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journal homepage: www.elsevier.com/puhe

Original Research

Attitudes, perceptions and practice of alcohol and drug screening, brief intervention and referral to treatment: a case study of New York State primary care physicians and non-physician providers

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ARTICLE INFO

Article history:
Received 9 February 2016
Received in revised form
14 April 2016
Accepted 11 May 2016
Available online 14 June 2016

Keywords:
Substance abuse
Screening
Brief intervention
Referral to treatment
SBIRT
Early intervention
Primary care
Physicians

ABSTRACT

Objectives: Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been endorsed by the United States Preventive Services Task Force as an evidence-based strategy to address risky alcohol use among adults in primary care. Nevertheless, very few healthcare professionals report using SBIRT in their practice. The purpose of this study was to explore attitudes regarding addressing substance use; perceptions of effectiveness, role responsibility, and self-efficacy; and current SBIRT practice among primary care physicians, nurse practitioners, and physician assistants to identify factors which may impact routine delivery of SBIRT in primary care.

Study design: A cross-sectional design was used to meet study objectives. Responses of physicians and non-physician providers (nurse practitioners and physician assistants) were compared.

Methods: Primary care members of three New York State physician, nurse practitioner, and physician assistant professional organizations were surveyed between October 2013 and November 2013.

Results: Barely half of participants (57%) reported screening their patients for substance use, and less than half provided brief intervention (46%) or referral to treatment (47%). Using a standardized tool to screen patients for risky substance use and assessing readiness to change were practised least frequently. Compared to physicians, nurse practitioners and physician assistants felt less responsible for addressing substance use ($P = 0.019$), felt less comfortable discussing substance use ($P = 0.004$), had more negative attitudes toward addressing substance use ($P = 0.015$), and were less likely to conduct brief intervention (52% vs 32%; $P < 0.0005$) and referral to treatment (50% vs 70%; $P = 0.001$).

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http://dx.doi.org/10.1016/j.puhe.2016.05.007

Conclusions: This study identifies important attitudinal and perceptual differences between physicians and non-physician providers which may be targeted by education and training and underscores an opportunity for using non-physician providers to conduct SBIRT.

Introduction

Substance use (alcohol and drugs) is a nationwide public health problem. Over half (52%) of Americans aged 12 years and over are current drinkers, almost one quarter (23%) are binge drinkers, and 10% report current use of illicit drugs. Marijuana use more than doubled over the past decade in the wake of changing polices and social norms,[1,2] while an epidemic of heroin and prescription opioid abuse has fuelled a 137% increase in drug overdose deaths since 2000. In fact, the 47,055 overdose deaths in 2014 exceeded the number of deaths from motor vehicle accidents by 50%.[3]

The death toll associated with alcohol and drug use among middle-aged white Americans, along with suicides, is so great that it has singlehandedly reversed the trend of decreasing all-cause mortality among this group.[4] Substance use also impacts morbidity; it increases the risk of liver disease, stroke, cancer, motor vehicle accidents, other accidents, injuries, domestic violence, marital conflict, child abuse, and childhood neurodevelopmental disorders.[5] Almost half of emergency department visits associated with substance use result in resource-intensive hospital admission, a rate of over 2.5 times that for emergency department visits related to other conditions.[6]

Unfortunately, problem substance users are not receiving services to help prevent these negative consequences. Of the 22.7 million Americans aged 12 years and over who needed treatment in 2013, only 2.5 million received it at a speciality facility.[1]

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an early intervention strategy aimed at addressing risky substance use and preventing more severe consequences. The SBIRT service model includes universal screening and, for those who screen positive, clinically appropriate brief intervention onsite. Referrals are provided when more intensive treatment is needed.[7]

Based on extensive research indicating that SBIRT reduces alcohol consumption, emergency department visits, non-fatal injuries, hospitalizations, arrests, and motor vehicle accidents,[8–12] the United States Preventive Services Task Force (USPSTF) recommends that primary care providers use screening and behavioural counselling interventions with their adult patients to reduce possible alcohol misuse.[13] Though research on the effectiveness of SBIRT for drug use is mixed,[14,15] the Substance Abuse and Mental Health Services Administration (SAMHSA) recommends SBIRT for both alcohol and drug use and has been funding state alcohol and drug SBIRT programs since 2003.[16]

Even so, most healthcare professionals have not followed these recommendations.[17] Studies have shown that only 15.7% of people have talked with a healthcare professional about drinking,[18] only 14% of those exceeding safe drinking guidelines have been asked and advised about their drinking,[19] and more than half (55%) of individuals in substance abuse treatment have said their primary care physician did nothing about their substance use.[20]

Existing research on lack of SBIRT practice has focused on individual-level, self-reported characteristics of physicians and nurses such as lack of education, time and resources, negative attitudes toward addressing substance use, and perceptions of role responsibility and self-efficacy for addressing substance use. These studies have found that time constraints and competing demands frequently prevent physicians from delivering SBIRT,[17,21–24] suggesting that utilizing multiple provider types in the SBIRT protocol may increase the likelihood that SBIRT is delivered routinely.[25]

Nurse practitioners, advanced-practice nurses who independently diagnose, treat, and prescribe, have been identified as a provider type especially well-suited for delivering SBIRT, because they are capable of providing high-quality care equivalent to that of physicians and because SBIRT addresses multiple competencies and priorities put forth by the field.[26,27] Physician assistants may also be well-suited for SBIRT. Yet research on utilization of nurse practitioners and physician assistants (defined in this study as non-physician providers) in the SBIRT model and attitudes and perceptions which may impact their delivery of the model is limited to one study of school-based health centres.[28]

Furthermore, because physicians and non-physician providers have different educational backgrounds and develop clinical skills in different practice environments,[29] factors impacting SBIRT delivery may be unique for both groups even within the same professional setting. No existing research examines these differences. This study aims to fill this gap in literature by exploring attitudes and perceptions regarding addressing substance use, current practice, and differences in attitudes, perceptions, and practice between primary care physicians and non-physician providers to identify strategies which may facilitate the adoption and integration of SBIRT in primary care settings.

Methods

Sample and procedures

A questionnaire, adapted from existing surveys,[17,28,30] collected information on primary care professionals' attitudes, perceptions, and practice regarding SBIRT. Primary care professionals were defined as physicians, nurse practitioners, and physician assistants currently practicing in general practice, family practice, or internal medicine. Members of the research team