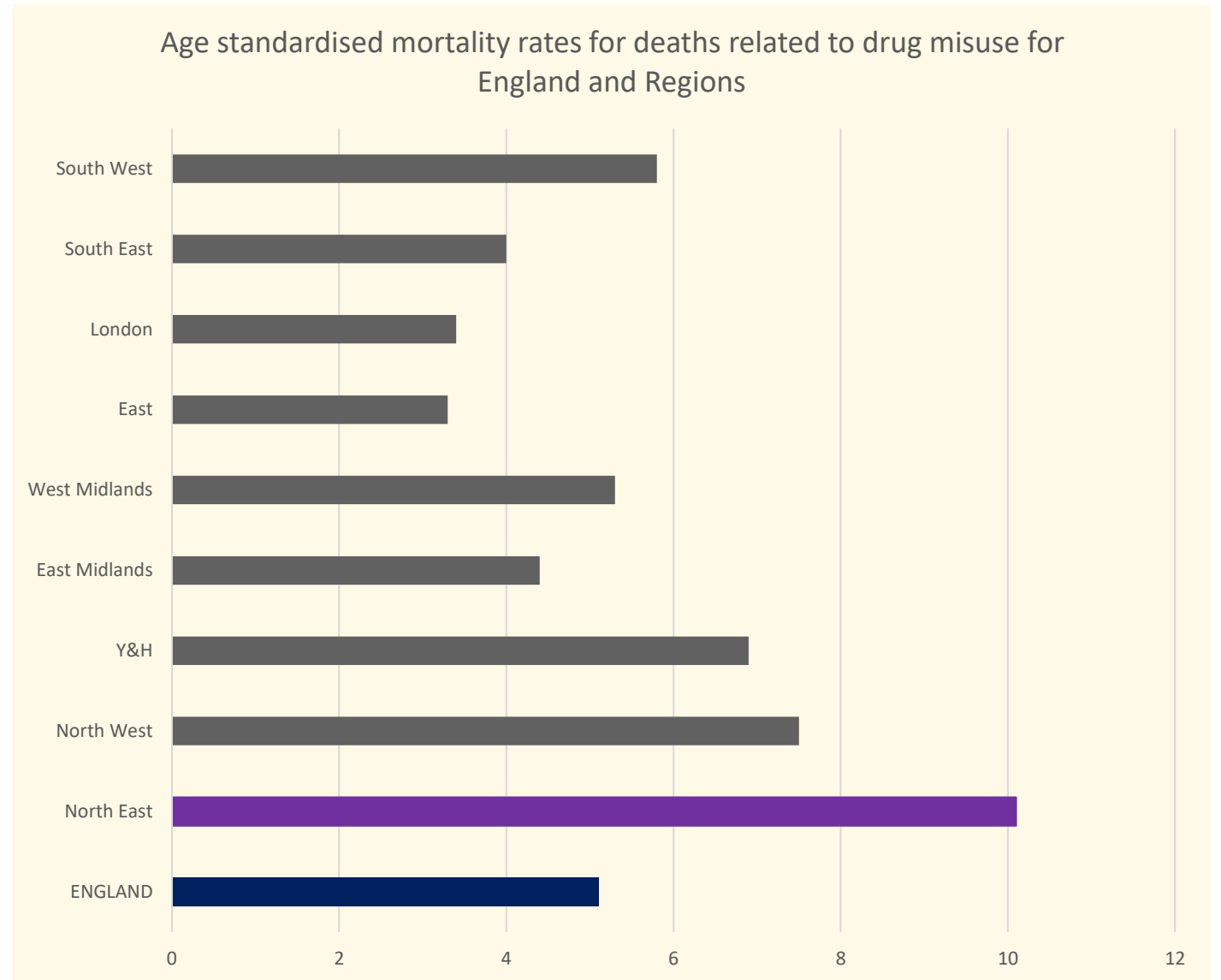
Figure 2: Rates of drug misuse deaths increased in 2021

Age-standardised mortality rates for deaths related to drug misuse, by sex, England and Wales, registered between 1993 and 2021



