HIV Health & Human Services
PLANNING COUNCIL OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

Meeting Minutes
NEEDS ASSESSMENT COMMITTEE
Lee Hildebrand, DSW, Chair

March 3, 2010
Cicatelli, 505 Eighth Avenue at 35th Street, Oak Room
3:00 pm – 5:00 pm

Members Present: Guillermo Garcia-Goldwyn, Jose Gonzalez, Lee Hildebrand, DSW, Sabina Hirshfield, PhD (alt. for Mary Ann Chiasson, DrPH), Jennifer Irwin, Rebecca Kim, Rosemary Lopez, Frank Machlica, Jan Carl Park, Ricardo Vanegas-Plata, DDS

Members Absent: Angela Aidala, PhD, Martin Bruner, Barbara Kobrin, Julie Lehane, PhD, Don McVinney, Freddy Molano, MD, Glen Phillip, Kate Sapadin, PhD, Robert Steptoe

NYC DOHMH Staff Present: Marybec Griffin-Tomas, JoAnn Hilger, Rafael Molina, Nina Rothschild, DrPH, Anthony Santella, DrPH

Public Health Solutions Staff Present: Tania Farmiga

Others Present: Douglas Bruce, MD, Gerald DeYounge, Ron Joyner, Aisha Muhammad, Shiela Strauss, PhD

Material Distributed:

- Agenda
- Presentation by Shiela Strauss, PhD, on Alcohol reduction Support for HIV Patients
- Presentation by R. Douglas Bruce, MD, on Medication-Assisted Treatment and HIV/AIDS: Aspects in Treating HIV-Infected Drug Users
- Article by Doug Bruce, et al., on Medication-Assisted Treatment and HIV/AIDS
- NYC Vital Signs on Illicit Drug Use in New York City
- Planning Council Calendar for March 2010

Welcome/Moment of Silence/Introductions/Review of the Meeting Packet: Dr. Lee Hildebrand welcomed meeting participants. Committee members observed a moment of silence. Members introduced themselves. Nina Rothschild reviewed the contents of the meeting packet.

Lessons Learned: Lee Hildebrand encouraged members to fill out the piece of paper labeled "Lessons Learned" in their packets with notes on meetings and submit their pages to Nina Rothschild.

Alcohol Reduction Support for HIV Patients: Dr. Shiela Strauss of NYU College of Nursing presented on Alcohol Reduction Support for HIV Patients. The presentation is available on the Planning Council website at nyhiv.org. Dr. Strauss noted:

- The goal of the intervention was to help patients with HIV in DACs (State-Designated AIDS Centers) to cut down on alcohol consumption. PLWHA frequently drink alcohol; for example, 20% of patients in three VA HIV clinics were hazardous drinkers and 33% were binge drinkers.
- The rate of alcohol consumption appears to be higher in HIV populations than in the non-infected population. Alcohol is a social lubricant and facilitates risky behavior, and even one drink per week can be serious.
- The problems associated with drinking are especially acute among people co-infected with hepatitis C: alcohol can accelerate HCV, increase the risk of liver cancer, and decrease the efficacy of antiretroviral treatment.
- Few providers support HIV patients' alcohol reduction. Many providers are concerned with multiple issues, don't deal with prevention, and don't want to damage their relationship with their patients, and these multiple barriers tend to prevent patients from obtaining assistance.
- In a study of 115 providers (MDs, NPs, PAs, RNs, and counselors), about three-quarters asked their patients about alcohol use, but only about half educated their patients about the risk of alcohol use. About one-third of providers provided suggestions to patients who drink, and only 11.5% created an alcohol reduction plan for patients. Some providers had a greater sense of self-efficacy regarding their ability to discuss alcohol use with patients, and some needed encouragement and support to initiate the conversation.
- Brief interventions can be effective for a good number of patients and can be framed as consistent with promoting patients' health. Researchers worked on a questionnaire to assess problems with alcohol. The Alcohol Use Disorders Identification Test (AUDIT) is a ten-item questionnaire that takes five minutes to complete, but 5 minutes is too long in the very compressed amount of time that providers have

with patients. Researchers investigated, therefore, whether they could cut the 10 items on the AUDIT to three items. They wanted to see whether they would be able to identify the individuals who drank excessively using an instrument with only three items and found that using just the first three items on the AUDIT was effective with HIV patients.
- Providers were less likely to think that use of the brief AUDIT was within the scope of their practice if they had a heavy caseload and if they had limited confidence in their ability to use the questionnaire.
- Overall, the brief AUDIT provided limited support for helping HIV patients with alcohol problems. One factor possibly limiting the success of the AUDIT is the constraints imposed by limited space: if a nurse, for example, works in a room with a lot of other nurses, she may not have the privacy to use the AUDIT.
- Possible strategies for increasing the usefulness of the AUDIT are to implement the instrument in community-based programs, rather than with hospital-based patients, and in spaces with more privacy.

