

The role of general practitioners' working style and brief alcohol intervention activity.

Aalto M; Varre T; Pekuri P; Seppa K. *Addiction* 98(10): 1447-1451, 2003. (19 refs.)

Aims: To examine correlates of general practitioners' (GP) activity delivery of brief alcohol interventions to patients with particular reference to their 'working style'. Design: A postal questionnaire survey. Setting and participants All 75 GPs in the Community Primary Health Care Centre of the City of Tampere, Finland. Measurements Measures of working style classifying GPs into 'problem solving' versus 'technological', self-reported brief advice activity and other demographic details. Findings and conclusions Of the respondents (response rate 85%) 45%, (29/64) reported carrying out brief alcohol interventions. Male GPs provided brief interventions more often than female GPs (71% versus 36%, $P = 0.017$). The respondents had mainly positive attitudes to brief interventions for excessive drinkers. The working style typology did not show any relationship with brief intervention activity. Copyright 2003, Society for the Study of Addiction to Alcohol and Other Drugs.

Pediatric smoking prevention interventions delivered by care providers: A systematic review. (review).

Christakis DA; Garrison MM; Ebel BE; Wiehe SE; Rivara FP. *American Journal of Preventive Medicine* 25(4): 358-362, 2003. (28 refs.)

Objective: To conduct a systematic review of randomized controlled trials of smoking prevention interventions for youth delivered via medical or dental providers' offices. Methods: Online bibliographic databases were searched as of July 2002, and reference lists from review articles and the selected articles were also reviewed for potential studies. The methodology and findings of all retrieved articles were critically evaluated. Data were extracted from each article regarding study methods, intervention studied, outcomes measured, and results. Results: The literature search returned 81 abstracts from MEDLINE and 49 from Cochrane Clinical Trials Registry (CCTR); of these, four articles met the inclusion criteria. Included were two studies conducted in primary care, and one each in dental and orthodontic offices. Only one study demonstrated a significant effect on smoking initiation; in that study, 5.1% of the intervention group and 7.8% of the control group reported smoking at 12-month follow-up (odds ratio = 0.63; 95% confidence interval, 0.44-0.91). None of the

studies had follow-up times greater than 3 years. Conclusions: There is very limited available evidence demonstrating efficacy of smoking prevention interventions in adolescents conducted in providers' offices and no evidence for long-term effectiveness of such interventions. Copyright 2003, American College of Preventive Medicine.

Health care practitioners' motivation for tobacco-dependence counseling.

Williams GC; Levesque C; Zeldman A; Wright S; Deci EL. *Health Education Research* 18(5): 538-553, 2003. (24 refs.)

Smoking cessation counseling by practitioners occurs at low rates in spite of strong evidence that counseling increases quit rates and reduces patient mortality. In a preliminary study, 1060 New York State physicians completed a survey concerning use of the Agency for Health Care Policy and Research (AHCPR) Guidelines, perceived autonomy and perceived competence for counseling, perceived autonomy support from insurers, and barriers to counseling. Considered together, perceived autonomy, perceived competence and perceived autonomy support predicted time devoted to counseling and use of the AHCPR guidelines. The primary, longitudinal study of 220 health care practitioners who attended a smoking cessation workshop predicted change in the practitioners' perceived autonomy and perceived competence for counseling as a function of the degree to which they experienced the workshop instructor as autonomy-supportive. In turn, change in perceived autonomy predicted change in time spent counseling and change in use of the AHCPR guidelines. Copyright 2003, Oxford University Press.

Recognition and prevention of inhalant abuse.

Anderson CE; Loomis GA. *American Family Physician* 68(5): 869-874, 2003. (22 refs.)