Source: Office for National Statistics – Deaths related to drug poisoning in England and Wales

# Drug misuse deaths by region



# Key Current Trends

- Generation X – highest rate of deaths
- Large regional differences
- NE highest for 9 consecutive years
- 50% > one drug
- 50% involve an opiate (rates involving methadone up)
- Cocaine deaths up sevenfold since 2011
- Increase in deaths involving NPS

# Dame Carol Black Review

## **Commissioned by the HO and DHSC**

### **Part 1 – February 2020**

Analysis of the challenges posed by drug supply and demand

### **Part 2 – July 2021**

Focus on drug treatment, recovery and prevention – 32 recommendations including:

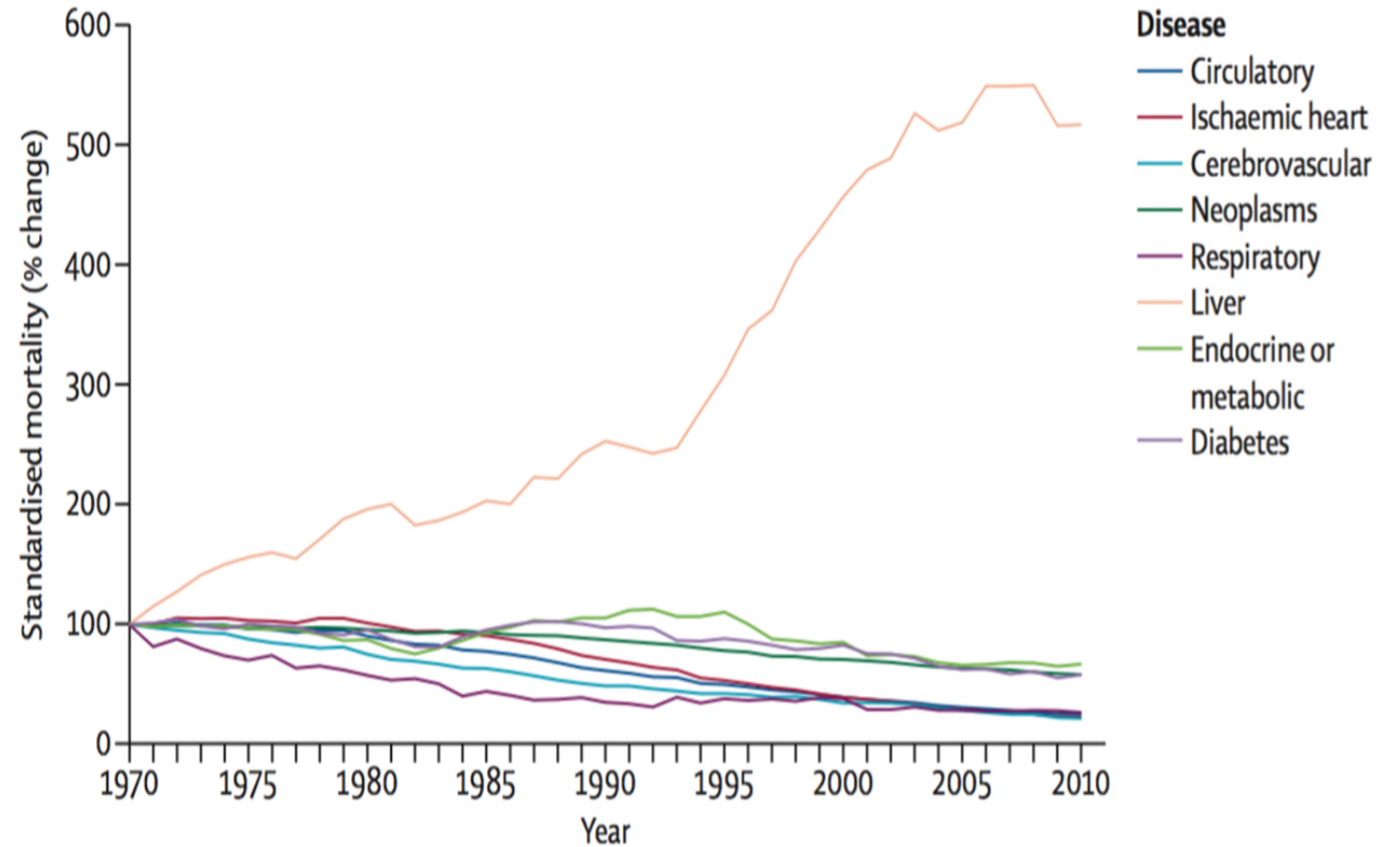
- Increased investment
- Creation of a Government Drugs Unit
- Increase in the professionally qualified workforce
- Establishment of an innovation fund
- Local authorities to commission a full range of treatment services

