

### **Trends in clinical toxicology: Advances that may change your practice. (review).**

Wiener SW; Hoffman RS. *Basic and Clinical Pharmacology & Toxicology* 97(1): 1-7, 2005. (29 refs.)

Recent studies have had a significant impact on the practice of medical toxicology. We review selected articles that have advanced our thinking about consequential issues such as gastrointestinal decontamination, paracetamol poisoning, ethanol withdrawal, cocaine-associated chest pain, carbon monoxide poisoning and over-anticoagulation. Copyright 2005, Blackwell Publishing.

### **Hazardous drinkers and drug users in HMO primary care: Prevalence, medical conditions, and costs.**

Mertens JR; Weisner C; Ray GT; Fireman B; Walsh K. *Alcoholism: Clinical and Experimental Research* 29(6): 989-998, 2005. (56 refs.)

Background: There exists substantial evidence that individuals with alcohol and drug disorders have heightened comorbidities and health care costs. However, little is known about the larger population of "hazardous" drinkers (those whose consumption increases their "risk of physical and psychological harm") and drug users. Methods: A sample of 1,419 patients from HMO primary care clinics was screened for hazardous drinking and drug use. Health plan databases were used to examine medical conditions and health care costs of hazardous drinkers and drug users in the year prior to screening, in comparison to 13,347 patients from the same clinics, excluding those screened. Results: We found a prevalence of 7.5% for hazardous drinking and 3.2% for drug use in primary care (10% had at least one of the two problems). Hazardous drinkers and drug users had heightened prevalences for eight medical conditions, including costly conditions such as injury and hypertension, and psychiatric conditions. Medical costs for the year examined were not higher, except for those who also had psychiatric conditions. Conclusions: The prevalence of hazardous drinking and drug use was similar to hypertension and diabetes. Hazardous drinkers and drug users' heightened medical conditions, especially those related to alcohol and drug

abuse, indicate that screening and brief intervention at this lower threshold of hazardous drinking and drug use will detect individuals with health risks sooner. Optimal treatment and prevention of some medical disorders may require identification and intervention of underlying hazardous alcohol or drug use. Copyright 2005, Research Society on Alcoholism.

### **The prescribing of methadone and other opioids to addicts: National survey of GPs in England and Wales.**

Strang J; Sheridan J; Hunt C; Kerr; Gerada C; Pringle M. *British Journal of General Practice* 55(515): 444-451, 2005. (43 refs.)

Background: GPs occupy a pivotal position in relation to providing services to opiate misusers in the UK, and this is now cited to support initiatives in other countries. Aims: To investigate GP involvement in the management of opiate misusers; and to examine the nature of this prescribing of methadone and other opioids. Design: GP data collected via self-completion postal questionnaire from a 10% random sample of the 30 000 GPs across England and Wales. Patient prescription data obtained on opiate misusers treated during the preceding 4 weeks. Setting: Primary health care practice in England and Wales in mid-2001. Method A questionnaire was mailed to a random 10% sample of GPs stratified by number of partners in the practice, with three follow-up mailshots. Data on drugs prescribed by these practitioners were also studied, including drug prescribed, form, dose and dispensing arrangements. Results: The response rate was 66%. Opiate misusers had been seen by 51% of GPs in the preceding 4 weeks (mean of 4.1 such patients), of whom 50% had prescribed opiate-substitution drugs. This provided a study sample of 1482 opiate misusers to whom GPs were prescribing methadone (86.7%), dihydrocodeine (8.5%) or buprenorphine (4.4%). Of 1292 methadone prescriptions, mean daily dose was 36.9 mg - 47.9% being for 30 mg or less. Daily interval dispensing was stipulated by 44.6%, while 42.9% permitted weekly take-away supply. Conclusions: In 2001 nearly three times as many GPs were seeing opiate misusers than was the case in 1985. Half were prescribing substitute-opiate drugs such as methadone (to an estimated 30 000 patients).

