Promoting Comprehensive Health Care for HIV-Infected Substance Users

Best Practices from New York State
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Preface to Promoting HIV Medical Care for Substance Users

Dear Colleague,

This newest installment in the AIDS Institute’s Best Practices series highlights innovative and successful examples of care provided to HIV-infected substance users. In the early 1990s when substance use was fueling the HIV epidemic in New York State, the New York State Department of Health AIDS Institute created an initiative, through a combination of state and federal funds, that involved co-location of HIV primary medical services in drug treatment programs. This initiative involved the complex task of licensing drug treatment programs as healthcare facilities in New York State and persuading drug treatment providers to accept a medical model which they had not warmly welcomed in the past. The urgency of the epidemic led them to embrace this model and integrate medical services into their programs.

As the field of HIV therapeutics evolved and chronic treatment became a reality for substance users living with HIV, the needs of HIV-infected drug users in these programs changed. Drug treatment programs had to begin to include a chronic care paradigm and provide long-term management of patients who would continue to need lifelong treatment and supportive services. Even though the incidence of drug-related HIV infection has waned, approximately 112,000 New Yorkers are living with chronic HIV infection and require HIV care and services.

These best practices capture two important aspects of successful healthcare models. Some of the examples in this booklet illustrate the co-located service model that places medical services in drug treatment programs. Other examples, however, show how drug treatment services can be integrated into medical care programs; both are models designed to achieve the same result of improving patient health outcomes.

Practices highlighted in this booklet show some unique ways in which medical services can effectively support antiretroviral treatment of substance users. Some examples demonstrate approaches that apply to all chronic diseases, such as enhanced decision support, information system development, and patient empowerment. Other examples show ways to respond to new medical and substance use issues, such as the raging epidemic of crystal methamphetamine use, the occurrence of comorbid hepatitis C infection, and the use of buprenorphine, a newly available medication that can be used to treat narcotic use in general medical practice.
Alcohol screening and treatment remain poorly integrated into HIV medical care programs. Many studies have shown that alcohol is the most commonly abused substance among people living with HIV.* As part of the CHAIN Study, 21% of respondents from New York City who were interviewed at least twice between 2002 and 2006 screened positive for problem alcohol use during at least one interview period. Alcohol use diminishes treatment adherence. Failure to adhere to ARV therapy results not only in poor patient outcomes but also in resurgence of infection that can be transmitted to others. Similarly, alcohol use results in disinhibition, which translates into failure to practice safe sex, again leading to enhanced transmission. Alcohol management can be better addressed in our HIV medical programs by implementing some of the same types of practices that are described in this booklet.

One important practice that is missing from these examples is overdose prevention. Overdose is now a commonly described cause of mortality among substance users. Both patient and provider education strategies and self-management methods can be adopted to prevent overdose and improve outcomes.

Finally, we still hope to see more medical providers directly engage their substance-using patients through brief interventions, motivational interviewing, and harm-reduction strategies, including syringe prescription. These types of patient-provider encounters promote open dialogue that will hopefully lead to increased access to drug treatment.

The AIDS Institute’s Office of the Medical Director identifies best practices as part of its HIV Guidelines Program to promote implementation of its guidelines. We refer you to our clinical guidelines *Substance Use in Patients with HIV/AIDS: HIV Clinical Guidelines for the Primary Care Clinician*, for more information. It is our hope that these practical examples will help pave the way to broader integration of substance use practices into medical care and innovative strategies to bring medical treatment into drug and alcohol treatment programs.

Sincerely,

Bruce D. Agins, MD, MPH

*Medical Director*

NYSDOH AIDS Institute

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## Table of Contents

I. **Introduction** .......................................................... 1

II. **Best Practices in Promoting Comprehensive Health Care for HIV-Infected Substance Users** ........................................... 5

   Screening for Substance Use ........................................... 6
   Developing Effective Substance Use Screening Tools
     ♦ **St. Luke’s Roosevelt Hospital – Center for Comprehensive Care** .... 8
   Incorporating Substance Use Screening into Routine Medical Care
     ♦ **Binghamton Family Care Center United Health Services Hospital** ..................... 11

Increasing Access to HIV Medical Care for Substance Users:
Co-location and Beyond .................................................. 13

Primary Care in Drug Treatment Settings
   ♦ **Addiction Research and Treatment Corporation** .......................... 14

Mobile Health Vans
   ♦ **Bronx-Lebanon Mobile HIV Primary Care Program** ..................... 15
     ♦ **Community Health Care Network** .................................... 18

Traveling Medical Staff
   ♦ **Mount Sinai’s Health Bridge Program** .................................. 19
     ♦ **CitiWide Harm Reduction and Montefiore Medical Center’s ROMEO Program** ....................... 20

Improving Engagement and Retention in Medical Care and Substance Use Treatment ............................................................. 23

Improving Continued Patient Engagement with Buprenorphine
   ♦ **Daytop Village** .......................................................... 23

Promoting Engagement in Care
   ♦ **Bedford Stuyvesant Family Health and Wellness Centers** ............ 26

Providing Comprehensive HIV and Substance Use Treatment to Patients and Their Families
   ♦ **Center for Comprehensive Health Practice** .............................. 27

Improving Patient Communication and Feedback
   ♦ **St. Luke’s Roosevelt Hospital – Center for Comprehensive Care** 30
Education, Patient Involvement, and Empowerment

Increasing Patient Knowledge and Decision-Making Skills
Patient Involvement and Empowerment: Practical Tips
Providing Harm-Reduction Education in Medical Settings
  ✦ Bellevue Hospital Center - Harm Reduction Program
Providing Harm Reduction and Primary Care Services to Substance Users
  ✦ Lower East Side Harm Reduction Center
Focus on Patient Education and Treatment Planning
  ✦ VIP Community Services
Empowering Patients by Forming Support Groups
  ✦ Albert Einstein College of Medicine Division of Substance Abuse
Hiring Consumers as Staff Members
  ✦ AIDS Community Health Center
Addressing Special Challenges to HIV Care
Developing a Crystal Methamphetamine Detoxification Treatment Program
  ✦ Callen-Lorde Community Health Center
Providing Access to Crystal Methamphetamine Treatment
  ✦ St. Vincent’s Catholic Medical Center - Manhattan
Improving Hepatitis C Care
  ✦ Daytop Village
Improving HIV Treatment Adherence
Improving Patient Communication
  ✦ Beth Israel Medical Center - Peter Krueger Clinic
Utilizing Motivational Interviewing Techniques to Improve Adherence
  ✦ Montefiore Medical Center Substance Abuse Treatment Program
Improving Information Management: Databases and Reminder Systems
Using Computerized Databases to Help Patients Navigate Care and Keep Appointments
  ✦ Albert Einstein College of Medicine Division of Substance Abuse - Melrose Clinic
Utilizing a Centralized Database to Improve Patient Care
  ✦ St. John’s Riverside Hospital – HOPE Center .................59

Coordinating Care and Developing Partnerships .................63
Focus on Care Coordination and Developing Referral Linkages
  ✦ Albany Medical Center – AIDS Treatment Center ........63

Developing Linkages and Partnerships
  ✦ AIDS Community Health Center ............................66

Coordination of Care and Access to Specialty Care
  ✦ VIP Community Services .....................................67

III. Quality Improvement ........................................68

Improving Comprehensive Care for HIV Infection and
Substance Use
  ✦ Bronx-Lebanon Mobile Primary Care Program ..........68

Increasing the Number of Patients Receiving Comprehensive
Substance Use Assessments
  ✦ St. John’s Riverside Hospital – HOPE Center ............70

Increasing Substance Use Assessments During the
Annual Comprehensive Examination
  ✦ Beth Israel Medical Center – Peter Krueger Clinic ..........71

Promoting Harm Reduction Among HIV-Infected
Substance Users
  ✦ Interfaith Medical Center – Primary Care Center ..........73

Integrating Hepatitis C Care into Primary Care
  ✦ Montefiore Medical Center/Albert Einstein College
    of Medicine ..................................................74

APPENDIX I: NYSDOH AI Clinical Guidelines: Recommendations
  from the Committee for the Care of HIV-Infected
  Substance Users ..............................................77

APPENDIX II: Commonly Used Substances: Basic Facts ........84

APPENDIX III: Substance Use Screening Tools ..................98

APPENDIX IV: Substance Use Treatment Resources ............117

REFERENCES .....................................................123

FURTHER READING ............................................127
I. Introduction

Substance use refers to the use of legal, socially acceptable substances, such as alcohol and tobacco, as well as the use of illicit substances, such as heroin and cocaine. Estimates from the 2006 National Survey on Drug Use and Health reveal that among persons aged 12 years or older, 8.3% (20.4 million) currently use illicit drugs, 50.9% (125 million) currently use alcohol, and 29.6% (72.9 million) currently use tobacco. An estimated 22.6 million (9.2%) persons were classified with substance dependence or abuse. These estimates do not include the homeless and incarcerated persons, among whom substance use prevalence is estimated to be even greater.

A history of substance use or current substance use may be more prevalent in people living with HIV/AIDS (PLWA) because PLWA may be more likely to use substances in response to the stressors that they face as a result of their HIV status.

As of December 2005, in New York State, 13.6% ($n = 5,719$) of people living with HIV ($n = 41,955$) and 27.5% ($n = 19,313$) of people living with AIDS ($n = 70,353$) acquired infection through injection drug use (IDU). In a National HIV Behavioral Surveillance System survey of approximately 10,000 men who have sex with men (MSM), 43% ($n = 4,322$) reported having used a non-injection drug within the last year. Almost 75% ($n = 3,198$) reported having been under the influence of a drug during sex.

In addition to contributing to the likelihood of HIV transmission, substance use directly affects the health of the HIV-infected patient by interfering with treatment adherence, interacting with treatment medications, and increasing the risk for development of comorbid conditions, such as hepatitis, sexually transmitted infections (STIs), and tuberculosis. Substance use contributes to the progression of HIV infection and other secondary deleterious conditions. For example, methamphetamine is associated with increased HIV replication and cognitive impairment, and alcohol is associated with increased viral load levels and decreased CD4 counts. Hazardous alcohol use, both alone and in combination with other substances, may contribute to decreased antiretroviral therapy (ART) adherence and viral suppression and often leads to risky behaviors that could result in HIV transmission.

* >7 drinks per week or >3 drinks per occasion for women.
>14 drinks per week or >4 drinks per occasion for men.
rapid increase in methamphetamine use* also has perpetuated high-risk sexual behaviors in both MSM and heterosexual individuals.\textsuperscript{15-19}

To achieve desirable health outcomes, HIV-infected substance users need access to comprehensive services that include HIV and primary medical care, substance use treatment, mental health services, and subspecialists trained in the management of comorbidities. However, engagement, retention, and coordination of care for HIV-infected substance users continue to be a challenge for both providers and patients.

Most healthcare providers are not well trained in the management of substance users; traditional curricula of most educational institutions do not usually address drug treatment in more than a superficial manner. Moreover, some medical professionals may avoid providing care to substance users because of lack of training and experience.\textsuperscript{20} Substance-using patients who seek care often experience stigma and discrimination, both from providers and the general public, and as a result, may avoid medical care unless absolutely necessary.

Concurrent mental health problems, personality disorders, homelessness, and incarceration—all common among substance users—also contribute to poor engagement of HIV-infected substance users in medical care. These additional medical and social barriers may further deter patients from accessing and engaging in medical care.\textsuperscript{21}

Barriers to providing care to this challenging patient population exist but are not insurmountable. Addiction, similar to any other chronic disease, is a primary, neurobiologic disease, with genetic, psychosocial, and environmental influences on its development and manifestations.\textsuperscript{22} Primary care providers who cultivate long-standing relationships with HIV-infected substance users may more effectively deliver care and achieve optimal health outcomes as well as reduce the risk of HIV transmission.

Many members of the medical community provide quality medical care to HIV-infected substance users. This booklet presents practical information from experienced healthcare providers and administrators to enable better understanding and to identify ways to meet the medical, social, and substance use treatment needs of HIV-infected substance users.

* Further information on methamphetamine can be obtained from the New York State Department of Health website.
www.health.state.ny.us/diseases/aids/harm_reduction/crystalmeth/index.htm
In an effort to improve primary care and HIV medical services to substance users, the New York State Department of Health AIDS Institute has funded co-located comprehensive HIV prevention and primary care services within several substance use treatment programs and community-based centers (see Appendix IV).\textsuperscript{23} The AIDS Institute also has funded mobile medical units to provide HIV testing, assessment, care, and referrals to residents of single-room occupancy (SRO) hotels and transitional housing sites in the Bronx and Harlem.

In addition, hospitals, community health centers, and substance use treatment programs have developed and implemented their own creative strategies to improve the engagement in, retention to, and delivery of primary medical care for HIV-infected substance users.

<table>
<thead>
<tr>
<th>How Can Primary Care Providers Address the Healthcare Needs of HIV-Infected Substance Users?</th>
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<tbody>
<tr>
<td><strong>Primary care providers can address the healthcare needs of HIV-infected substance users in the following ways:</strong></td>
</tr>
<tr>
<td>✦ Link clients to drug treatment and harm-reduction programs to achieve better health outcomes.\textsuperscript{24,25}</td>
</tr>
<tr>
<td>✦ Offer adherence support services and referrals to mental health professionals. Such interventions often result in better treatment adherence and maximal treatment outcomes.\textsuperscript{21,26,27}</td>
</tr>
<tr>
<td>✦ Provide emotional support within the drug treatment setting.</td>
</tr>
<tr>
<td>✦ Diagnose and treat STIs early, which can lower the risk of transmission and improve both HIV and STI treatment outcomes.\textsuperscript{18,28-37}</td>
</tr>
<tr>
<td>✦ Screen, vaccinate, and treat patients for hepatitis.\textsuperscript{38}</td>
</tr>
<tr>
<td>✦ Diagnose and treat TB, and prevent active TB in patients with latent TB infections.\textsuperscript{39}</td>
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This booklet highlights best practices that have been implemented in facilities around New York State. The booklet is organized into the following sections:

**Best Practices** – This section identifies strategies that have contributed to effective care for HIV-infected substance users. The section covers topics such as substance use screening, access to care, patient education, patient involvement and empowerment, information management and databases, and the coordination and development of partnerships. Case studies illustrate effective strategies modeled by New York State facilities.

**Quality Improvement** – This section outlines model Quality Improvement projects on the provision of HIV and primary medical care for substance users that have been implemented by facilities in New York State.

**Appendices** – This section includes recommendations developed by the Committee for the Care of HIV-Infected Substance Users of the New York State Department of Health AIDS Institute. This section also provides information on commonly used substances, substance use screening tools, useful internet resources, contact information of primary care and drug treatment programs, and screening tools.
II. Best Practices in Promoting Comprehensive Health Care for HIV-Infected Substance Users

The HIV providers and program administrators interviewed for this booklet identified best practices that address the healthcare needs—both medical and otherwise—of HIV-infected substance users. The best practices are categorized as follows:

- Screening for substance use
- Increasing access to HIV medical care for substance users
- Improving engagement and retention in medical care and substance use treatment
- Encouraging, educating, involving, and empowering patients
- Addressing special challenges to HIV care
- Improving HIV treatment adherence
- Improving information management: Databases and reminder systems
- Coordinating care and developing partnerships
The sooner that a provider identifies a patient’s substance use behaviors, the sooner he or she can intervene to improve health outcomes. New York State performance data, obtained from facility-specific patient screenings, indicate high rates of substance use among HIV-infected individuals. However, some facilities still miss opportunities to screen for substance use. Additionally, these data do not indicate the completeness or quality of facilities’ risk assessments. Limited time for patient interaction, large caseloads, inadequate training in the management of substance use, and reluctance of patients to disclose their substance use because of associated stigma and fear of losing benefits often result in a failure to identify past or current substance use and to obtain an accurate patient history.20

Providers should screen all HIV-infected patients for substance use at baseline and at least annually. The AIDS Institute’s Committee for the Care of HIV-Infected Substance Users has issued the following recommendations.

- **Screen all new clients for active substance use, regardless of their known substance use histories.** Blood alcohol levels (BAL) and urine drug screens should not be ordered as routine screening tests. Appendix III includes samples of screening tools that can help identify active substance users.

- **Ask patients about previous substance use treatment and its efficacy.** Providers should be aware of a patient’s propensity for relapse after completing or leaving treatment. Relapse is a common occurrence during substance use treatment.

- **Reassess substance use on an ongoing basis.** If relapse occurs, providers should help patients obtain proper care and support, including harm reduction, drug treatment, and adherence counseling.

- **Show a nonjudgmental attitude toward substance use.**
Screening Techniques and Tools

Although providers should complete a comprehensive substance use assessment for all patients, simple, routine questions at each visit can prompt more thorough assessments. Providers can ask questions such as:

- When was the last time you got high?
- What did you get high on?
- How often do you get high?
- What is your drug of choice?
- Is your drug or alcohol use getting in the way of your life?
- What’s your drug scene like?
- What do you like to drink—liquor, beer, or wine?
- When is the last time you had even a sip?

Several screening tools, including the Single Alcohol Screening Question, CAGE, AUDIT, and TWEAK questionnaires, require minimal time and are available in Appendix III. Some New York State facilities have developed questionnaires tailored to their patient population.
Developing Effective Substance Use Screening Tools

St. Luke’s Roosevelt Hospital – Center for Comprehensive Care

St. Luke’s Roosevelt Hospital Center provides care to PLWA through the Center for Comprehensive Care (CCC). The Center is located on the West Side of Manhattan and operates two clinics, which serve communities in Chelsea, upper-Manhattan, Harlem, and the Bronx. Approximately 2800 patients per year access services. The Center is staffed by an interdisciplinary team of infectious disease specialists, primary care providers, women’s health practitioners, a psychiatrist and psychiatric nurse practitioner, a pediatrician, nurses, case managers, a nutritionist, psychologists, complementary medicine therapists, peer counselors, and administrative personnel.

CCC offers an extensive array of services at both clinical sites, including HIV counseling and testing, HIV primary care, specialty care, gynecology and family planning, mental health care, dental care, nutritional counseling, social work and case management, violence prevention, methadone maintenance, and complementary therapies. The Center also offers educational and support groups that help PLWA and their families address emerging issues.

In response to the prevalence of substance use and mental health issues among PLWA, CCC trained its primary care providers to implement universal screening to identify substance use, mental health issues, and domestic violence. With the help of substance use and harm-reduction specialists, CCC staff developed a substance use assessment tool tailored to its patient population. The Center staff also conducted focus groups to assess patients’ perspectives on the questions included in the assessment tool. Some patients described the questions as invasive and stigmatizing while others deemed them intimate and expressive of concern. Patients agreed that the screening questions were necessary even if they felt uncomfortable answering them.

CCC’s substance use assessment questionnaire appears on the following page.
HIV Primary Care Provider:  
Substance Abuse Screening and Evaluation

1. Introductory Statement

- As part of the initial intake I ask all patients about substance use and their health. I know this can be a sensitive issue and before we go forward, it is important for me to let you know that whatever we discuss, you will not be denied services or access to care in this clinic because of substance use.
- Is substance use an issue in your life?
- How is your drug use affecting your life/health?
- So now I am going to ask you about the substances you have used:

2. Inventory (Check Classification categories)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Begin</th>
<th>Last</th>
<th>Quantity</th>
<th>Frequency</th>
<th>Route</th>
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<td><strong>Stimulants</strong></td>
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<td>Tobacco</td>
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<td>Crack cocaine</td>
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<td>Speed (methamphetamine)</td>
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<td><strong>Depressants</strong></td>
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<td>Alcohol</td>
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<td>Barbiturates (ludes)</td>
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<td>GHB (gamma hydroxybutyrate)</td>
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<td>Hypnotics (Placidyl)</td>
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<td>Narcotics (heroin, opium, methadone)</td>
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<td>Sleeping pills</td>
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<td>Tranquilizers (benzos: xanax, valium, ativa)</td>
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<td>Tricyclics (Elavil)</td>
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<td><strong>Psychedelics</strong></td>
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<td>Ecstasy (MDMA)</td>
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<td>LSD</td>
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<td>Mescaline</td>
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<td>Mushrooms (psilocybin)</td>
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<tr>
<td><strong>Marijuana</strong></td>
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<td><strong>Inhalants</strong></td>
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<td>(nitrites-poppers, locker room)</td>
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<td><strong>Other</strong></td>
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</tbody>
</table>
3. Have you ever felt that you ought to cut down on using?