# Alcohol

- **Leading risk factor for early mortality**, ill-health and disability among 15-49-year-olds in England. Continuing to worsen as a direct result of COVID-19 pandemic **ONS, 2021**
- **58.6% increase** in increasing risk and higher-risk levels of drinking March 2020 – March 2021 increasing >14 units, higher risk > 50 units men, >35 units women per week **PHE, 2021**
- In 2020, deaths from mental and behavioural disorders due to alcohol **increased by 10.8%** (1.1% increase between 2018 and 2019), and deaths from alcohol poisoning increased by 15.4% (4.5% between 2018 and 2019) **PHE 2021**
- ARLD deaths **increased by 21%** during the pandemic (highest levels recorded) alongside liver mortality rates in England increasing by 43% 2001 and 2019.



# Alcohol and Liver Disease



# Alcohol and HIV

- Those with AUD > than general population to contract HIV
- Those with HIV more likely to abuse alcohol
- Alcohol use associated with high risk sexual behaviours and injecting drug use
- Alcohol increases susceptibility to infection

*Petry 1999*

*Cook et al., 2001*

*Lucas et al., 2002*

# Alcohol and HIV

- Increased medical and psychiatric complications
  - Delays in seeking treatment
  - Problems with concordance
  - With HIV, blood alcohol levels are higher per unit consumed
- 
- Alcohol does not stop anti-HIV drugs from working properly

# Alcohol Healthcare Needs Assessment Findings (June 2022)

## **North East and North Cumbria ICS:**

- Alcohol causal factor in over 60 medical conditions
- Alcohol related harm estimated NHS cost = £3.5 billion / year
- Consumption and harm increased during the pandemic
- Estimated 79 - 91% dependent drinkers not in treatment (NENC)
- 16 500 unplanned admissions to hospital (NENC)
- 2020 / 21 – 1000 alcohol specific deaths (NENC)

# Alcohol Healthcare Needs Assessment Recommendations (June 2022)

## 20 Recommendations:

- Workforce (4) – training, support, directory and communication and engagement
- Data (6) – data quality, coding, datasets, health management, research
- Service Delivery (5) – access, lived experience, discharge documentation, regular audit
- Strategic Leadership (5) – awareness, young people, inequality, change culture

# Treatment

## **Pharmacotherapy**

- Optimisation of existing treatments (OST)
- Provision of existing treatments (heroin)
- New treatments (buprenorphine film / depot)
- Take home naloxone

## **Other Approaches**

- Improving access to treatment and recovery services
- Drug Consumption Rooms
- Advancing better practices for pain management



# Optimising treatment

- Reassessment
- ORT – choice, dose, supervision
- Increase intensity of keyworker /support
- Additional psychosocial interventions e.g. contingency management, relapse prevention
- Naloxone and harm reduction advice (include carers)
- Therapeutic relationships– continuity of care, non punitive and flexible approaches

# Buprenorphine Depot

- Implemented initially in USA and now in UK
- Weekly / Monthly subcutaneous injection
- Range of products available
- On-going research
- Application

