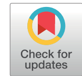
Journal of Substance Abuse Treatment 92 (2018) 85–90

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

Is screening and intervention associated with treatment receipt among individuals with alcohol use disorder? Evidence from a national survey



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ARTICLE INFO

Keywords:
Alcohol
Alcohol screening
Alcohol treatment
United States

ABSTRACT

Background: Most individuals with alcohol use disorder do not receive treatment and little national-level United States (U.S.) data exist on the association between screening and intervention with receipt of treatment.
Methods: The sample includes adults 18 years and older reporting prior year symptoms of alcohol use disorder from 2013 and 2014 National Survey on Drug Use and Health. Survey-weight adjusted prevalence of prior year receipt of ambulatory care, alcohol screening in a medical setting, alcohol intervention in a medical setting and alcohol treatment receipt and setting were calculated. Regression-adjusted odds ratios were calculated for alcohol treatment outcomes of interest.
Results: Despite high use of ambulatory care (74.4%, 95%CI: 72.8, 75.6), prevalence of screening (52.5%, 95%CI: 50.5, 54.5), intervention (13.5%, 95%CI: 12.1, 15.0) and treatment (6.8%, 95%CI: 5.8, 7.9) were low. Screening (AOR: 1.7, $p < 0.050$) and intervention (AOR: 4.7, $p < 0.001$) were associated with increased odds of treatment. Screening and intervention were associated with increased odds of receiving treatment in medical and specialty behavioral health settings and decreased odds of receiving treatment in only self-help groups.
Conclusions: While prior year receipt of screening and intervention were low overall among adults with alcohol use disorder, receipt of these services was strongly associated with use of alcohol treatment. This likely indicates a missed opportunity to encourage a high-risk population to access treatment services. Receipt of screening and intervention was most strongly associated with treatment in medical and specialty behavioral health settings. Future research should examine this prospectively to assess whether entry into treatment settings may be mediated by screening and intervention in ambulatory care settings or if brief intervention is occurring at the time of treatment.

1. Introduction

In 2015, approximately 15 million United States (U.S.) adults – roughly 6% of the adult population – met diagnostic criteria for alcohol use disorder in the prior 12 months (Substance Abuse and Mental Health Services Administration, 2016). Heavy alcohol use is associated with increased risk of injuries, experiencing violence, liver disease, cancer, hypertensive heart disease, depressive disorders and social problems, such as unemployment (Booth & Feng, 2002; Parker & Auerhahn, 1998; Shield, Parry, & Rehm, 2013; Smith, Branas, & Miller, 1999; Stahre, Roeber, Kanny, Brewer, & Zhang, 2014). Despite the existence of effective treatments, most individuals with an alcohol use disorder do not receive treatment, even in more informal treatment settings (e.g., self-help groups such as Alcoholics Anonymous) (Alvanzo et al., 2014).

Increasing the uptake of treatment for alcohol use disorder is an important policy priority. Medical settings, and particularly primary care, can provide one important pathway into treatment. Many individuals with alcohol use disorder come into contact with medical providers, particularly because there is a high burden of comorbid physical and mental health problems in this population (Grant et al., 2015; Hasin, Stinson, Ogburn, & Grant, 2007; Rehm, 2011). A large body of research has focused on screening and brief intervention as a potential approach to improve alcohol use outcomes among individuals seen in primary care or emergency departments. Screening assesses all patients for risky drinking or other substance use behaviors using standardized screening tools, and brief intervention occurs when the provider engages patients who exhibit problem alcohol use in a short

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https://doi.org/10.1016/j.jsat.2018.06.009
Received 7 November 2017; Received in revised form 19 June 2018; Accepted 19 June 2018
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conversation and provides motivating information and advice about avoiding risky substance use (Substance Abuse and Mental Health Services Administration, 2017). The U.S. Preventive Services Task Force recommends that clinicians screen all adults for alcohol use disorder and provide brief interventions for individuals engaged in risky or hazardous drinking (Moyer & Preventive Services Task Force, 2013). Overall, screening and brief intervention has been associated with reductions in alcohol intake, risky drinking, and driving under the influence (Aldridge, Linford, & Bray, 2017; Babor et al., 2007; Kaner et al., 2007; Moyer & Preventive Services Task Force, 2013).

Despite the evidence base supporting screening and brief intervention in medical settings, relatively little national-level U.S. data is available about the role of screening and intervention in the overall pathway to treatment for individuals with an alcohol use disorder. In this study, we take advantage of 2013 and 2014 data from the National Survey on Drug Use and Health (NSDUH), a nationally representative survey that includes structured questions used to identify symptoms of alcohol use disorder and detailed information about receipt of alcohol treatment in a variety of settings. Beginning in 2013, the NSDUH added items related to receipt of screening and provider intervention among individuals who had received care in general medical settings. Using 2013 NSDUH data, Glass and colleagues found that few individuals with alcohol problems received alcohol intervention in ambulatory care settings and that disparities may exist in those who are offered intervention, with lower rates among women compared to men (Glass, Bohnert, & Brown, 2016). We build upon this work by exploring the extent to which receipt of screening or intervention is associated with the probability that individuals with an alcohol use disorder receive treatment. We hypothesize that among U.S. adults with alcohol use disorder, those who received an ambulatory care visit, screening, or provider intervention would be more likely to report any treatment for alcohol use disorder.

