Library watch on substance use in primary care

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Measuring the quality of preventive and developmental services for young children: National estimates and patterns of clinicians' performance.
Bethell C; Reuland CHP; Halfon N; Schor EL. *Pediatrics* 113(6 Supplement S): 1973-1983, 2004. (34 refs.)
Objective. To generate a national picture of performance in the area of preventive and developmental services for children aged 4 to 35 months using 4 composite quality measures in the areas of 1) anticipatory guidance and parental education, 2) screening for family psychosocial risks, 3) screening for smoking and drug and alcohol use in the home, and 4) provision of family-centered care. Methods. Data from the National Survey on Early Childhood Health (N = 2068) were used to calculate the 4 composite performance measures, which, taken together, represent 23 topics included in the American Academy of Pediatrics health supervision guidelines. The reliability and degree of redundancy within and across these 4 measures were evaluated. Four methods for scoring these measures were used. Quality scores for subgroups of children were calculated, and logistic regression analysis was performed to examine the association of demographic, health, and health system variables with receiving recommended care. Results. Regardless of the scoring method used, performance is highest in areas of family-centered care and screening for smoking and drug and alcohol use in the home. Performance is lowest in the areas of anticipatory guidance and education and assessment for family psychosocial risks. Using a scoring method that takes into account parent preferences for guidance and beliefs about discussing psychosocial topics, composite quality measure scores ranged from 13.5% to 59.6% of parents of young children receiving recommended care. Overall, 94.0% of parents reported 1 or more unmet needs for parenting guidance, education, and screening by pediatric clinician(s) in 1 or more of the content of care areas evaluated. Uninsured children and children aged 18 to 35 months are disproportionately represented among the 15.3% of children whose parents indicated an unmet need in each of the 4 areas of care. Although the reliability of each composite measure was high, no single item in any composite was highly correlated with the remaining combined items. Performance on any 1 composite measure for a child was only somewhat predictive of performance for the other measures. There are significant variations in performance on the basis of child age, race, insurance status, maternal education, marital status, and parent language as well as other factors. Conclusions. National results using 4 complementary composite quality measures confirm the need for improving the quality of preventive and developmental services for young children in the United States. The 4 measures identify areas of care and subgroups of children for whom improvements in quality are most needed. The measures provide a parsimonious yet comprehensive assessment across distinct health supervision topics and 4 essential aspects of preventive and developmental services. Until valid measures of outcomes of preventive and developmental services are identified or 1 single process of care measure is shown to be highly predictive of these outcomes, assessing multiple aspects of recommended care will be necessary to assess performance of health care providers or systems of care.
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Randomized trial of brief office-based interventions to reduce adolescent alcohol use.
Boekeloo BO; Jerry J; Lee-Ougo WI; Worrell KD; Hamburger EK; Russek-Cohen E; Snyder MH. *Archives of Pediatrics & Adolescent Medicine* 158(7): 635-642, 2004. (35 refs.)
Objective: To determine whether office-based interventions change adolescents' alcohol beliefs and alcohol use. Design: Randomized, controlled trial. Setting: Five managed care group practices in Washington, DC. Participants: Consecutive 12- to 17-year-olds (N = 409) seeing primary care providers (N = 26) for general checkups. Most of the adolescents (79%) were African American, 44% were male, and 16% currently drank. Interventions: Usual care (Group I), adolescent priming with alcohol self-assessment just prior to check-up (Group II), adolescent priming and provider prompting with adolescent self-assessment and brochure (Group III). Main Outcome Measures: Adolescent alcohol beliefs at exit interview and self-reported behaviors at 6- and 12-month follow-up. Results: At exit interview, Groups II and III reported that less alcohol was needed for impaired thinking and a greater intent to drink alcohol in the next 3 months than Group I. At 6 months, Group III reported more resistance to peer pressure to drink, and Groups II and III reported more bingeing than Group I. At 1-year follow-up, controlling for baseline levels, Groups II (odds ratio [OR], 3.44; 95% confidence interval [CI], 1.44-6.24) and III (OR, 2.86; CI, 1.13-7.26) reported more bingeing in the last 3 months than Group I. Group II reported more drinking in the last 30 days (OR, 2.31; CI, 1.31-4.07) and in the last 3 months (OR, 1.76; CI, 1.12-2.77) than Group

I. Conclusion: Brief office-based interventions were ineffective in reducing adolescent alcohol use but may increase adolescent reporting of alcohol use. Copyright 2004, American Medical Association.

Buprenorphine maintenance: Office-based treatment with addiction clinic support.

