



Factors associated with hazardous alcohol use and motivation to reduce drinking among HIV primary care patients: Baseline findings from the Health & Motivation study

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HIGHLIGHTS

- Limited data exist about strategies to reduce risky alcohol use in HIV primary care.
- Anxiety, depression and other substance use were linked to greater alcohol severity.
- Marijuana, used by 50%, was linked to lower importance to reduce alcohol use.
- Depression and other substance use were linked to higher importance to reduce use.
- Alcohol interventions in HIV primary care can use results to maximize effectiveness.

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ABSTRACT

Background: Limited primary care-based research has examined hazardous drinking risk factors and motivation to reduce use in persons with HIV (PWH).

Methods: We computed prevalence ratios (PR) for factors associated with recent (< 30 days) hazardous alcohol use (i.e., 4+/5+ drinks in a single day for women/men), elevated Alcohol Use Disorders Identification Test (AUDIT) scores, and importance and confidence (1–10 Likert scales) to reduce drinking among PWH in primary care.

Results: Of 614 participants, 48% reported recent hazardous drinking and 12% reported high alcohol use severity (i.e., AUDIT zone 3 or higher). Factors associated with greater alcohol severity included moderate/severe anxiety (PR: 2.07; 95% CI: 1.18, 3.63), tobacco use (PR: 1.79; 1.11, 2.88), and other substance use (PR: 1.72; 1.04, 2.83). Factors associated with lower alcohol severity included age 50–59 years (PR: 0.46; 0.22, 2.00) compared with age 20–39 years, and having some college/college degree (PR: 0.61; 0.38, 0.97) compared with ≤ high school. Factors associated with greater importance to reduce drinking (scores > 5) included: moderate/severe depression (PR: 1.43; 1.03, 2.00) and other substance use (PR: 1.49; 1.11, 2.01). Lower importance was associated with incomes above \$50,000 (PR: 0.65; 0.46, 0.91) and marijuana use (PR: 0.65; 0.49, 0.87). HIV-specific factors (e.g., CD4 and HIV RNA levels) were not associated with alcohol outcomes.

Conclusions: This study identified modifiable participant characteristics associated with alcohol outcomes in PWH, including anxiety and depression severity, tobacco use, and other substance use.

1. Introduction

People with HIV (PWH) have high rates of hazardous drinking

(Azar, Springer, Meyer, & Altice, 2010) and are two to four times more likely than HIV-negative individuals to have an alcohol use disorder (Park, Hernandez-Ramirez, Silverberg, Crothers, & Dubrow, 2016).

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Drinking at hazardous levels can compromise antiretroviral therapy (ART) response (Hahn et al., 2010) and has also been associated with sexual practices that increase risk for HIV transmission (Gerbi, Habtemariam, Tameru, Nganwa, & Robnett, 2009; Shuper, Joharchi, Irving, & Rehm, 2009). In an era in which ART enables PWH to live longer, hazardous drinking is increasingly impacting individuals' long-term health (Williams et al., 2016). Adverse outcomes include a higher risk of physical and mental health comorbidities (Bonacini, 2011; Freiberg, McGinnis, Kraemer, et al., 2010; Persidsky, Ho, Ramirez, et al., 2011; Silverberg, Chao, Leyden, et al., 2011; Sullivan, Goulet, Justice, & Fiellin, 2011), and mortality (DeLorenzo, Weisner, Tsai, Satre, & Quesenberry, 2011; Neblett et al., 2011). For these reasons, alcohol use among PWH continues to be an issue of great public health concern.

Unfortunately, hazardous drinking has not often been addressed in healthcare settings (Hormes, Gerhardstein, & Griffin, 2011). Providers often fail to discuss alcohol use even when potential problems are recognized (Straussner & Byrne, 2009), and PWH with alcohol use disorders may be less likely than the general population to initiate specialty alcohol treatment (DeLorenzo et al., 2011; Weaver, Conover, Proescholdbell, et al., 2008) or to receive brief alcohol-related intervention following positive screens for unhealthy alcohol use (Williams, Lapham, Shortreed, et al., 2017). Furthermore, alcohol interventions have had limited success in reducing alcohol use in the HIV setting (Williams et al., 2016). This disparity underscores the need for HIV treatment strategies that incorporate alcohol screening and behavioral interventions. In response to this high clinical priority, we initiated a 12-month randomized trial of behavioral interventions designed to decrease hazardous drinking among PWH in a large primary care clinic who reported a range of alcohol use in the prior year.