We also compare differences in receipt of screening and intervention across the specific settings in which individuals received alcohol treatment in order to provide information as to whether populations who receive treatment may be influenced by interactions with a medical provider relative to other potential referral sources. Prior research has shown that 38% of individuals in alcohol treatment programs were referred by the criminal justice system versus 8% referred by a substance use care provider and 10% referred by another health care provider (Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics, & and Quality, 2015). Establishing a linkage between a clinician and treatment programs may be beneficial for coordinating the care of individuals with alcohol use disorder, yet some treatment settings may have relatively limited connection to medical care. We hypothesize that among adults who received alcohol treatment, receipt of screening and provider intervention would be more commonly reported among people receiving care in medical settings (such as a physician's office) compared to those in informal settings (e.g., self-help) or in jails.

2. Methods

2.1. Sample and measures

NSDUH is a cross-sectional nationally representative survey of non-institutionalized civilians 12 years of age and older in the United States. NSDUH is administered to approximately 70,000 individuals annually. The survey uses an address-based household sampling strategy, and respondents are interviewed in their homes using computer-assisted interviewing to improve confidentiality for reporting on substance use. Cross-sectional data from the 2013 and 2014 waves of the NSDUH were analyzed. During this study period, overall response rates were 72% in 2013 and 71% in 2014.

NSDUH includes questions screening for alcohol abuse and dependence based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (Substance Abuse and Mental Health Services Administration, 2015). We define alcohol use disorder as the presence of symptoms of abuse (such as serious problems at home, work or school due to alcohol use) or dependence (such as feeling symptoms of withdrawal from non-use). To assess use of screening and intervention among individuals most likely to need intervention and treatment, our sample is restricted to individuals 18 years of age and older who meet criteria for alcohol use disorder.

Our main predictors of interest are receipt of ambulatory care, receipt of alcohol screening and receipt of alcohol intervention. We define a respondent as having an ambulatory care visit if they report having "visited a doctor, nurse, physician assistant or nurse practitioner about (their) own health at a doctor's office, a clinic or some other place" at least once in the prior year. Starting in 2013, NSDUH began collecting information on whether respondents who received medical care in the prior year (defined as having an emergency room visit, overnight hospitalization or outpatient visit) had discussions with providers about risky alcohol use, providing a new and unique opportunity to examine alcohol screening and intervention trends nationwide. Individuals were prompted with the following text: "Please think about all the talks you had with a doctor or other health professional during the past 12 months when you answer this question. Choose the statement or statements that describe any discussions you may have had in person with a doctor or other health professional about your alcohol use." Individuals were considered to have received an alcohol screening from a health professional if they chose any of the following three statements: 1) "The doctor asked how much I drink." 2) "The doctor asked how often I drink." 3) "The doctor asked if I have any problems because of my drinking." Individuals were considered to have received an intervention from a health professional if they chose either of the following statements: 1) "The doctor advised me to cut down on my drinking." 2) "The doctor offered to give me more information about alcohol use and treatment for problems with alcohol use."

Our outcomes of interest are receipt of alcohol treatment and the settings in which this treatment was received. In a separate set of NSDUH questions, individuals were asked, "During the past 12 months, that is, since [DATE], have you received treatment or counseling for your use of alcohol or any drug, not counting cigarettes?" Individuals were considered as having received alcohol treatment if they responded yes for receiving treatment for alcohol use only or both alcohol and drug use. Those who received alcohol treatment were then asked whether they were treated in any of the following settings: outpatient rehabilitation facility, inpatient rehabilitation facility, mental health center, emergency room, doctor's office, jail, and self-help group. Respondents could select more than one setting. For our purposes, treatment occurring in a hospital, doctor's office or emergency room was considered to have occurred in a medical setting. Treatment occurring in an outpatient or inpatient rehabilitation facility, or in a mental health center were defined as specialty behavioral health settings. Finally, treatment occurring in jails or self-help groups were considered non-medical settings. We generated a variable of receiving treatment "only in a self-help group" for respondents who endorsed receiving treatment in a self-help group but no other settings.

2.2. Statistical analysis

We applied survey weights created by NSDUH analysts to calculate nationally representative estimates of the non-institutionalized adult population and adjusted standard errors to account for the complex sampling design. We examined the distribution of sociodemographic characteristics and the frequency of a prior year ambulatory care visit, alcohol screening, alcohol intervention and receipt of alcohol treatment in our overall sample of adults with alcohol use disorder.

Next, we calculated four separate logistic regression models each with the outcome for receiving alcohol treatment in the prior year. In Model 1, the primary predictor was prior year receipt of ambulatory

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