CME/CNE Activity Inside and Online

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City Health Information

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Improving the Health of People Who Use Drugs

- **Ask all patients about substance use, including drugs, alcohol, and tobacco. Discuss health problems and risky behaviors that may be associated with drug use.**
- **Screen, vaccinate, and treat patients who use drugs for infectious diseases, physical health problems, and mental health issues commonly linked to drug use.**
- **Offer brief interventions for risky or harmful drug use and provide buprenorphine for treatment of opioid dependence.**
- **Refer patients to drug-treatment and harm-reduction programs when necessary.**

Drug use is a serious public health problem that demands attention in primary care. In 2007, 9% of people aged 12 and older in the United States (US) were classified as having substance abuse or dependence.[1] In New York City (NYC), 10% reported illicit drug use in the past month, including 5% who used drugs other than marijuana.[2] Nonmedical use of opioids is a growing problem, with the number of new opioid users now exceeding the number of new marijuana users in the US.[1,3]

TABLE 1. MORBIDITY AND MORTALITY AMONG DRUG USERS IN NYC—2007

- Emergency Department use[4]
  - 35,706 visits by cocaine users.
  - 28,435 visits by users of heroin or other opioids.
- Overdose[5]
  - 849 deaths.
  - Third-leading cause of death among adults aged 25 to 34 years.
  - Fourth-leading cause of death among adults aged 35 to 54 years.
- HIV/AIDS[6]
  - Up to 21% of people living with HIV/AIDS were infected through injection drug use.

Drug use is associated with high morbidity and mortality (**Table 1**), including higher risk for overdose, injuries, HIV, hepatitis B and C, liver disease, hypertension, depression, insomnia, and violence.[7-10] Because of the pressures of addiction and fears of stigmatization, people who use drugs often seek medical care only in times of crisis, and they give low priority to routine care for chronic diseases, dental care, and other preventive health measures.[11-13] Still, people who use drugs are more often seen in physicians' offices and emergency departments than in drug treatment settings,[1] even if the drug use is not known to the clinician or stated as the reason for the visit.

REIMBURSEMENT FOR SUBSTANCE USE SCREENING AND BRIEF INTERVENTION

Medicare and some commercial insurers reimburse substance use **screening** and **brief intervention** provided in general office practice settings. See http://sbirt.samhsa.gov/coding.htm.

Primary care providers (PCPs) can thus play a critical role in improving the health of their drug-using patients. Many PCPs are unaware of their patients' drug use or feel unprepared to address it.[14-16] Patients who use drugs can be reluctant to discuss their problems out of embarrassment, or because they fear that it will compromise their relationship with the physician.[13,16] Nonjudgmental discussions about drug use can lead to effective provider-patient partnerships, and screening for drug use and related problems can trigger patient openness to prevention messages, brief interventions, treatment, and referrals.[10,17] Addressing drug use can also lead to better care of chronic health conditions.[12]

IDENTIFYING SUBSTANCE USE

Some patients who inject drugs may have evidence of skin puncture (including track marks) or soft tissue infections (cellulitis, abscesses); intranasal users can have damage to the nasal mucosa or septum.[10] However, **most people who use drugs do not have physical signs of drug use.**

Asking About Substance Use

Asking about substance use, including drugs, tobacco, and alcohol, is an important component of eliciting a patient's medical history. Patients may be more comfortable answering questions about drug use when these questions are linked to the reason for their visit or to routine preventive health issues. Ask about drugs at the same time you ask about tobacco or alcohol use, and in the same nonjudgmental tone. Ask:

- What drugs or prescription medications have you ever used not as prescribed?
- In the last 3 months, have you used drugs or prescription medications not as prescribed?

Many patients will not be willing to discuss their drug use during the first visit, and patterns of use may change; ask again at follow-up visits.[17] Urine drug screening is not a substitute for asking patients about drug use. With the exception of marijuana, which may be detected in the urine for a month or more following use, a positive drug screen usually reflects only recent use (past few days or week). Be aware that commonly used assays do not test for all drugs and do not distinguish between prescription and illicit opioid use.