Here, we report baseline results of the trial, including the prevalence of recent hazardous drinking (≥ 4 drinks in a day for women and ≥ 5 drinks in a day for men within past 30 days) and greater drinking severity based on the validated Alcohol Use Disorders Identification Test (AUDIT) measure (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). We anticipated that participants with a recent history of hazardous drinking and greater severity would also have a higher prevalence of smoking, marijuana and other drug use, and an increased prevalence of psychiatric symptoms, including depression and anxiety, based on prior studies in PWH (Azar et al., 2010; Cioe et al., 2016; Monroe, Lau, Mugavero, et al., 2016). In addition, we examined clinical factors associated with motivation (i.e., importance and confidence) to reduce drinking, which have rarely been examined among PWH. We expected that depression severity and alcohol-related problems would be associated with importance/confidence to reduce drinking in PWH, similar to findings in mental health (Satre, Chi, Eisendrath, & Weisner, 2011) and other high-risk drinking samples (Diulio, Cero, Witte, & Correia, 2014; Small, Ounpraseuth, Curran, & Booth, 2012; Wells-Parker et al., 2009). These analyses aim to provide new knowledge regarding the burden of problem drinking in a generalizable sample of PWH in primary care. Specifically, since existing alcohol behavioral interventions have seen mixed success (Chander, Hutton, Lau, Xu, & McCaul, 2015; Williams, Lapham, Bobb, et al., 2017), improved clinical understanding of modifiers of alcohol treatment effectiveness may help improve success of future primary-care based alcohol interventions in PWH.

2. Materials and methods

2.1. Overview

Participants were from an ongoing randomized clinical trial named the “The Health and Motivation Study,” which examined two behavioral alcohol use interventions among hazardous-drinking PWH in a primary care clinic in San Francisco, CA. The two intervention arms consisted of: (1) motivational interviewing to reduce alcohol use, and

(2) electronic feedback regarding alcohol use risks via secure messages embedded in the electronic health record (EHR). A third arm was usual care. Here we analyzed the association of baseline demographic and clinical factors associated with recent hazardous drinking, AUDIT scores which indicates alcohol problem severity, and participants' perception of the importance of alcohol use reduction and self-confidence in their ability to reduce or eliminate drinking.

2.2. Setting

The study setting was Kaiser Permanente Northern California (KPNC), a large private non-profit integrated health system of 4 million members. HIV care has been supported by the long-standing HIV registry consisting of a centralized list of all PWH in KPNC, including clinical EHR data. The registry included > 26,000 historical patients, including 8740 currently active patients. The study was based in the KPNC San Francisco Medical Center, which serves > 2900 PWH.

2.3. Participants

Participants were eligible for the parent trial if they reported any days of drinking ≥ 3 drinks in a day (for women) and ≥ 4 drinks in a day (for men) in the prior 12 months. Patients were excluded from recruitment if there was a clinical recommendation from providers that patients were not appropriate due to acute psychiatric problems or inability to understand consent procedures. The demographics of the recruited sample were virtually identical to the demographics of all PWH from the KPNC San Francisco Medical Center (data not shown). All eligible patients recruited for the parent trial were included in the baseline analyses reported here.

2.4. Procedures

Using mailed recruitment letters, flyers, newsletters, and referrals, we contacted 2873 PWH between April 25, 2013 through May 29, 2015. Of these 2873 patients, we screened 1568 (55%) by telephone, and were unable to screen the remaining 1305 (45%). Of the 1305 patients we were unable to screen, 810 (62%) were unresponsive, 406 (31%) declined to be screened, 73 (6%) had transportation issues and 16 (1%) were non-English speakers. Of the 1568 patients that we did screen, 773 (49%) were eligible for study recruitment. Patients were offered \$50 for completing the baseline and 6-month assessments, and \$100 for the 12-month follow-up assessment (\$200 total). We enrolled 614 (79%) of the 773 eligible patients, since 85 (11%) patients declined to participate, and 74 (9%) patients did not show for their appointment and were unresponsive thereafter. Participants completed written informed consent at the clinic prior to enrollment in the study.

2.5. Measures

At enrollment, participants completed a self-administered questionnaire that included demographics and socioeconomic status (age, sex, marital status, education levels, employment, and income), quantity and frequency of alcohol, tobacco, marijuana and other substance use (i.e., prescription drug use other than as prescribed, tranquilizers, stimulants, cocaine, painkillers, heroin, hallucinogens, and ecstasy), and self-reported depression and anxiety. Alcohol use severity was assessed using the 10-item AUDIT which is a validated measure designed to detect alcohol use disorders in the U.S. and internationally (Babor et al., 2001), including in PWH. AUDIT scores were categorized by levels of risk: zone 1 (scores 0–7) corresponding with no risk or alcohol abstinence, zone 2 (scores 8–15) corresponding with a recommendation for brief advice regarding alcohol use, zone 3 (scores 16–19) corresponding with additional recommendation for brief counseling and monitoring, and zone 4 (scores 20–40) corresponding with a recommendation for referral to a specialist and treatment (Babor et al.,

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