4. Are you interested now in any substance use services or treatment?

5. Interview patient to assess impact of substance use on:
   a. Physical Well Being: Any medical complication of substance abuse?
      • Endocarditis
      • Tetanus
      • Necrotizing Fasciitis
      • Hepatitis
      • Septum defects
      • Tracking & Bruising
      • Vein Collapse
      • Abscesses
      • Emboli
      • Overdose
   b. Other Medical Conditions:
   c. Drug-Drug Interactions:
   d. HIV Treatment:
   e. ARV Adherence:
Incorporating Substance Use Screening into Routine Medical Care

The Binghamton Family Care Center is part of the United Health Services Hospital network of family care centers. The healthcare team at the Center includes four internists, one of whom is an HIV specialist certified in addiction medicine. A small, specific substance use section appears on many facilities’ initial and annual exam forms. Unless the provider remembers to inquire about substance use during routine care, he or she assesses it only during select patient encounters. Consequently, providers may miss opportunities to identify substance use and implement risk-reduction measures. These missed opportunities can negatively affect the care of HIV-infected patients, who may initiate substance use or relapse because of aforementioned stressors. The Binghamton Family Care Center’s initiative to integrate simple substance use screening questions that address tobacco, alcohol, and drug use prompts providers to reassess substance use on an ongoing basis. Providers follow up positive responses to substance use questions with a more comprehensive assessment.

Screening for substance use involves more than a simple run-through of questions on the chart. The Center’s medical director reminds providers that substance users are frequently reluctant to disclose their substance use behavior and also encourages providers to follow up negative responses to screening questions. For example, when a patient denies drinking, she suggests that the provider still screen for alcohol use by asking, “When was the last time you even had a sip?”

When patients are in recovery from drug or alcohol dependence, providers can frame their questions to support recovery. “I know you are in recovery. How long now? Two years? That’s great! During that time have you had any minor slips or sips?”

If patients object to being asked at every visit, the provider can respond honestly, “We ask everyone these questions because it is such an important part of ongoing health care.”
Binghamton Family Care Center – Patient Visit Form

DATE: 

PATIENT NAME: 

DOB: 

REASON FOR VISIT: 

Last annual visit: 

Last monitoring visit: 

<table>
<thead>
<tr>
<th>Last VL</th>
<th>ART:</th>
<th>PPD</th>
<th>Dental visit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
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CASE MANAGEMENT: 

STAP CM: 

OTHER: 

BFCC Internal Medicine, 33 Mitchell Ave, Binghamton, NY 13903 
Phone: (607) 762-3281, Fax: (607) 762-329
The medical system has historically underserved and stigmatized substance users, many of whom, in turn, mistrust their medical providers. Furthermore, many substance users reside in areas with limited healthcare resources and have difficulty traveling to healthcare and substance use treatment facilities. To engage this hard-to-reach population in medical care and to overcome both stigma and geographic access, the New York State Department of Health AIDS Institute’s Substance Abuse Initiative promotes the provision of comprehensive HIV primary care and prevention services, co-located with substance use treatment facilities.40

Co-Located Primary Health Care Within Substance Use Treatment Programs

The co-location of HIV primary care and addiction services, also known as a “one-stop-shopping” model, serves the multiple needs of the HIV-infected substance user and removes the need for patients to travel to more than one clinic to receive services. By offering HIV care services at drug treatment sites, patients are more likely to receive medical care, because often patients cannot visit two clinics, and the drug treatment site becomes the only place they go for care. Obtaining co-located services attracts otherwise marginalized, co-affected clients and improves their engagement in medical care.

Providing primary medical care and HIV testing services at drug treatment sites enhances the opportunity for early HIV diagnosis and initiation of antiretroviral therapy. Since patients have to visit drug treatment programs frequently to receive medications, providers may promote adherence to medications by utilizing various strategies, including modified directly observed therapy. More frequent physician-patient communication also increases opportunities to discuss risk-reduction strategies and prevent relapse.
Primary Care in Drug Treatment Settings

❖ Addiction Research and Treatment Corporation

The Addiction Research and Treatment Corporation (ARTC), one of New York State’s largest non-hospital-based methadone treatment organizations, reaches out specifically to substance users of minority communities living in the poverty-stricken neighborhoods of New York City. Its seven methadone maintenance treatment programs (MMTPs) and two outpatient drug-free chemical dependency programs in Manhattan and Brooklyn serve approximately 3,000 patients, more than 95% of whom identify with minority communities. ARTC also provides specialized treatment for methadone maintained alcohol abusers through a partnership with the Marguerite T. Saunders Urban Center for Alcoholism and Addiction Services.

ARTC has integrated primary care and HIV/AIDS-specific services throughout its treatment programs to offer clients the convenience of a one-stop shopping model. Co-located services include primary and HIV medical care, gynecological care, mental health care, case management, health education, and nutritional counseling.

The primary care clinics are staffed by physicians, PAs, and nurses experienced in providing primary and HIV-specific care. On-site clinical management includes initial and annual comprehensive medical examinations, ongoing clinical HIV disease monitoring, HIV-specific therapies and prophylactic management, and substance use treatment.

ARTC embraces an interdisciplinary team approach. Substance use treatment providers work closely with both primary care and HIV specialty providers, as well as patients, to develop individualized treatment plans. HIV-infected patients who attend methadone maintenance programs at ARTC but do not have access to regular primary care may sign up for on-site HIV primary care services. Clients who have not yet been tested for HIV can get tested on-site and immediately enroll in HIV primary care if positive.
By effectively co-locating services, ARTC not only improves access, but also reduces the likelihood that patients will miss scheduled appointments. If a patient has an abnormal laboratory result and needs further evaluation, providers can flag the patient’s computerized record, which can be seen by providers at the methadone-dispensing clinic; when the patient visits the methadone clinic, methadone providers can refer the patient to a medical provider the same day. Patients can also easily reschedule their medical visits since all of the medical providers are available 5 days/week.

**Mobile Health Vans**

Co-location of medical services in substance use treatment programs benefits only those substance users who seek treatment for their addiction. Many active users only sporadically access health care and substance use treatment. Engaging these users in medical care requires other approaches.

In New York State, traveling staff and mobile medical vans provide outreach and directly deliver healthcare services to hard-to-reach populations. Healthcare professionals can eventually transition patients from such non-traditional medical settings to traditional healthcare settings. Mobile health unit staff members provide on-site primary care and referrals to drug treatment programs, housing programs, food pantries, and specialty medical care.\(^{41,42}\)

The New York State Department of Health AIDS Institute funds mobile medical units equipped to provide HIV primary care, including physical exams, lab work, and supportive services, such as psychosocial assessments and adherence interventions. These mobile health vans are usually parked outside of SRO hotels or syringe exchange programs.

▶ **Bronx-Lebanon Mobile HIV Primary Care Program**

Bronx-Lebanon Mobile Primary Care Program—a New York State Department of Health AIDS Institute-funded initiative—provides comprehensive medical services, social work and case management, and health education to HIV-infected individuals in the Bronx community.
The 38-foot mobile van is equipped with a spacious examination room, a social work office, a triage area, and a lab. The van is staffed by a physician, PA, nurse, social worker, peer educator, substance abuse counselor, program coordinator, and administrative assistant.

The mobile van operates 5 days/week and spends 3 to 4 hours outside each of the SRO hotels and residences in the Bronx. Peer educators enter the residences to inform residents of the services available in the van. Available services include:

- Complete HIV primary care
- Gynecological examinations
- Social work/case management
- Emergency food pantry
- Housing referrals
- Harm reduction/substance abuse counseling and education
- Syringe distribution

The mobile care program’s success hinges on the presence and effectiveness of the peer educators who share their similar life experiences and relate in a nonjudgmental and caring manner with patients. Peer educators can quickly establish patients’ trust and bring them into care.

Mobile service providers address common barriers to care such as substance use, childcare, and housing, which can inhibit patients from seeking care in a more traditional setting. The social workers and substance use counselor refer patients to drug treatment programs, mental health providers, and other supportive services outside of the van. Because the clinicians in the mobile van also see patients at the Bronx-Lebanon Infectious Disease clinic, patients who transition to the clinic from the mobile van develop a sense of continuity in their care. If a patient prefers to attend other medical facilities due to residential proximity or connection to a particular provider, the mobile van staff provides referrals.

Staff members promote harm reduction with their patients through one-on-one education, referrals to support groups, and distribution of harm-reduction kits. These kits include sharps containers, syringes, condoms, cleaning equipment, and “one-line” messages in English and Spanish. The messages include facts and motivational messages such as:

- **Help end the health crisis. Don’t share needles or have unprotected sex.**
- **You have the power to make a big difference in the world. Go for it!**
- **HIV-positive people who stay in primary care have better health outcomes. Stay with us, we are here to help!**
Bronx-Lebanon Mobile Primary Care Program
Substance Use Assessment Form

Questions for the counselor to ask the client:

Name: ________________________________ MRN: __________________

Have you ever used alcohol or drugs?  □ Yes  □ No

If yes, what kind (of drugs)?  □ Alcohol  □ Crack  □ Cocaine  □ Heroin
□ Marijuana  □ PCP  □ Barbiturate  □ Amphetamines  □ Other

When was the last time you used drugs or alcohol?  □ This week  □ This month
□ This year  □ Within past five years

Have you used within the last two weeks?  □ Yes  □ No

If currently using, what is your method of use?  □ Injection  □ Orally (by mouth)
□ Drinking  □ Inhaled (sniffing/snorting)  □ Smoking  □ Other (please specify)

If you are currently using drugs, how often do you use?  □ Once a day  □ Two or three times  □ Every day  □ As often as you can  □ Binge  □ Socially  □ Other

Do you feel you have a substance abuse problem?  □ Yes  □ No

Would you like help in resolving the issue of your substance use?  □ Yes  □ No

Have you ever been in a substance abuse program?  □ Detoxification  □ Rehabilitation
□ Half-way House  □ Three-Quarter house  □ Treatment Living Center

If yes, did you complete the program?  □ Yes  □ No

Would you like to be referred for substance abuse treatment?  □ Yes  □ No

Counselor’s Comments

Age ____________ Gender ____________ Ethnicity ____________

How did client appear?  □ Relaxed  □ Agitated  □ Composed  □ Intoxicated
□ Disoriented  □ Low Level ADL Functioning  □ High Level ADL Functioning
□ Other (please specify)__________________________________________

Did the client’s appearance match how the client said he/she felt?  □ Yes  □ No

If no, please explain (e.g., Did the client appear sad while claiming to be happy):
___________________________________________________________________

Additional Comments:
Community Health Care Network (CHN)—one of New York City’s largest networks of community-based healthcare centers—provides primary care, mental health services, and social services to low-income and medically underserved communities throughout Manhattan, Brooklyn, Queens, and the Bronx.

CHN operates eight health centers and two case management offices and employs approximately 300 medical providers, nurses, nutritionists, social workers, case managers, counselors, and professional and administrative staff. The healthcare team provides comprehensive, culturally competent services to over 60,000 patients annually. Mirroring the diversity of the population they serve, staff members speak Spanish, Mandarin, Cantonese, Haitian Creole, French, and Vietnamese.

CHN provides on-site primary care services and referrals for specialty care at hospitals near the patients’ residences. All CHN centers provide HIV medical care, dental services, treatment adherence programs, early identification and intervention services, HIV counseling and testing, health education, nutrition and weight loss prevention therapy, intensive case management, women’s supportive services, and transgender programs.

CHN also operates two mobile medical units, which offer health services to those unable to visit a health center. CHN’s Mobile Health Vans are connected with 13 community-based health centers. The vans’ staff includes a family practitioner, a nurse, a patient care associate who is responsible for all of the lab work, and the program director. All services on the mobile health vans are provided on a walk-in basis and free-of-charge.

The main services provided on the mobile health vans include:

- HIV counseling and testing
- STI screening and treatment
- Family planning
- Health education
- Adult medicine, including basic care for people with HIV
CHN uses its mobile units as stepping stones to engage patients in permanent medical care. The two mobile health vans park outside of drug treatment programs (Phoenix House, Anchor House, Bailey House, El Regresso), syringe exchange programs (Lower East Side Harm Reduction Center), high schools, food pantries, homeless shelters, and the Department of Probation in Downtown Brooklyn. When patients enter the mobile health van, they learn about the services offered at the stationary CHN clinics, and staff members encourage patients to obtain stationary clinical services on a regular basis.

Traveling Medical Staff

Mobile medical care can also take the form of medical staff visits to SRO hotels and other transient housing units.

Medical personnel work with outreach workers to provide services for patients in their home environment. Providers gain patients’ trust by making routine home visits. Staff members also provide referrals for hospital care and arrange for regular transportation.

Mount Sinai’s Health Bridge Program

Mount Sinai’s Health Bridge program is a home-based clinical care program, which provides primary care and case management services to HIV-infected clients living in SRO hotels in Upper Manhattan. Health Bridge allows patients who have little or no contact with the healthcare system to obtain comprehensive medical care and receive referrals to Mount Sinai’s medical clinics and methadone or other drug treatment programs. Health Bridge staff members include four care coordinators, a PA, a nurse practitioner, a psychiatry fellow, and the program director.

Each day, care coordinators visit SRO hotels and inform residents of the program. If a resident agrees to enroll in the program, a care coordinator completes a client intake form and records the patient’s pharmacy information, Medicaid/insurance status, HIV status, substance use treatment, and food pantry information. The care coordinator encourages patients to visit the Mount Sinai HIV Clinic to receive comprehensive services and can
also arrange for transportation to the clinic and an escort to ease the patient’s fear of navigating the healthcare system.

Care coordinators also keep patients on track with medications and methadone, schedule appointments for specialty care, and provide appointment reminders in person or by phone. Health Bridge patients fill out easy-to-carry cards, which contain important contact numbers at Health Bridge and Mount Sinai, as well as the patient’s pharmacy and Medicaid information. Care coordinators alert the medical providers at Health Bridge of medical services necessary for specific patients.

The PA and the psychiatry fellow provide all patients enrolled into the program with in-home primary care, wound care, vaccinations, and mental health assessments. If patients require further care, the Health Bridge program staff members transport them to Mount Sinai hospital where Health Bridge providers continue to provide care.

The clinical director of the Health Bridge program attributes successful patient engagement in care to the close, continuous relationship that the medical providers and care coordinators develop with patients.

❖ CitiWide Harm Reduction and Montefiore Medical Center – ROMEO Program

The Bronx-based CitiWide Harm Reduction Program is New York City's first syringe exchange program authorized to provide harm-reduction supplies, including syringes, in SRO hotels. CitiWide's SRO program operates in hotels used as emergency shelter for HIV-positive individuals until they can establish permanent housing.
The ROMEO (ROom-based MEdical care and Outreach) Program

CitiWide and Montefiore Medical Center collaborated to create the ROMEO program, which renders HIV care more readily accessible to those living in SRO hotels. The ROMEO program provides services in 15 SRO hotels each week. Physicians, PAs, and nurse practitioners from Montefiore staff the program along with outreach counselors from CitiWide’s Health Services team. The outreach team consists of an outreach coordinator, community health outreach workers, case managers, and a driver.

The program’s success depends on the consistent trusting nature of the relationships that have been built between patients and outreach workers. **Workers strive to interact with the patients in a respectful, non-judgmental, and confidential manner.** During evening outreach activities, the outreach staff members visit every resident in the SRO hotels and introduce the services of CitiWide and Montefiore to new residents. At this time, residents have the option to meet with an accompanying medical provider. This introduction by the community outreach workers who have established relationships with the SRO residents endows medical providers with automatic credibility. **Establishing a credible physician-patient relationship from the onset ensures patients’ receipt of quality on-site primary care and facilitates patients’ entry or re-entry into the healthcare system.**

SRO hotel residents receive medical services including physical examinations, triage and evaluation, wound care, vaccinations, Pap tests, blood tests, prescription refills, and health education in their rooms. Medical providers encourage residents of the SRO hotels to visit the Medical Assessment Clinic (MAC) program at CitiWide’s drop-in center. CitiWide’s SRO outreach team provides transportation upon request.

While the medical provider interacts with or evaluates patients at the SRO hotel, the outreach team members assemble kits with supplies such as personal care items (e.g., soap, toothbrush, tampons, shampoo), first-aid kits (alcohol pads, cotton balls, adhesive bandages, gauze, and antibiotic ointments), harm-reduction supplies, and emergency food pantry bags. Subsequently, the accompanying case managers conduct service needs assessments and arrange referrals for needed services.
The MAC (Medical Assessment Clinic) Program: HIV Primary Care at the Drop-In Center

The MAC (Medical Assessment Clinic) Program—another joint initiative of CitiWide Harm Reduction and Montefiore Medical Center—offers primary care in a harm-reduction setting at the CitiWide drop-in center in the South Bronx. The program is staffed by physicians, PAs, and nurse practitioners from Montefiore and program staff from CitiWide’s Health Services team.

The MAC Program provides CitiWide participants with the opportunity to access medical practitioners at the drop-in center. In addition to providing primary care, the Center staff members process blood work, fill prescriptions, and provide gynecologic exams. While the MAC program focuses its efforts on HIV-positive participants, all individuals can access HIV and HCV testing, HAV and HBV vaccinations, and care for basic wounds and other uncomplicated medical conditions.

If patients require specialty care services (e.g., oncology, dermatology), staff members schedule appointments and provide transportation. CitiWide staff members complete enrollment documents to expedite patients’ entry into the Montefiore Medical Center where they can access specialty care.

The ROMEO and MAC programs and syringe exchange are only part of CitiWide’s portfolio of services. The program currently offers the following services at its drop-in centers:

- Low-threshold case management services such as advocacy, referrals, follow-up for substance use services, legal services, domestic violence issues, and entitlements
- Mental health counseling and management
- Peer education and training
- Health and nutrition education
- Housing placement assistance
- Transportation assistance
- Meals, clothing, and showers
- Peer support groups on topics such as hepatitis C, harm reduction, health awareness, substance use, nutrition, and coping
- Overdose prevention training
- Complementary alternative therapies, including acupuncture, tui na massage, herbal teas and patches, aromatherapy, and Gi-gong exercise
IMPROVING ENGAGEMENT AND RETENTION IN MEDICAL CARE AND SUBSTANCE USE TREATMENT

Substance users often access medical care or substance use treatment sporadically. Chaotic lifestyles, sometimes punctuated by homelessness and incarceration, may contribute to dropping out of care. Mental health disorders may also contribute to irregular attendance at medical visits. Facilities can promote patient engagement and retention and address clients’ barriers to care by using enticements, such as outreach activities and complementary and alternative therapies for patients and family members. Some of these strategies may depart from traditional models of care, but providers must keep in mind the unique needs of HIV-positive substance users and accommodate them accordingly.

Improving Continued Patient Engagement with Buprenorphine

Daytop Village

Buprenorphine is an opioid partial agonist that was approved in 2002 for the management of opioid use in office-based settings. Buprenorphine therapy mirrors methadone treatment but has a lower abuse potential, less overdose risk, and produces fewer withdrawal symptoms following cessation.43,44 Physicians must complete an 8-hour training course to receive a certificate to prescribe buprenorphine.*

Results of a number of clinical trials have shown that buprenorphine in combination with appropriate behavioral strategies is both safe and effective for reducing opiate use. Buprenorphine can be used for both maintenance and medically supervised withdrawal (detoxification) and as an evidence-based practice to improve the outcomes of substance use treatment.44 A year ago, Daytop initiated a buprenorphine program for clients in early residential treatment.

