Journal of Substance Abuse Treatment 69 (2016) 57–63

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

HIV patients' preference for integrated models of addiction and HIV treatment in Vietnam

Diep Nguyen Bich, M.D., M.P.H. [a,*], P. Todd Korthuis, M.D., M.P.H. [b], Trang Nguyen Thu, M.A. [a], Hoa Van Dinh, M.D., M.P.H. [a], Giang Le Minh, M.D., Ph.D. [a]

[a] Hanoi Medical University, Hanoi, Vietnam
[b] Oregon Health and Science University, Portland, OR, USA

ARTICLE INFO

Article history:
Received 28 March 2016
Received in revised form 29 June 2016
Accepted 13 July 2016
Available online xxxx

Keywords:
HIV
Integrated model
Injection drug use
Alcohol abuse
Vietnam

ABSTRACT

Background: Integrated care models for HIV and substance use disorder (SUD) care are proposed as a strategy for closing gaps in the HIV care continuum and decreasing HIV transmission. We examined attitudes regarding integration of HIV and SUD treatment among HIV-infected patients with illicit drug and unhealthy alcohol use.
Method: We conducted a cross-sectional survey of HIV-infected patients receiving care at 5 HIV clinics in Hanoi, Vietnam, regarding substance use and attitudes toward HIV and SUD treatment integration. We used multivariate logistic regression to identify correlates of integrated care preference.
Result: Among 312 participants with current or past illicit drug use or unhealthy alcohol use, 81.4% preferred integrated treatment for HIV and SUD. In multivariate analysis, completing a college education (aOR 0.22, 95% CI 0.08, 0.65), risk of depression (aOR 3.51, 95% CI 1.57, 7.87), ever having received medication-assisted treatment for opioid use disorder (aOR 4.20, 95% CI 1.65, 10.69), being comfortable discussing substance use with counselors/nurses (aOR 3.86, 95% CI 1.38, 10.81) and having discussed alcohol use with their health providers (aOR 2.34, 95% CI 1.09, 4.99) were associated with patients' preference for integrated care, after adjusting for age and gender.
Conclusion: Most, but not all, HIV-infected patients with substance use preferred integrated HIV and SUD treatment. Our findings suggest that policies to expand integration of HIV and SUD treatment will be well received by most patients, and that stand-alone treatment options should be preserved for a significant minority.

1. Introduction

Vietnam has a concentrated HIV epidemic in which people who inject drugs have the highest prevalence of HIV (Nguyen, Nguyen, Pham, Vu, & Mulvey, 2012). Since the first diagnosed case of HIV in 1990, Vietnam has scaled up a free antiretroviral therapy (ART) program, nationwide, that began in 2005 through a network of outpatient HIV clinics and has greatly expanded access to HIV care (Nguyen et al., 2013). International momentum is building to reach the UNAIDS 90–90–90 goal of closing gaps in the HIV continuum by 2020: 90% of people living with HIV know their HIV status; 90% of people who know their status are on HIV treatment; and 90% of people on treatment will have undetectable levels of HIV, known as viral suppression (UNAIDS, 2014a). In September 2015, Vietnam became the first country in Asia to commit to these ambitious targets with the goal of ending its AIDS epidemic by 2030 (UNAIDS, 2014b). Responding to this commitment, the Ministry of Health 2016 HIV/AIDS plan calls for the goal of retaining 82% of patients in treatment and achieving 86% viral suppression within 12 months of starting ART during 2016 (Ministry of Health, 2016). However, the most recent data show that while an estimated 80% of people living with HIV in Vietnam are aware of their infection, only 42% receive ART (Vietnam Authority of HIV/AIDS Control, 2016) and, in one study, 72% of these achieved viral suppression within 12 months (Cuong et al., 2012). Effective interventions to address these gaps are greatly needed in order to achieve the 90–90–90 goal in Vietnam, and globally.