General Practitioner Addiction Team; Ortner R; Jagsch R; Schindler SD; Primorac A; Fischer G. *European Addiction Research* 10(3): 105-111, 2004. (29 refs.)

Introduction: Buprenorphine has already been registered in 27 European countries for maintenance therapy in opioid-dependent patients. In our office-based prescription study we applied sublingual buprenorphine, initiating the treatment at the addiction clinic with subsequent treatment at the offices of general practitioners (GPs) to evaluate its efficacy and feasibility in two different treatment settings. Methods: Sixty opioid-dependent patients were studied for a period of 15 weeks. The first 3 weeks of treatment initiation took place at the addiction clinic, followed by 12 weeks of treatment by GPs. Mean outcome measures were retention rate and additional consumption of illicit substances in addition to the evaluation of whether buprenorphine can be prescribed successfully by GPs. Results: The retention rate was 57% (n = 34). No significant differences occurred between the treatment phases at the specialized addiction unit and the GPs' offices. During the 15-week period a significant improvement in well-being and a significant reduction in craving for heroin ($p < 0.001$) and cocaine ($p < 0.001$) could be calculated for patients stabilized on a mean dose of 16 mg buprenorphine. Furthermore a significant reduction in additional consumption of opioids ($p < 0.001$) was found. Discussion: Our results show the involvement of office-based prescription, which should further encourage colleagues to treat opioid-dependent subjects with buprenorphine to make more treatment options for this target group available. Copyright 2004, Karger Basel.

Smoking cessation from office to bedside: An evidence-based, practical approach.

Grable JC; Ternullo S. *Postgraduate Medicine* 114(2): 45+, 2003. (21 refs.)

Cigarette smoking imparts a staggering healthcare cost, yet its toll can be prevented. Smoking cessation is a desirable patient goal, but most physicians have not been trained to counsel patients to quit. Although many barriers exist to smoking cessation, effective counseling guidelines and pharmacologic treatments are now available. In this article, the authors offer a smoking cessation approach modeled on the US Public Health Service (PHS) guideline for treating tobacco use and dependence. Copyright 2002, McGraw Hill Healthcare Publications.

The utilization of treatment and case management services by HIV-infected youth.

Johnson RL; Botwinick G; Sell RL; Martinez J; Siciliano C; Friedman LB et al. *Journal of Adolescent Health* 33(2 Supplement): 31-38, 2003. (4 refs.)

PURPOSE: This article describes the essential components for effective and comprehensive HIV care for youth who have tested positive and have been linked to HIV treatment. Descriptive profile data are also presented that detail the demographics, risk behaviors and health care barriers of youth served in the five Special Projects of National Significance (SPNS), which focused on adolescents and young adults. METHODS: Data presented are from the core multi-site data set, which was standardized across the five youth-oriented SPNS projects. Substance use and mental health symptoms were gathered using the Personal Problem Questionnaire (PPQ) screener, which was an adaptation of the PRIME-MD. In-depth qualitative interviews with enrolled HIV-positive youth were also conducted by several Projects. RESULTS AND CONCLUSIONS: Medical care alone is not enough and cannot be effective without supportive program components such as flexible scheduling, and a multi-disciplinary team approach that includes assertive case management. Case Managers help enrolled youth with concrete service needs such as housing, emergency financial assistance for food/utilities, transportation, child care, coverage for prescriptions, and public entitlements. They also help isolated youth to connect with a personal support system. Addressing those needs helps to facilitate and reinforce treatment adherence and retention. In addition to other identified needs such as stable housing and transportation, a significant number of enrolled youth self-reported having experienced physical, sexual, and/or emotional abuse in their lives and articulated a need for mental health services. Therefore, effective HIV care for youth must be multi-faceted; it must consist of more than a medical component. Copyright 2003, Society of Adolescent Medicine.

Evolving use of buprenorphine in the treatment of addiction.

Martin J. *Journal of Psychoactive Drugs* Supplement 2: 129-137, 2004. (15 refs.)

Two formulations of buprenorphine were approved in the United States for treatment of opioid dependence in 2002. This newly available treatment offers a safe and effective alternative to addicted individuals who are not currently in treatment. This article focuses on the steps that physicians and patients may take, as of this writing, if they should wish to participate in this new treatment. The content is clinically oriented and intelligible to an audience that is not medically trained. In the article, buprenorphine is

placed in context of the standard opioid pharmacotherapy of methadone maintenance, and the expansion of opioid pharmacotherapy into the office setting is described. Copyright 2004, Haight-Ashbury Publishing.

