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fall 2010

Primary care services provided to adolescents in detention: A cross-sectional study using ICPC-2.

Haller DM; Sebo P; Cerutti B; Bertrand D; Eytan A; Niveau G et al. *Acta Paediatrica* 99(7): 1060-1064, 2010. (29 refs.)

Aim: The aim of this study was to provide a detailed description of the health problems for which primary care services are provided to adolescents in a juvenile detention facility in Europe. **Methods:** We reviewed the medical files of all detainees in a juvenile detention centre in Switzerland in 2007. The health problems for which primary care services were provided were coded using the International Classification for Primary Care, version 2. Analysis was descriptive, stratified by gender. **Results:** A total of 314 adolescents (18% female) aged 11-19 years were included. Most (89%) had a health assessment and 195 (62%) had consultations with a primary care physician; 80% of the latter had a physical health problem, and 60% had a mental health problem. The most commonly managed problems were skin (49.7%), respiratory (23.6%), behavioural (22.6%) and gynaecological problems (females: 23.9%); 13% females (no males) had sexually transmitted infections (STI), and 8.7% were pregnant. Substance abuse was common (tobacco: 64.6%, alcohol: 26.2%, cannabis: 31.3%). **Conclusion:** In addition to health problems known to be more prevalent among young offenders, such as mental health problems and STI, these adolescent detainees required care for a range of common primary care problems. These data should inform the development of comprehensive primary care services in all juvenile detention facilities in Europe. Copyright 2010, Wiley-Blackwell.

Using the guidelines for adolescent preventive services to estimate adolescent depressive symptoms in school-based health centers.

Kopec MT; Randel J; Naz B; Bartoces M; Monsur J; Neale AV et al. *Family Medicine* 42(3): 193-201, 2010. (47 refs.)

Background and Objectives: The study objective was to understand the relationship between depressive symptoms and demographic, behavioral, and environmental risk variables among adolescents attending school-based health centers (SBHCs) using

the Guidelines for Adolescent Preventive Services (GAPS) questionnaires. **Methods:** Using GAPS questionnaires, we conducted a retrospective medical record review of 672 adolescents attending two Detroit-area school-based health clinics. Bivariate and multivariate analyses were conducted to determine which factors were associated with depressive symptoms while adjusting for other relevant factors. **Results:** Overall, 26.5% of adolescents reported depressive symptoms. Bivariate analysis revealed associations between depressive symptoms and female gender, older age, disordered eating, lack of physical activity, sexual activity, poor school performance, substance use of all types, violence, law trouble, and an abuse history. Multivariate regression models revealed that female gender, sexual activity, weapon carrying, law trouble, poor physical activity, and a history of abuse were most strongly related to self reported depressive symptoms. Substance use was not a significant factor after controlling for potential confounders. **Conclusions:** Targeting the above factors during routine adolescent examinations may help providers at SBHCs and other clinics identify those at highest risk for depression and provide appropriate interventions. Copyright 2010, Society of Teachers of Family Medicine.

Opportunities for enhancing and integrating HIV and drug services for drug using vulnerable populations in South Africa.

Parry CDH; Petersen P; Carney T; Needle R. *International Journal of Drug Policy* 21(4): 289-295, 2010. (40 refs.)

Background: Little has been done to improve the integration of drug use and HIV services in sub-Saharan Africa where substance use and HIV epidemics often co-exist. **Methods:** Data were collected using rapid assessment methods in two phases in Cape Town, Durban and Pretoria, South Africa. Phase I (2005) comprised 140 key informant and focus group drug using interviewees and 19 service providers (SPs), and Phase 2 (2007) comprised 69 drug using focus group interviewees and 11 SPs. **Results:** Drug users put themselves at risk for HIV transmission through various drug-related sexual practices as well as through needle sharing. Drug users

in both phases had limited knowledge of the availability of drug treatment services, and those that had accessed treatment identified a number of barriers, including affordability, stigma and a lack of aftercare and reintegration services. SPs identified similar barriers. Drug users displayed a general awareness of both HIV transmission routes and prevention strategies, but the findings also indicated a number of misperceptions, and problematic access to materials such as condoms and safe injection equipment. Knowledge around HIV treatment was low, and VCT experiences were mixed. SPs recognized the importance of integrating HIV and substance use services, but barriers such as funding issues, networking/referral gaps and additional burden on staff were reported in Phase 2. Conclusion: A comprehensive, accessible, multi-component intervention strategy to prevent HIV risk in drug users needs to be developed including community outreach, risk reduction counselling, VCT and substance use treatment. Copyright 2010, Elsevier Science.

The Healthy Ageing Model: Health behaviour change for older adults.

Potempa KM; Butterworth SW; Flaherty-Robb MK; Gaynor WL. *Collegian* 17(2, special issue): 51-55, 2010. (26 refs.)