However, there are grounds for concern about the quality of this prescribing. Most doses were too low to constitute optimal methadone maintenance; widespread disregard of the availability of supervised or interval dispensing increases the risks of diversion to the blackmarket and deaths from methadone overdose. Increased quantity of care has been achieved. Increased quality is now required. Copyright 2005, Royal College of General Practitioners.

### **The practice of office-based buprenorphine treatment of opioid dependence: Is it associated with new patients entering into treatment?**

Sullivan LE; Chawarski M; O'Connor PG; Schottenfeld RS; Fiellin DA. *Drug and Alcohol Dependence* 79(1): 113-116, 2005. (9 refs.)

Office-based buprenorphine holds the promise of bringing patients who have never received pharmacotherapy into treatment. In a cross-sectional and longitudinal analysis, we compared patients entering a clinical trial of buprenorphine in a Primary Care Clinic (PCC) and those entering a local Opioid Treatment Program (OTP) and we compared the clinical characteristics and treatment outcomes of PCC patients with no history of methadone treatment (new-to-treatment) to those with prior methadone treatment. PCC subjects (N=96) were enrolled in a 26-week randomized clinical trial of office-based buprenorphine/naloxone provided in a PCC. OTP subjects (N= 94) were enrolled in methadone maintenance during the same time period. PCC subjects compared with OTP subjects were more likely to be male (77% versus 55%,  $p < 0.01$ ), full-time employed (46% versus 15%,  $p < 0.001$ ), have no history of methadone treatment (46% versus 61%,  $p < 0.05$ ), have fewer years of opioid dependence (10 versus 15,  $p < 0.001$ ), and lower rates of injection drug use (IDU) (44% versus 60%,  $p = 0.03$ ). The new-to-treatment PCC subjects were younger (36 years versus 41 years,  $p = 0.001$ ), more likely to be white (77% versus 57%,  $p = 0.04$ ), had fewer years of opioid dependence (7 versus 14,  $p < 0.001$ ), were less likely to have a history of IDU (35% versus 54%,  $p = 0.07$ ), and had lower rates of hepatitis C (25% versus 61%,  $p = 0.002$ ) than subjects with prior methadone treatment. Abstinence and treatment retention were comparable in both groups. The results suggest that office-based treatment of opioid dependence is associated with new types of patients entering into treatment. Treatment outcomes with buprenorphine in a PCC do not vary based on history of prior methadone treatment. Copyright 2005, Elsevier Ireland.

### **Intimate partner violence and patient screening across medical specialties.**

McCloskey LA; Lichter E; Ganz ML; Williams CM; Gerber MR; Sege R et al. *Academic Emergency Medicine* 12(8): 712-722, 2005. (33 refs.)

Objectives: The aims of this study were to compare rates of intimate partner violence (IPV) across different medical specialties and health care sites in one metropolitan area, describe demographic characteristics of women with abusive partners, characterize health care provider assessment of IPV, and describe patient characteristics associated with health care assessment for partner violence. Methods: Women (N = 2,465) completed written surveys about partner violence and health care screening for violence in the waiting rooms of five types of health care settings (obstetrician/gynecologist office, emergency department, primary care office, pediatrics, and addiction recovery) across eight different hospitals in the greater Boston area. Results: The overall survey response rate was 62%. The 12-month prevalence rate of IPV was 14%, with 37% disclosing lifetime prevalence. The highest rates of recent IPV were disclosed in the hospital-based addiction recovery unit (36%) and in emergency departments (17%). Adjusted demographic risk characteristics for IPV included age (younger than 24 years), low income, and unemployment. Health care providers were more likely to discuss IPV with low-income women than with middle- or high-income women but were no more likely to assess violence within the youngest age group. Among women who disclosed abuse to their health care provider, 50% reported receiving direct interventions or services as a result. Conclusions: Using the same instrument and protocol, different rates of IPV and detection of IPV were found across medical departments, with the highest rates in emergency departments and an addiction recovery program. It is especially important for assessment of IPV to include young women who present to medical departments. Copyright 2005, Society for Academic Emergency Medicine.

### **Health services for women in outpatient substance abuse treatment.**

Campbell CI; Alexander JA. *Health Services Research* 40(3): 781-810, 2005. (47 refs.)