* All regulations and training opportunities can be found on SAMHSA's website at www.buprenorphine.samhsa.gov/publications.html. Further information on buprenorphine also can be accessed at www.hivguidelines.org
**Opiate Use and Patient Retention**

Daytop admits approximately 1,000 adult clients to its Assessment and Referral Unit (Entry Unit) each year, and refers most of them to long-term residential treatment at one of the Daytop facilities in Upstate New York. About 25% of these clients report an opiate, mainly heroin, as their drug of choice.

In the past, because they did not offer methadone on-site, Daytop providers had to refer opiate-dependent clients to a hospital-based detoxification center before admitting them to Daytop. Since active users often cannot overcome persistent drug habits with treatment of physical dependence alone, patients were required to complete this medically supervised withdrawal before beginning treatment at Daytop. Many of these clients never returned to complete the required behavioral treatment protocol and were lost to follow-up when they relapsed.

In addition, several heroin users who returned to Daytop for behavioral treatment following completion of detoxification dropped out of treatment within the first 30 days of admission.

**Daytop’s policy of offering buprenorphine as a short-term sub- or post-acute support medication presumably minimizes the risk of losing clients to follow-up and improves clients’ engagement in substance use treatment.** Engagement in care unequivocally helps cease drug use and promotes long-term recovery.

Members of Daytop’s Research and Evaluation Division evaluate the on-site use of buprenorphine for detoxification, reduction of opioid withdrawal symptoms, engagement of clients in the behavioral treatment community and early retention in treatment. Daytop intends to expand the use of buprenorphine to all of its outpatient programs.
Buprenorphine Support for Withdrawal

Before initiating buprenorphine therapy, clients should discontinue the use of illicit opioids and should exhibit early symptoms of withdrawal in order to prevent more extensive withdrawal symptoms.

Federal agencies have developed current treatment protocols. The physicians in the Entry Unit (Far Rockaway) and Daytop’s medical director are certified to prescribe and supervise buprenorphine therapy. During the initial medical examination, they establish the client’s buprenorphine therapy regimen and duration of treatment.

At Daytop, the initial stabilization dose of buprenorphine is decreased over an average period of 10-14 days. Daytop providers prescribe a combination of buprenorphine/naloxone tablets for clients who are dependent on short-acting opioids. Certified physicians determine the daily dose and phased reduction. Trained members of the nursing staff administer the prescribed medication on a daily basis and monitor client health status as well as the sublingual intake and dissolution of buprenorphine. Daytop staff members record client withdrawal status through the Clinical Opioid Withdrawal Scale.

Improvement of withdrawal symptoms allows clients prescribed buprenorphine support to fully integrate into the treatment community at the Entry Unit. They participate in all scheduled general assessment and behavioral treatment activities and receive daily specialized group education and counseling.
Promoting Engagement in Care

❖ Bedford Stuyvesant Family Health and Wellness Centers

The Bedford Stuyvesant Family Health and Wellness Center provides primary health care in Brooklyn, offering a broad range of services and targeting Brooklyn’s under- and uninsured.

The Family Health Center houses medical services including primary care, dentistry, podiatry, psychiatry, cardiology, gynecology, neurology, virology, x-rays, and mammography. Members of the Center’s staff speak English, Spanish, French Creole, and many other dialects, and provide culturally sensitive care to a diverse patient population. All clients can access HIV counseling and testing at the Family Health Center. Providers refer HIV-positive clients to the nearby Wellness Center for case management intake and psychosocial assessment.

Case managers, community outreach and mental health workers, an activity coordinator, an acupuncturist, a nutritionist, the clinic manager, and program directors staff the Wellness Center, which serves approximately 250 HIV-infected and HIV-affected adults. Most patients have a history of substance use and regularly meet with the substance use counselor.

The Wellness Center promotes healthy living and prevention. Its motto, “restoration and maintenance of health and well-being,” is intended to empower patients to take responsibility for their own health. Staff members work with patients to build self-esteem as well as to provide them with practical skills to reinforce harm reduction and engagement in care.

At the Center, patients receive a range of services that include nutritional groups, mental health support, medication management, stress management, support groups, arts and crafts programs, HIV health information, massage therapy, chiropractic care, Reiki, yoga, and traditional eastern medicine.

Engaging patients in these activities improves their confidence and equips them with the necessary skills to cope with substance use, while they are receiving medical care at the same facility.
Providing Comprehensive HIV and Substance Use Treatment to Patients and Their Families

Center for Comprehensive Health Practice

The not-for-profit, community-based Center for Comprehensive Health Practice (CCHP) offers primary care and addiction services and primarily serves upper Manhattan and South Bronx communities. CCHP’s two sites share a staff of 6 internists, an infectious disease specialist, 2 psychiatrists, 10 nurses, and about 20 social workers.

Addiction Services

Substance use treatment services offered at CCHP include an outpatient drug treatment program and three primary care programs, which offer methadone maintenance. Besides its regular methadone maintenance treatment program, CCHP also offers comprehensive outpatient services to opioid-using women who are pregnant or have children and an outpatient methadone-to-abstinence program.

CCHP’s Pregnant Addicts/Addicted Mothers (PAAM) program offers addiction services, such as methadone maintenance, individual counseling, group treatment, and comprehensive medical services, including internal medicine, obstetrics, gynecology, pediatrics, and psychiatry. Participants also benefit from parenting and vocational preparation groups.

CCHP’s methadone-to-abstinence outpatient program provides individualized treatment to patients who usually require up to a year to complete the program. If patients decide not to withdraw from methadone, CCHP staff arrange for long-term methadone maintenance.
Primary Care

The primary care program at CCHP emphasizes prevention and health maintenance and addresses patients’ medical, mental health, and social struggles. A team of internists, pediatricians, a nurse-health educator, a psychiatrist, a social worker, and a child development specialist provide and coordinate care. The family development unit of the program offers mental health counseling.

Staff members in the primary care program at CCHP excel at providing personalized care. Intake coordinators screen patients upon entry to the system. A counselor subsequently takes over and maintains a personal relationship with each patient throughout his or her time at CCHP. Staff members coordinate schedules so the same physician provides medical care to the same patients. In addition to ensuring continuity of care, these provider-patient matches serve to make patients more comfortable with and trusting of their caregivers.

Screening and Assessment

Providers screen all patients for substance use during initial, routine, and annual comprehensive visits. CCHP counselors also administer a behavioral risk-assessment survey to identify risk behaviors and provide patient-specific risk-reduction education. Counselors at CCHP apply their training in motivational interviewing techniques during clinical encounters. Due to the co-location of addiction services, counselors are able to arrange substance use treatment initiation upon request.

Patient Education

Both physicians and counselors conduct weekly health education groups in smoking cessation, HIV awareness, men’s health, and women’s health. Information about these groups is posted in the lobby, elevators, and hallway of the Center. CCHP staff members also provide patients with educational pamphlets, brochures, and videos.
Patient Feedback
Providers at CCHP actively seek patient feedback. Long-standing provider-patient relationships allow patients to express their opinions about their care and suggest improvements. Patients can also use traditional suggestion boxes in order to maintain anonymity. CCHP relies on patient participation through the Consumer Advisory Board (CAB) and bi-annual patient satisfaction surveys to improve care provision.

Interdisciplinary Approach
The medical director identifies CCHP’s interdisciplinary team approach to patient care as a key feature of the program’s success. This team consists of the internist, HIV specialist, nurse, case manager/substance use counselor, pediatrician, child development specialist, and psychiatrist who meet at least monthly to discuss cases. Case conferences cover the following nine areas:

1. Family and social
2. Medical
3. Parenting and childcare
4. Substance use
5. Mental health
6. Housing
7. Finance
8. Education and employment
9. Legal

Case conferences capture clinical information as well as underlying familial and social factors. The interdisciplinary team establishes individual treatment plans during the reviews and targets areas for intervention, defines interventions to be used, and identifies the staff responsible for implementing interventions.
HIV Family Rehabilitation Program

CCHP’s HIV Family Rehabilitation Program helps to keep substance users engaged in medical care by assigning patients to an infectious disease specialist who provides comprehensive HIV treatment and medication management. With a patient’s approval, family members and partners may participate and receive care themselves. Services include HIV care, primary medical care, individual and group counseling, parenting and family counseling, addiction services, psychiatric assessments, and case management. CCHP staff members also work to improve the family’s relationships with schools, employers, courts, and landlords. For substance users and their family members at risk for HIV infection, counseling and testing services are available. Having such a range of services for the patient and his/her family members in one location increases the patient’s engagement and retention in care at CCHP.

Improving Patient Communication and Feedback

❖ St. Luke’s Roosevelt Hospital – Center for Comprehensive Care

A nurse practitioner at St. Luke’s Roosevelt Hospital Center developed a contact form for new patients to be used at their first clinical encounter. This form lists the provider’s name, contact phone and beeper numbers, working hours, reasons to call, and information on how to proceed in case of an emergency or when the provider is unavailable. Each provider gives all patients this contact form and documents the best times to reach the patient and what a staff member should say when calling the patient’s home. The form creates a sense of accountability on the part of both the patient and provider. St. Luke’s Roosevelt staff members also routinely assess patient satisfaction by giving surveys during focus groups.
Welcome to the Samuels Clinic – From your new primary care provider

Provider Name: _______________________________________________________

Clinic hours: ___________________ Telephone number: ________________

If the clinic is closed you can still call the above number and an answering service will take your call and tell you what you should do.

Provider’s clinic hours: I am not in clinic at all on Tuesdays

Monday 9-12 noon & 1-5 pm Thursday 9:40-12 noon
Wednesday 4-8 pm Friday 9-12 noon & 1-5 pm

How to contact me:

Office telephone number: ________________ Beeper number: ______________

Reasons why you may want to contact me:

1. A new symptom comes up
2. A concern about a medication
3. You have stopped or started a medication
4. You need to change an appointment
5. You have a healthcare question
6. You have been hospitalized
7. You need paperwork completed
8. Some other reason

Office:

• You can call me anytime Monday, Thursday, Friday 9-5, Wednesday 2-8.
• If I am not at my desk, you can leave a message for non-urgent issues.
• I will return your call that day or the following day.

Beeper:

• You can beep me anytime Monday, Thursday, Friday 9-5, Wednesday 2-8
• I try my best to answer my pages as soon as possible, but sometimes this is not possible. If I am not able to answer your page, you can call my office number and leave a message.

When I am out of the hospital:

• There are other staff in the clinic who cover for me.
• They can provide you with your needed service.

IF IT IS AN EMERGENCY:

• Get to an emergency room – Do not beep or call me or the clinic.
• If possible, give the emergency room my contact information, so I can be contacted and help with your care.
Increasing Patient Knowledge and Decision-Making Skills

Empowering HIV-infected substance users with information about HIV, substance use, and associated health risks inspires patients to reduce or eliminate drug use and risky sexual behaviors and to increase medication adherence.

Providers should assess patients’ understanding of the implications of HIV infection and substance use as well as obtain detailed information about patients’ risk behaviors in order to provide appropriate education. Providers should present information, education, and instructions in a detailed and clear manner. As education level may not correlate with health literacy, a patient who can read and write may have difficulty following instructions on a prescription or appointment slip. Because doctors often have a limited amount of time for patient education, other clinical staff may be utilized to conduct education sessions. Providers should give patients specific strategies, skills, and tools to reduce drug use, prevent secondary transmission of HIV, and reinforce positive behavioral changes.

Education

- Provide patients with harm-reduction education and counseling in individual or small group sessions
- Tailor harm-reduction education to each patient, depending on his/her risks
- Educate patients about HIV, HCV, substance use, and smoking cessation
- Provide an opportunity for clients to be safer through education on syringe access
- Participate in the Expanded Syringe Access Program (ESAP)
Patient Involvement and Empowerment: Practical Tips

Communicate with patients about how best to reach them, and why and how they should reach their providers.

Giving patients specific information about how and when to contact a provider creates a strong provider-patient relationship and empowers patients to control their own health care.

Ask patients for feedback about their medical care.

Patients can readily identify their unmet medical needs. Patient feedback—both formal and informal—should inform most quality improvement (QI) efforts. The New York State Department of Health AIDS Institute has developed a patient assessment tool—“The patient satisfaction survey for HIV ambulatory care (PSS - HIV)”—specifically for HIV primary care sites. In addition to a core survey, the assessment tool includes five optional modules for case management, substance use, mental health, women’s health, and Medicaid managed care. Providers can download the survey from the AIDS Institute’s clinical guidelines website and can easily modify or adapt it to meet the needs of a particular clinic.†

Facilitate peer support groups.

Patients often find group settings comfortable forums in which to discuss barriers to improving their health status. Peer support provides patients with a camaraderie that may help them better adhere to their medical care.

Encourage patients to give educational presentations to their peers.

Giving patients the opportunity to research a particular topic area and present information to other people boosts confidence.

* [www.health.state.ny.us/diseases/aids/about/prevsup.htm#esap](http://www.health.state.ny.us/diseases/aids/about/prevsup.htm#esap)
Providing Harm-Reduction Education in Medical Settings

Bellevue Hospital Center – Harm Reduction Program

Bellevue’s Harm Reduction Program provides services to PLWA with active or past alcohol and/or drug use. The program also provides services to partners and family members. Bellevue’s program combines low-threshold counseling and education services based on a behavior modification model that is focused on risk reduction. Referrals are made to and care is coordinated with hospital-based inpatient units, outpatient clinics, day treatment programs, and supportive services, including syringe exchange, 12-step programs, and job training.

Based in Bellevue’s Virology Clinic, the Harm Reduction Program works closely with medical providers, mental health providers, social workers, and treatment support educators to ensure coordinated care and an interdisciplinary approach. A physician’s utilization of the harm-reduction team can engage patients from the beginning of their care.

Bilingual English/Spanish harm-reduction counselors practice client-centered communication and use reflective listening to help patients identify their substance use behavior and to reduce drug-related harm. The counselors educate patients about the importance of avoiding needle-sharing and emphasize the use of sterile injection equipment, which can be obtained in the clinic. Patients are also taught how to use condoms and dental dams, which are also available in the clinic. Bellevue also participates in ESAP.

The Harm Reduction Program provides both individual and group counseling. Current groups include an active drug user group and relapse prevention groups conducted in English and Spanish. Attendees receive incentives such as Metrocards, snacks, and personal hygiene kits to join and to continue participation.

The Bellevue Harm Reduction Program’s success results, in large part, from its co-location with medical care.
Providing Harm Reduction and Primary Care Services to Substance Users

Lower East Side Harm Reduction Center

The Lower East Side Harm Reduction Center (LESHRC) provides needle exchange and other harm-reduction services to New York City’s Lower East Side community. The program began as a volunteer organization and now has 23 full-time trained employees and approximately 10 regular volunteers. LESHRC integrates the stages of change model into all aspects of care. Program staff members attempt to motivate patients to improve their own lives without feeling criticized.

LESHRC offers needle exchange services 6 days/week as well as the “Vital Services Program,” which provides enrolled HIV-infected clients with crisis intervention, substance use counseling, case management, and mental health services. LESHRC serves more than 700 clients each week.

Primary Care at LESHRC

All clients at LESHRC can access primary medical and dental care 1 day/week. A mobile medical unit operated by the Gouverneur Medical Center parks in front of LESHRC every Wednesday afternoon and delivers primary care, including physical examinations, STI screening, pregnancy testing, Pap tests, and other basic medical services. Gouverneur’s Dental Mobile Unit provides dental care services, including x-rays, examinations, cleanings, and prosthetics.

Social workers, client care coordinators, case managers, and other staff members also help clients obtain medical care at other facilities. In addition, LESHRC staff members help clients determine their eligibility for benefits, apply for Medicaid, make appointments, and follow up with appropriate medical providers. The Center emphasizes continuity of care through its collaboration with many of the neighboring hospitals.

LESHRC also provides a range of mental health services and a part-time psychiatrist provides consultations and prescriptions for naloxone and buprenorphine.
Patient Education
At LESHRC, daily activities focus on peer- and staff-led HIV education and prevention efforts. Clients at LESHRC have monthly seminars on topics such as hepatitis C, abscesses, and opportunistic infections. LESHRC offers several support groups coordinated by program staff, peer trainers, and volunteers. Current groups include a hepatitis C group, a women’s living well group, a co-ed HIV group, both Spanish and English Positive Experience groups, and a weekly meditation group.

The program staff focuses on improving the participants’ self-esteem and understanding of their own substance use behavior. In addition, the Center offers intervention programs to support women who have a history of physical and sexual abuse.

The Hepatitis Project
LESHRC initiated its hepatitis C program in response to findings that early identification of hepatitis reduces morbidity and prevents further transmission.

The program staff includes an HCV Program Coordinator and medical students who work under the direct supervision of licensed physicians. Services provided include hepatitis A, B, and C prevention counseling; testing; vaccination; referrals; and follow-up care.

To date, the Hepatitis Project has tested over 700 clients for viral hepatitis and vaccinated over 700. The program has developed educational brochures and videos specific to the prevention needs of IDUs. Topics include information on hepatitis prevention, risk factors, testing, and treatment. The program has also trained several hepatitis-infected, past and current substance users to be peer educators and to perform outreach in the community.
Focus on Patient Education and Treatment Planning

VIP Community Services

VIP Community Services is a not-for-profit multi-service substance use treatment program in the Bronx. The program serves approximately 1,300 substance-using patients, the majority of whom are also HIV-infected. VIP Community Services’ Behavioral Health Services Division offers a variety of substance use treatment options, including opioid treatment, an ambulatory treatment program, and residential programs for men and women.

As one of the largest treatment sites in New York City, VIP’s opioid treatment program serves more than 1,000 clients at any given time and more than 2,000 each year. It is also the only non-hospital program in the Bronx to dispense liquid methadone, which enables providers to more accurately titrate methadone dosages.

Staff members in a centralized intake unit admit clients and integrate their services during the first visit. A physician and four to five additional staff members monitor the unit. A comprehensive assessment of the client’s past and present substance use, physical and mental health, family and social issues, education, work skills, and financial status is conducted. The team uses this information, together with patient input, to develop individualized treatment plans.

VIP’s physical health services division provides primary medical care for all clients and a full range of HIV-related treatment and prevention services through the HIV primary care clinic. A multidisciplinary team of HIV specialist physicians, PAs, case managers, a nutritionist, and HIV counselors staff the health services division. In addition to medical services, the team also provides preventive care, testing, and health education. Patients can also access on-site psychiatric services 3 days/week. The psychiatrist provides services exclusively to HIV-infected patients on one of these days.
Patient Education

VIP Community Services supports an active patient education program. Providers discuss diseases such as hepatitis C at every encounter, and educational programs and activities cover conditions that are currently part of national and statewide campaigns. Recent educational workshops include the national Smokeout Day-patch program, gynecological cancer awareness, and oral health day. The VIP team also participates in local community health fairs and other outreach activities.

In addition, VIP’s prevention unit provides health education and risk-reduction workshops that focus on substance use, condom use, and negotiation skills. The prevention unit promotes harm reduction, HIV counseling, testing, and education through community outreach in the Bronx. Outreach workers use incentives such as Metrocards and snacks to encourage participation in substance use and HIV treatment programs.

Clients who are HIV-positive or have risk factors for HIV/AIDS may see prevention case managers, most of whom are also HIV-positive. Case managers offer individualized counseling, risk reduction, and supportive services, such as assistance with medical referrals, access to entitlements, vocational/educational opportunities, and housing. VIP also provides syringe disposal services, support groups for anger management, domestic violence, relapse prevention, family reunification, and living positive. VIP’s providers will accompany clients to access services outside the agency.
Empowering Patients by Forming Support Groups

Albert Einstein College of Medicine Division of Substance Abuse

Physicians at the Albert Einstein College of Medicine Division of Substance Abuse developed an HCV support group to provide education, peer support, and to raise awareness about HCV. The program has three components: support, advocacy, and education.

The support group component of the program empowers substance users enrolled in MMTPs to share information, experiences, successful HCV treatment stories, and to support each other. The support groups often motivate patients to seek treatment for HCV.