Proposed is a model of primary care for older adults with chronic health conditions that focuses on active engagement in health care. The Healthy Ageing Model is anchored in established theory on motivation and health behaviour change. The model draws on empirical and applied clinical underpinnings in such diverse areas as health promotion and education, treatment of addictions or obesity, management of chronic diseases, goal-setting, and coaching techniques. The conceptual foundation for the Healthy Ageing Model is described first, followed by a brief description of the key characteristics of the model. In conclusion, suggestions are offered for the clinical application and for further developing the model. Copyright 2010, Royal College of Nursing, Australia.

Care of the returning veteran.

Quinlan JD; Gauron MR; Deschere BR; Stephens MB. *American Family Physician* 82(1): 43-49, 2010. (25 refs)

Of the 23.8 million military veterans living in the United States, approximately 3 million have served in Operation Enduring Freedom or Operation Iraqi Freedom. The injuries and illnesses that affect veterans returning from combat are predictable. Blast injuries are common and most often present as mild traumatic

brain injury, which is synonymous with concussion. Family physicians caring for returning veterans will also encounter conditions such as posttraumatic stress disorder at rates higher than those in the general population. The symptoms associated with posttraumatic stress disorder and mild traumatic brain injury often overlap and can present concurrently. Treatment of traumatic brain injury should be based on symptoms and guided by clinical practice guidelines from the U.S. Department of Veterans Affairs and Department of Defense. Family physicians should understand the range of post-war health concerns and screen returning service members for posttraumatic stress disorder, substance abuse, suicidality, and clinical depression. Family physicians are well positioned to offer continuity of care for issues affecting returning service members and to coordinate the delivery of specialized care when needed. Copyright 2010, American Academy of Family Physicians.

A single-question screening test for drug use in primary care.

Smith PC; Schmidt SM; Allensworth-Davies D; Saitz R. *Archives of Internal Medicine* 170(13): 1155-1160, 2010. (23 refs.)

Background: Drug use (illicit drug use and nonmedical use of prescription drugs) is common but underrecognized in primary care settings. We validated a single-question screening test for drug use and drug use disorders in primary care. Methods: Adult patients recruited from primary care waiting rooms were asked the single screening question, "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?" A response of at least 1 time was considered positive for drug use. They were also asked the 10-item Drug Abuse Screening Test (DAST-10). The reference standard was the presence or absence of current (past year) drug use or a drug use disorder (abuse or dependence) as determined by a standardized diagnostic interview. Drug use was also determined by oral fluid testing for common drugs of abuse. Results: Of 394 eligible primary care patients, 286 (73%) completed the interview. The single screening question was 100% sensitive (95% confidence interval [CI], 90.6%-100%) and 73.5% specific (95% CI, 67.7%-78.6%) for the detection of a drug use disorder. It was less sensitive for the detection of self-reported current drug use (92.9%; 95% CI, 86.1%-96.5%) and drug use detected by oral fluid testing or self-report (81.8%; 95% CI, 72.5%-88.5%). Test characteristics were similar to those of the DAST-10 and were affected very little by participant demographic characteristics.

Conclusion: The single screening question accurately identified drug use in this sample of primary care patients, supporting the usefulness of this brief screen in primary care. Copyright 2010, American Medical Association.

Why do general practitioners not screen and intervene regarding alcohol consumption in Slovenia? A focus group study.

Susic TP; Kersnik J; Kolsek M. Wiener Klinische Wochenschrift 122(Supplement 2): 68-73, 2010. (36 refs.)

Aim: To identify barriers influencing general practitioners' decisions regarding alcohol screening and brief intervention (SBI) in Slovenia. Background: Slovenia occupies third place in a league of 51 European countries with respect to alcohol consumption. General practitioners in Slovenia have the majority of contacts with patients in primary health care but they rarely or never ask patients about their drinking habits. Method: Six focus groups with a total of 32 general practitioners from different parts of the country were set up. Participants discussed varied topics and the most significant barriers were identified through qualitative analysis. Results: The identified barriers were lack of funding, absence of societal support, lack of knowledge and guidelines, inadequate counselling skills, different interpretations regarding definitions of what constitutes an alcoholic beverage, lack of time, alcohol screening not considered to be an integral part of general practice, personal characteristics of general practitioners, patients' unwillingness to participate in SBI, and ethical dilemmas. Conclusion: Lack of knowledge and guidelines, and inadequate counselling skills can be solved through educational programs. In order to change drinking habits, substantial changes in public and personal attitudes towards alcohol consumption, involving many partners, are necessary. Copyright 2010, Springer Wien.

National survey of US health professionals' smoking prevalence, cessation practices, and beliefs.

Tong EK; Strouse R; Hall J; Kovac M; Schroeder SA. *Nicotine & Tobacco Research* 12(7): 724-733, 2010. (35 refs.)