Delivery of HIV prevention counseling by physicians at HIV medical care settings in 4 US cities.
Metsch LR; Pereyra M; del Rio C; Gardner L; Duffus WA; Dickinson G et al. *American Journal of Public Health* 94(7): 1186-1192, 2004. (41 refs.)
Objectives. We investigated physicians' delivery of HIV prevention counseling to newly diagnosed and established HIV-positive patients. Methods. A questionnaire was developed and mailed to 417 HIV physicians in 4 US cities. Results. Overall, rates of counseling on the part of physicians were low. Physicians reported counseling newly diagnosed patients more than established patients. Factors associated with increased counseling included having sufficient time with patients and familiarity with treatment guidelines. Physicians who perceived their patients to have mental health and substance abuse problems, who served more male patients, and who were infectious disease specialists were less likely to counsel patients. Conclusions. Intervention strategies with physicians should be developed to overcome barriers to providing counseling to HIV-positive patients. Copyright 2004, American Public Health Association.

Benzodiazepine prescription practices and substance abuse in persons with severe mental illness.
Clark RE; Xie HY; Brunette MF. *Journal of Clinical Psychiatry* 65(2): 151-155, 2004. (10 refs.)
Background: Benzodiazepines have many benefits for persons with severe mental disorders, but they may also lead to or exacerbate substance abuse. An American Psychiatric Association taskforce established practice guidelines in 1990 to assist physicians in managing these and other potential side effects of benzodiazepine use. The objectives of this study were to determine the prevalence of benzodiazepine use among persons with psychiatric disorders and to evaluate compliance with published prescribing guidelines. Method: We studied benzodiazepine use among New Hampshire Medicaid beneficiaries aged 18 to 64 years with ICD-9 diagnoses that were grouped under the headings "schizophrenia," "bipolar disorder," "major depression," and "other psychiatric disorders" from Jan. 1995 through Dec. 1999. Rates and length of use, frequency of high-potency/fast-acting prescriptions, and diazepam-equivalent dosages were compared for those with and without retrospectively determined evidence of substance abuse, substance dependence, or a procedure code indicating treatment for a substance use disorder (SUD). Results: Five-year prevalence of benzodiazepine use for persons with and without SUD was 63% versus 54% for schizophrenia, 75% versus 58% for bipolar disorder, 66% versus 49% for major depression, and 48% versus 40% for other psychiatric disorders. Differences were statistically significant over 5 years and in 1999 ($p < .0001$). Among persons with major depression or other psychiatric disorders, those with comorbid SUD were more likely to use fast-acting/high-potency benzodiazepines; there were no such differences for those with schizophrenia or bipolar disorder. Persons with bipolar disorder or other psychiatric disorders and SUD received significantly higher diazepam-equivalent dosages than did those without SUD. Conclusion: Contrary to published guidelines, rates of benzodiazepine use are higher among Medicaid beneficiaries with severe mental illness and co-occurring SUD than among persons with severe mental illness alone. Copyright 2004, Physicians' Postgraduate Press.

Self-report and biomarker alcohol screening by primary care physicians: The need to translate research into guidelines and practice.
Miller PM; Ornstein SM; Nietert PJ; Anton RF. *Alcohol and Alcoholism* 39(4): 325-328, 2004. (16 refs.)
Aims: To assess knowledge and use of alcohol self-report and biomarker screening by physicians. Methods: Forty-eight primary care physicians were surveyed. Results: Knowledge of MCV and GGT was as good as that for non-biomarker screening tools (CAGE, AUDIT) although use was significantly less. Knowledge and use of carbohydrate-deficient transferrin (CDT) was extremely low. Conclusions: Little translation of alcohol biomarker research into guidelines for primary care medicine has occurred. Most physicians report they would utilize these tests more frequently with additional knowledge about availability and use. Copyright 2004, Oxford Univ. Press.

Provider self-efficacy and the screening of adolescents for risky health behaviors.
Ozer EM; Adams SH; Gardner LR; Mailloux DE; Wibbelsman CJ; Irwin CE. *Journal of Adolescent Health* 35(2): 101-107, 2004. (37 refs.)
Purpose: To examine the extent to which providers' perceived self-efficacy to deliver adolescent preventive services relates to their screening practices. Methods: Screening rates were determined by both provider self-reported screening practices and the independent report of the adolescent patient. First, 66 pediatric providers (pediatricians and nurse-practitioners), working in three pediatric clinics within a managed care organization, completed surveys assessing: (a) self-efficacy for screening adolescent patients in the areas of tobacco use, alcohol use, sexual behavior, seat belt use, and helmet use;

