Managing Patients with Substance Abuse

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Objectives for this Presentation:

- Review the epidemiology of substances most likely for misuse in care settings.
- Identify diagnostic and behavioral considerations in assessing substance use.
- Summarize screening and brief intervention in HIV care settings.
- Review medications and evidence-based behavioral interventions that can be used in care settings.
Faculty and Planning Committee Disclosures

Please consult your program book.

Off-Label Disclosure

There will be no off-label/investigational uses discussed in this presentation.
Major Substances in Clinical Settings

- **ALCOHOL**
  - Withdrawal concerns, sedating effects

- **NICOTINE**
  - In context of immune compromise

- **OTHER STIMULANTS (esp meth, cocaine)**

- **OPIATES**
  - Holy Trinity: benzo, muscle relaxant, Oxy/Norco

- **POT (5.8% in 2007; 7.5% in 2013, NSDUH)**
  - Aspergillus
DSM-5 Definition: Substance Use Disorder

Maladaptive pattern of use, *clinically significant impairment or distress* and 2+ of the following in the same 12-month period:

1. Tolerance
2. Withdrawal
3. Used for longer periods than intended
4. Can’t cut down or quit
5. Time spent getting, using or recovering
6. Give up social, work or fun activities
7. Craving or a strong desire or urge to use a substance
8. Continued use despite knowledge of negative consequences
9. Failure to fulfill major role obligations
10. Use in physically hazardous situations
11. Continued use despite social and interpersonal problems
Lifetime and Past Year Prevalence of Alcohol and Drug Use Disorders in the NESARC by Reported Sexual Identities ($n=34,653$)

<table>
<thead>
<tr>
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<th>Lifetime (%)&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Past Year (%)&lt;sup&gt;2&lt;/sup&gt;</th>
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<tbody>
<tr>
<td></td>
<td>Alcohol Use Disorder</td>
<td>Drug Use Disorder</td>
</tr>
<tr>
<td>Gay</td>
<td>58.7</td>
<td>32.7†</td>
</tr>
<tr>
<td>Bisexual</td>
<td>52.1</td>
<td>25.0</td>
</tr>
<tr>
<td>Hetero</td>
<td>47.7</td>
<td>15.7</td>
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</table>

<sup>†</sup>p<0.01; Differences between Gay, Bisexual compared to Heterosexual men


The Most Devastating Drug is Licit

- Most preventable cause of morbidity and mortality
- 440,000+ premature deaths annually

Worm et al. 2013; BMC Inf Dis, 13:71
Alcohol and HIV

- In the Veterans Aging Cohort Study, compared to other types of alcohol drinkers, severe chronic alcohol drinkers started drinking at younger age, had longer duration of cigarette smoking and more cocaine use (Jacob T et al., 2013. *Alc Clin Exp Res;* 37: 1179-1187)

- In the Moore Clinic, 10.4% reported hazardous drinking, 11.6% had markers indicating liver fibrosis (Chaudrey et al. 2008. *HIV Med;* 10:133-142)
Cannabis and HIV: Hazy Conclusions

- 21-day RCT of TID dronabinol, smoked marijuana, or placebo
  - No differences on RNA (copies/mL, counts of UDL) or counts of CD4, CD8 in 62 HIV-positive subjects (Abrams D, Ann Intern Med. 2003; 139:258-266)

- IQ drops in chronic smokers (Meier et al., PNAS, 2012)

Pain Ratings (n=21)

Cocaine and Meth: Health and Behavioral Effects

• Crack cocaine (WIHS):

• Meth (MACS):
  – No effects on mortality (Carrico et al. 2014 JAIDS; 67:508-13);

• Acute meth use:
Opioids

• About 1 million Americans
• Only 160,000 in opioid agonist treatment
• Difference in HIV prevalence in heroin injectors in U.S. depends upon geography, with Western U.S. very low; Eastern U.S. moderate to high

ACTHIV 2015: A State-of-the-Science Conference for Frontline Health Professionals
Your patient tells you that he is an occasional user of crystal methamphetamine. What do you do regarding his HIV care regimen?

A. Schedule a treatment interruption until his meth use is under control
B. Require treatment for crystal methamphetamine
C. Engage a discussion on importance of ART adherence, especially when using
D. Advise your patient not to take ART medications during periods of crystal use
Ensure Access to cART
Screening Tools
Medication Assisted Therapies (opiates, nicotine, alcohol)
Brief Behavioral Interventions

