

## **Risk of drug-related mortality during periods of transition in methadone maintenance treatment: A cohort study.**

Cousins G; Teljeur C; Motterlini N; McCowan C; Dimitrov BD; Fahey T. *Journal of Substance Abuse Treatment* 41(3): 252-260, 2011. (38 refs.)

This study aims to identify periods of elevated risk of drug-related mortality during methadone maintenance treatment (MMT) in primary care using a cohort of 3,162 Scottish drug users between January 1993 and February 2004. Deaths occurring during treatment or within 3 days after last methadone prescription expired were considered as cases "on treatment." Fatalities occurring 4 days or more after leaving treatment were cases "off treatment." Sixty-four drug-related deaths were identified. The greatest risk of drug-related death was in the first 2 weeks of treatment (adjusted hazard ratio 2.60, 95% confidence interval 1.03-6.56). Risk of drug-related death was lower after the first 30 days following treatment cessation, relative to the first 30 days off treatment. History of psychiatric admission was associated with increased risk of drug-related death in treatment. Increasing numbers of treatment episodes and urine testing were protective. History of psychiatric admission, increasing numbers of urine tests, and coprescriptions of benzodiazepines increased the risk of mortality out of treatment. The risk of drug-related mortality in MMT is elevated during periods of treatment transition, specifically treatment initiation and the first 30 days following treatment dropout or discharge. Copyright 2011, Elsevier Science.

## **Identifying harmful drinking using a single screening question in a psychiatric consultation-liaison population.**

Massey SH; Norris L; Lausin M; Nwaneri C; Lieberman DZ. *Psychosomatics* 52(4): 362-366, 2011. (22 refs.)

Background: Harmful drinking is common in medical inpatients, yet commonly missed due in part to time pressures. A screening question about past year heavy drinking recommended by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has been validated in primary care and emergency room settings. We tested the psychometric properties of a modified single screening question (SSQ) in

hospitalized patients referred to a consultation-liaison service. Methods: A psychiatry attending (n = 40), a psychiatry resident (n = 30) and a medical student (n = 30) administered the SSQ, followed by a self-report 10-item Alcohol Use Disorders Identification Test (AUDIT) to a sample of 100 consultation-liaison patients who were able to give informed consent for participation. Results: Using the AUDIT as a reference, the sensitivity and specificity of the SSQ to detect harmful drinking in this sample were .96 and .82, respectively. Gender differences in specificity were not found. The single question also had a strong correlation with dependence ( $r(b) = .457, p < .001$ ), and harmful use ( $r(b) = .620, p < .001$ ) subscales of the AUDIT. Conclusion: The SSQ about past year heavy drinking can rapidly identify harmful drinking in alert nonpsychotic consultation-liaison patients. Note: "The" question, after asking if someone sometimes drinks beer wine, or other alcoholic beverages is "Have you had five or more drinks (four or more for women) in a single day in the past year?". A response of yes is considered positive and indicating the need for a more comprehensive assessment.] Copyright 2011, Academy of Psychosomatic Medicine.

## **Potential roles for new communication technologies in treatment of addiction.**

Johnson K; Isham A; Shah DV; Gustafson DH. *Current Psychiatry Reports* 13(5): 390-397, 2011. (81 refs.)

Information and communication technologies offer clinicians the opportunity to work with patients to manage chronic conditions, including addiction. The early research on the efficacy of electronic treatment and support tools is promising. Sensors have recently received increased attention as key components of electronic treatment and recovery management systems. Although results of the research are very promising, concerns at the clinical and policy level must be addressed before widespread adoption of these technologies can become practical. First, clinicians must adapt their practices to incorporate a continuing flow of patient information. Second, payment and regulatory systems must make adjustments far beyond what telemedicine and electronic medical records have required. This paper examines potential roles of

information and communication technologies as well as process and regulatory challenges. Copyright 2011, Springer.