Inhalant abuse is a prevalent and often overlooked form of substance abuse in adolescents. Survey results consistently show that nearly 20 percent of children in middle school and high school have experimented with inhaled substances. The method of delivery is inhalation of a solvent from its container, a soaked rag, or a bag. Solvents include almost any household cleaning agent or propellant, paint thinner, glue, and lighter fluid. Inhalant abuse typically can cause a euphoric feeling and can become

addictive. Acute effects include sudden sniffing death syndrome, asphyxia, and serious injuries (e.g., falls, burns, frostbite). Chronic inhalant abuse can damage cardiac, renal, hepatic, and neurologic systems. Inhalant abuse during pregnancy can cause fetal abnormalities. Diagnosis of inhalant abuse is difficult and relies almost entirely on a thorough history and a high index of suspicion. No specific laboratory tests confirm solvent inhalation. Treatment is generally supportive, because there are no reversal agents for inhalant intoxication. Education of young persons and their parents is essential to decrease experimentation with inhalants. Copyright 2003, American Academy of Family Physicians. Used with permission.

Barriers to identification and treatment of hazardous drinkers as assessed by urban/rural primary care doctors.

Ferguson L; Ries R; Russo J. *Journal of Addictive Diseases* 22(2): 79-90, 2003. (35 refs.)

This pilot study analyzed three types of barriers encountered by forty family physicians when identifying and treating patients with hazardous drinking and alcohol dependence. The Patient Centered category included patient denial and lack of motivation to change. The Physician Centered category included lack of physician time and lack of addiction medicine training. The System Centered category included lack of community resources and distance to treatment programs. The Patient Centered barriers were rated significantly greater ($p < .001$) than the Physician Centered or the System Centered barriers. There was also a significant negative correlation ($r = -0.49$, $p < .001$) between the Physician Centered and the Patient Centered categories, meaning that the more problematic the patients were rated, the less problematic the physicians rated their time or training. The types of barriers that were rated as most problematic varied depending on rural/urban practice location and how current the physician's training was. Copyright 2003, The Haworth Press, Inc.

Office-based treatment of opiate addiction with a sublingual-tablet formulation of buprenorphine and naloxone.

Fudala PJ; Bridge TP; Herbert S; Williford WO; Chiang CN; Jones K; D. *New England Journal of Medicine* 349(10): 949-958, 2003. (32 refs.)

Background: Office-based treatment of opiate addiction with a sublingual-tablet formulation of buprenorphine and naloxone has been proposed, but its efficacy and safety have not been well studied. Methods: We conducted a multicenter, randomized, placebo-controlled trial involving 326 opiate-addicted persons who were assigned to office-based treatment with sublingual tablets consisting of buprenorphine (16 mg) in combination with naloxone (4

mg), buprenorphine alone (16 mg), or placebo given daily for four weeks. The primary outcome measures were the percentage of urine samples negative for opiates and the subjects' self-reported craving for opiates. Safety data were obtained on 461 opiate-addicted persons who participated in an open-label study of buprenorphine and naloxone (at daily doses of up to 24 mg and 6 mg, respectively) and another 11 persons who received this combination only during the trial. Results: The double-blind trial was terminated early because buprenorphine and naloxone in combination and buprenorphine alone were found to have greater efficacy than placebo. The proportion of urine samples that were negative for opiates was greater in the combined-treatment and buprenorphine groups (17.8 percent and 20.7 percent, respectively) than in the placebo group (5.8 percent, $P < 0.001$ for both comparisons); the active-treatment groups also reported less opiate craving ($P < 0.001$ for both comparisons with placebo). Rates of adverse events were similar in the active-treatment and placebo groups. During the open-label phase, the percentage of urine samples negative for opiates ranged from 35.2 percent to 67.4 percent. Results from the open-label follow-up study indicated that the combined treatment was safe and well tolerated. Conclusions: Buprenorphine and naloxone in combination and buprenorphine alone are safe and reduce the use of opiates and the craving for opiates among opiate-addicted persons who receive these medications in an office-based setting. Copyright 2003, Massachusetts Medical Society.

Physicians' missed opportunities to address tobacco use during prenatal care.

Moran S; Thorndike AN; Armstrong K; Rigotti NA. *Nicotine & Tobacco Research* 5(3): 363-368, 2003. (22 refs.)