INTERVENTIONS
ART in IDUs and NIDUs: Access Denied

<table>
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<tr>
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<th>EVER Get ART? N=1730</th>
<th>ART for 95%+ of Time N=1275</th>
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<tbody>
<tr>
<td>Age (per year)</td>
<td>1.03 CI 1.02-1.04</td>
<td>1.02 CI 1.01-1.04</td>
</tr>
<tr>
<td>Baseline CD4&lt;200 cell</td>
<td>4.43 CI 3.19-6.16</td>
<td>1.15 CI 0.89-1.48</td>
</tr>
<tr>
<td>Baseline PVL&gt;5 log_{10}</td>
<td>1.68 CI 1.2-2.35</td>
<td>0.68 CI 0.47-0.81</td>
</tr>
<tr>
<td>Black Race</td>
<td>0.57 CI 0.44-0.73</td>
<td>0.65 CI 0.51-0.83</td>
</tr>
<tr>
<td>IDU History</td>
<td>0.47 CI 0.33-0.67</td>
<td>0.63 CI 0.44-0.90</td>
</tr>
<tr>
<td>NIDU History</td>
<td>0.62 CI 0.47-0.81</td>
<td>0.66 CI 0.52-0.85</td>
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McGowan et al., 2011. *PLOSOne, 6:e18462*
Screening Tools

“Knock it off”

“2 Questions”

- How many times in the past year have you had 5 drinks or more in a day [for men] OR 4 or more drinks in a day [for women]?

- How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?

# Brief Intervention – 5 A’s

<table>
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<tr>
<th>Ask</th>
<th>Implement an office-wide system that ensures that, for every patient at every visit, ATOD use status is queried and documented</th>
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<tr>
<td>Advise</td>
<td>In a clear, strong, and personalized manner, urge every patient using ATOD to quit</td>
</tr>
<tr>
<td>Assess</td>
<td>Ask every ATOD using patient if s/he is willing to make a quit attempt now (next 30 days)</td>
</tr>
<tr>
<td>Assist</td>
<td>Help the ATOD using patient plan, provide practical counseling, recommend meds, be supportive</td>
</tr>
<tr>
<td>Arrange</td>
<td>Provide for follow-up support, phone calls</td>
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Adapted from Fiore et al., 2008, Clinical Practice Guidelines for Smoking Cessation
Opioid Agonist Treatments

- Cheap (especially for methadone)
- Potent
- Portable (especially for buprenorphine)
“Quitting smoking is easy. I’ve done it a thousand times” (Mark Twain)

Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates:

- Bupropion SR
- Nicotine gum
- Nicotine inhaler
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine patch
- Varenicline

Clinicians should also consider the use of certain combinations of medications identified as effective in the Guideline.

AHRQ, 2008
Smoking Cessation Treatment Tailored for HIV-Positive

If single pharmacotherapy for smoking cessation has failed for your patient, what might be your next consideration for a patient willing to continue trying to quit?

A. Naltrexone
B. Varenicline plus Bupropion
C. Buprenorphine
D. Nicotine Replacement Therapy
Alcohol Medications

*Naltrexone* (ReVia) – oral opioid antagonist

*Naltrexone* (Vivitrol) – depot opioid antagonist

*Acamprosate* (Campral) – calcium channel blocker, glutamate antagonist

...Modest, significant gain in relative benefit for alcoholism treatment when using acamprosate and naltrexone...

Contingency Management

• Incentives for biological markers of healthy behaviors
  – Chennai India: Significantly improved engagement in HIV care and number initiating ART among HIV-positive users of injection opiates (Solomon et al. 2012, CROI #1145)
  – Los Angeles: Significantly increased completion rates of PEP among meth-using MSM in Los Angeles (Landovitz et al., 2015, OFID)
  – Incredibly flexible intervention tool to address a variety of behavior problems.
Self-Help Approaches

- 12-Step Programs are effective, despite lack of efficacy data
  - Application to many “addictions”

- SMART Recovery
  - Enhance motivation; cope with urges; manage harmful behavior; establish lifestyle balance.
Question #3

• Your patient is stable for many years, has few problems with care, but he suffers a great deal from chronic prostatitis that is imperfectly, but adequately managed using 10 mg Oxycodone BID and 10 mg hydrocodone PRN for breakthrough. He tells you that he has started using a vaporizer for inhaling cannabis and found that he no longer needs meds for breakthrough pain and now needs only one Oxy in the morning. He is interested in your opinion as to whether he should continue using the vaporized cannabis or should return to managing his pain using only prescription narcotics.
Do you...

1. Advise your patient to stop the cannabinoid and return to the original narcotic pain protocol.
2. Educate your patient of the interaction between cannabinoids and opioids for pain relief, but suggest using dronabinol instead of the vaporizer.
3. Advise your patient to continue using the cannabinoid and his pain medications with frequent follow-up visits to monitor safety.
4. Advise your patient to undergo detoxification of all narcotics and seek treatment for addiction if he is unable to stop using the cannabinoid.
Conclusions

• Patients in care settings use substance at similar or higher levels than general population
• Stimulants, particularly nicotine, present enhanced risks for morbidity and mortality
• Ensuring access to ART for individuals who use substances facilitates better overall and HIV-outcomes
• Medically Assisted Treatments for nicotine, opioids; less effective medications for alcohol
• Screening tools can be implemented into the care setting to identify patients at risk for substance related morbidities
• Behavioral treatments for substance misuse in care settings can be successfully and creatively used