The advocacy component of the program identifies patients in each of the MMTPs who have leadership abilities. Identified patient leaders accompany other patients to procedures and make hospital visits.

The educational component of the program focuses on the development of peer educators to deliver HCV education. Fourteen trained peer educators work with both patients and staff. In 1 year, the peers conducted 35 educational sessions; 22 at the MMTPs and 11 at the syringe exchange outreach sites. Approximately 250 patients and 30 staff members have attended these informal sessions.
Hiring Consumers as Staff Members

**AIDS Community Health Center**

The AIDS Community Health Center (ACHC) is a community-based healthcare center for PLWA in Rochester, New York. ACHC provides comprehensive medical and social services including HIV specialty care, primary medical care, ophthalmology, gynecology, neurological care, nutrition counseling, treatment adherence counseling, laboratory and pharmacy services, medical case management, mental health counseling, substance use evaluation and treatment, HIV testing, outreach, and prevention services.

Some ACHC patients also work as staff. Currently, patients hold the positions of an adherence educator, a peer outreach educator, a case manager, and an information coordinator. Additionally, the co-chairs of ACHC’s Patient Advisory Committee serve on the board of directors of the clinic.
Developing a Crystal Methamphetamine Detoxification Treatment Program

Callen-Lorde Community Health Center

The Callen-Lorde Community Health Center in New York City focuses on meeting the healthcare needs of the lesbian, gay, bisexual, and transgender communities and PLWA. Clients can access all services regardless of their ability to pay. Callen-Lorde offers an integrated model of medical and mental health services and emphasizes preventive health and wellness. Providers at Callen-Lorde take a bio-psychosocial approach that considers all aspects of patients’ lives in the evaluation and management of their health.

Services provided include general medicine, lesbian health services, HIV/AIDS services, transgender health services, adolescent health services, transgender counseling and education, substance use assessment and referral, support groups, sexual health screening and treatment, mental health services, and oral health care.
The Crystal Methamphetamine Detoxification Program

The Callen-Lorde team piloted an abstinence-based crystal methamphetamine detoxification program in response to the growing epidemic of crystal methamphetamine use.

The outpatient program offered medical and psychiatric assessment, a 10-day detoxification protocol (with or without medication assistance), and daily counseling either in-person or via phone. Patients were not required to go through the detoxification protocol. If a patient was not ready for behavior change intervention at the initial assessment, they were offered enrollment in a 12-week psychosocial support group and individual counseling. Patients still using crystal methamphetamine were referred to external harm-reduction programs and more intensive inpatient or outpatient treatment programs.

The staff evaluated patients who accepted the medical detoxification protocol for medication and substance use histories and assessed the possibility of interactions with the detoxification protocol medications, including lorazepam, trazodone, and bupropion or amantadine. The Center pharmacists filled prescriptions for 4 to 6 days, depending on the start day of the protocol, and ensured that patients received enough medications to last until their visit with the psychiatrist on the fifth day. Providers instructed patients that the Center could fill the prescriptions only once and that staff would not provide refills, even if the medication was lost or misplaced. The staff and providers also advised patients not to use crystal methamphetamine when taking any of the medications. If relapse occurred, patients were instructed to stop the medications for 1 to 2 days before resuming the protocol.

Callen-Lorde continues to use a one-page examination screening form to assess methamphetamine use. Patients can also request a comprehensive substance use assessment by a licensed clinical social worker and a psychiatric assessment with short-term individual counseling.

Callen-Lorde has now linked with programs such as the Addiction Institute and the Manhattan Addiction Treatment Center to provide necessary treatment services for patients using methamphetamines and other substances.
Crystal Methamphetamine Screening Tool

Do you have questions about crystal meth? Fill out this brief survey and take it with you into your appointment. Your Callen-Lorde provider can help you find answers to your questions and concerns.

1. Have you ever used crystal methamphetamine (crystal, tina, speed)?
   - No [If no, questionnaire is completed]
   - Yes

2. How many weekends in the past month have you used crystal?
   - 0-1
   - 2
   - 3
   - 4-5

3. How many days have you used crystal within the last 30 days? ____ days

4. Have you ever smoked crystal?
   - No
   - Yes

5. Have you ever injected crystal?
   - No
   - Yes

6. Have you ever used crystal anally (“booty bump”)?
   - No
   - Yes

7. Have you ever used crystal on a work day (day when you were actually working or supposed to be working)?
   - No
   - Yes

8. Have you ever used crystal for the drug experience alone (i.e., not for sex)?
   - No
   - Yes
9. Have you ever experienced any of the following due to your use of crystal or because you were coming down from crystal?

Check all that apply:

- Hypertension
- Skin infections, sores or abscesses
- Antibiotic-resistant staph infection (MRSA)
- Tooth clenching or grinding
- Anxiety
- Paranoia
- Depression
- Insomnia
- Weight loss
- Fatigue
- Forgotten to take other medications
- Trouble meeting responsibilities (e.g., work, school)
- Trouble in your personal relationships
- Other __________________________________________________

10. Have you ever tried to cut back your use of crystal?

- No
- Yes

11. Do others annoy you by talking to you about your level of crystal use?

- No
- Yes

12. Have you ever felt guilty about what happened after you used?

- No
- Yes

13. Have you ever needed to use in the morning, as sort of an “eye opener”?

- No
- Yes

If you want to talk with someone about your use of crystal or this topic, talk to your provider or call and make an appointment to access the Crystal Meth Detox Program.
Providing Access to Crystal Methamphetamine Treatment

❖ St. Vincent’s Catholic Medical Center – Manhattan

St. Vincent’s Catholic Medical Center offers a range of medical, psychiatric, and substance use services in hospital and ambulatory care settings.

As one of the largest Designated AIDS Centers (DACs) in New York State and one of the largest HIV programs in the nation, St. Vincent’s – Manhattan provides a comprehensive array of HIV-specific and primary care services. Currently, the program serves approximately 3,000 patients, 100 of whom access services daily. Fifty-five percent of St. Vincent’s patients have a history of substance use. Thirteen percent of these patients report crystal methamphetamine as their drug of choice.

Crystal Methamphetamine Treatment Program

St. Vincent’s Manhattan Center’s Behavioral Health Division offers both inpatient and outpatient mental health and substance use services. The outpatient services include ambulatory detoxification, day rehabilitation, relapse prevention, and other aftercare programs. Co-location of services enables providers at both the HIV center and Behavioral Health Services to easily access and share information.

The Chemical Dependence Outpatient Program’s staff of five social workers, an occupational therapist, the program manager, and several psychiatrists recently initiated an abstinence-based crystal methamphetamine program. The Life Beyond Meth track offers specialized services for individuals using methamphetamine. Treatment focuses on educating patients about the impact of drug use and risky behavior. A thorough intake evaluation assesses each patient’s readiness to stop using drugs. The healthcare team helps each patient design an individualized treatment plan based on the patient’s specific needs. Patients can participate in individual and group counseling sessions and inpatient support groups such as the Gay Men’s support group and the Social Relationships group. Education groups cover topics related to various drugs, smoking cessation, HIV, hepatitis C, and other medical and psychiatric issues.

The length of treatment depends on each patient’s ability to stop using crystal methamphetamine. Patients who progress through the treatment protocol and successfully achieve abstinence can participate in relapse prevention groups, which help patients develop effective coping strategies.
After the patient orientation, all new patients at St. Vincent’s meet with a social worker who conducts a comprehensive intake assessment and works with each patient to identify an appropriate provider. The social worker then schedules the next available appointment with the medical provider. Identification of active substance use usually occurs during the intake assessment or the first comprehensive medical examination. **All staff members continue to address substance use with all patients at every routine clinical encounter.**

**Maintenance in Care Program**

Providers can refer patients who frequently miss appointments or fail to follow up for long periods of time to the Maintenance in Care program, in which a registered nurse engages patients in more intensive medical case management and offers home visits. Substance use, mental health, and social issues often prevent patients from engaging in regular care. Providers address these barriers and make appropriate referrals for treatment and supportive services. The Minority AIDS Initiative supports this program.

All providers at St. Vincent’s are trained in motivational interviewing. Both medical and social work staff use these techniques to help patients think about their substance use behavior. If a patient wishes to initiate substance use treatment, providers can select various treatment options including detoxification and methadone maintenance within the St. Vincent’s healthcare system or any other facility desired by the patient.
St. Vincent’s has adapted an electronic medical record system to help providers manage substance use treatment and other preventive services. Each tab records substance use, smoking, drinking, and sexual risk behaviors, and at every visit providers update areas in which the patient has high-risk behavior. Annual examination reminders prompt reevaluation of substance use and other mental health issues.

**Talk Safe Program**

Talk Safe provides counseling to both HIV-negative and HIV-positive men who have sex with men (MSM). Counselors work one-on-one with clients to address issues of mental health, self-esteem, and substance use.
Daytop Village

Daytop Village, the oldest and largest drug-free program in the United States, utilizes the Therapeutic Community Concept. Daytop offers both residential and outpatient treatment to adults and adolescents living in every New York City borough.

Staff members at local organizations, hospitals, and community centers refer outpatient clients to Daytop. The intake process for adults who require residential treatment services begins at Daytop’s Manhattan office. Clients move on to residential facilities located in Dutchess and Sullivan counties. Besides local outreach, clients also enroll through self-referral, family referral or referral from other sources. Upon intake, providers and patients develop individualized treatment plans based on the client’s clinical, legal, and social needs.

Daytop Village facilities provide comprehensive primary medical care services. Physicians, nurse practitioners, PAs, psychiatrists, psychologists, registered nurses, certified social workers, and dieticians staff both the residential and outpatient centers and conduct detailed health assessments for all clients. Daytop facilities also provide HIV counseling, testing, and partner notification services.

HIV-positive clients receive comprehensive medical treatment including diagnostic testing, education, medication management, and nutritional counseling. In addition to medical services, Daytop clients can access alternative therapies such as acupuncture, as well as treatment support groups specifically designed for HIV-infected clients. IDUs may access a range of hepatitis C services, including education, counseling, testing, and treatment.
The Hepatitis C Taskforce

In response to the prevalence of hepatitis C among its clients, Daytop’s Medical Services Division developed a taskforce comprised of the medical director, nursing supervisors, nurses, mental health supervisors, social workers, administrators, facility directors, and research psychologists. This task force developed official procedures for the prevention and management of hepatitis C and detailed protocols for the provision of HCV-specific medical, mental health, and nutritional services.

Upon entering residential treatment, all clients may attend hepatitis C education sessions that cover the modes of transmission, risk factors for acquisition of HCV infection, symptoms, and the natural history of the disease. Patients receive hepatitis C testing as part of the initial medical evaluation and annually thereafter, if indicated. Hepatitis C-infected patients receive individual and group counseling. Daytop providers follow guidelines for nutritional counseling that promote liver health and prevent further liver damage. Nutritional counseling includes the completion of a dietary assessment and a dietary care plan. The program also incorporates education and prevention components, which target clients and their families. Activities include educational presentations about HIV and HCV to the Daytop Family Association and the quarterly publication of an HIV and HCV newsletter.

In addition, Daytop employs HIV and HCV physician consultants who screen, diagnose, and treat co-infected clients. A case management technician helps HIV- and HCV-positive clients negotiate off-site medical appointments. Technicians will also escort patients to their appointments. The Hepatitis Task Force meets quarterly to discuss HCV-related patient issues and information about current research. The Task Force provides a forum for Daytop staff to share information, make policy decisions, and make suggestions for future improvements.
DAYTOP VILLAGE, Inc.
Hepatitis C Risk Assessment Survey

We would like to find out what you think about hepatitis C and we also would like to learn more about the transmission of the hepatitis C virus (HCV). This information will help us to provide you and your peers with better HCV prevention and education. Please take a few minutes to answer the questions on the following pages and answer as honestly as possible. Your answers are completely confidential. Thank you for your cooperation.

Instructions: Please place a check mark in the box next to the appropriate answer for each question. Please do not leave any questions blank.

1. Symptoms of Hepatitis C are always visible and obvious.
   - True
   - False

2. No one will want to have sex with me if I have Hepatitis C.
   - Agree
   - Disagree

3. Hepatitis C can be spread through casual contact like hugging or sharing food.
   - True
   - False

4. If I had Hepatitis C, I would not go for treatment because it does not work.
   - Agree
   - Disagree

5. If I have Hepatitis C, I will probably die from it.
   - True
   - False

6. I wouldn’t tell my significant other if I had Hepatitis C because they would leave me.
   - Agree
   - Disagree

7. Once you get Hepatitis C, you can never contract it again.
   - True
   - False

8. I can have Hepatitis C and lead a full and productive life.
   - Agree
   - Disagree

9. Sharing a needle only once doesn’t put you at risk for contracting Hepatitis C.
   - True
   - False
10. Women who have Hepatitis C should not have children.
   - Agree
   - Disagree

11. Have you EVER shared a razor, toothbrush, or nail clippers with someone who had Hepatitis C?
   - Yes
   - No

12. Have you EVER had a blood or blood product transfusion?
   - Never
   - Yes, before June 1992
   - Yes, after June 1992

13. Are you exposed to blood as part of your job (i.e., nurse, lab worker)?
   - Yes
   - No

14. Have you EVER had a needle-stick injury at work?
   - Yes
   - No

15. Have you EVER had a “blood brother/sister” bond with someone (“blood brothers/sisters” prick themselves and mix their blood together)?
   - Yes
   - No

16. How many tattoos do you have?
   - None
   - 1 or 2
   - 3-5
   - More than 5

17. Where did you have your tattoos done (check all that apply)?
   - Not applicable – no tattoos
   - Prison
   - Professional tattoo parlor
   - Non-professional setting

18. How many body piercings do you have?
   - None
   - 1 or 2
   - 3-5
   - More than 5

19. Where did you have your piercings done (check all that apply)?
   - Not applicable – no tattoos
   - Prison
   - Professional tattoo parlor
   - Non-professional setting

20. Have you EVER used drugs by injection (even once)?
   - Yes
   - No
21. When was the LAST TIME you used IV drugs?
   - Never
   - 1-5 years ago
   - In the last 6 mos
   - More than 5 years ago
   - 6 months-1 year ago

22. Have you EVER shared needles, filters, or spoons with anyone?
   - Yes
   - No

23. Have you EVER snorted drugs (even once)?
   - Yes
   - No

24. When was the LAST TIME you snorted drugs?
   - Never
   - 1-5 years ago
   - In the last 6 months
   - More than 5 years ago
   - 6 months-1 year ago

25. Have you EVER shared straws for snorting drugs with anyone?
   - Yes
   - No

26. How many sexual partners have you had in your lifetime?
   - 0-10
   - 10-30
   - 30 or more

27. Do you EVER have unprotected sex?
   - Never
   - Most of the time
   - Occasionally
   - Always

28. Have you EVER engaged in anal intercourse?
   - Yes
   - No

29. Have you EVER had sex with strangers or someone that you hardly knew?
   - Yes
   - No

30. Have you EVER exchanged sex for money or drugs?
   - Yes
   - No

Thank you very much for your participation!

For more information on Hepatitis C, please ask our medical staff for a copy of our fact sheets and other Hepatitis C materials!
Improving Patient Communication

Beth Israel Medical Center – Peter Krueger Clinic

Beth Israel Medical Center functions as a 1,368-bed, full-service tertiary teaching hospital and offers a spectrum of substance use treatment services. The Stuyvesant Square Chemical Dependency program at the hospital offers outpatient and inpatient detoxification, intensive day services, ambulatory care, gender-specific treatment, family programs, and inpatient rehabilitation. Substance users with co-occurring psychiatric conditions receive services from the Addiction Psychiatry Division. Services offered through this division include acute inpatient psychiatric care with concurrent substance disorder treatment, inpatient detoxification in both psychiatric and non-psychiatric settings, outpatient addiction psychiatry treatment, outpatient detoxification, 28-day inpatient drug and alcohol rehabilitation treatment, outpatient partial-hospital drug and alcohol rehabilitation, part-time and evening outpatient rehabilitation, and referrals to MMTPs.

Beth Israel operates 20 MMTPs in Brooklyn and Manhattan, which serve over 7,000 opioid-addicted patients. The MMTPs deliver basic medical care, counseling, vocational services, and health education. MMTP providers refer HIV-infected substance users to the adjacent Peter Krueger Clinic for HIV services and primary care.

The clinic supports a staff of HIV specialists, nurses, nutritionists, social workers, psychologists, and psychiatrists. Peter Krueger has a 28-bed inpatient unit, which offers comprehensive inpatient medical and social services and a unique HIV/AIDS psychiatry program staffed by two full-time psychiatrists and two full-time psychologists. In addition to these services, the clinic’s Stepping Up program provides mental health and case management services to HIV-positive patients receiving methadone.

Approximately 40% of the patients at Peter Krueger actively use substances. The clinic promotes harm reduction and provides patients with referrals to local syringe exchange programs. Providers can also refer patients to one of several substance use treatment programs available at Beth Israel.
Improving HIV Treatment Adherence

A program coordinator and two health educators, including one peer educator, staff the treatment adherence program at Peter Krueger. Staff members assess new patients’ medication and substance use history. Providers develop patient-specific treatment plans, which program staff, social workers, and case managers help the patient to implement.

At Peter Krueger, patients can participate in weekly treatment adherence discussion groups. Health educators, mental health staff, and physicians conduct these sessions, which provide an important opportunity for patients to interact with physicians in a non-clinical setting. Physicians encourage participants to communicate their expectations of their providers. The treatment adherence staff also delivers presentations at monthly provider meetings to enhance understanding of treatment adherence issues.

Peter Krueger patients also publish a quarterly newsletter in which they share treatment and life experiences and personal tips on how to adhere to medications. Patients collaborate on the newsletter’s content during patient newsletter workshops, which occur twice monthly. In one newsletter, patients shared the following medication adherence tips:

- I put them on a shelf with my washcloth.
- I put the medications in a bottle and when I lay out my clothes, I put them in a pocket or on top of my pocket.
- I put them on the TV and take them with my favorite shows.
- I set the radio alarm. When I hear the music, I know it’s time to take my pills.
- I always carry some pills with me, so when I rush out of the house in the morning, I still have them with me. It also works if I stay over at someone else’s house.

Some actively using patients who are able to adhere to their HIV medications derive confidence from their success and express the desire to initiate substance use treatment.
Montefiore Medical Center Substance Abuse Treatment Program

Montefiore Medical Center has implemented a training initiative that utilizes motivational interviewing techniques to address barriers to HIV medication adherence. Providers meet with patients one-on-one and help them explore the behaviors that contribute to their non-adherence. Patients perform practice exercises and fill out the following form.

| Triggers (What sets me up for not taking my meds?) |
| Thoughts and feelings (What was I thinking? What was I feeling?) |
| Behavior (What did I do then?) |
| Positive consequences (What positive thing happened?) |
| Negative consequences (What negative thing happened?) |
| Function (What did I expect to get out of not taking my meds?) |

**To be filled out in session**

These exercises also remind patients of the management of side effects, explore their past attempts to manage side effects, and aid in the development of new side-effect management plans.
Reminders for managing side effects

When you are feeling bad after taking your medication, you can:

- Call your provider
- Look up information on the web
- Change your diet at the suggestion of your doctor or a dietician
- Practice relaxation techniques and breathing exercises
- Practice guided imagery
- Try massage or acupuncture
- Avoid alcohol/drugs
- Increase rest
- Exercise
- Try over-the-counter or prescription remedies (e.g., Imodium®)
- Decrease caffeine
- Increase water and fluid intake

Sample Relaxation Exercise

When practicing guided imagery, it is important not only to visualize an image but also to get in touch with all the sensations that the image would invoke (i.e., smells, taste, sounds, touch). You may want to have someone read this to you, you may want to record it so you have it, or you may read it several times beforehand and follow it as you remember. Use this as an overall guide and do what is most comfortable for you.