Smoking cessation during pregnancy reduces the risk of adverse perinatal outcomes and leads to long-term cessation for at least some women smokers. Prenatal care offers repeated opportunities for smoking status identification and smoking cessation counseling. Using cross-sectional data from the 1991-1996 National Ambulatory Medical Care Survey, we assessed how frequently physicians caring for pregnant women identified pregnant women's smoking status and provided counseling to pregnant smokers. Data were available from 793 physicians reporting on 5,622 office visits by pregnant patients from 1991 through 1996. Physicians identified pregnant women's smoking status at 81% of visits but provided smoking counseling at only 23% of visits by pregnant smokers. Physicians were less likely to identify smoking status of non-White pregnant women but no less likely to counsel non-White smokers. These results indicate a clear need to improve quality of care provided to

pregnant women who use tobacco. Copyright 2003, Carfax Publishing.

Comparison of nicotine patch alone versus nicotine nasal spray alone versus a combination for treating smokers: A minimal intervention, randomized multicenter trial in a nonspecialized setting.

Johnson PA; Tschetter LK; Loprinzi C. *Nicotine & Tobacco Research* 5(2): 181-187, 2003. (28 refs.)

This multicenter, randomized, open-label clinical trial was conducted to determine whether the combined use of nicotine patch therapy and a nicotine nasal spray would improve smoking abstinence rates compared to either treatment alone, without behavioral counseling. Data were collected at 15 regional cancer control oncology centers within the North Central Cancer Treatment Group. Of the 1384 smokers randomized to the study, 20% were abstinent from smoking at 6 weeks and 8% were abstinent at 6 months. At 6 weeks, the 7-day point prevalence smoking abstinence rate for the patch alone (21.1%) was superior to the spray (13.6%) but was significantly lower than the rate for combination therapy (27.1%). At 6 months, the 7-day point prevalence abstinence rates were not significantly different among the three groups. Combination nicotine nasal spray and nicotine patches were delivered safely in a nonspecialized outpatient clinical setting and enhanced short-term smoking abstinence rates, but these rates were not sustained at 6 months. Copyright 2003, Carfax Publishing.

The primary prevention of heart disease in women through health behavior change promotion in primary care.

Whitlock EP; Williams SB. *Women's Health Issues* 13(4): 122-141, 2003. (62 refs.)

Purpose. To summarize recent evidence-based recommendations for physical activity promotion, dietary improvement, and tobacco cessation from the U.S. Preventive Services Task Force (USPSTF) and the Task Force on Community Preventive Services (CTF), and examine their applicability to the primary prevention of cardiovascular disease (CVD) in women through primary care interventions. Methods. For the behaviors cited, USPSTF and CTF recommendations and their associated systematic evidence reviews (SERs) were retrieved. Individual articles from the USPSTF healthy diet and physical activity SERs that met our inclusion criteria were systematically examined to determine the applicability of this research to women. We supplemented findings from these sources with comprehensive federal research summaries and SERs from focused searches of systematic review databases relevant to primary CVD prevention in women through healthy behavior change. Main Findings.

The USPSTF strongly recommends primary care interventions for tobacco cessation. Strong CTF recommendations for multicomponent systems supports for clinicians, telephone support for quitters, and reduced patient costs for effective cessation therapies guide complementary approaches to assist clinicians. The USPSTF recommends intensive behavioral dietary counseling by specialists for high-risk CVD patients, but found insufficient evidence to recommend for routine healthy diet or physical activity promotion in primary care. The evidence base for these recommendations generally applies to women. Better reporting of gender and minority subgroup outcomes will assist more in-depth understanding of potential differences in either the processes or outcomes of behavior change interventions. Conclusions. Primary care clinicians, including obstetrician-gynecologists, can contribute to preventing CVD in women through implementing credible evidence-based recommendations for clinical interventions in tobacco and healthy diet. Researchers can further our understanding of gender-specific issues in healthy behavior interventions by reporting process and outcome data for gender and minority subgroups. Copyright 2003, Elsevier Science Ltd.

Smoking status identification: Two managed care organizations' experiences with a pilot project to implement identification systems in independent practice associations.

Marcy TW; Thabault P; Olson J; Tooze JA; Liberty B; Nolan S. *American Journal of Managed Care* 9(10): 672-676, 2003. (14 refs.)