Tobacco dependence treatment efforts have focused on primary care physicians (PCPs), but evidence suggests that they are insufficient to help most smokers quit. Other health professionals also frequently encounter smokers, but their smoking prevalence, cessation

practices, and beliefs are less well known. The study included 2,804 subjects from seven health professional groups: PCPs, emergency medicine physicians, psychiatrists, registered nurses, dentists, dental hygienists, and pharmacists. Outcomes included self-reported smoking status, smoking cessation practices, and beliefs. Multivariate regression was used to examine factors associated with health professionals (except pharmacists) self-reportedly performing the "5 A's": asking, advising, assessing, assisting, or arranging follow-up about tobacco. Health professionals have a low smoking prevalence (< 6%), except nurses (13%). Many health professionals report asking (87.3%-99.5%) and advising (65.6%-94.9%) about smoking but much less assessing smokers' interest (38.7%-84.8%), assisting (16.4%-63.7%), and arranging follow-up (1.3%-23.1%). Controlling for health professional and practice demographics, factors positively associated in the multivariate analyses with self-reportedly performing multiple components of the 5 A's include awareness of the Public Health Service guidelines, having had cessation training, and believing that treatment was an important professional responsibility. Negative associations include the health professional being a current smoker, not being a PCP, being uncomfortable asking patients if they smoke, believing counseling was not an appropriate service, and reporting competing priorities. U.S. health professionals report not fully performing the 5 A's. The common barriers and facilitators identified may help inform strategies for increasing the involvement of all health professionals in conducting tobacco dependence treatments. Copyright 2010, Oxford University Press.

Effect of incarceration history on outcomes of primary care office-based buprenorphine/naloxone.

Wang EA; Moore BA; Sullivan LE; Fiellin DA. *Journal of General Internal Medicine* 25(7): 670-674, 2010. (42 refs.)

Behaviors associated with opioid dependence often involve criminal activity, which can lead to incarceration. The impact of a history of incarceration on outcomes in primary care office-based buprenorphine/naloxone is not known. The purpose of this study is to determine whether having a history of incarceration affects response to primary care office-based buprenorphine/naloxone treatment. In this post hoc secondary analysis of a randomized clinical trial, we compared demographic, clinical characteristics, and treatment outcomes among 166 participants receiving primary care office-based buprenorphine/naloxone treatment stratifying on history of

incarceration. Participants with a history of incarceration have similar treatment outcomes with primary care office-based buprenorphine/naloxone than those without a history of incarceration (consecutive weeks of opioid-negative urine samples, 6.2 vs. 5.9, $p = 0.43$; treatment retention, 38% vs. 46%, $p = 0.28$). Prior history of incarceration does not appear to impact primary care office-based treatment of opioid dependence with buprenorphine/naloxone. Community health care providers can be reassured that initiating buprenorphine/naloxone in opioid dependent individuals with a history of incarceration will have similar outcomes as those without this history. Copyright 2010, Springer.

Management of smokers motivated to quit: A qualitative study of smokers and GPs.

Wilson A; Agarwal S; Bonas S; Murtagh G; Coleman T; Taub N et al. *Family Practice* 27(4): 404-409, 2010. (21 refs.)

Objective. To explore how smokers motivated to quit are managed in the GP consultation, specifically how treatment and referral are negotiated from the perspectives of both parties. **Methods.** Twenty patients, identified in a consultation with their GP as motivated to quit smoking, and 10 participating GPs were interviewed. Interviews were recorded, transcribed, coded and analysed using the framework approach. **Results.** Three strategies (treatment and follow-up by the GP, referral to SSS without treatment and immediate treatment with referral for follow-up) were evidenced in patient and GP accounts. Most patients were satisfied with their management and how this was negotiated, but some expressed surprise or dissatisfaction with lack of immediate treatment and questioned the need for referral to SSS. GPs welcomed

the availability of SSS but some felt it important that they themselves also continued to support a quit attempt. Several saw advantages in offering NAT at the time the patient was motivated to stop. **Conclusions.** Smokers appear less convinced than GPs about the value of referral to SSS, although these differences may be resolved through negotiation. An alternative strategy to that proposed by NICE, which may be more acceptable to some smokers, is immediate treatment with subsequent support from SSS. Copyright 2010, Oxford University Press.

Drug Policy And The Public Good: A summary of the book.

Babor TF. *Addiction* 105(7): 1137-1145, 2010. (30 refs.)

Drug Policy and the Public Good was written by an international group of scientists from the fields of addiction, public health, criminology and policy studies to improve the linkages between drug research and drug policy. The book provides a conceptual basis for evidence-informed drug policy and describes epidemiological data on the global dimensions of drug misuse. The core of the book is a critical review of the cumulative scientific evidence in five general areas of drug policy: primary prevention programmes in schools and other settings; health and social services for drug users; attempts to control the supply of drugs, including the international treaty system; law enforcement and ventures into decriminalization; and control of the psychotropic substance market through prescription drug regimes. The final chapters discuss the current state of drug policies in different parts of the world and describe the need for future approaches to drug policy that are coordinated and informed by evidence. Copyright 2010, Wiley-Blackwell.