Substance use is a major contributor to gaps in the HIV care continuum. HIV-infected patients who acquire HIV through injecting drugs have a higher risk of late presentation to HIV care, delayed initiation of antiretroviral treatment, and poorer treatment outcomes than those who acquire HIV through sexual transmission (Suárez-García et al., 2016). Substance use and abuse are common among HIV-infected individuals internationally and in Vietnam, with about 50% of people living with HIV reporting current or past history of drug or alcohol use disorders (Erickson, Becker, Shaw, Kasper, & Keynan, 2015; Korthuis, Josephs, et al., 2008; Korthuis, Zephyrin, et al., 2008; Samet, Horton, Traphagen, Lyon, & Freedberg, 2003; Tran et al., 2013). Moreover, the prevalence of alcohol consumption among people who use drugs is higher than among those who do not use drugs (Tran et al., 2013;

* Corresponding author at: Room 604, A1 Building, Hanoi Medical University, No.1 Ton That Tung Str., Hanoi, Vietnam. Tel.: +84 435746825.
E-mail address: nguyenbichdiep@hmu.edu.vn (D. Nguyen Bich).

http://dx.doi.org/10.1016/j.jsat.2016.07.003
0740-5472/

Tran, Nguyen, Do, Nguyen, & Maher, 2014). Substance use is associated with increased HIV risk-taking behaviors (Scott-Sheldon, Walstrom, Carey, Johnson, & Carey, 2013), delays in HIV diagnosis, decreased receipt of ART, adherence to treatment (Azar, Springer, Meyer, & Altice, 2010; Erickson et al., 2015; Hinkin et al., 2007; Jordan et al., 2013; Lucas, 2011; Lucas, Gebo, Chaisson, & Moore, 2002; Nicholas et al., 2014), mental health comorbidities (Gupta, Kumar, & Garg, 2013), treatment outcomes including viral suppression (Azar et al., 2010; Lucas et al., 2002) and quality of life (Tran et al., 2014; Korthuis, Josephs, et al., 2008; Korthuis, Zephyrin, et al., 2008).

Mental disorders, mostly depression, are among the most common comorbidities in patients with substance use disorders and/or HIV. Current literature reports a high prevalence of depression among substance-abusing adults with HIV/AIDS (Berger-Greenstein et al., 2007; Chander, Himelhoch, & Moore, 2006; Durvasula & Miller, 2014). Studies also suggested that clinical management of HIV must account for the "triple diagnosis" of HIV, psychiatric diagnosis, and substance use disorders and required integrated treatment services to provide comprehensive interventions (Durvasula & Miller, 2014; Willenbring, 2005). Another study in Vietnam also indicated that patients reporting anxiety/depression problems were more likely to select integrative models for more comprehensive health care services (Tran, Nguyen, Phan, Nguyen, & Latkin, 2015).

Integrating treatment for HIV and substance use disorders (SUD) has the potential to close these gaps in care. Substance abuse treatment for people living with HIV occurs on a continuum of individuals (1) becoming aware of their HIV status, (2) engaging in HIV, psychiatric and substance use related care, (3) preventing relapse and adhering to treatment (Lucas, 2011), and improving SUD and HIV treatment outcomes (Altice, Kamarulzaman, Soriano, Schechter, & Friedland, 2010; Howe et al., 2014; Korthuis, Josephs, et al., 2008; Korthuis, Zephyrin, et al., 2008; Palepu, Horton, Tibbetts, Meli, & Samet, 2004). Existing models of SUD treatment can improve many steps in this continuum (Durvasula & Miller, 2014), however, previous studies suggest that they may be more effective and cost-efficient when integrated with HIV care (Bouis et al., 2007; Bruce & Altice, 2007; Celentano & Lucas, 2007; Esposito-Smythers et al., 2014; Kamarulzaman & Altice, 2015; Lucas et al., 2007; WHO, 2013; Wolfe, Carrieri, & Shepard, 2010). Vietnam health policy consequently prioritizes development of integrated models of HIV and SUD treatment.

In Vietnam, with support from donors such as PEPFAR and Global Fund, outpatient HIV clinics and methadone maintenance therapy (MMT) clinics were traditionally established as two parallel systems that are independent from the general health care system. However, over the past five years, partly because of substantial decline in donor funding, Vietnam health policy increasingly supports development of integrated models of HIV and SUD treatments and integration of these services into the existing health care system. A number of models for integration have been tested. At the time of this study, co-located and co-staffed MMT and ART clinics were preferred. In this study, the preference of integration refers to the model of co-located and co-staffed ART and MMT clinics. Most recently, the government is looking to move ART clinics into the hospital system whereas MMT clinics remain with preventive medicine system. Furthermore, both dispensing of ART and methadone for patients who are stable are pushed to take place at the commune health centers instead of ART and MMT clinics.