Objective: To determine whether managed care organizations (MCOs) can effectively promote the sustained use of smoking status identification systems among independent practice associations. Study Design: Quasi-experimental design measuring smoking status documentation before and after an intervention. Methods: A chart review of the MCOs' patients at 4 participating primary care clinics determined the baseline for smoking status documentation before intervention. Baseline data were unavailable from a fifth participating clinic. Two quality improvement personnel were sent by the MCOs to help the clinics chose and implement a system for identifying smoking status. All of the clinics chose a sticker system. The change in smoking status documentation was assessed by chart reviews of patients enrolled in the MCOs who were seen during the period between 3 and 16 months after implementation of the system. Results: Following the intervention, a significant increase in smoking status documentation was noted among participating clinics. The proportion of patients whose smoking status was identified and documented by

any method increased from 50% to 87% ($P < .01$) at the 4 clinics with baseline data. By clinic, the increase varied from 6% to 60%. The sticker system was the method by which most patients' smoking status was documented (77%). There were no controls, so the influence of outside factors, including a regional smoking cessation campaign that coincided with this study, cannot be quantified. Conclusions: Managed care organizations may be an effective change agent for implementing the guidelines for tobacco use and dependence treatment. Copyright 2003, American Medical Publishing.

Evaluation of buprenorphine maintenance treatment in a French cohort of HIV-infected injecting drug users.

Carrieri MP; Rey D; Loundou A; Lepeu G; Sobel A; Obadia Y; The MANIF-2000 Study Group. *Drug and Alcohol Dependence* 72(1): 13-21, 2003. (57 refs.)

Background: Buprenorphine was approved in France for treating opiate dependence in July 1995 and can be prescribed by general practitioners (GPs). Most studies assessing buprenorphine maintenance treatment (BMT) outcomes have taken place in GP settings. An evaluation of BMT outcomes in patients already followed for their HIV-infection could supply additional information about the changes in addictive practices in a non-GP setting. **Methods:** We assessed BMT discontinuations and the course of self-reported addictive behaviours and characteristics associated with buprenorphine-injection misuse in 114 HIV-infected patients on BMT who were followed in a hospital-based outpatient department. **Results:** The continuous series of follow-up visits at which these 114 patients reported regular buprenorphine prescriptions accounted for 237.5 person-years of observation, i.e. 475 follow-up visits. Of the 114 patients on BMT, 43% continued BMT throughout the follow-up, 40% stopped it, and results for 17% were not available either because they did not answer the self-administered questionnaire (5%) or because they were lost to follow-up (12%). Addictive behaviours declined but buprenorphine

injection misuse remained stable. Depression measured by the CESD score (RR=1.04 95%CI, cocaine use (RR=2.48 95%CI and alcohol consumption exceeding 4 alcohol units (AU) per day (RR=2.29, 95%CI were independently associated with buprenorphine injection misuse among stabilised BMT patients. Conclusions: Despite the reduction in drug injection after starting BMT, buprenorphine injection misuse mainly involves patients with characteristics of severe addiction. Better monitoring of the illicit drug use patterns of patients on BMT may suggest new medical strategies for GPs to improve BMT outcomes. Copyright 2003, Elsevier Science.

Substance abuse during pregnancy: Clinical and public health approaches.

Jos PH; Perlmutter M; Marshall MF. *Journal of Law, Medicine & Ethics* 31(3): 340-350, 2003. (74 refs.)

The authors explore the issues related to interventions involving drug-using women during pregnancy. Currently there are thirty-five states that have criminally prosecuted women for substance abuse or alcohol use during pregnancy. In addition involuntary commitment has been used to protect fetus. There have also been mandatory reporting mechanisms for health care professionals that has generated concerns. This essay acknowledges the concerns about need to protect the clinical encounter from intrusion by government, HMOs, or insurers. This essay approaches the issues of maternal addiction through a public health model. It presents what the authors view as inherent limits is the clinical encounter, and the problems which arise from the intrusion in the clinical encounter. The key elements of a public health approach is described which includes attention to macro-level policy and programs rooted in the community. Copyright 2003, American Society of Law, Medicine and Ethics.