Objective. To evaluate how a sample of outpatient substance abuse treatment units respond to organizational and environmental influences by adopting and implementing treatment services for women. Data Sources. The National Drug Abuse Treatment System Survey from 1995 and 2000, a national survey of

outpatient substance abuse treatment units. Study Design. Health services for women are the dependent variables. The predictors include organizational and environmental factors that represent resource dependence and institutional pressures for the treatment unit. Logistic regression and Heckman selection models were used to test hypotheses. Data Collection. Program directors and clinical supervisors at each treatment unit were interviewed by telephone in 1995 and 2000. Principal Findings. Units that depended on specific funding for women's programs and that depended on government funds were more likely to adopt, but not necessarily implement, women's services. Methadone units and units that train more staff to work with women were more likely to adopt as well as implement women's services. Private not-for-profit units were more likely to adopt some services, while for-profit units were less so. However, in general, neither for-profit nor not-for-profit units significantly implemented services. There was evidence that the odds of adopting services were greater in 2000 than 1995 for two services, but were otherwise stable. Conclusions. There is considerable variation in the adoption and implementation of women's services. In addition, not all adopted services are significantly implemented, which could reflect limited organizational resources and/or conflicting expectations. Women's services appear more available in methadone units, suggesting that regulation has been influential and that the recent methadone accreditation system should be evaluated. Staff training may be one strategy to encourage implementation of these services. For the most part, the adoption of services for women did not change between 1995 and 2000. Copyright 2005, Blackwell Publishing Inc.

**Perceived preparedness to provide preventive counseling: Reports of graduating primary care residents at academic health centers.**

Park ER; Wolfe TJ; Gokhale M; Winickoff JP; Rigotti NA. *Journal of General Internal Medicine* 20(5): 386-391, 2005. (45 refs.)

OBJECTIVE: To assess the perceived preparedness of residents in adult primary care specialties to counsel patients about preventive care and psychosocial issues. DESIGN: Cross-sectional national mail survey of residents (63% response rate). PARTICIPANTS: Nine hundred twenty-eight final-year primary care residents in Internal Medicine (IM), family practice (FP), and Obstetrics/Gynecology (OB/GYN) at 162 U.S. academic health centers. MEASUREMENTS: Residents self-rated preparedness to counsel patients about smoking, diet and exercise, substance abuse, domestic

violence, and depression. RESULTS: Residents felt better prepared to counsel about smoking (62%) and diet and exercise (53%) than about depression (37%), substance abuse (36%), or domestic violence (21%). In most areas, females felt better prepared than males. Rates of counseling preparedness varied significantly by specialty after adjustment for gender, race, medical school location, and percent of training spent in ambulatory settings. FP residents felt better prepared than OB/GYN residents to counsel about smoking, diet and exercise, and depression, while OB/GYN residents felt better prepared to address domestic violence than IM or FP residents. IM residents' perceptions of preparedness were between the other 2 specialties. Proportion of training spent in ambulatory settings was not associated with residents' perceived preparedness. CONCLUSIONS: Physicians completing residencies in adult primary care did not feel very well prepared to counsel patients about preventive and psychosocial issues. Significant differences exist among specialties, even after adjusting for differences in time spent in ambulatory settings. Increasing residency time in ambulatory settings may not alone be sufficient to ensure that residents emerge with adequate counseling skills. Copyright 2005, Blackwell Publishing Inc.

**Barriers to health and social services for street-based sex workers.**

Kurtz SP; Surratt HL; Kiley MC; Inciardi JA. *Journal of Health Care for the Poor and Underserved* 16(2): 345-361, 2005. (58 refs.)

Homelessness, poverty, drug abuse and violent victimization faced by street-based women sex workers create needs for a variety of health and social services, yet simultaneously serve as barriers to accessing these very services. The present study utilized interview (n = 586) and focus group (n = 25) data to examine the service needs and associated barriers to access among women sex workers in Miami, Florida. Women most often reported acute of service needs for shelter, fresh water, transportation, crisis intervention, and drug detoxification, as well as long-term needs for mental and physical health care, drug treatment, and legal and employment services. Barriers included both structural (e.g., program target population, travel costs, office hours, and social stigma) and individual (e.g., drug use, mental stability, and fear) factors. Bridging these gaps is tremendously important from a public health perspective given the disease burden among this population. Recommendations include service staff training, outreach, and promising research directions. Copyright 2005, Johns Hopkins University Press.