Assessing Substance Use

Substance use can range from low to high risk. If patients answer "yes" to any recent drug use, screen them with the National Institute on Drug Abuse's Modified ASSIST (NIDA-Modified ASSIST), available at www.drugabuse.gov/nidamed/screening, to characterize the risk level of an individual's pattern of substance use (drugs, tobacco, and alcohol). Classifying a patient's drug use as low, moderate, or high risk will help guide your subsequent intervention (see page 24). A full drug use and treatment history will inform your discussion about risks of use and options for treatment.

Ask all patients who report drug use in the past 3 months about:

1. Drug use history: *Which drugs? Amount, frequency, route of administration, and duration?* Use of more than one drug is the norm rather than the exception. Using substances such as opioids (heroin or prescription opioids) or cocaine on a daily or almost-daily basis almost always meets criteria for dependence.
2. Behavioral risk assessment: *Have you ever injected any drug, overdosed, or had a near overdose? How do drugs affect choices you make about sex (partners, condom use)?* Prior overdose is the strongest predictor of subsequent overdose. Using drugs such as alcohol, cocaine, and methamphetamine has been linked to high-risk sexual activity among HIV-infected patients in primary care.[18]
3. Treatment history: *Have you ever been in drug treatment? If yes, what type of treatment? Was it helpful and did you achieve a period of abstinence or reduced use?*

HEALTH ASSESSMENT AND PREVENTIVE CARE

Physical Health Assessment

Many chronic conditions are more common among people who use drugs than among the general population.[7,8,19] Be alert to signs and symptoms of

the following conditions in patients screening positive for moderate- or high-risk use:

- Musculoskeletal: arthritis, low back pain, sequelae of traumatic injuries.
- Infections: HIV, hepatitis B and C, sexually transmitted infections (STIs).
- Pulmonary: chronic obstructive pulmonary disease, asthma, pneumonia.
- Cardiovascular: hypertension is common in heavy alcohol and cocaine users; cocaine is a cause of chest pain and myocardial infarction in young adults and is associated with accelerated atherosclerosis and dilated cardiomyopathy.[19]
- Gastrointestinal: hepatitis, cirrhosis, pancreatic disease, gastritis, acid reflux.
- Neurologic: cerebrovascular events associated with stimulants (cocaine, amphetamines); seizures are common in benzodiazepine or alcohol withdrawal and may be caused by stimulant intoxication.

Preventive Care

Provide preventive care (**Table 2**) to patients who use drugs, whether or not they are attempting to change their drug-using behavior.

Mental Health Assessment

Co-occurring affective disorders are common in substance-misusing patients.[7,8] Serious mental illness is reported by 19% of adults with alcohol dependence or abuse and by 29% with illicit drug dependence or abuse.[20] Screen for depression using the PHQ-2:

During the past month, have you been bothered by:

- little interest or pleasure in doing things?
- feeling down, depressed, or hopeless?

A "yes" to either question requires further evaluation with the PHQ-9, which is available along with guidelines for treating depression at www.nyc.gov/html/doh/downloads/pdf/chi/chi26-9.pdf.

TABLE 2. PREVENTIVE CARE FOR PATIENTS WHO USE DRUGS

- ❑ HIV testing.
- ❑ Hepatitis B and C screening.
  - ❑ Alcohol counseling* for all patients with chronic hepatitis.
- ❑ Tuberculosis (TB): annual screening with PPD.*
  - ❑ Patients with positive PPDs should be treated for latent TB infection after active TB is ruled out.
- ❑ Vaccinations.
  - ❑ Hepatitis A and B, tetanus, and influenza vaccinations for all drug-using patients.
  - ❑ Pneumococcal vaccination for all individuals 65 and older, and regardless of age for those with unhealthy alcohol use, HIV, and other chronic conditions (including heart, lung, or liver disease; diabetes; sickle cell disease).
- ❑ Safe sex: screen for high-risk sex behavior; counsel on condom use/safe sex practices.
  - ❑ Consider STI screening for gonorrhea, chlamydia, and syphilis.
- ❑ Tobacco use and smoking cessation.*
- ❑ Intimate partner violence screening and discussion of risks.*
- ❑ Pregnancy: current and future plans; contraception; counseling on risks to the fetus of continued smoking, alcohol, and drug use.*
- ❑ Injecting drug use: counsel in safe injecting techniques (no sharing of any drugs, paraphernalia, or syringes; single use of paraphernalia and syringes only) and the availability of syringes at New York pharmacies for purchase without prescription.
- ❑ Overdose prevention: counsel on risk of overdose, particularly with users combining opioids with alcohol, benzodiazepines, or cocaine. Refer patients interested in obtaining naloxone for opioid overdose response to overdose prevention programs (**Resources**).