Commenting on Dr. Strauss's presentation, Jennifer Irwin noted that the results with the brief AUDIT might be different with a youth population. Guillermo Garcia Goldwyn noted the increasing use of alcohol in youth populations.

Medication-Assisted Treatment and HIV/AIDS: Aspects in Treating HIV-Infected Drug Users: Dr. Douglas Bruce of Yale University, Medical Director for a one-stop shopping center for drug treatment, spoke about treating HIV-infected drug users. His presentation is available on the Planning Council website at nyhiv.org. Dr. Bruce noted that the definition of addiction is a problem. A patient with chronic pain, for example, may be dependent on opiates without being an addict.

- Students in junior high school and in high school become hooked on prescription drugs and sometimes graduate to illicit drugs.
- For people who are hooked on alcohol, benzodiazepines, and barbiturates, stopping cold turkey can lead to a seizure and death.
- The choice of specific drugs to abuse often stems from neurobiology, and the body comes to associate a behavior with a neurobiological reward.
- Medication can assist in the treatment of dependence on alcohol, opioids, cocaine, and nicotine.
- Other treatments in addition to medication include behavioral therapy, medical treatment for the complications of addiction (i.e., HIV, HCV), and social services.
- The first premise of addiction treatment is that patients have lost control in limiting drug intake.

- Substance use is a relapsing disorder, as are other illnesses such as diabetes, hypertension, and asthma. Taking medicine all the time can be very challenging. To encourage patients, the message needs to be positive – i.e., even if you're drinking, it's better that you're drinking less today.
- In the next five to ten years, more medications for treating addictions will emerge, along with a push for primary care physicians to use them to treat patients.
- HRSA is trying to be more proactive in educating providers about substance abuse treatment.
- In many parts of the country, accessing drugs is easier than accessing treatment.
- Psychotropic drugs can be prescribed to HIV patients with addiction problems because mental illness may drive the addiction.
- Reducing federal and state barriers impeding access to treatment is critical.

Dr. Bruce spoke about specific illegal drugs:

Heroin:

- According to one study, half of heroin addicts have major depression – and for them to "just say no" is impossible.
- People describe using heroin in sexual terms.
- Buprenorphine and methadone are very different drugs and are both helpful in treating heroin addiction.
- Patients younger than 18 have a hard time obtaining methadone and an easier time obtaining Buprenorphine.
- Patients can overdose on methadone but almost can't overdose on Buprenorphine.
- A lot of primary care providers are afraid of giving Buprenorphine, and a contingent of addiction doctors is concerned that primary care providers wouldn't prescribe the drug properly.
- Nurse practitioners can prescribe methadone but not Buprenorphine.
- Both Buprenorphine and methadone help patients stabilize their lives and get into care, but methadone is better than Buprenorphine at retaining heroin users with really chaotic lives in treatment.

Cocaine:

- Cocaine addicts need frequent doses of the drug because the half-life is short.
- Cocaine induces a sense of euphoria and power and can come with volatile behavior and lead rapidly to dependence.

- Disulfiram is a treatment for cocaine users that will decrease use. It leads to a decrease in craving for the drug. Unfortunately, however, it takes hours to kick in – and drug users usually want a "fix" right away.
- No studies exist of Disulfiram in HIV/HCV populations.
- Adherence to Disulfiram is a problem. Disulfiram can work well for a patient who is motivated or who takes it with methadone.

Methamphetamine:

- Methamphetamine induces euphoria, and the effect of a single dose can last for 6-8 hours.
- Tolerance develops quickly, meaning that the user needs to take more of the drug more frequently.
- Use of meth often comes with high risk sexual activity, particularly in MSM
- Methamphetamine can cause permanent brain damage in HIV patients.
- The best treatment for meth problems is cognitive behavioral therapy, but changing cognition is hard if the brain is already altered.
- Wellbutrin, an antidepressant useful in helping smokers to quit, also may have some benefit for quitting meth.

Alcohol:

- Alcohol leads to disinhibition, increased engagement in risky behaviors, and poor adherence to treatment.
- Alcohol is neurotoxic and accelerates the progression of HCV.
- Naltrexone is the best treatment for alcohol. Other options are acamprosate and disulfiram. Topiramate (Topamax) is not FDA approved for treating alcoholism but is helpful. Topamax can be given to patients on opiods and moderates the symptoms of withdrawal.

Nicotine:

- Nicotine replacement (patch or gum) helps with quitting smoking.
- Nicotine seems to offer help with some mental illnesses. In a schizophrenia clinic, all the patients smoke.

Marijuana:

- Marijuana can combat nausea and anxiety, but inhaling a burning substance is not good for your lungs.
- When patients with Hepatitis C smoke marijuana, they get more liver scarring.

Dr. Ricardo Vanegas-Plata noted that a lot of political and religious barriers keep providers from giving treatment.

Public Comment:

No members of the public commented.

Adjournment:

The meeting was adjourned.