### **Primary health care and alcohol. (editorial).**

Seppa K. *Zdravstveno Varstvo* 50(3): 143-147, 2011. (39 refs.)

In his famous novel 'Anna Karenina' Konstantin Levin, a farmer who is commonly considered to represent the author Leo Tolstoy himself, listens to another farmer's opinions on the land reform. He highly respects these opinions which, as he says, 'had been brought not by a desire of finding some exercise for an idle brain, but a thought which had grown up out of the conditions of his life'. Researchers and policy makers, far from the realities of primary health care, seem to be more interested in brief alcohol interventions for hazardous drinkers than do general practitioners or other professionals working in this setting. Should brief intervention be removed to some other setting, buried forever as not being suitable for real life, or would it just now be perfect time for general practitioners and nurses in primary health care to take command of brief interventions and make it suitable for their own setting? Copyright 2011, Institute of Public Health, Republic of Slovenia.

### **Adherence to clinical guidelines for opioid therapy for chronic pain in patients with substance use disorder.**

Morasco BJ; Duckart JP; Dobscha SK. *Journal of General Internal Medicine* 26(9): 965-971, 2011. (42 refs.)

**BACKGROUND:** Patients with chronic non-cancer pain (CNC) have high rates of substance use disorders (SUD). SUD complicates pain treatment and may lead to worse outcomes. However, little information is available describing adherence to opioid treatment guidelines for CNC generally, or guideline adherence for patients with comorbid SUD. **OBJECTIVE:** Examine adherence to clinical guidelines for opioid therapy over 12 months, comparing patients with SUD diagnoses made during the prior year to patients without SUD. **DESIGN:** Cohort study. **PARTICIPANTS:** Administrative data were collected from veterans with CNC receiving treatment within a Veterans Affairs regional healthcare network who were prescribed chronic opioid therapy in 2008 (n = 5814). **KEY RESULTS:** Twenty percent of CNC patients prescribed chronic opioid therapy had a prior-year diagnosis of SUD. Patients with SUD were more likely to have pain diagnoses and psychiatric comorbidities. In adjusted analyses, patients with SUD were more likely than those without

SUD to have had a mental health appointment (29.7% versus 17.2%, OR = 1.49, 95% CI = 1.26-1.77) and a urine drug screen (UDS) (47.0% versus 18.2%, OR = 3.53, 95% CI = 3.06-4.06) over 12 months. There were no significant differences between groups on receiving more intensive treatment in primary care (63.4% versus 61.0%), long-acting opioids (26.9% versus 26.0%), prescriptions for antidepressants (88.2% versus 85.8%, among patients with depression), or participating in physical therapy (30.6% versus 28.6%). Only 35% of patients with SUD received substance abuse treatment. **CONCLUSIONS:** CNC patients with SUD were more likely to have mental health appointments and receive UDS monitoring, but not more likely to participate in other aspects of pain care compared to those without SUD. Given data suggesting patients with comorbid SUD may need more intensive treatment to achieve improvements in pain-related function, SUD patients may be at high risk for poor outcomes. Copyright 2011, Springer.

### **Preventing disparities in alcohol screening and brief intervention: The need to move beyond primary care.**

Mulia N; Schmidt LA; Ye Y; Greenfield TK.

*Alcoholism: Clinical and Experimental Research* 35(9): 1557-1560, 2011. (43 refs.)

The alcohol treatment field has focused on promoting screening and brief intervention (SBI) in medically based settings, particularly primary care. In this Commentary, we consider the potential unintended consequences for disparities in access to care for alcohol problems. National data show significant racial/ethnic and socioeconomic differences in the rates at which at-risk drinkers and persons with alcohol use disorders come into contact with primary care providers. This suggests that implementing SBI in mostly primary care settings could inadvertently widen the gap in alcohol-related health disparities. To ensure that all populations in need benefit from this evidence-based treatment, SBI should be considered and adapted for a wider range of service venues, including Federally Qualified Health Centers and venues frequented by racial/ethnic minorities and the uninsured. Copyright 2011, Wiley-Blackwell.