*See www.nyc.gov/html/doh/html/pub/pub.shtml?y=chi for NYC guidance (*City Health Information*) on these topics.

Be alert also to symptoms of anxiety, sleep disorders, and post-traumatic stress disorder. If you suspect a comorbid mental illness, refer to a mental health provider. Initial resistance to psychiatric treatment is common; reassure patients that mental health problems are as treatable as many other medical illnesses, and point out that treatment for underlying psychiatric problems can help patients make progress in changing their drug-use behaviors.

ADDRESSING DRUG USE

Use the patient's score on the NIDA-Modified ASSIST to guide your approach (see box at right). Educate patients whose use is classified as low risk on harms of increased use and ask about their use at future visits. Patients with moderate- or high-risk drug use should be offered brief office-based intervention.

Brief Intervention

Brief intervention[21] improves smoking cessation rates and reduces harmful drinking.[22,23] A growing body of literature indicates that brief interventions may also reduce substance use and improve the health of primary care patients who use illicit drugs.[22,24,25]

Brief interventions can follow the "A's" format: Advise, Assess, Assist, Arrange.[23] Use the patient's responses to the NIDA-Modified ASSIST as a guide (**Resources—NIDA Clinician Guide**).

1. ***Advise*: *Provide information and feedback about personal risk***. The brief intervention begins with a strong statement of the specific health risks posed by the patient's drug use and advice to make a change if he or she is engaged in any risky use. Let the patient know that there is a moderate or high risk of developing a substance use disorder, based on his or her NIDA-Modified ASSIST responses. For guidance on the health risks of specific substances, see **Resources—Basic Information About Drug Use**.

   Emphasize the health consequences of the patient's current substance use and how changing behavior will improve his or her health. Point out that there are many ways to change substance use behavior and that you are here to provide support, treatment, and referrals.

2. ***Assess** readiness to change and set priorities*. Ask the patient, "Given what we have talked about, are you interested in changing your use?" Encourage patients resistant to change or further treatment to engage in preventive care and to agree to continue the discussion at the next visit. Focus on:

   - Health improvement goals—changing drug use: As with smoking cessation, goals may range from abstinence to using less frequently or in smaller quantities. Avoiding settings in which drugs are likely to be used may help reduce drug use.
   - Harm reduction (eg, overdose prevention, safer use, sterile syringes, condoms). If drug abstinence is not a realistic goal, preventing adverse consequences is a priority. See **Table 2** and **Resources—Harm Reduction**.

3. ***Assist** the patient in developing a plan*.[26] What are the patient's short- and long-term goals? Help the patient craft a plan for cutting back or eliminating drug use. Keep expectations realistic and develop contingency plans. Remind the patient that relapse and other setbacks are often part of the process. Consider using the Change Plan Worksheet as a guide (www.motivationalinterview.org/clinical/changeplan.pdf).

NIDA-MODIFIED ASSIST DRUG USE RISK ASSESSMENT AND BRIEF INTERVENTION

Lower Risk (Score 0-3)

- Provide feedback on score
- Offer continuing support
- Reinforce abstinence

Moderate Risk (Score 4-26)

- Bullets 1 and 2 from Lower Risk
- **Advise, Assess,** and **Assist**
- Consider **Arranging** referral

High Risk (Score ≥27)

- Bullets 1 and 2 from Lower Risk
- **Advise, Assess,** and **Assist**
- **Arrange** referral

Adapted from NIDA Resource Guide: Screening for Drug Use in General Medical Settings. www.drugabuse.gov/nidamed/resguide/screeningtool.html.