Turn down the lighting in the room and get in a comfortable position either sitting or lying down. Close your eyes and focus on your breathing, paying attention to how the air moves in and out. Spend a few moments in silence just noticing your breathing. Now imagine a special place... it may be one that you’ve been to or one in your imagination. Picture yourself there and look around you. Notice whatever it is that you might see. Smell the scent of this place. What sounds do you hear? Feel yourself breathing it in. Slow, deep breaths. You are relaxed and comfortable. Stay here for a while.

Whenever you are ready, open your eyes, trying to hold on to the feeling of being relaxed.
YOUR MEDS

List your meds, dosage, special instructions (e.g., take with food), side effects you feel, and level of discomfort from 1 to 10 (10 being the most discomfort ever felt and 1 as least discomfort ever felt).

<table>
<thead>
<tr>
<th>Meds</th>
<th>Dose</th>
<th>Special Instructions</th>
<th>Side Effects</th>
<th>Level of Discomfort</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Past attempts at controlling side effects:

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

New Plan:

*Side Effect 1*

1.  
2.  

*Side Effect 2*

1.  
2.  

*Side Effect 3*

1.  
2.  
HIV-infected substance users frequently visit several providers in a clinic for their various healthcare needs. The use of electronic databases and reminder systems enables providers to focus on patient treatment needs and minimize the time spent addressing details. Such improvements can help maintain an efficient patient flow within the center and help ensure the provision of quality care.

**Store patient information in one centralized database.**

By centralizing patient data, providers can look at trends and easily extract data to monitor and improve clinical care. Well-constructed databases allow staff to make queries about a particular topic.

**Utilize computerized reminder systems to alert providers of needed laboratory tests, examinations, appointments, etc.**

Electronic medical records (EMRs) can set off “ticklers” to remind providers of services a patient needs. The provider can then insert a reminder that will appear when the patient checks in at the clinic so that staff members can immediately identify and prepare for needed tests and services.

**Using Computerized Databases to Help Patients Navigate Care and Keep Appointments**

- Albert Einstein College of Medicine Division of Substance Abuse  
  – Melrose Clinic

**Screening and Assessment**

In the network of clinics at AECOM, patients seeking substance use treatment undergo screening and assessment at the Melrose Ontrack Clinic—the Division of Substance Abuse’s centralized diagnostic and intake center. At Melrose Ontrack, patients meet with an admissions counselor who collects necessary demographic information and directs the patient to the substance use counselor. The counselor assesses
the patient’s addiction characteristics and severity. Following this assessment, 
the patient undergoes a comprehensive physical examination by one of the 
physicians. If the patient does not know his/her HIV status, a health educator 
distributes HIV education, counseling, and testing. Patients can then 
continue treatment at one of several methadone maintenance programs.

Both known and newly identified HIV-infected patients can access HIV 
primary care. Patients see physicians at quarterly monitoring visits and 
annual comprehensive examinations. Providers and patients develop and 
follow individualized medical, mental health, and social services care plans.

---

**Appointment Reminder System**

Staff members integrate all of a patient’s care plans into the computer 
system. When a patient comes into the clinic, he/she meets with a staff 
member called the Interceptor who enters the client’s identification 
number into the system. All appointments the patient has scheduled for 
that day appear on the monitor. The Interceptor briefs the patient on the 
appointments for that day. The system also brings up missed 
appointments so that the Interceptor can arrange make-up appointments.

---

**Utilizing a Centralized Database to Improve Patient Care**

- **St. John’s Riverside Hospital – HOPE Center**

St. John’s Riverside Hospital, a 407-bed community hospital, serves Yonkers 
and southern Westchester county. The HOPE Center, a DAC, provides 
comprehensive care for PLWA using electronic records to track each patient.

Staff members perform daily database queries for patients with scheduled 
appointments. Administrative staff members create a “planned visit” form to 
indicate each patient’s needs. For example, the planned visit form will show 
that the case manager should update a patient’s self-care plan and complete 
a substance use assessment. It also indicates if a patient needs gynecological 
care, dental care, a PPD, chest x-rays, or other lab tests. All the medical 
providers and case managers review the day’s “planned visit” forms during 
the morning staff meeting.
More than 80% of patients at the HOPE Center identify as substance users and HIV-infected substance users have access to co-located inpatient and outpatient addiction treatment services at St. John’s Riverside.

Behavioral Health Services (BHS) include methadone maintenance, medically managed detoxification, inpatient rehabilitation, a crisis center, day rehabilitation, and outpatient clinics including a satellite clinic at a homeless shelter. **Co-location breaks down barriers to sharing patient information and coordinating care.**

Staff at the HOPE Center can easily case conference with their BHS colleagues.

Co-location of these services facilitates follow-up on medical needs. For example, HOPE Center case managers can work with BHS providers to obtain an updated chest x-ray or PPD test during a client’s inpatient stay. In addition, the HOPE Center case managers coordinate with the outpatient BHS program staff to follow up with patients who have missed medical appointments or who may need regular appointment reminders.

Providers at the HOPE Center do not push their patients to obtain substance use treatment but rather help patients seek their own treatment.
Members of the HOPE Center’s staff remain up-to-date on patients’ medical and social issues and treatment progress. All members of the HIV care team, including at least one medical provider, gather every morning for a team meeting. At the meeting, the team discusses patient care issues and duties of individual team members. The primary care staff member enters the meeting proceedings into a communication log—a document available on the HOPE Center’s shared computer server. The communication log ensures that all staff members and medical providers can remain current with the meeting proceedings and patient issues.
St. John’s Riverside Hospital, Park Care Pavilion, H.O.P.E. Center
Substance Use Assessment Form

Patient Name: _______________________________   MR#: _______________
DOB: _______________

<table>
<thead>
<tr>
<th>Substance</th>
<th>✔</th>
<th>Route (Please circle)</th>
<th>Amount/Frequency</th>
<th>Last Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td></td>
<td>Injection</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>IV</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Intradermal</td>
<td></td>
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<td></td>
<td></td>
<td>Intranasal</td>
<td></td>
<td></td>
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<tr>
<td>Cocaine</td>
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<td>Injection</td>
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<td>IV</td>
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<td>Intradermal</td>
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<td></td>
<td>Intranasal</td>
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<td></td>
<td></td>
<td>Smoked</td>
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<tr>
<td>ETOH</td>
<td></td>
<td>Specify:</td>
<td></td>
<td></td>
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<tr>
<td>Pills</td>
<td></td>
<td>Specify:</td>
<td></td>
<td></td>
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<tr>
<td>Marijuana</td>
<td></td>
<td>Smoked</td>
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</tr>
<tr>
<td>Tobacco</td>
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<td></td>
<td></td>
<td>Chewed</td>
<td></td>
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</tr>
<tr>
<td>Other</td>
<td></td>
<td>Specify:</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Program</th>
<th>✔</th>
<th>Institution</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detoxification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone Amt _____ mg</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Outpatient (Non-Methadone)</td>
<td></td>
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<tr>
<td>Residential</td>
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<tr>
<td>12-step</td>
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<td>Other</td>
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<td>Specify:</td>
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</table>
Successful coordination of care reduces fragmentation and duplication of medical services and allows both patients and providers to use their time efficiently.

Facilities should conduct routine interdisciplinary case conferences involving physicians, nurses, social workers, and program coordinators. Case conferences provide an opportunity for staff members to discuss challenging cases and educate each other about the issues involved.

Staff members who are involved in the ongoing care of patients can benefit from convening daily. In addition to improving care coordination, staff meetings can provide peer support for those who care for a demanding patient population. Informal meetings or “huddles” can be brief and still provide important information.

Developing Linkages

Often healthcare or substance use treatment facilities cannot provide all the services that HIV-infected substance users require. Such facilities should make efforts to link their patients with services at other organizations. Essential services for HIV-infected substance users include specialty medical care services, mental health services, syringe exchange programs, drug treatment programs, food pantries, housing facilities, employment services, case management, and adherence counseling.

Ideally, organizations should develop written referral agreements to facilitate information sharing and care coordination.

Focus on Care Coordination and Developing Referral Linkages

- Albany Medical Center – AIDS Treatment Center

Albany Medical Center (AMC) serves 2.8 million residents. As a DAC, Albany Medical Center provides HIV-infected patients with comprehensive medical, dental, social, nutritional, psychological, educational, and clinical research services.
The Albany DAC is located close to the main hospital campus and offers clients a relaxed atmosphere. The AIDS Center is staffed by eight physicians (including a psychiatrist) experienced in HIV care, three PAs, six registered nurses, a nurse practitioner, a substance use counselor, a mental health counselor, and a pharmacist.

The program serves approximately 1,600 patients, 20% of whom formerly or currently use injection drugs.

Substance Use Evaluation and Management

Upon intake, medical providers and case managers evaluate all patients for past or current substance use. Patients can also speak with the on-site substance use counselor. The counselor assesses physical health, mental health, current living environment, family and social support, history of domestic violence and other trauma, legal difficulties, employment situation, financial status, and past and current substance use. The counselor also inquires whether a patient’s current medical provider expresses concern about substance use.

This assessment helps the substance use counselor identify a patient’s needs and the required level of care so that an individualized treatment plan can be developed. The medical providers and case managers also contribute to the development of treatment plans and use the transtheoretical stages of change model. All staff members involved in patient care meet on a regular basis to update each other on each patient’s status.

Patients currently using substances can visit the substance use specialist. This counselor assesses the clients’ readiness to change their behaviors and presents available and appropriate substance use treatment options to them.

AMC has referral agreements with local substance use treatment agencies including MMTPs and alcohol detoxification centers. The substance use specialist gives a one-page form to patients that outlines their medical and mental health history, care requirements, dietary restrictions, and current medications.

For patients not interested in substance use treatment, the substance use counselor provides harm-reduction counseling.
Support Groups
All patients at AMC can participate in support groups at the local Damien Center—a community center for PLWA. The AMC substance use counselor also visits the Damien Center and participates in some of the support groups. Meeting patients in this relaxed and informal setting strengthens the counselor’s relationship with support group participants.

Smoking Cessation
Providers discuss smoking cessation with all AMC patients. Medical providers assess readiness to quit, provide brief counseling on smoking cessation, and prescribe appropriate treatment if needed. Patients can give permission for the NYS Smoker’s Quitline program to follow up on their smoking cessation efforts and use “Fax-to-quit” referral forms that transmit patient information to the NYS Smokers Quitline.

AMC also participates in “The Butt Stops Here” smoking cessation program delivered by Seton Health in Troy, NY. Every time AMC providers identify 8 to 10 patients interested in quitting smoking, Seton Health sends trained smoking cessation counselors—often ex-smokers themselves—to work with the group for 6 to 8 weeks.

Consortium for Coordinated Care
In order to bridge gaps in and improve HIV care, AMC joined the Consortium for Coordinated Care. The Consortium for Coordinated Care originated in 2001 as a coalition of local medical, mental health, and substance use treatment providers who meet on a regular basis to identify barriers in providing care and to provide cross-education and training to service providers. Most recently, the group designed a common information release form that can be used to coordinate care across disciplines and facilities.
Developing Linkages and Partnerships

- AIDS Community Health Center

AIDS Community Health Center (ACHC) offers on-site primary and specialty HIV care and has formal bi-directional agreements with more than 28 agencies in the Rochester area. Most importantly, ACHC has partnered with Huther-Doyle, a leading substance use treatment agency serving the greater Rochester community.

A substance use counselor from Huther-Doyle works full-time at ACHC and provides on-site substance use evaluation, treatment, and referral services. The counselor conducts both individual and group counseling and utilizes the stages of change model to tailor treatment plans to each patient’s specific needs.

ACHC has also established linkages with methadone maintenance and detoxification programs; financial, meals, housing, and transportation support services; educational, street outreach, and syringe exchange programs; mental health providers; legal aid; and permanency planning services.

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Pain Management Contract

HIV-infected substance users report under-treatment of HIV-related chronic pain conditions because providers fear medication abuse. Although potential for misuse exists, providers must adequately address treatment of pain to improve the patients’ quality of life.

AMC has developed a pain management contract that patients sign before receiving prescription pain medications. This contract reassures patients that they will not be denied pain medications because of their substance use history. In addition, this simple one-page contract informs patients that they may not receive early refills and that refills require at least 3 to 7 days of prior notice. The patient, the physician, and the substance use counselor sign this contract. Patients who do not adhere to the contract see the substance use counselor for further counseling.
Coordination of Care and Access to Specialty Care

VIP Community Services

VIP Community Services extends access to specialty care to its clients through a partnership with Lincoln Medical and Mental Health Center’s Department of Ambulatory Medicine. VIP providers can usually schedule appointments for their patients with specialists at Lincoln within 2 weeks. With the patient’s consent, staff members can transfer information between institutions via fax and phone.

VIP also has a working partnership for patient care with St. Barnabas and Bronx-Lebanon Hospitals. Although a formal agreement does not exist between these institutions, the PAs at VIP have developed close working relationships with the respective staffs at St. Barnabas and Bronx-Lebanon and are able to schedule appointments in a timely manner.
III. Quality Improvement

**Improving Comprehensive Care for HIV Infection and Substance Use**

❖ Bronx-Lebanon Mobile Primary Care Program

**Background**

The majority of clients reached through the Bronx-Lebanon Mobile Primary Care program actively use substances. The program staff has implemented several QI projects to improve care.

**Substance Use Assessment**

The goal of this project was to conduct substance use assessments for all clients. Staff members reviewed 150 patient records. Eighty six percent ($n = 129$) had received a substance use assessment—a 20% increase from the previous year. Staff members conduct a semi-annual chart review to monitor progress and address barriers.

**Follow-Up to Improve Substance Use Assessment Rates**

**Process/assessment:** The goal of the program was for all eligible clients to receive substance use assessment follow-up.

**Implementation:** Staff members reviewed 23 medical records for the documentation of substance use assessment follow-up.

**Results:** Six of 23 eligible candidates received substance use assessment follow-up (26%).

**Problem:** The harm-reduction counselor was not offering follow-up for all clients due to time constraints. Patients who first saw the medical provider and social worker were occasionally unwilling to wait for their assessment. In addition, the harm-reduction counselor may have been engaged with another client, which resulted in a longer patient wait time.

**Plan:** The harm-reduction counselor would go room-to-room with peers at SRO hotels to meet with each client who needed a follow-up substance use assessment.

**Outcome:** A random review of 20 charts in 2006 showed 17 of 20 (85%) patients had follow-up to substance use assessments. The revised protocol seemed to garner results.
Mental Health Assessment and Treatment

Process/assessment: Staff members should refer all patients with identified need for mental health treatment to proper care.

Implementation: Staff members reviewed 41 patient records to determine whether mental health assessment was performed. Staff members made referrals when necessary and if patients received referrals, reviewers checked the chart to see if the patient actually received mental health care.

Results: Thirty-four patients (82.9%) received mental health assessment. Of the 34, 17 (41.5%) needed referrals. Fourteen (82.4%) received referrals and seven (50%) kept their mental health appointment.

Problem: The transitional nature of many patients’ lives may have prohibited them from keeping appointments.

Plan: Staff members should offer to escort all patients referred for mental health assessment to and from that appointment.

Outcome: Of 25 charts randomly selected from the patient cohort of the first quarter of 2007, 25 had received mental health assessments.

- ♦ 17 of 25 (68%) needed mental health referral
- ♦ 13 of 17 (76.5%) received referrals; 3 of the 17 (17.6%) were already in care; 1 of the 17 (5%) refused a referral
- ♦ 6 of the 13 (46%) referred went to their appointment

The availability of patient escorts does not seem to have had a positive influence on the numbers of patients keeping their mental health appointments. Other factors were certainly involved; the high rates of substance use and the instability of life in the SRO system are likely reasons why the rate of appointment attendance remained fairly low.

The substance use counselor and the program social worker will facilitate support groups at two of the SRO site. Staff members will use client focus groups to gather information to improve compliance with mental health referrals.
Increasing the Number of Patients Receiving Comprehensive Substance Use Assessments

St. John’s Riverside Hospital – HOPE Center

Background

In 2004, 86% of patients at the HOPE Center had a documented substance use assessment in their medical record. To improve upon this rate, the interdisciplinary HOPE Center team of executives, members of the medical team, a social worker, service supervisors, and a consumer initiated a QI project using Plan Do Study Act (PDSA) methodology.

Previously, providers completed the substance use assessment separate from other assessments. Without a well-organized assessment tracking system, administrators lost track of some patients who lacked documentation of a substance use assessment.

Methodology

In response, the QI team decided to integrate the substance use assessment with the needs assessment/self-care plan—a patient-driven treatment plan that incorporates the evaluation of specific patient needs, short-term goals, and a safe-sex assessment.

In addition, when a patient needed a substance use assessment, administrators included a “reminder” on the patient’s daily planned visit form for case managers.

Results

Case managers completed substance use assessments on a regular basis. Documentation of substance use assessment in the medical record improved from the baseline of 86% at the end of 2004 to 98% at the end of 2005.
Conclusion
The HOPE Center’s QI initiative increased the rate of substance use assessments performed from 86% to 98%. Integrating the assessment into patients’ needs assessment/self-care plan and instating a reminder system resulted in fewer missed substance use assessments.

Increasing Substance Use Assessments During the Annual Comprehensive Examination

Beth Israel Medical Center – Peter Krueger Clinic

Background
Providers use the annual comprehensive exam to evaluate patients’ physical health, mental health, social history, and substance use. This yearly appointment presents an important opportunity to review patients’ substance use behavior and link them to necessary services. However, in 1999, only 29.8% of patients at PKC received an annual comprehensive exam.

Methodology
The QI team at PKC began an initiative based on Beth Israel’s QI methodology “ACES” (Assess the process, Collect and analyze data, Evaluate and implement solutions, Sustain improvements).

As a first step, the lead medical clinicians met with all providers to reinforce the importance of the annual comprehensive examination. Providers also received periodic reminders. Other strategies included the review of upcoming appointments in order to identify patients who had not undergone a comprehensive examination during the past 12 months. Staff members changed these patients’ next routine visit to a more time-intensive annual comprehensive visit in the electronic scheduling template.

Electronic alerts called “stop codes” appeared in medical records and did not allow providers to enter information without reading and responding to them. “Stop codes” reminded providers of pending annual comprehensive examinations.
PKC staff collected and analyzed individual provider annual comprehensive examination data. Providers with low completion rates met individually with their superiors to develop improvement strategies. The medical director received a monthly report that tracked the level of improvement among these providers.

Beth Israel Medical Center – Department of Medicine, AIDS Center
Peter Krueger Clinic

Percentage Comprehensive Visits Completed per Eligible* Census (n)

Conclusions
Since the implementation of this QI project, the percentage of patients who receive a comprehensive examination at PKC has increased from 29.8% in 1999 to 72.9% in 2004.
Promoting Harm Reduction Among HIV-Infected Substance Users

Interfaith Medical Center – Primary Care Center

Background
Interfaith combined prevention with harm reduction to decrease the number of new HIV infections by increasing the use of condoms/latex barriers and reducing substance use behaviors.

Methodology
Patients and staff members identified the following areas for improvement: assessment of patients’ harm- and risk-reduction needs, patients’ access to risk-reduction services (including condoms), and staff members’ access to prevention resources.

The Center formed an interdisciplinary team of clinical and non-clinical providers, educators, support staff members, members of the administration, and a hepatitis C program representative. The QI team found a sporadic, disorganized distribution of condoms and, for patients who were receiving harm-reduction counseling, a lack of identification of the patients’ stages of change.

The QI team made several changes to improve the condom distribution system and harm-reduction services. Facility staff members began to offer condoms at every patient visit and to complete a condom distribution log to monitor activity. Staff received additional training on harm-reduction counseling and motivational interviewing.
Results

Standardization of condom distribution and information about available harm-reduction services increased patient access to condoms and services. Standardization of harm-reduction counseling increased the number of patients who received risk-reduction services tailored to their needs.

Conclusion

Standardization of condom distribution and information about available harm-reduction services increased patient access to condoms and services. Standardization of harm-reduction counseling increased the number of patients who received risk-reduction services tailored to their needs.