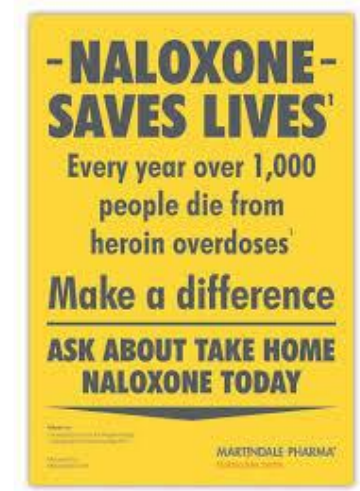
# Heroin Assisted Treatment

- UK, Switzerland, Canada, Germany Netherlands etc.
- Health outcomes improved
- Reduction in use of illicit heroin
- Reduction in criminal activity
- Increase uptake of other treatments e.g. methadone
- No diversion of heroin
- Substantial costs but offset by savings to society (EMCDDA)

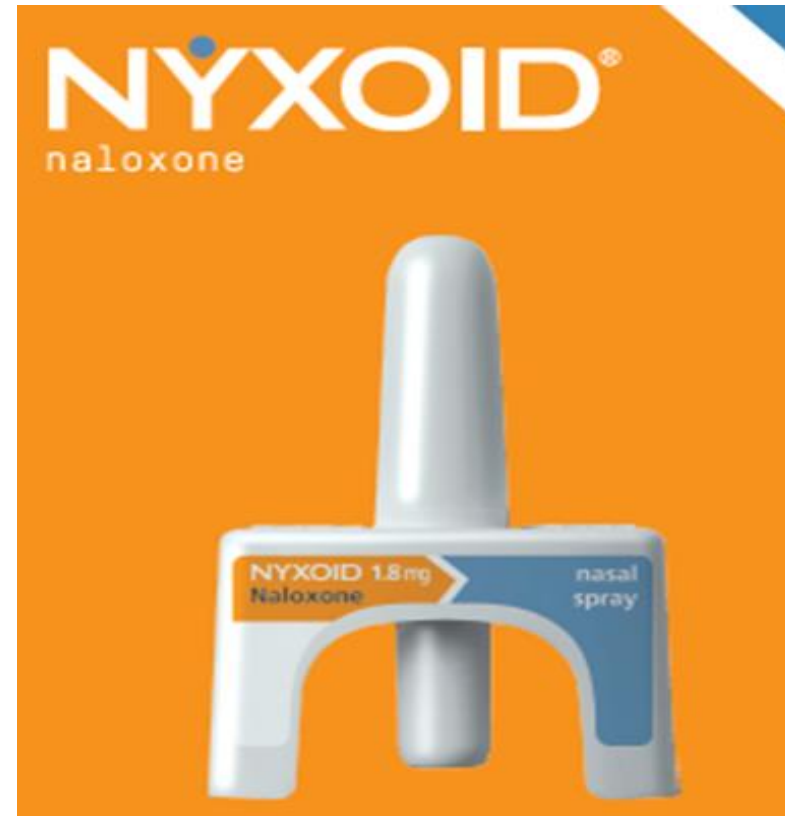
# Naloxone

2015 - Legislation allowing distribution without a prescription but challenges in:

- Reporting
- Replenishing
- Recording
- Locality variations
- Appropriate distribution / rate
- GOVERNANCE!



# Nasal Naloxone



# Managing Co-morbidity

- Physical Health e.g.
  - Infectious Diseases
  - Respiratory Diseases
  - Chronic Pain
  - DVT/PE
- Mental Health



# Drug Consumption Rooms



# Drug Consumption Rooms

- Supervised use of own drugs in safe setting
- Three models
- None in UK (at present)
- Europe (from 1986), Australia and Canada
- Evidence – positive impact on local area, on street based injecting, saving lives, reduction of BBV, engaging marginalised groups
- No evidence of increased drug use in area

*Belackova & Salmon 2017, EMCDDA 2018*

# What can services do?

- Screen patients for alcohol and drugs – ask the question
- Consider routine use of screening tools
- Refer directly to Addictions Services (no signposting)
- Monitor use – encourage open discussion
- Regular liaison with Addiction Services (named links / joint clinics)
- Integration with primary care