TABLE 3. DRUG TREATMENT PROGRAMS

Treatment Modality	Type of Patients	Treatment Duration
Inpatient		
Residential rehabilitation	Patients needing brief intensive treatment, usually following medically managed detoxification.	28 days
Drug-free residential treatment (includes therapeutic communities)	Patients with chronic drug problems and few social supports.	6–12 months
Outpatient		
Methadone maintenance*	Patients with opioid dependence. Pharmacotherapy (either methadone or buprenorphine) works best for these patients. Buprenorphine has fewer side effects and a lower risk of abuse than methadone.	Variable
Buprenorphine office-based treatment*		
Drug-free outpatient treatment programs • Range from highly structured treatment to flexible or weekly meetings and may employ mixed approaches (eg, individual therapy, group therapy, 12-step approaches).	Patients who are stable enough to follow an outpatient regimen and are not candidates for pharmacotherapy (methadone, buprenorphine) alone.	Determined by program, typically several months

*No need for prior inpatient detoxification.

Source: HIV Clinical Resource. Substance Use Treatment Modalities for HIV-Infected Substance Users. www.hivguidelines.org/GuideLine.aspx?pageID=262&guideLineID=85.

4. ***Arrange*** *follow-up*. Several visits may be required to help patients move toward recovery. Summarize the discussion and plans for follow-up and end the visit on positive terms. Also recommend that patients who use drugs seek voluntary mutual support groups such as Narcotics Anonymous, Cocaine Anonymous, or Rational Recovery, and refer those with high-risk use to drug treatment (**Table 3** and **Resources—Treatment**).

Alcohol

Many people who use drugs also use alcohol excessively. An estimated 17% of NYC adults—961,000 people—report excessive drinking,[27] and each year about 25,000 New Yorkers are hospitalized and more than 1,500 die from alcohol-related injuries and illnesses.[5] Screening and brief intervention can also help many patients with alcohol problems. See www.nyc.gov/html/doh/downloads/pdf/chi/chi25-10.pdf.

TREATMENT AND REFERRAL

Patients unlikely or unable to quit or cut down on their drug use with brief intervention, or those with a psychiatric diagnosis, should be offered drug treatment and harm-reduction services (**Resources**).

- Inpatient detoxification for opioid, benzodiazepine, and alcohol dependence: Patients at risk for life-threatening (benzodiazepine or alcohol) or extremely uncomfortable (opioid) withdrawal symptoms are eligible for hospital-based detoxification, which typically lasts 2 to 7 days. Encourage patients who go through detox to seek longer-lasting drug treatment.
- Drug treatment programs for all forms of drug abuse and dependence (**Table 3**): Ongoing drug treatment can be either medication assisted or medication free. Medication-assisted treatment (buprenorphine or methadone maintenance) should generally be considered for opioid dependence (see Buprenorphine box below) and can be effective in treating alcohol dependence as well (eg, with naltrexone, acamprosate, disulfiram). Medication-free counseling, psychotherapy, and behavior modification are complementary cornerstones of treating drug problems.
- Harm-reduction programs for all forms of drug use, especially for individuals involved in risky behaviors: In addition to offering syringe exchange, harm-reduction programs often provide meals and offer support groups, risk-reduction education, healthy living classes, and HIV/hepatitis testing. Some programs can also help with public benefits and medical and social service referrals.

BUPRENORPHINE[28]

- Buprenorphine is the only approved pharmacologic treatment for opioid dependence that physicians can prescribe in general office-based practice.
- Primary care physicians can initiate and manage opioid-dependence treatment with buprenorphine.
- Patients can have their buprenorphine prescriptions filled at a pharmacy.

For more information, see www.nyc.gov/html/doh/downloads/pdf/chi/chi27-4.pdf.