Integrating Hepatitis C Care into Primary Care

Montefiore Medical Center/Albert Einstein College of Medicine

Background

Before the implementation of the QI process, these facilities monitored quality of care by the number of patients tested for HCV infection and the number of HCV-infected patients educated and counseled on support services.

Methodology

This project aimed to achieve a 90% completion rate of HCV viral load and genotype testing (benchmark set by QI team at 90%) and to increase referrals for evaluation and treatment on-site or by a hepatologist to 80%.
The QI team offered hepatitis C education and training to its providers at Albert Einstein College of Medicine (AECOM) and a substance use site (SATP). New hepatitis C indicators (viral load and treatment referral) supplemented existing indicators. The team also developed a new monitoring visit form that included a hepatitis C section.

Results

<table>
<thead>
<tr>
<th></th>
<th>AECOM</th>
<th>SATP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis C (+) (co-infected)</td>
<td>87%</td>
<td>76%</td>
</tr>
<tr>
<td>Hepatitis C (+) with viral load testing</td>
<td>85%</td>
<td>89%</td>
</tr>
<tr>
<td>Hepatitis C (+) with no viral load test</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Hepatitis C (+) with detectable viral load</td>
<td>74%</td>
<td>71%</td>
</tr>
<tr>
<td>Hepatitis C (+) with undetectable viral load</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Referral or evaluation for treatment</td>
<td>100%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Conclusions

This QI project resulted in an increase in viral load testing of HCV-infected patients and an increase in the number of referrals for treatment evaluation. The team expects ongoing provider education and the newly implemented monitoring visit form to further improve performance.
HIV MONITORING VISIT

Name: ________________________ ID# ___________ Date: ____________

1. Current problems/complaints: (•review Utox, ETOH, and OWS)
   CD4 _____ Date: _____
   VL _____ Date: _____

   Psychiatric (circle if present): depressed, anxious, insomnia, hallucination, suicidal ideation, appetite problems

   Prevention review: sexual risk behaviors, partner notification, IDU, STD’s reproductive health

2. Current medications:
   If taking HAART # of missed doses in previous 7 days _____

   QD regimen _____ BiD regimen _____

   Reason for missed doses __________________

   1 Abacavir  5 Combivir  9 Efavirenz  13 Fuzeon (T20)  17 Nelfinavir  21 Tenofovir
   2 Amprenavir  6 ddI  10 Emtriva  14 Indinavir  18 Nevirapine  22 Tipranavir
   3 Atazanavir  7 d4T  11 Epivir (3TC)  15 Lexiva  19 Ritonavir  23 Trizivir
   4 AZT  8 Delavirdine  12 Epzicom  16 Lopinavir/Rito  20 Saquinavir  24 Truvada

   Other Meds ______________________________________________________________________________

3. Physical Exam:
   Weight ____________ BP (if indicated) ____________

4. Is patient Hepatitis C positive?    YES _______   NO _______

   IF YES: Has patient received Rx for Hepatitis C? YES _____ (skip section) NO _______

   IF NO: Has Hepatitis C viral load been sent?  YES _____ NO _____

   IF YES: Is viral load detectable? YES _____ NO _____ (Confirm once in 6-12 months)

   IF YES: Hepatology referral or on-site evaluation and treatment offered? YES _____ NO _____

   IF YES: ON SITE __________________________      OFF SITE (Where) __________________________

   IF NO: Specify reason: __________________________________________________________________

5. Other laboratory test results: ______________________________________________________________

6. Assessment/Plan (UPDATE HIV FLOW SHEET) / (ADDRESS PLAN FOR HEP C & PSYCHOSOCIAL ISSUES)

   1) HIV: STABLE/UNSTABLE (circle one) ______________________________________________________

   Referred/Scheduled: _____ GYN Exam (Annually) _____ Dental _____ Ophtho (CD4 <50 or DM)

   __________________________ RPA-C: __________________________ RPA-C: __________________________

   Print  Sign  Date

   __________________________ MD: __________________________ MD: __________________________

   Print  Sign  Date
Screening and Ongoing Assessment

- Screen all HIV-infected patients for substance use at baseline and at least annually. Screening questions should be phrased to include both alcohol and drug use.
- Do not screen patients while they are under the influence of substances.
- If the initial drug screening result is positive, or if the patient has a history of substance use, reevaluate the patient’s drug use at least quarterly.

Working With the Active User

Communication and Engaging Patients in Care

- Ensure that substance users are engaged in medical care regardless of whether or not they are actively using drugs.
- Use nonjudgmental language when inquiring about substance and alcohol use.
- Actively engage HIV-infected substance users early in the treatment-planning process.

Educating Patients About Substance Use and Risk Reduction

- Educate substance-using patients about the detrimental effects of illicit drug use, alcohol use, and misuse of prescription drugs to help stimulate behavior change.
- Counsel substance-using patients about the risk of overdose and how it may be prevented.
- Advocate safer sex practices and discuss behavioral risk-reduction measures for prevention of sexually transmitted infections on a routine and ongoing basis.

Coordination of Care and Making Referrals

- Establish systems that ensure coordination of care with service providers from other sites.
Collaborate with social work staff and other mental health providers, when available, to determine which treatment programs or substance use services best meet the patient’s needs.

Offer referral to appropriate substance use treatment programs and case management services to patients with active substance use/abuse problems.

Ensure that programs that frequently provide referrals to each other develop written, working interagency agreements.

Confidentiality


Readiness for Treatment

At the initial visit and routine monitoring visits, address substance use with active substance users and assess their readiness for substance use treatment.

Offer and support a repertoire of substance use treatment goals for HIV-infected substance users, such as abstinence, a reduction in use, or safer use.

Harm Reduction for Injection Drug Users

Discuss safe injection techniques with injection drug users who are not ready or willing to stop injecting drugs.

Issue prescriptions for new needles and syringes to patients who inject drugs.

Discuss other options for patients to access new needles and syringes, including use of the Expanded Syringe Access Demonstration Program and Syringe Exchange Programs, New York State’s two syringe access initiatives.

Ensure that injection drug users receive instructions concerning safe techniques for storage and disposal of sharps.

Relapse

To help diagnose relapses earlier, ask patients who have been abstinent from illicit drug use or alcohol use for less than 1 year about the date of last use at routine monitoring visits.

Inform patients that relapse is common and part of the therapeutic process.
Substance Use Treatment Modalities for HIV-Infected Patients

♦ Be familiar with the substance use treatment programs and services available in the community.

♦ Discuss treatment options with substance-using patients and ask which treatment options they prefer. Inquire about use of multiple substances and the full spectrum of the patient’s drug use when discussing treatment options with the patient.

Clinical Management of Alcohol Use and Abuse in HIV-Infected Patients

Screening for Alcohol Use and Clinical Indicators of Alcohol Use

♦ Screen all HIV-infected patients for alcohol use at baseline and at least annually. Screening methods should assess quantity and frequency of alcohol use as well as per-occasion amounts to identify binge drinking.

♦ Consider alcohol misuse in the differential diagnosis of certain medical disorders that may be alcohol-induced, such as elevated liver enzymes, hypertension, seizures, gastrointestinal bleeding, cognitive impairment, and depression.

Brief Interventions

♦ Conduct brief interventions with patients who are at-risk drinkers.

♦ Use brief interventions to help motivate patients who meet diagnostic criteria for an alcohol use disorder (abuse and/or dependence) but who decline referral for care.

Referral for Treatment

♦ Refer patients:
  - With active alcohol use/abuse problems to treatment programs
  - With alcohol abuse or dependence who are not willing to cut down on their alcohol consumption for further assessment and treatment by professional alcohol treatment services
  - Who require more intensive management for alcohol withdrawal to inpatient treatment or to addiction specialists

Follow Up for Patients Who Use Alcohol

♦ Reinforce safe drinking levels.

♦ Arrange follow-up appointments to monitor the patient’s alcohol consumption and progress.
Smoking Cessation in HIV-Infected Patients

✦ Routinely assess HIV-infected patients’ smoking status and readiness to quit.

✦ Use evidence-based interventions to promote smoking cessation in HIV-infected patients.

Aspects of Primary Care for the HIV-Infected Substance User

Viral Hepatitis (Hepatitis A, B, and C)

✦ Obtain hepatitis serologies and evaluate liver function as part of the baseline assessment of HIV-infected patients.

✦ Counsel patients about behavior modifications that decrease their risk of acquiring hepatitis infection through unprotected sexual activity and injection drug use.

See www.hivguidelines.org for complete guidelines on viral hepatitis in HIV-infected patients.

Tuberculosis

✦ Evaluate HIV-infected substance users for latent tuberculosis infection (LTBI) using a TST (tuberculin skin test, or PPD) or other FDA-approved test, unless the patient has previously tested positive or has had previously documented TB. In the absence of medical contraindications, patients diagnosed with LTBI should be offered treatment.

✦ Provide HIV-infected substance users who have active TB with expedited treatment and enroll them into a directly observed therapy (DOT) program. Therapy of patients who refuse DOT should be carefully monitored.

See www.hivguidelines.org for complete guidelines on mycobacterial infections in HIV-infected patients.

Sexually Transmitted Infections in HIV-Infected Substance Users

✦ Reinforce behavioral risk-reduction measures for STI prevention, including consistent condom use.

✦ Screen HIV-infected substance users for syphilis.
Screen HIV-infected women and men who have sex with men for gonorrhea and chlamydia at baseline and at least annually. A sexual history should be obtained to determine sites of possible exposures, and all sites of exposure should be screened.

See www.hivguidelines.org for complete guidelines on management of STIs in HIV-infected patients.

**Soft-Tissue Disorders**

- Counsel injection drug users about risk reduction for soft-tissue infections.

**Adherence to Antiretroviral Therapy Among Substance Users**

- Identify and address potential barriers to adherence before initiating HAART in HIV-infected substance users.
- Assess adherence at every routine monitoring visit. Routinely ask about alcohol and drug use when assessing adherence.
- Refer patients to substance use treatment programs to optimize patients’ ability to successfully utilize and adhere to HAART and other medical therapies.

**Drug-Drug Interactions Between HAART, Medications Used in Substance Use Treatment, and Recreational Drugs**

- Conduct a thorough medication history at each visit that includes prescription medications, including those prescribed by other providers, over-the-counter medications, recreational drugs, and herbal/alternative therapies.
- Discuss potential drug interactions with patients receiving methadone before initiating ARV therapy and report all prescribed HAART-related drug changes for patients receiving methadone to the patient’s methadone maintenance program.
- Monitor HIV-infected substance users receiving concurrent methadone and ARV therapy for symptoms of withdrawal and/or excess sedation when ARV therapy is initiated or changed.

See www.hivguidelines.org for complete guidelines on drug-drug interactions.
Pain in the HIV-Infected Substance User

- Ask HIV-infected patients about pain at each visit. The nature and severity of the pain should be defined by history and physical examination.
- Offer concurrent treatment for both pain and substance use to patients with unstable substance use and significant pain.

Using Opioids to Treat Pain in HIV-Infected Substance Users

- Individualize, monitor, and document prescriptions for opioid treatment of long-term pain in patients with a history of opioid use and determine whether effective alternatives are available, and, if not, weigh the risk-to-benefit ratio of opioid use.

Management of Hospitalized HIV-Infected Substance Users

- When possible, ensure that hospitalized HIV-infected substance users are managed by a multidisciplinary team, including a clinician, mental health provider, and social worker. To ensure continuity of care, the patient’s primary outpatient treatment provider should be part of the team or should follow the patient’s care.
- Consult with a substance use specialist when the initial management of withdrawal in hospitalized HIV-infected substance users does not stabilize symptoms.
- Address barriers to the post-discharge medical treatment of hospitalized HIV-infected substance users by integrating brief intervention, education, and, when appropriate, harm-reduction and motivational interviewing techniques into patient care.

Medical Care of HIV-Infected Substance-Using Women

- Inquire about the addiction patterns of the patient’s partner(s) when obtaining a patient’s substance use history.
- Screen all substance-using women for trauma and physical and/or sexual abuse.
- Ensure that pregnant HIV-infected substance users are co-managed by an HIV Specialist and an obstetrical care provider experienced in the care of HIV-infected women.
- Do not initiate medication-assisted opioid withdrawal in opioid-dependent pregnant women. Rather, opioid-dependent pregnant women should be referred for treatment in a methadone maintenance treatment program.
Mental Health Disorders Among Substance-Using HIV-Infected Patients

✦ Screen HIV-infected patients who are actively using alcohol or other substances for mental health disorders at baseline and at least every 4 months thereafter.

✦ Include HIV-related or other medical causes, including medications, in the differential diagnosis of aberrant behavior or acute change in mental status in patients with concurrent substance use.

✦ Assess for depression and suicidal and violent behavior at baseline and at least annually; assess more frequently in patients who present with increased somatic complaints or changes in mental health or medical status.

✦ Consult a psychiatrist with expertise in substance use when pharmacotherapy is indicated for patients with comorbid substance use and mental health disorders.

✦ Ensure that patients receive behavioral therapy in conjunction with pharmacotherapy whenever possible.
 Clinicians caring for substance-using patients need to have a basic knowledge of the substances their patients may be using. Included here are some of the more commonly used substances with a brief explanation of how and why people use them and some of the negative consequences. This knowledge may help clinicians understand their patients’ choices and challenges, as well as formulate counseling messages and motivational interviewing strategies.
**BENZODIAZEPINES**

| What are they? | • Benzodiazepines are sedatives often prescribed for anxiety, panic attacks, and insomnia  
• For illicit use, may be obtained on the street or from physicians  
• High potency formulations such as alprazolam and clonazepam are often most sought after |
| --- | --- |
| Street names | • Benzos  
• Downers  
• Sticks |
| How are they used? | • Orally |
| Why do people use them? | • Reduce anxiety  
• Cause sedation  
• Enhance the effects of other depressants  
• Offset the side effects of stimulants |
| Acute effects | • Sedation  
• Psychomotor retardation  
• Memory impairment  
• Respiratory depression  
• Ataxia  
• Drowsiness  
• Disinhibition |
| Chronic effects | • May worsen depression |
| Withdrawal | • Anxiety, insomnia, tremulousness, headache  
• Seizures and death can occur  
• In some cases, withdrawal is very similar to that seen in alcohol dependence  
• There may be a prolonged withdrawal syndrome characterized by insomnia, anxiety, and sensory hypersensitivity, which may contribute to inability to maintain abstinence |
| Pregnancy/ Fetal issues | • Sedation  
• “Floppy baby syndrome”  
• Dependence with withdrawal signs, including hypertonia, restlessness, irritability, and possibly seizures |
| Comments | • Benzodiazepine misuse is common among methadone patients and contributes to the nodding observed in some patients  
• Benzodiazepines are also frequently implicated in mixed-drug overdoses |
## Cocaine

### What is it?
- Derived from the coca plant
- Two principal forms: powder (cocaine hydrochloride) and solid (“crack” or “base”)
- Crack cocaine has a more rapid and intense effect, but both forms are the same drug with the same physiology

### Street names
- Coke
- Nose candy
- Rock
- Blow
- Crack

### How is it used?
- “Powder” cocaine is usually sniffed or dissolved in water and injected
- Crack cocaine is usually smoked. Some people inject it after first dissolving it in an acidic solution (like Vitamin C or lemon juice).
- When smoked or injected, the euphoria (rush) is rapid, intense, and short lived (3-10 minutes); may last up to 30 minutes when sniffed

### Why do people use it?
- Euphoria
- Increased sexual interest
- Alertness and confidence

### Acute effects
- Increased heart rate and blood pressure
- Loss of appetite
- Anxiety with paranoid ideation
- Lowered seizure threshold
- Arrhythmias
- Vasospasm, which may lead to myocardial infarction or cerebral vascular accident
- Hyperthermia, which can be fatal
- Extreme dysphoria and despondency often follow the euphoria, leading users to binge

### Chronic effects
- Weight loss
- Dysphoria
- Depression
- Nasal perforation

### Withdrawal
- No physical syndrome of withdrawal
- Craving for more cocaine can be intense

### Pregnancy/Fetal issues
- Risk of spontaneous abortion, premature labor, abruptio placenta, and low birth weight
- Debate in the literature over long-term effects on development but most studies have not found a strong effect

### Comments
- Under federal law, possession of 5 grams of crack cocaine or 500 grams of powder carries a mandatory penalty of 5 years in prison
<table>
<thead>
<tr>
<th><strong>Marijuana</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
</tr>
<tr>
<td>• Derived from the flowers and leaves of the <em>Cannabis sativa</em> plant</td>
</tr>
<tr>
<td>• Hashish is the concentrated resin</td>
</tr>
<tr>
<td>• Primary active ingredient is Δ9-THC, but a number of other chemicals are believed to have a role in its effects</td>
</tr>
<tr>
<td>• Cannabinoids act on receptors that also respond to endogenous CNS ligands</td>
</tr>
<tr>
<td><strong>Street names</strong></td>
</tr>
<tr>
<td>• Pot  • Weed</td>
</tr>
<tr>
<td>• Reefer  • Dope</td>
</tr>
<tr>
<td>• Joint  • Blunt</td>
</tr>
<tr>
<td><strong>How is it used?</strong></td>
</tr>
<tr>
<td>• Smoked or ingested orally</td>
</tr>
<tr>
<td><strong>Why do people use it?</strong></td>
</tr>
<tr>
<td>• Euphoria</td>
</tr>
<tr>
<td>• Relaxation</td>
</tr>
<tr>
<td>• Perceptual alterations</td>
</tr>
<tr>
<td>• Intensification of sensory experiences</td>
</tr>
<tr>
<td><strong>Acute effects</strong></td>
</tr>
<tr>
<td>• Increased heart rate</td>
</tr>
<tr>
<td>• Impairment of short-term memory and motor skills</td>
</tr>
<tr>
<td>• Increased appetite</td>
</tr>
<tr>
<td>• Conjunctival injection</td>
</tr>
<tr>
<td>• Sometimes anxiety and panic</td>
</tr>
<tr>
<td><strong>Chronic effects</strong></td>
</tr>
<tr>
<td>• Cannabis smokers may be at increased risk for chronic bronchitis and respiratory cancers</td>
</tr>
<tr>
<td>• Most studies have not found any irreversible long-term effects on cognition, although debate continues</td>
</tr>
<tr>
<td>• The possibility that use of marijuana at a young age raises the risk of schizophrenia is also under debate</td>
</tr>
<tr>
<td><strong>Withdrawal</strong></td>
</tr>
<tr>
<td>• Sleep and appetite disorders</td>
</tr>
<tr>
<td>• Irritability and anxiety sometimes accompany abrupt cessation of chronic marijuana use</td>
</tr>
<tr>
<td><strong>Pregnancy/Fetal issues</strong></td>
</tr>
<tr>
<td>• No evidence of fetal malformations</td>
</tr>
<tr>
<td>• Various inconsistent results include associations with lower birth weight and childhood cancers</td>
</tr>
<tr>
<td><strong>Comments</strong></td>
</tr>
<tr>
<td>• Medically, marijuana has been found to increase appetite, reduce nausea, and relieve pain. Debate continues on efficacy and risk in comparison with other medications.</td>
</tr>
<tr>
<td><strong>What is it?</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
</tbody>
</table>
| **Street names** | • Ecstasy  
• E  
• X |
| **How is it used?** | • Ingested orally, intranasally, and sometimes injected  
• Effects last 3-5 hours |
| **Why do people use it?** | • Euphoria  
• Sensory enhancement  
• Empathy  
• Energy |
| **Acute effects** | • Increased heart rate, bruxism, tremor, anorexia, anxiety, dry mouth  
• Rarely: seizures, hyperthermia leading to disseminated intravascular coagulation (DIC), and organ failure  
• MDMA users are often advised to stay well hydrated; however, consuming large amounts of hypotonic fluids with MDMA has been documented to lead to hyponatremia (MDMA increases release of antidiuretic hormone) |
| **Chronic effects** | • Long-term damage to serotonergic neurons in animal studies, but this has not been clearly shown in humans  
• Anecdotal evidence that chronic use leads to depression |
| **Withdrawal** | • No withdrawal syndrome, but some people use it compulsively |
| **Pregnancy/ Fetal issues** | • No data which controls for other variables |
| **Comments** | • MDMA was first synthesized in 1912 and was used in psychotherapy in the 1970s  
• Recreational use began in the 1980s at which point it was classified as Schedule I  
• The FDA has approved a research protocol on the use of MDMA in posttraumatic stress disorder |
<table>
<thead>
<tr>
<th><strong>Opiates</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What are they?</strong></td>
</tr>
<tr>
<td>• Originally derived from the poppy plant, although there are now a semi-synthetic (heroin) and a synthetic one</td>
</tr>
<tr>
<td>• Most commonly used to treat severe or chronic pain</td>
</tr>
<tr>
<td>• For illicit use, may be obtained on the street or from physicians</td>
</tr>
<tr>
<td>• High potency formulations such as OxyContin are often most sought after</td>
</tr>
<tr>
<td><strong>Street names</strong></td>
</tr>
<tr>
<td>• Dope</td>
</tr>
<tr>
<td>• Smack</td>
</tr>
<tr>
<td>• Junk</td>
</tr>
<tr>
<td>• Horse</td>
</tr>
<tr>
<td>• Manteca</td>
</tr>
<tr>
<td>• Generally sold in $10 bags, 10 of which make a “bundle”</td>
</tr>
<tr>
<td><strong>How are they used?</strong></td>
</tr>
<tr>
<td>• Orally, nasally inhaled, smoked, injected intravenously or subcutaneously</td>
</tr>
<tr>
<td><strong>Why do people use them?</strong></td>
</tr>
<tr>
<td>• Opiates reduce pain, but opiate abusers experience feelings of sedation, euphoria, analgesia, and “a rush”</td>
</tr>
<tr>
<td><strong>Acute effects</strong></td>
</tr>
<tr>
<td>• Sedation, euphoria</td>
</tr>
<tr>
<td>• Respiratory depression</td>
</tr>
<tr>
<td>• Decrease in blood pressure and heart rate</td>
</tr>
<tr>
<td>• Noncardiogenic pulmonary edema has been associated with acute opiate use</td>
</tr>
<tr>
<td><strong>Chronic effects</strong></td>
</tr>
<tr>
<td>• Many of the medical consequences of opiate use are effects of the route of administration and not the drug itself</td>
</tr>
<tr>
<td>• Injection can lead to endocarditis, abscess formation, clots, skin tracks, and scarring</td>
</tr>
<tr>
<td>• Infected needles can transmit hepatitis B and C, and HIV infection</td>
</tr>
<tr>
<td><strong>Opiates (Cont’d.)</strong></td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Withdrawal</strong></td>
</tr>
</tbody>
</table>
| - Can be divided into early, middle, and late phases:  
  - *Early:* yawning, sweating, teary eyes, and runny nose  
  - *Middle:* restless sleep, dilated pupils, gooseflesh, tremor, irritability  
  - *Late:* an increase in all early and middle signs and symptoms with an increase in blood pressure, nausea, vomiting, diarrhea, abdominal cramps, labile mood, depression, muscle spasm, weakness, and bone pain  
- Heroin withdrawal usually starts 8-12 hours after the last use and peaks at 48 hours, lasting from 5-10 days  
- Methadone withdrawal generally begins 24-48 hours after the last dose; it is somewhat more gradual in onset but lasts several weeks |
| **Pregnancy/ Fetal issues** |
| - If a woman who is dependent on opioids becomes pregnant, the clinician should discuss treatment options with her, informing her that methadone maintenance is preferred to detoxification with its attendant risks of withdrawal and relapse. If she is already enrolled in a methadone maintenance program, the clinician should advise her to continue it.  
- Opiate withdrawal during pregnancy can lead to spontaneous abortion or premature labor |
### Alcohol