Understanding patient views of integrated care models is essential for developing patient-centered approaches to addiction and HIV care and for predicting the feasibility of implementing integrated care models. Studies of patient attitudes in the United States suggest that HIV infected patients appreciate the increased convenience and efficiency of integrating care for medical and substance use disorders (Drainoni et al., 2014; Egan et al., 2011; Samet, Friedmann, & Saitz, 2001) and view co-located models of HIV and addiction care as more patient-centered (Korthuis et al., 2010). In Vietnam, one study suggests that patients enrolled in methadone treatment prefer integrated HIV and methadone service delivery models, despite some concerns about stigma and privacy (Tran, Nguyen, Phan, Nguyen and Latkin, 2015). However, little is known about the attitudes of patients engaged in HIV care regarding integrated models of substance use and HIV treatment. Our study aims to assess patient attitudes toward integrated models of HIV and addiction care and to assess correlates of patient preference for integrated care among patients engaged in HIV treatment.

2. Methods

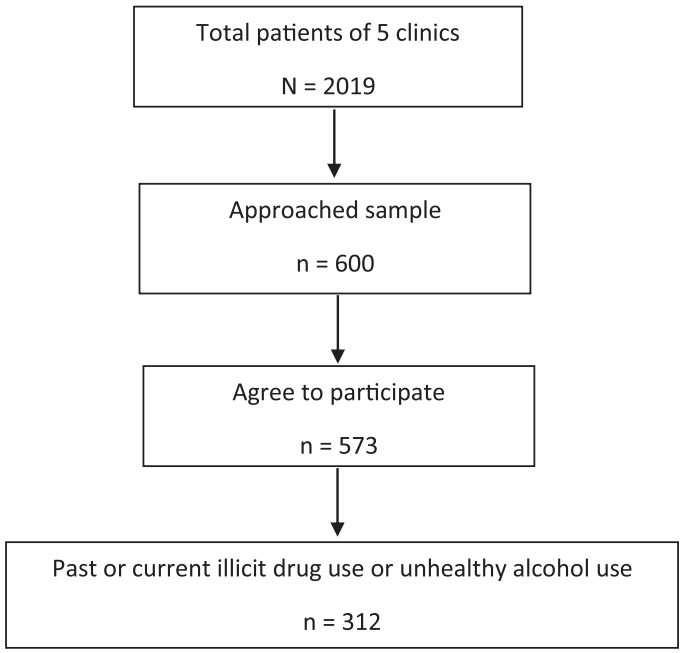
2.1. Setting

We conducted a cross-sectional survey from May to December 2013 among HIV-infected patients receiving treatment in HIV clinics in Hanoi, Vietnam. From 17 HIV clinics in Hanoi, 5 HIV clinics were selected purposively for participation based on the level of HIV and SUD treatment integration: 3 clinics provided integrated HIV and methadone maintenance treatment and 2 clinics were non-integrated care with HIV and methadone maintenance being provided by separate staff and separate locations.

2.2. Subjects

Participants were eligible if they were (1) over 18 years old; (2) enrolled in the HIV clinic for at least 6 months; (3) able to understand and voluntarily complete informed consent. Six hundred patients were selected randomly from a comprehensive list of a total 2091 patients active in care across the five participating HIV clinics (861 integrated; 1230 non-integrated). Out of those patients who were approached, 573 consented to participate in this study.

Participants were included in the current analysis if they met one of the following criteria: (1) past illicit drug use; (2) current illicit drug use in the past 3 months; (3) unhealthy alcohol use in the past 12 months. Current illicit drug use in the past 3 months and unhealthy alcohol use in the past 12 months were assessed using survey data. Past illicit drug use was assessed by survey and abstracted from patient medical records. 137 participants were identified only from medical record data. In total, survey and medical record data, combined, identified an analytic sample of 312 participants of the larger study (see diagram).



2.3. Data source/collection

When patients came to the clinic to pick up their monthly medication, a research staff explained the study to eligible patients and invited