SUMMARY

Drug use is associated with mortality and serious morbidity and should be assessed. After establishing that a patient is using drugs, pay attention to common comorbid conditions, including HIV and hepatitis B and C, as well as to tobacco and alcohol use. Provide preventive health measures such as vaccinations. Remind drug-using patients about the dangers of overdose and injurious behavior, and offer brief intervention to patients with medium- or high-risk drug use. If brief intervention is unsuccessful, refer patients to harm-reduction programs, inpatient detoxification, or drug treatment programs. ◆

HOW TO CONTACT CHI:

- For reprints, call 311.
- To subscribe by e-mail, visit www.nyc.gov/html/doh/html/chi/chi.shtml.
- For other correspondence, e-mail nycdohrp@health.nyc.gov.

- **For an update on lead poisoning, including the latest NYC data:** www.nyc.gov/html/doh/downloads/pdf/chi/chi28-suppl3.pdf

RESOURCES

Basic Information About Drug Use

- WHO ASSIST Feedback Report Card: Provides information on the health risks of specific substances and of intravenous drug use. Available in multiple languages:
  www.who.int/substance_abuse/activities/assist_v3_english.pdf
  www.who.int/substance_abuse/activities/assist_spanish.pdf
- Commonly Used Drugs:
  www.hivguidelines.org/GuideLine.aspx?pageID=262&guideLineID=101
  www.nida.nih.gov/DrugPages/DrugsofAbuse.html

Screening

- NIDA-Modified ASSIST:
  www.drugabuse.gov/nidamed/screening
- NIDA Clinician Guide:
  www.drugabuse.gov/nidamed/resguide
- Other Screening Instruments:
  http://sbirt.samhsa.gov/index.htm

Health Assessment and Preventive Care

- Depression CHI:
  www.nyc.gov/html/doh/downloads/pdf/chi/chi26-9.pdf
- Primary Care for Drug Users:
  www.hivguidelines.org/Content.aspx?PageID=262
  www.nyhiv.com/pdfs/NYAMmanual.pdf
- Rapid HIV Test Centers in NYC:
  - Call 311 to find the nearest rapid HIV testing and/or HCV testing location.
  - NYC DOHMH STD Clinics:
    www.nyc.gov/html/doh/html/std/std2.shtml

Intervention and Referral

- Buprenorphine CHI (contains DSM-IV Criteria for Substance Abuse and Dependence):
  www.nyc.gov/html/doh/downloads/pdf/chi/chi27-4.pdf
- Motivational Interviewing:
  http://motivationalinterview.org
- Buprenorphine Training and Certification for Primary Care Providers:
  Substance Abuse and Mental Health Services Administration (SAMHSA): 866-287-2728
  www.buprenorphine.samhsa.gov/pls/bwns/training
  Buprenorphine Physician Locator:
  www.buprenorphine.samhsa.gov/bwns_locator/aboutphysician.htm

Harm Reduction

- Call 800-LIFENET for syringe exchange program locations and hours.
- Call 311 to order DOHMH's patient education brochure "Take Charge Take Care" (covers safe injecting hygiene, overdose prevention).
- The New York State Department of Health Web site for registered opioid overdose prevention programs providing naloxone:
  www.health.state.ny.us/diseases/aids/harm_reduction/opioidprevention/programdirectory.htm
  In NYC, call 311 and ask for "Overdose Prevention."

Treatment

- Treatment Facility Locator (all types):
  http://dasis3.samhsa.gov/PrxInput.aspx?STATE=New%20York
- LIFENET (24 hours a day and 7 days a week)
  In English: 800-LIFENET/800-543-3638
  In Spanish: 877-AYUDESE/877-298-3373
  In Chinese: ASIAN LIFENET/877-990-8585
  For other languages, call 800-LIFENET and ask for an interpreter. TTY (hard of hearing), call 212-982-5284.
  http://mhaofnyc.org/2lifenet.html
- NYC 9/11 Benefit Program for Mental Health and Substance-Use Services:
  http://home2.nyc.gov/html/doh/wtc/downloads/pdf/mhb/9-11MentalHealthBenefitFactsheet.pdf
- Narcotics Anonymous: www.newyorkna.org
- Cocaine Anonymous: www.ca.org
- Rational Recovery: www.rational.org

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REFERENCES AVAILABLE ONLINE: www.nyc.gov/html/doh/downloads/pdf/chi/chi28-3.pdf.