<table>
<thead>
<tr>
<th>What is it?</th>
<th>Ethanol, derived from a variety of plant sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why do people use it?</td>
<td>To feel pleasure, relax, decrease anxiety and sexual inhibitions. Among persons with alcohol dependence, alcohol is ingested to avert uncomfortable withdrawal symptoms.</td>
</tr>
<tr>
<td>Acute effects</td>
<td>Signs and symptoms of alcohol intoxication (increased severity according to amount of alcohol consumed): Diminished muscular coordination, confusion, nystagmus, ataxia, dysarthria, nausea, vomiting, diplopia, sluggish pupils, hypothermia, cold sweats, stupor, amnesia, risk of coma.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chronic effects</th>
<th>System</th>
<th>Chronic Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nervous system</td>
<td>Insomnia, anxiety, cerebellar dysfunction, optic neuropathy, peripheral neuropathy, seizures, Wernicke-Korsakoff syndrome</td>
</tr>
<tr>
<td></td>
<td>Cardiac</td>
<td>Arrhythmia, cardiomyopathy, worsening hypertension</td>
</tr>
<tr>
<td></td>
<td>Hepatic</td>
<td>Fatty liver, hepatitis, cirrhosis with complications (e.g., gynecomastia, testicular atrophy, ascites, varices, encephalopathy)</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal</td>
<td>Gastritis, peptic ulcer disease, pancreatitis</td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal</td>
<td>Myopathy, osteoporosis</td>
</tr>
<tr>
<td></td>
<td>Metabolic</td>
<td>Chronic malnutrition, vitamin deficiencies, including thiamine, folate, and vitamin $B_{12}$</td>
</tr>
<tr>
<td></td>
<td>Dermatologic</td>
<td>Spider angiomata, palmar erythema</td>
</tr>
<tr>
<td>Chronic effects</td>
<td>System</td>
<td>Chronic Effect</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Hematologic/Immunologic</td>
<td>Anemia, thrombocytopenia, decreased WBC function</td>
</tr>
<tr>
<td></td>
<td>Cancer</td>
<td>Increased risk of cancer of the liver, pancreas, mouth, tongue, pharynx, larynx, and esophagus</td>
</tr>
</tbody>
</table>

**Withdrawal**
- Occurs 6 to 60 hours after last drink
- Manifested by tremors, sweats, flush, anxiety, insomnia, anorexia, nightmares, diarrhea, nausea, vomiting, aches, abdominal cramps, restlessness, and elevated vital signs
- Withdrawal can last 3 – 5 days
  - *Major withdrawal (DTs)* is manifested by confusion, markedly elevated vital signs, agitation often with belligerence, pronounced tremor, diaphoresis, and hallucinations. Mortality, even if treated, is between 1% and 3%.
  - *Withdrawal seizures* are usually isolated, although can be recurrent (25%)
  - *Persistent mild withdrawal* consisting of sleep disturbances, mild tremors, anxiety, and depression can last for several weeks to months
- Treatment of withdrawal consists of benzodiazepine taper protocols usually titrated to signs and symptoms

**Pregnancy/ Fetal issues**
- In the United States, 1 in 300-1000 births have fetal alcohol syndrome or fetal alcohol effect. Hallmarks of fetal alcohol syndrome include:
  - Fetal growth retardation
  - Facial dysmorphism
  - Central nervous system dysfunction

**Comments**
- Pharmacologic treatments for alcohol dependence and to help prevent relapse include:
  - Disulfiram: causes aversive symptoms if alcohol is ingested
  - Naltrexone (oral or injectable): opioid antagonist that blunts the pleasurable effects of and craving for alcohol
  - Acamprosate: mechanism is unknown, can help sustain abstinence
<table>
<thead>
<tr>
<th><strong>Ketamine</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
</tr>
</tbody>
</table>
| • Ketamine hydrochloride  
• Developed as an animal anesthetic  
• Dissociative anesthetic similar to PCP |
| **Street names** |
| • K  
• Vitamin K  
• Special K  
• A K-hole is a deeply dissociated state |
| **How is it used?** |
| • Smoked, intravenously, orally, inhaled |
| **Why do people use it?** |
| • One of the “club drugs”  
• Hallucinogen-like, visual illusions, distortion of body image |
| **Acute effects** |
| • Increase in blood pressure, hallucinations, anxiety, muscle rigidity, feelings of strength and special insights  
• Impaired motor skills, judgment, and speech |
<p>| <strong>Chronic effects</strong> |
| • Protracted psychosis similar to that seen with PCP |
| <strong>Withdrawal</strong> |
| • None, craving can develop |
| <strong>Pregnancy/ Fetal issues</strong> |
| • Neuronal cell death in the fetus seen in experimental studies |</p>
<table>
<thead>
<tr>
<th>GHB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
</tr>
<tr>
<td>• Gamma Hydroxybutyrate (similar to sedatives)</td>
</tr>
<tr>
<td>• Developed as an anesthetic</td>
</tr>
<tr>
<td><strong>Street names</strong></td>
</tr>
<tr>
<td>• Liquid ecstasy</td>
</tr>
<tr>
<td>• Grievous bodily harm</td>
</tr>
<tr>
<td><strong>How is it used?</strong></td>
</tr>
<tr>
<td>• Clear liquid, powder, or pill most often taken orally</td>
</tr>
<tr>
<td><strong>Why do people use it?</strong></td>
</tr>
<tr>
<td>• Mild euphoria</td>
</tr>
<tr>
<td>• Body builders use it to build muscles (growth hormone release)</td>
</tr>
<tr>
<td><strong>Acute effects</strong></td>
</tr>
<tr>
<td>• Mild euphoria, relaxation; at high levels, loss of consciousness, seizures, vomiting</td>
</tr>
<tr>
<td><strong>Chronic effects</strong></td>
</tr>
<tr>
<td>• Tolerance and dependence</td>
</tr>
<tr>
<td><strong>Withdrawal</strong></td>
</tr>
<tr>
<td>• 1-6 hours after use: anxiety, restlessness, insomnia, tremor, confusion, delirium, hallucinations, tachycardia, elevated BP, nausea, and vomiting</td>
</tr>
<tr>
<td><strong>Pregnancy/Fetal issues</strong></td>
</tr>
<tr>
<td>• Little known</td>
</tr>
<tr>
<td><strong>Comments</strong></td>
</tr>
<tr>
<td>• Effects of any dose are very unpredictable</td>
</tr>
</tbody>
</table>
## Methamphetamine

<table>
<thead>
<tr>
<th><strong>What is it?</strong></th>
<th>• Synthetic stimulant similar to cocaine but with longer period of effect</th>
</tr>
</thead>
</table>
| **Street names**| • Crystal  
• Tina  
• Speed  
• Crank |
| **How is it used?** | • Orally, intravenously, smoked, intranasally, rectally |
| **Why do people use it?** | • Weight loss  
• Reduced fatigue, sustained alertness  
• “Rush”  
• Energy  
• Increased interest in sex |
| **Acute effects** | • Smoking can produce a high of 7-24 hours in duration  
• Increased energy and alertness, elevated mood, dilated pupils, increased heart rate and blood pressure, decreased appetite, tremors, sweats, headache |
| **Chronic effects** | • Psychosis, depression  
• Memory loss  
• Dependence  
• Insomnia  
• Tolerance (develops in several weeks)  
• Damage to dopamine and serotonin-containing neuron terminals |
| **Withdrawal** | • Extreme fatigue (“crash effect”)  
• Depression  
• Paranoia |
| **Pregnancy/Fetal issues** | • Neonatal behavior problems (hyperirritable, poor feeding, lethargy)  
• Increase in placental abruptions  
• Reduced gestational age  
• Low birth weight, length, and head circumference |
| **Comments** | • Use has spread from the west coast of the US to the east, particularly among MSM where it is associated with high-risk sexual activity |
REFERENCES


**Benzodiazepines**


**Cocaine**


**Marijuana**


Ecstasy

Pentney AR. An exploration of the history and controversies surrounding MDMA and MDA. J Psychoactive Drugs 2001;33:213-221.

Alcohol

Ketamine


GHB


Methamphetamine
New York State Office of Alcoholism and Substance Abuse Services (OASAS). Available at: www.oasas.state.ny.us/index.cfm


APPENDIX III

Substance Use Screening Tools*

I. SINGLE ALCOHOL SCREENING QUESTION

Target Population: Adults

This single question about the last episode of heavy drinking has clinically useful sensitivity and specificity in detecting hazardous drinking and alcohol use disorders.

<table>
<thead>
<tr>
<th>How many times in the past year have you had x or more drinks in 1 day? where x = 4 for women and x = 5 for men, and one or more heavy drinking days in the past year is considered a positive screen.</th>
</tr>
</thead>
</table>

II. TWO-QUESTION SCREENS

Target Population: Adults

Short screening instruments are useful in the primary care setting and have been shown to identify patients with substance use problems/addiction as effectively as longer screens.

The combination of the following two questions has a sensitivity of 91% in identifying problem drinkers:

1. Have you ever had a drinking problem?
2. When was your last drink?

Reprinted with permission from Cyr MG, Wartman SA. The effectiveness of routine screening questions in the detection of alcoholism. *JAMA* 1988;259:51-54.

*Except for the TICS, the clinical utility of the screening instruments listed in this appendix was based on their use in identifying alcohol problems only.*
A more recent two-item screen, the Two-Item Conjoint Screen (TICS), is easy to administer, has been shown to identify 80% of current substance abusers, and is particularly sensitive to polysubstance use disorders:

1. In the last year, have you ever drunk or used drugs more than you meant to?
2. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

≥1 positive may be suggestive of a problem


### III. CAGE-AID (CAGE – Adapted to Include Drugs)

**Target Population:** Adults and Adolescents >16

CAGE is a short screen that is essentially nonjudgmental and non-confrontational. The CAGE questionnaire has been shown to be more effective if introduced with an open-ended statement, such as “Please tell me about your drinking.”¹ Using open-ended questions, such as “have you ever,” helps reveal present or past use, and it can be modified by using the phrase *drinking or substance use* instead of just *drinking* (CAGE-AID).² The validity of CAGE-AID is less extensively studied, but many clinicians think it is a reliable tool. Limitations to the CAGE are that it does not distinguish between active and inactive problems and has not been validated for identifying hazardous or harmful drinking.³

1. Have you ever felt the need to cut down on your use of alcohol or drugs?
2. Has anyone annoyed you by criticizing your use of alcohol or drugs?
3. Have you ever felt guilty because of something you’ve done while drinking or using drugs?
4. Have you ever taken a drink or used drugs to steady your nerves or get over a hangover (*eye-opener*)?

A total of ≥2 may be suggestive of a problem

IV. TWEAK

**Target Population:** Adults

TWEAK was developed and validated to screen for risk drinking in pregnant women. It also has been used to screen for harmful drinking in the general population for both inpatients and outpatients. TWEAK is intended to identify individuals who need more thorough screening for alcohol problems.

(2) *Tolerance:* How many drinks can you hold? (>5 = positive)

(2) *Worry:* Have close friends or relatives worried or complained about your drinking?

(1) *Eye-opener:* Have you ever taken a drink to steady your nerves or get over a hangover?

(1) *Amnesia:* Has a close friend or relative ever told you about things you said or did when drinking that you could not remember?

(1) *Kut down:* Have you ever felt the need to cut down on your use of alcohol?

**A score of ≥3 is suggestive of harmful drinking**

V. **AUDIT C (QUESTIONS 1,2,3 ONLY) AND AUDIT (QUESTIONS 1-10)**

**Target Population:** Adults

*AUDIT C* is an initial screen shown to discriminate effectively between patients with a history of drinking problems and those without such a history, including hazardous drinking. Its brevity ensures that clinicians will remember it, and administration time is minimal. A positive total score is an indication to administer the remaining questions on the full *AUDIT* or the CAGE to determine the presence of a more severe alcohol problem.\(^5\)\(^6\)

*AUDIT* includes questions on amount, frequency, dependence, and problems caused by alcohol. It is used to identify individuals who may have more serious drinking problems and who could benefit from referral to a treatment program or counseling. It is relatively free of gender and cultural bias.\(^7\)
1. How often do you have a drink containing alcohol?
(0) Never, (1) Monthly or less, (2) 2 to 4 times a month, (3) 2 to 3 times a week, (4) ≥4 times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2, (1) 3 or 4, (2) 5 or 6, (3) 7 to 9, (4) 10 or more

3. How often do you have ≥6 drinks on one occasion?
(0) Never, (1) Less than monthly, (2) Monthly, (3) Weekly, (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative, friend, or a physician, or other healthcare worker been concerned about your drinking or suggested you cut down?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year

A score of ≥8 indicates a strong likelihood of hazardous or harmful alcohol consumption

VI. Alcohol-Related Trauma Questionnaire

**Target Population:** Adults >18

This questionnaire was developed for earlier detection of problem drinking in ambulatory patients compared with the results of laboratory results, which seem to have high sensitivity in more chronic alcoholics only.

<table>
<thead>
<tr>
<th>Since your 18th birthday:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Have you had any fractures or dislocations to your bones or joints?</td>
</tr>
<tr>
<td>(1) Have you been injured in a road traffic accident?</td>
</tr>
<tr>
<td>(1) Have you injured your head?</td>
</tr>
<tr>
<td>(1) Have you been injured in an assault or fight (excluding injuries during sports)?</td>
</tr>
<tr>
<td>(1) Have you been injured after drinking?</td>
</tr>
</tbody>
</table>

**Result:** 0 - low probability

≥3 - moderate to high (85%-95%) probability


VII. Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

**Target Population:** Adolescents and Adults

ASSIST is a concise screening questionnaire developed by WHO. The study and analysis found that the ASSIST could differentiate between patients who: 1) were low-risk substance users or abstainers, 2) were at risk for, or already had, substance use problems, or were at risk for developing dependence, or 3) were dependent on a substance.8

## A. WHO - ASSIST V3.0

### Instructions

- Please provide your name and date of birth.

- If you have used any of the substances listed below, please indicate "Yes" and describe your use in the space provided.

### Question 1

All questions below refer to the patient's use of substances for the first time. Any changes in substance use should be recorded.

<table>
<thead>
<tr>
<th>Substance Description</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (all types)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cannabis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Over-the-Counter Drugs</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Note:** If an answer is "Yes" and the answer is "No" for alcohol, please indicate whether any other substances were used.

**Questions if all answers are negative:**

- "Not used when you were in school?"

**If "No" in all boxes, stop interview.

- "Yes" in any of the boxes, use Question 2 for each substance used."
### Question 2

In the past three months, how often have you used the substance you mentioned first? (EVERY DAY, 5-6 TIMES A WEEK, 2-4 TIMES A WEEK, 1-2 TIMES A WEEK, 1 TIME A WEEK)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Daily</th>
<th>5-6 Times</th>
<th>2-4 Times</th>
<th>1-2 Times</th>
<th>1 Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol in any form (beer, wine, spirits, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamine-type stimulants (speed, crank, methylphenidate, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana (cannabis), crack, pot, joint, hash, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedatives or Sleeping Pills (Valium, Xanax, Rohypnol, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinogens (LSD, acid, hallucinogens, PCP, Special K, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes**: If none of the substances listed is used or if none of the responses apply, just proceed with Question 3. A check mark is not included.