**What to do with a patient who smokes.**

Schroeder SA. *Journal of the American Medical Association* 294(4): 482-487, 2005. (37 refs.)

Despite the reality that smoking remains the most important preventable cause of death and disability, most clinicians underperform in helping smokers quit. Of the 46 million current smokers in the United States, 70% say they would like to quit, but only a small fraction are able to do so on their own because nicotine is so highly addictive. One third to one half of all smokers die prematurely. Reasons clinicians avoid helping smokers quit include time constraints, lack of expertise, lack of financial incentives, respect for a smoker's privacy, fear that a negative message might lose customers, pessimism because most smokers are unable to quit, stigma, and clinicians being smokers. The gold standard for cessation treatment is the 5 As (ask, advise, assess, assist, and arrange). Yet, only a minority of physicians know about these, and fewer put them to use. Acceptable shortcuts are asking, advising, and referring to a telephone "quit line" or an internal referral system. Successful treatment combines counseling with pharmacotherapy (nicotine replacement therapy with or without psychotropic medication such as bupropion). Nicotine replacement therapy comes in long-acting (patch) or short-acting (gum, lozenge, nasal spray, or inhaler) forms. Ways to counter clinicians' pessimism about cessation include the knowledge that most smokers require multiple quit attempts before they succeed, that rigorous studies show long-term quit rates of 14% to 20%, with 1 report as high as 35%, that cessation rates for users of telephone quit lines and integrated health care systems are comparable with those of individual clinicians, and that no other clinical intervention can offer such a large potential benefit. Copyright 2005, American Medical Association.

**Risk and protective factors associated with alcohol, cigarette, and marijuana use during adolescence.**

Graves KN; Fernandez ME; Shelton TL; Frabutt JM; Williford AP. *Journal of Youth and Adolescence* 34(4): 379-387, 2005. (31 refs.)

The purpose of this study was to increase the knowledge base of adolescent substance use by examining the influences of risk and protective factors for specific substance use, namely alcohol, cigarettes, and

marijuana. Participants included 271 adolescents and their primary caregivers referred for mental health services across North Carolina. A series of hierarchical multiple regressions showed that the relative influences of risk and protective factors differed depending on the target substance in some cases. History of parental felony predicted use of all 3 substances, although the direction of association was substance specific. Parental behavioral control (how families express and maintain standards of behavior) was predictive only of cigarette and marijuana use, not alcohol use. The different links among risk factors, protective factors, and specific substance use are discussed, and recommendations for both mental health and substance use professionals are offered. Copyright 2005, Plenum Press.

**An integrated computer-based system to support nicotine dependence treatment in primary care.**

McDaniel AM; Benson PL; Roesener GH; Martindale J. *Nicotine & Tobacco Research* 7(Supplement 1): S57-S66, 2005. (20 refs.)

The purpose of this study was to develop, implement, and evaluate the feasibility of an integrated computer-based system for tobacco-user identification and smoking cessation intervention for primary care patients in a medically indigent, managed care population. Interactive voice response (IVR) technology was used to screen for tobacco use prior to scheduled primary care visits at two inner-city clinics. The IVR system placed calls to 2,039 patients scheduled for clinic visits, and 1,086 (53%) patients completed the automated tobacco-use question set. Current smokers were identified in 421 (39%) of the calls. Computer-generated reminders for clinicians that incorporated information obtained from the automated calls were placed on all smokers' encounter forms. In a postvisit interview of 120 smokers, 58 participants (48%) reported that they discussed smoking cessation with their provider. Some 71% of participants agreed that use of the IVR system to obtain information was a "good way for patients to give information about their health to doctors." Automated capture of patient-reported data via IVR technology is a potentially useful strategy for tobacco-use screening in primary care. Copyright 2005, Taylor & Francis.