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IMPROVING THE HEALTH OF PEOPLE WHO USE DRUGS

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Continuing Education Activity

Improving the Health of People Who Use Drugs

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CITY HEALTH INFORMATION
MAY/JUNE 2009 VOL. 28(3):21-28

Objectives

At the conclusion of the activity, the participants should be able to:

1. Understand the prevalence of drug use in NYC.
2. Learn how to ask patients about drug use.
3. Identify health risks and comorbid conditions associated with drug use.
4. Understand office-based interventions and referral options for drug treatment services.

CME Accreditation Statement

The New York City Department of Health and Mental Hygiene is accredited by the Medical Society of the State of New York to sponsor continuing medical education for physicians. The New York City Department of Health and Mental Hygiene designates this continuing medical education activity for a maximum of 1 AMA PRA Category 1 credit(s).™ Each physician should only claim credit commensurate with the extent of their participation in the activity.

CNE Accreditation Statement

The New York City Department of Health and Mental Hygiene is an approved provider of continuing nursing education by the New York State Nurses Association, an accredited approver by the AmericaNurses Credentialing Center's Commission on Accreditation.

This CNE activity has been assigned code 6WXLFX-PRV-090.

It has been awarded 1 contact hour.

Participants are required to submit name, address, and professional degree. This information will be maintained in the Department's CME/CNE program database. If you request, the CME/CNE Program will verify your participation and whether you passed the exam.

We will *not* share information with other organizations without your permission, except in certain emergencies when communication with health care providers is deemed by the public health agencies to be essential or when required by law. Participants who provide e-mail addresses may receive electronic announcements from the Department about future CME/CNE activities as well as other public health information.

CME participants must submit the accompanying exam by June 30, 2012.

CNE participants must submit the accompanying exam by June 30, 2011.

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Drs. McNeely, Lee, and Gourevitch are affiliated with New York University Medical Center. Ms. Heller and Ms. Paone are affiliated with the NYC DOHMH. With the exception of Dr. Gourevitch, who has an unpaid relationship with Cephalon Corp., the faculty does not have any financial arrangements or affiliations with any commercial entities whose products, research, or services may be discussed in these materials.

1. Regarding morbidity and mortality associated with drug use, all of the following are true EXCEPT:

- ❑ A. Hypertension is more common among heavy cocaine and alcohol users.
- ❑ B. Overdose is the third-leading cause of death for New Yorkers between 25 and 34 years of age.
- ❑ C. Drug use is not associated with risk for hepatitis B and C.
- ❑ D. Opioid-related overdose can be prevented.

2. Which of the following statements is FALSE?

- ❑ A. More people who use drugs are seen in primary care and emergency departments than in drug treatment.
- ❑ B. Many people who use drugs avoid discussing their drug use out of fear of stigmatization.
- ❑ C. Nonjudgmental discussions with patients who use drugs rarely have a positive impact.
- ❑ D. Primary care providers can play a critical role in preventing problem drug use and in improving the health of people who use drugs.

3. When assessing the care and treatment needs of patients who use drugs, all of the following statements are true EXCEPT:

- ❑ A. A drug history includes questions about specific drugs.
- ❑ B. A behavioral risk assessment should address sexual risk behavior.
- ❑ C. Drug dependence is defined as self-reported drug use occurring at least two times a day.
- ❑ D. A patient's drug treatment history should include questions exploring which interventions or services helped the patient address prior drug use.

4. Routine health assessment for people who use drugs should include all of the following EXCEPT:

- ❑ A. Sexually transmitted infections.
- ❑ B. Chronic obstructive pulmonary disease.
- ❑ C. Overall mental health.
- ❑ D. Thyroid exam.

5. How well did this continuing education activity achieve its educational objectives?

❑ A. Very well. ❑ B. Adequately. ❑ C. Poorly.

6. Will the content learned from this activity impact your practice?

❑ A. Yes. ❑ B. No. ❑ C. Not applicable.

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