### Question 3

During the same time period, how often have you used any other drugs for non-medical purposes? (EVERY DAY, 5-6 TIMES A WEEK, 2-4 TIMES A WEEK, 1-2 TIMES A WEEK, 1 TIME A WEEK)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Daily</th>
<th>5-6 Times</th>
<th>2-4 Times</th>
<th>1-2 Times</th>
<th>1 Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crack</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamines (speed, crank, methylphenidate, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana (cannabis), crack, pot, joint, hash, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedatives or Sleeping Pills (Valium, Xanax, Rohypnol, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinogens (LSD, acid, hallucinogens, PCP, Special K, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Question 4**

During the past three months, how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problems?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>b. Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>c. Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>d. Cocaine (coke, crack, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>e. Amphetamine-type stimulants (speed, diet pills, ecstasy, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>f. Inhalants (nitrous, glue, patrol, paint thinner, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>g. Sedatives or Sleeping Pills (Vitium, Serenox, Robynol, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>i. Opioids (heroin, morphine, methadone, codeine, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>j. Other - specify</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

**Question 5**

During the past three months, how often have you failed to do what was normally expected of you because of your use of (FIRST DRUG, SECOND DRUG, ETC)?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Tobacco products</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>c. Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>d. Cocaine (coke, crack, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>e. Amphetamine-type stimulants (speed, diet pills, ecstasy, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>f. Inhalants (nitrous, glue, patrol, paint thinner, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>g. Sedatives or Sleeping Pills (Vitium, Serenox, Robynol, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>i. Opioids (heroin, morphine, methadone, codeine, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>j. Other - specify</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>
### Ask Questions 6 & 7 for all substances ever used (e.g. those endorsed in Question 1)

#### Question 6

Has a friend or relative or anyone else ever expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC.)?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Never</th>
<th>Yes, in the past 3 months</th>
<th>Yes, but not in the past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>b. Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>c. Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>d. Cocaine (coke, crack, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>e. Amphetamine-type stimulants (speed, diet pills, ecstasy, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>g. Sedatives or Sleeping Pills (Valium, Seroquel, Rohypnol, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>i. Opioids (heroin, morphine, methadone, codeine, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>j. Other – specify:</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>

#### Question 7

Have you ever tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC.)?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Never</th>
<th>Yes, in the past 3 months</th>
<th>Yes, but not in the past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>b. Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>c. Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>d. Cocaine (coke, crack, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>e. Amphetamine-type stimulants (speed, diet pills, ecstasy, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>g. Sedatives or Sleeping Pills (Valium, Seroquel, Rohypnol, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>i. Opioids (heroin, morphine, methadone, codeine, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>j. Other – specify:</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>
Question 8

Have you ever used any drug by injection? (NOT MEDICAL USE ONLY)

<table>
<thead>
<tr>
<th>Res. No.</th>
<th>Verbal</th>
<th>Physical</th>
<th>Verbal + Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Important Note:**
Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during the period to determine their risk level and the best course of treatment.

**Pattern of Injection**

<table>
<thead>
<tr>
<th>Once weekly or less</th>
<th>or</th>
<th>Power than 5 days in a row</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief intervention including &quot;use associated with injecting&quot; card</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>More than once per week</th>
<th>or</th>
<th>5 or more days in a row</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further assessment and more intensive treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**How to Calculate a Specific Substance Intake Score:**

For each substance (listed a. to j.) add up the score received for questions 2 through 7 inclusive. Do not include the results from either Q8 or Q9 in the score. For example, a score for cannabis would be calculated as: Q2a + Q3a + Q4a + Q5a + Q6a + Q7a

Note that Q8 for Theatre is not included and is calculated as: Q2a + Q3a + Q4a + Q5a + Q6a + Q7a

The type of intervention is determined by the patient’s specific substance intake score:

<table>
<thead>
<tr>
<th>Substance</th>
<th>Score</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>0-3</td>
<td>4-76</td>
</tr>
<tr>
<td>Tobacco</td>
<td>0-10</td>
<td>11-24</td>
</tr>
<tr>
<td>Cannabis</td>
<td>0-3</td>
<td>4-24</td>
</tr>
<tr>
<td>Marijuana</td>
<td>0-3</td>
<td>4-24</td>
</tr>
<tr>
<td>Opioids</td>
<td>0-3</td>
<td>4-24</td>
</tr>
<tr>
<td>Alcohol</td>
<td>0-3</td>
<td>4-24</td>
</tr>
<tr>
<td>Opioids</td>
<td>0-3</td>
<td>4-24</td>
</tr>
<tr>
<td>Other</td>
<td>0-3</td>
<td>4-24</td>
</tr>
</tbody>
</table>

**Note:** The assessment can more intensive treatment may be provided by the health professional within your primary care setting or by a specialist drug and alcohol treatment service when available.
### B. WHO ASSIST V3.0 RESPONSE CARD FOR PATIENTS

**Response Card - substances**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
</tr>
<tr>
<td>b.</td>
<td>Alcoholic beverages (beer, wine, spirits, etc.)</td>
</tr>
<tr>
<td>c.</td>
<td>Cannabis (marijuana, pot, grass, hash, etc.)</td>
</tr>
<tr>
<td>d.</td>
<td>Cocaine (coca, crack, etc.)</td>
</tr>
<tr>
<td>e.</td>
<td>Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)</td>
</tr>
<tr>
<td>f.</td>
<td>Inhalants (nitrous, glue, petrol, paint thinner, etc.)</td>
</tr>
<tr>
<td>g.</td>
<td>Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)</td>
</tr>
<tr>
<td>h.</td>
<td>Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)</td>
</tr>
<tr>
<td>i.</td>
<td>Opioids (heroin, morphine, methadone, codeine, etc.)</td>
</tr>
<tr>
<td>j.</td>
<td>Other - specify:</td>
</tr>
</tbody>
</table>

---

**Response Card (ASSIST Questions 2 - 5)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never:</td>
<td>not used in the last 3 months.</td>
</tr>
<tr>
<td>Once or twice:</td>
<td>1 to 2 times in the last 3 months.</td>
</tr>
<tr>
<td>Monthly:</td>
<td>1 to 3 times in one month.</td>
</tr>
<tr>
<td>Weekly:</td>
<td>1 to 4 times per week.</td>
</tr>
<tr>
<td>Daily or almost daily:</td>
<td>5 to 7 days per week.</td>
</tr>
</tbody>
</table>

---

**Response Card (ASSIST Questions 6 to 8)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No, Never:</td>
<td></td>
</tr>
<tr>
<td>Yes, but not in the past 3 months:</td>
<td></td>
</tr>
<tr>
<td>Yes, in the past 3 months:</td>
<td></td>
</tr>
</tbody>
</table>
C. **ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (WHO ASSIST V3.0) FEEDBACK REPORT CARD FOR PATIENTS**

Name: ______________________  Test Date: ______________________

### Specific Substance Involvement Scores

<table>
<thead>
<tr>
<th>Substance</th>
<th>Score</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Tobacco products</td>
<td>0-3</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>4-20</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>High</td>
</tr>
<tr>
<td>b. Alcoholic Beverages</td>
<td>0-10</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>11-20</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>High</td>
</tr>
<tr>
<td>c. Cannabis</td>
<td>0-3</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>4-20</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>High</td>
</tr>
<tr>
<td>d. Cocaine</td>
<td>0-3</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>4-20</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>High</td>
</tr>
<tr>
<td>e. Amphetamine type stimulants</td>
<td>0-3</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>4-20</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>High</td>
</tr>
<tr>
<td>f. Inhalants</td>
<td>0-3</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>4-20</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>High</td>
</tr>
<tr>
<td>g. Sedatives or Sleeping Pills</td>
<td>0-3</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>4-20</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>High</td>
</tr>
<tr>
<td>h. Hallucinogens</td>
<td>0-3</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>4-20</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>High</td>
</tr>
<tr>
<td>i. Opioids</td>
<td>0-3</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>4-20</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>High</td>
</tr>
<tr>
<td>j. Other - specify</td>
<td>0-3</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>4-20</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>High</td>
</tr>
</tbody>
</table>

### What do your scores mean?

- **Low:** You are at low risk of health and other problems from your current pattern of use.
- **Moderate:** You are at risk of health and other problems from your current pattern of substance use.
- **High:** You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent.

### Are you concerned about your substance use?
<table>
<thead>
<tr>
<th>Substance</th>
<th>Your risk of experiencing these harms is:</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Regular excessive alcohol use is associated with:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td>Regular tobacco smoking is associated with:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td>Regular use of cannabis is associated with:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Cocaine</td>
<td>Your risk of experiencing these harms is</td>
<td>Low ☐ Moderate ☐ High ☐</td>
<td>Regular use of cocaine is associated with:</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------</td>
<td>-------------------------</td>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Difficulty sleeping, heart racing, headaches, weight loss</td>
<td></td>
<td></td>
<td>Numbness, tingling, staring eyes, skin scratching or picking</td>
<td></td>
</tr>
<tr>
<td>Numbness, tingling, staring eyes, skin scratching or picking</td>
<td></td>
<td></td>
<td>Accidents and injury, financial problems</td>
<td></td>
</tr>
<tr>
<td>Accidents and injury, financial problems</td>
<td></td>
<td></td>
<td>In altered thoughts</td>
<td></td>
</tr>
<tr>
<td>In altered thoughts</td>
<td></td>
<td></td>
<td>Mood swings - anxiety, depression, mania</td>
<td></td>
</tr>
<tr>
<td>Mood swings - anxiety, depression, mania</td>
<td></td>
<td></td>
<td>Aggression and paranoia</td>
<td></td>
</tr>
<tr>
<td>Aggression and paranoia</td>
<td></td>
<td></td>
<td>Intense anger, stress from the lifestyle</td>
<td></td>
</tr>
<tr>
<td>Intense anger, stress from the lifestyle</td>
<td></td>
<td></td>
<td>Psychosis after repeated use of high doses</td>
<td></td>
</tr>
<tr>
<td>Psychosis after repeated use of high doses</td>
<td></td>
<td></td>
<td>Sudden death from heart problems</td>
<td></td>
</tr>
<tr>
<td>Sudden death from heart problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Amphetamines / type stimulants</td>
<td>Your risk of experiencing these harms is</td>
<td>Low ☐ Moderate ☐ High ☐</td>
<td>Regular use of amphetamine type stimulants is associated with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Difficulty sleeping, loss of appetite and weight loss, dehydration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Jaw clenching, headaches, muscle pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mood swings - anxiety, depression, agitation, mania, panic, paranoia</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fever, increased heartbeat, shortness of breath</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Aggression and violent behavior</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychosis after repeated use of high doses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Permanent damage to brain cells</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Liver damage, brain hemorrhage, sudden death (often in rare situations)</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Inhalants</td>
<td>Your risk of experiencing these harms is</td>
<td>Low ☐ Moderate ☐ High ☐</td>
<td>Regular use of inhalants is associated with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dizziness and hallucinations, drowsiness, disorientation, slurred speech</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fatigue, symptoms, shakiness, tremors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Irritability, mood swings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Accidents and injury</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Memory loss, confusion, depression, aggression</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Coordination difficulties, slowed reaction, hypnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Death from heart failure</td>
<td></td>
</tr>
</tbody>
</table>
### Sedatives

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty concentrating and remembering things</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea, headache, constipation pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLEEPING PROBLEMS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety and depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerance and dependence after a short period of use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe withdrawal symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overdose and death if used with alcohol, spices or other depressant drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Hallucinogens

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallucinations (pleasant or unpleasant), visual, auditory, tactile, olfactory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty sleeping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increases heart rate and blood pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood swings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety, panic, paranoia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt sick</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the effects of mental illness such as schizophrenia</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Opioids

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebinding, nausea and vomiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drowsiness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation, bowel disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty concentrating and remembering things</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced sexual desire and sexual performance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship difficulties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial and work problems, violations of law</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerance and dependence: withdrawal symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overdose and death from respiratory failure</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
D. RISKS OF INJECTING CARD – INFORMATION FOR PATIENTS

Using substances by injection increases the risk of harm from substance use.

This harm can come from:

- The substance
  - If you inject any drug you are more likely to become dependent.
  - If you inject amphetamines or cocaine you are more likely to experience psychosis.
  - If you inject heroin or other sedatives you are more likely to overdose.

- The injecting behaviour
  - If you inject you may damage your skin and veins and get infections.
  - You may cause scars, bruises, swelling, abscesses and ulcers.
  - Your veins might collapse.
  - If you inject into the neck you can cause a stroke.

- Sharing of injecting equipment
  - If you share injecting equipment (needles & syringes, spoons, filters, etc.) you are more likely to spread blood borne virus infections like Hepatitis B, Hepatitis C and HIV.

- It is safer not to inject

- If you do inject:
  - Always use clean equipment (e.g., needles & syringes, spoons, filters, etc.)
  - Always use a new needle and syringe
  - Don’t share equipment with other people
  - Clean the preparation area
  - Clean your hands
  - Clean the injecting site
  - Use a different injecting site each time
  - Inject slowly
  - Put your used needle and syringe in a hard container and dispose of it safely

- If you use stimulant drugs like amphetamines or cocaine the following tips will help you reduce your risk of psychosis.
  - Avoid injecting and smoking
  - Avoid using on a regular basis

- If you use depressant drugs like heroin the following tips will help you reduce your risk of overdose.
  - Avoid using other drugs, especially sedatives or alcohol, on the same day
  - Use a small amount and always have a trial “taste” of a new batch
  - Have someone with you when you are using
  - Avoid injecting in places where no one can get to you if you do overdose
  - Know the telephone numbers of the ambulance service
E. TRANSLATION AND ADAPTATION TO LOCAL LANGUAGES AND CULTURE: A RESOURCE FOR CLINICIANS AND RESEARCHERS

The ASSIST instrument, instructions, drug cards, response scales and resource manuals may need to be translated into local languages for use in particular countries or regions. Translation from English should be as direct as possible to maintain the integrity of the tools and documents. However, in some cultural settings and linguistic groups, aspects of the ASSIST and its companion documents may not be able to be translated literally and there may be socio-cultural factors that will need to be taken into account in addition to semantic meaning. In particular, substance names may require adaptation to conform to local conditions, and it is also worth noting that the definition of a standard drink may vary from country to country.

Translation should be undertaken by a bi-lingual translator, preferably a health professional with experience in interviewing. For the ASSIST instrument itself, translations should be reviewed by a bi-lingual expert panel to ensure that the instrument is not ambiguous. Back translation into English should then be carried out by another independent translator whose main language is English to ensure that no meaning has been lost in the translation. This strict translation procedure is critical for the ASSIST instrument to ensure that comparable information is obtained wherever the ASSIST is used across the world.

Translation of this manual and companion documents may also be undertaken if required. These do not need to undergo the full procedure described above, but should include an expert bi-lingual panel.

Before attempting to translate the ASSIST and related documents into other languages, interested individuals should consult with the WHO about the procedures to be followed and the availability of other translations. Write to the Department of Mental Health and Substance Dependence, World Health Organisation, 1211 Geneva 27, Switzerland.
REFERENCES


APPENDIX IV

Substance Use Treatment Resources

FOR PROVIDERS

Substance use information and resources

✦ Addiction Technology Transfer Centers
  www.nattec.org

✦ American Society of Addiction Medicine
  www.asam.org

✦ Centers for Disease Control and Prevention
  www.cdc.gov/ida

✦ Interactions between HIV-related medications and methadone
  www.hivguidelines.org

✦ National Center on Addiction and Substance Abuse
  www.casacolumbia.org

✦ SAMHSA's National Clearinghouse for Alcohol & Drug Information
  www.health.org

✦ National Institute on Alcohol Abuse & Alcoholism
  www.niaaa.nih.gov

✦ National Institute on Drug Addiction
  www.nida.nih.gov

✦ New York State Smokers’ Quitsite
  www.nysmokefree.com

✦ World Health Organization
  www.who.int/substance_abuse
Other materials

New York State Department of Health AIDS Institute materials:

♦ New York State Department of Health AIDS Institute Clinical Guidelines on HIV Medical Care for Substance Users:
  www.hivguidelines.org

♦ Interactions Between HIV-Related Medications and Methadone: An Overview, Marc N. Gourevitch, MD, MPH:
  www.hivguidelines.org/admin/files/other/adult_meth_interact_table2.htm

♦ Methadone References:
  www.hivguidelines.org/admin/files/ce/slide-presentations/methadone.ppt

♦ Syringe Exchange Programs:
  “Towards a Comprehensive Plan for Syringe Exchange in New York City.”
  New York Academy of Medicine – Library - Publications
  www.nyam.org/library/pages/publications_by_topic_substance_use

Harm reduction and syringe access information

♦ Expanded Syringe Access Demonstration Project (ESAP): Overview of the ESAP law & regulations:
  www.health.state.ny.us/diseases/aids/harm_reduction/needles_syringes/index.htm

♦ Harm Reduction Coalition:
  www.harmreduction.org

Drug treatment information

♦ SAMHSA’s Substance Abuse Treatment Facility Locator:
  www.findtreatment.samhsa.gov

♦ The New York State Office of Alcoholism and Substance Abuse Services (OASAS): www.oasas.state.ny.us/index.cfm

Motivational interviewing

♦ Motivational Interviewing Resources for Clinicians, Researchers, and Trainers: www.motivationalinterview.org

Buprenorphine

♦ General Information about Buprenorphine
  www.buprenorphine.samhsa.gov

♦ Buprenorphine Guide
  www.hivguidelines.org
Mental health

- New York City Department of Health and Mental Hygiene (NYC DOHMH)
  LifeNet
  1-800-LifeNet (1-800-543-3638)

- New York State Office of Mental Health (NYSOMH)
  Customer Relations Service: 1-800-597-8481 and 1-518-474-2121 (TDDY)
  (Monday-Friday: 9 am to 4 pm)
  The Customer Relations Service provides information and referral for mental health problems throughout New York State. It is not an emergency or suicide hotline. For emergencies, individuals should call their local county mental health office.

- NYS Local County Mental Health Department Directory
  The New York State Conference of Local Mental Hygiene Directors (CLMHD) is a statewide organization comprised of local mental hygiene directors and commissioners in all of the 57 counties and the City of New York. The NYS Local County Mental Health Department Directory provides a list of each of the 57 local mental hygiene departments in New York State. The directory is available on the CLMHD website under the link “County Directory”:
  - CLMHD website:
    www.clmhd.org
  - CLMHD County Directory:
    www.clmhd.org/county_directory.html

- New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS)
  Substance Abuse Hotline: 1-800-522-5353
  (Daily: 8 am to 10 pm)
  The Substance Abuse Hotline provides information and referral for substance use problems throughout New York State.

- The National Institute of Mental Health
  www.nimh.nih.gov
Publications from the New York State Department of Health AIDS Institute

Many brochures, booklets, and posters pertaining to HIV/AIDS and substance are available online at:
www.health.state.ny.us/diseases/aids/publications/index.htm

Topics include the following:

HIV prevention and injection drug use

- HIV/AIDS transmission, prevention, and awareness
- HIV counseling and testing
- HIV reporting and partner notification
- Living with HIV/AIDS
- Hepatitis C

Most are available in Spanish, as well as English, and some are available in other languages.
AI-FUNDED ORGANIZATIONS PROVIDING CO-LOCATED HIV CARE WITHIN DRUG TREATMENT FACILITIES

Addiction Research & Treatment Corp  
(718) 260-2900  
www.arteny.org  

AIDS Community Health Center  
(585) 244-9000  
www.achcrochester.org  

Albert Einstein College of Medicine  
(718) 409-9450  
www.montefiore.org  

Beth Israel Medical Center, Peter Krueger Clinic  
(212) 420-2620  
www.wehealny.org/patients/bimc_description.html  

Bronx-Lebanon Hospital Center MMTP  
(718) 503-7750  
www.bronx-leb.org  

Caritas Health Care  
(718) 523-3260  

Center for Comprehensive Health Practice  
(212) 360-7874  

Daytop Village, Inc.  
(212) 904-1500  
www.daytop.org  

Greenwich House, Inc.  
(212) 255-8980  
www.greenwichhouse.org/meth_tre.htm  

Interfaith Medical Center  
(718) 613-4000  
www.interfaithmedical.com  

Lower Eastside Service Center  
(212) 566-5372  
www.lese.org
Montefiore Medical Center Substance Abuse Treatment Program  
(718) 409-9450  
www.montefiore.org

Narco Freedom  
(718) 292-2240  
www.narcofreedom.com

Project Samaritan Health Services  
(718) 298-5100  
www.aidsnyc.org/help-psi

Promesa  
(718) 299-1100  
www.promesa.org

St. Vincent’s Catholic Medical Center  
(212) 604-8273  
http://www.svcmc.org

Staten Island University Hospital  
(718) 226-2643  
www.siuh.edu

VIP Community Services, Inc.  
(718) 583-5150  
www.vipservices.org
References


Further Reading


Gafoor M. Alcohol is a co-factor in HIV-transmission and hastens the onset of AIDS. Nurs Times 1990;86:14.