### **Low use of opioid risk reduction strategies in primary care even for high risk patients with chronic pain.**

Starrels JL; Becker WC; Weiner MG; Li X; Heo M; Turner BJ. *Journal of General Internal Medicine* 26(9): 958-964, 2011. (53 refs.)

**Background/Objective:** Experts recommend close oversight of patients receiving opioid analgesics for

chronic non-cancer pain (CNCP), especially those at increased risk of misuse. We hypothesized that physicians employ opioid risk reduction strategies more frequently in higher risk patients. Design: Retrospective cohort using electronic medical records. Participants: Patients on long-term opioids (a parts per thousand yen<sup>3</sup> monthly prescriptions in 6 months) treated for CNCP in eight primary care practices. Main Results: We examined three risk reduction strategies: (1) any urine drug test; (2) regular office visits (at least once per 6 months and within 30 days of modifying opioid treatment); and (3) restricted early refills (one or fewer opioid refills more than a week early). Risk factors for opioid misuse included: age < 45 years old, drug or alcohol use disorder, tobacco use, or mental health disorder. Associations of risk factors with each outcome were assessed in non-linear mixed effects models adjusting for patient clustering within physicians, demographics and clinical factors. Main results: Of 1,612 patients, 8.0% had urine drug testing, 49.8% visited the office regularly, and 76.6% received restricted (one or fewer) early refills. Patient risk factors were: age < 45 (29%), drug use disorder (7.6%), alcohol use disorder (4.5%), tobacco use (16.1%), and mental health disorder (48.4%). Adjusted odds ratios (AOR) of urine drug testing were significantly increased for patients with a drug use disorder (3.18; CI 1.94, 5.21) or a mental health disorder (1.73; CI 1.14, 2.65). However, the AOR for restricted early refills was significantly decreased for patients with a drug use disorder (0.56; CI 0.34, 0.92). After adjustment, no risk factor was significantly associated with regular office visits. An increasing number of risk factors was positively associated with urine drug testing ( $p < 0.001$ ), but negatively associated with restricted early refills ( $p = 0.009$ ). Conclusion: Primary care physicians' adoption of opioid risk reduction strategies is limited, even among patients at increased risk of misuse. Copyright 2011, Springer.

### **Intervention against excessive alcohol consumption in primary health care: A survey of GPs' attitudes and practices in England 10 years on.**

Wilson GB; Lock CA; Heather N; Cassidy P; Christie MM; Kaner EF. *Alcohol and Alcoholism* 46(5): 570-577, 2011. (48 refs.)

Aims: To ascertain the views of general practitioners (GPs) regarding the prevention and management of alcohol-related problems in practice, together with perceived barriers and incentives for this work; to compare our findings with a comparable survey conducted 10 years earlier. Methods: In total, 282 (73%) of 419 GPs surveyed in East Midlands, UK,

completed a postal questionnaire, measuring practices and attitudes, including the Shortened Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ). Results: GPs reported lower levels of post-graduate education or training on alcohol-related issues (< 4 h for the majority) than in 1999 but not significantly so ( $P = 0.031$ ). In the last year, GPs had most commonly requested more than 12 blood tests and managed 1-6 patients for alcohol. Reports of these preventive practices were significantly increased from 1999 ( $P < 0.001$ ). Most felt that problem or dependent drinkers' alcohol issues could be legitimately (88%, 87%) and adequately (78%, 69%) addressed by GPs. However, they had low levels of motivation (42%, 35%), task-related self-esteem (53%, 49%) and job satisfaction (15%, 12%) for this. Busyness (63%) and lack of training (57%) or contractual incentives (48%) were key barriers. Endorsement for government policies on alcohol was very low. Conclusion: Among GPs, there still appears to be a gap between actual practice and potential for preventive work relating to alcohol problems; they report little specific training and a lack of support. Translational work on understanding the evidence-base supporting screening and brief intervention could incentivize intervention against excessive drinking and embedding it into everyday primary care practice. Copyright 2011, Oxford University Press.