and (b) self-reported screening of adolescents during well-visits over the past month. Second, a sample of patients, aged 14 years to 16 years, reported on whether their clinicians screened them for these behaviors during a well-visit. Adolescents completed reports (N = 323) immediately following the well visit. Data were analyzed using Pearson product-moment correlation coefficients. Results: Provider self-efficacy to deliver preventive services was correlated with self-reported screening in each of the five content areas, ranging from $r = .24$ ($p < .05$) for seat belt use to $r = .51$ ($p < .001$) for helmet use. Provider self-efficacy was significantly related to adolescent reports of screening in three of the five content areas; $r = .25$ ($p < .05$) for sexual behavior and tobacco use; and $r = .23$ ($p = .06$) for alcohol use. Conclusions: Providers' self-efficacy to screen adolescents for risky behaviors was significantly related to both clinician self-report and independent adolescent reports of screening during well-visits. These findings point to the importance of enhancing clinicians' sense of competence to deliver adolescent preventive services. Copyright 2004, Society for Adolescent Medicine.

Depressive symptoms amongst adolescent primary care attenders: Levels and associations.
Yates P; Kramer T; Garralda E. *Social Psychiatry and Psychiatric Epidemiology* 39(7): 588-594, 2004. (30 refs.)
Background High rates of depressive disorder have been documented amongst adolescents attending general practitioners (GPs) in urban areas. However, little is known about the associations of adolescent depression in primary care. Method We completed a cross-sectional questionnaire survey of adolescents, their parents and general practitioners, following adolescent attendance at the surgery. Results We found high levels of depressive symptoms to be present in adolescent attenders of a broad range of social backgrounds. Depressive symptoms were associated with the following demographic and contextual factors: older age, female gender and parental psychiatric symptoms. They were also associated with the presence of physical symptoms causing psychosocial impairment, with health risks (use of cannabis and exposure to drugs) and with use of services (both primary care and mental health services). Levels of depressive symptoms were similar in urban and suburban groups. However, associations of depressive symptoms with smoking, exposure to drugs, cannabis use and primary care attendance were demonstrated in the suburban group and not the urban group. Conclusion Adolescent GP attenders have high levels of depressive symptomatology. GP recognition and intervention should have the potential to impact on adolescent depression and on associated risks. Copyright 2004, Springer-Verlag.

A brief intervention for risky drinking. Analysis of videotaped consultations in primary health care.
Seppa K; Aalto M; Raevaara L; Perakyla A. *Drug and Alcohol Review* 23(2): 167-170, 2004. (17 refs.)
In order to study activity in conducting brief alcohol intervention, a total of 83 consecutive consultations by eight general practitioners were videotaped. The categorization included the nature of the patient's health problems and whether alcohol consumption was elicited. The discussions were compared to previously given instructions. Alcohol consumption was elicited in 9/34 of the consultations where enquiry was indicated by the instructions, and rarely in any other situations. The activity among the individual physicians varied, but none of them elicited systematically in all situations with indication. No information was given to any of these patients concerning the relation between their symptoms and alcohol consumption. In conclusion, enquiring and advising on alcohol were seldom performed. More training is needed, especially on how to inform individual patients of the health risks of alcohol.
Copyright 2004, Australian Society Alcohol and Other Drugs.

Attitudes and managing alcohol problems in general practice: An interaction analysis based on findings from a WHO collaborative study.
WHO Brief Intervention Study Group; Anderson P; Kaner E; Wutzke S; Funk M; Heather N; Wensing M et al.
Alcohol and Alcoholism 39(4): 351-356, 2004. (37 refs.)
Aims: To determine if GPs' attitudes towards working with drinkers moderated the impact that training and support had on screening and brief intervention activity in routine practice. Methods: Subjects were 340 GPs from four countries who were part of a World Health Organization randomized controlled trial to evaluate the effectiveness of training and support in increasing screening and brief alcohol intervention. GPs' self-reported attitudes towards working with drinkers were measured with the Shortened Alcohol and Alcohol Problems Perception Questionnaire. Results: Whereas training and support increased GPs' screening and brief intervention rates, it did so only for practitioners who already felt secure and committed in working with drinkers. Training and support did not improve attitudes towards working with drinkers and, moreover, worsened the attitudes of those who were already insecure and uncommitted. Conclusions: To enhance the involvement of GPs in the management of alcohol problems, interventions that increase both actual experience and address practitioners' attitudes is required. Such support could take the form of on-site support agents and facilitators. Copyright 2004, Oxford University Press.