### **Protect your patients, protect your practice. Practical risk assessment in the structuring of opioid therapy in chronic pain.**

Fine PG; Finnegan T; Portenoy RK. *Journal of Family Practice* 59(9, supplement 2): S1-S16, 59. (42 refs.)

Primary care clinicians play a crucial role in the assessment and management of chronic pain. As many as one-third of primary care patients report having chronic pain. Unfortunately, the increased availability and prescription of opioid analgesics in recent years have been accompanied by a parallel increase in prescription opioid abuse and misuse and related morbidity and mortality.<sup>3-5</sup> Prescription drug abuse is an increasingly serious public health problem, and this reality has reinforced the view that primary care clinicians must possess skills in risk assessment and management, as well as the ability to optimize the potentially favorable effects of opioid drugs on pain and function. To help address the problem of prescription drug abuse while still allowing for the prescription of opioids for pain relief, policy makers involved in the development of health care regulations have started adopting the principle of balance. The key principles for assessment and management of the risks associated with misuse, abuse, addiction, and diversion

are described, as are indications for referral to pain/addiction specialists. Copyright 2010, Dowden Health Media.

**Does delivering preventive services in primary care reduce adolescent risky behavior?**

Ozer EM; Adams SH; Orrell-Valente JK; Wibbelsman CJ; Lustig JL; Millstein SG et al. *Journal of Adolescent Health* 49(5): 476-482, 2011. (39 refs.)

Purpose: To determine whether the delivery of preventive services changes adolescent behavior. This exploratory study examined the trajectory of risk behavior among adolescents receiving care in three pediatric clinics, in which a preventive services intervention was delivered during well visits. Methods: The intervention consisted of screening and brief counseling from a provider, followed by a health educator visit. At age 14 (year 1), 904 adolescents had a risk assessment and intervention, followed by a risk assessment 1 year later at age 15 (year 2). Outcomes were changes in adolescent behavior related to seat belt and helmet use; tobacco, alcohol, and drug use; and sexual behavior. Analysis involved age-related comparisons between the intervention and several cross-sectional comparison samples from the age of 14-15 years. Results: The change in helmet use in the intervention sample was 100% higher ( $p < .05$ ), and the change in seat belt use among males was 50% higher ( $p = .14$ ); the change in smoking among males was 54% lower ( $p < .10$ ), in alcohol use was no different, and in drug use was 10% higher (not significant [NS]); and the change in rate of sexual intercourse was 18% and 22% lower than cohort comparison samples (NS). Conclusions: The intervention had the strongest effect in the area of

helmet use, shows promise for increasing seat belt use and reducing smoking among male adolescents, and indicates a nonsignificant trend toward delaying the onset of sexual activity. Participation in the intervention seemed to have no effect on the rates of experimentation with alcohol and drugs between the ages of 14 and 15 years. Copyright 2011, Elsevier Science.

**Developing the Climate Schools Alcohol and Cannabis Module: A harm-minimization, universal drug prevention program facilitated by the internet.**

Newton NC; Vogl L; Teesson M; Andrews G. *Substance Use & Misuse* 46(13): 1651-1663, 2011. (68 refs.)

The Climate Schools: Alcohol and Cannabis Module is a universal harm-minimization school-based prevention program for adolescents aged 13-15 years. The core content of the program is delivered over the Internet using cartoon storylines to engage students, and teacher-driven activities reinforce the core information. The program is embedded within the school health curriculum and is easy to implement with minimal teacher training required. The program was developed in 2007 through extensive collaboration with teachers, students, and health professionals ( $N = 24$ ) in Sydney, Australia and has since been evaluated ( $N = 764$ ). This article describes the formative research and process of planning that formed the development of the program and the evidence base underpinning the approach. The study's limitations are noted. Copyright 2011, Informa Healthcare.