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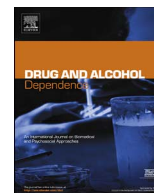

Full length article

Alcohol use and receipt of alcohol screening and brief intervention in a representative sample of sexual minority and heterosexual adults receiving health care

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ABSTRACT

Background: Despite evidence of alcohol disparities between sexual minority and heterosexual individuals in the general population, research has not examined whether there are disparities in receipt of alcohol screening and brief intervention − together considered one of the highest prevention priorities for US adults. This study examined differences in alcohol use and receipt of alcohol screening and brief intervention across sexual minority status.

Methods: Behavioral Risk Factor Surveillance System 2014 data from eight US states were used to estimate patterns of alcohol use and receipt of alcohol screening and brief intervention among persons reporting sexual orientation and a checkup in the last two years (N = 47,800). Analyses were conducted in 2016–2017.

Results: Gay men and bisexual women reported higher rates of alcohol use on some measures compared to heterosexual men and women, respectively. There were some differences in screening and brief intervention by sexual orientation. Lesbian women were more likely to report being asked about heavy episodic drinking than heterosexual women, and among those reporting unhealthy alcohol use, gay men were less likely, and bisexual men were more likely, to report receiving brief intervention compared to heterosexual men.

Conclusions: Overall similarities between sexual minorities and heterosexuals in alcohol use and receipt of screening and brief intervention are encouraging. Nonetheless, research is needed to confirm findings and understand mechanisms underlying disparities in receipt of brief intervention between gay and heterosexual men.

1. Introduction

Sexual minorities, including lesbian, gay, and bisexual women and men, experience a wide array of health disparities and have recently been designated as a health disparity population by the National Institutes of Health (2016). Unhealthy alcohol use, which ranges from drinking above recommended drinking limits to presence of alcohol use disorders (Saitz, 2005), is a leading cause of morbidity and mortality (Rehm et al., 2010) and one of the health outcomes more heavily impacting sexual minority communities. Research has detected disparities in unhealthy alcohol use for both sexual minority men and women compared to their heterosexual counterparts (Gonzales et al., 2016; Nawyn et al., 2000). Nonetheless, recent data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) demonstrated that lesbian (59%) and bisexual (54%) women were more likely than heterosexual women (22%) to have lifetime alcohol use disorder, but no such differences were detected between gay and bisexual men compared to heterosexual men (59% and 52% vs. 48%, respectively; McCabe et al., 2013). Other research has found that lesbian and bisexual women are more likely to drink alcohol, engage in unhealthy alcohol use, and experience alcohol-related problems compared to heterosexual women (Cochran et al., 2000; Diamant et al., 2000; Drabble et al., 2005; Drabble and Trocki, 2005; Gilman et al., 2001; Hughes and Eliason, 2002; Ziyadeh et al., 2007) and that bisexual individuals report higher prevalence of unhealthy alcohol use compared to individuals who identify as gay, lesbian, or heterosexual, with particularly high rates among bisexual women (Eisenberg and Wechsler, 2003; McCabe et al., 2009).

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While disparities in unhealthy alcohol use by sexual orientation have been well-documented, particularly among women, much less is known about whether sexual minorities receive recommended care for unhealthy alcohol use to the same extent as their heterosexual counterparts. Among populations receiving primary care, both alcohol screening and brief intervention for those who screen positive for unhealthy alcohol use are recommended. Based on the clinical burden of unhealthy alcohol use and the effectiveness of brief interventions for reducing drinking (Jonas et al., 2012; Kaner et al., 2007), routine screening and brief intervention are together considered one of the highest prevention priorities for US adults (Solberg et al., 2008). Brief interventions vary in their content and delivery (Jonas et al., 2012), although one of their key components is advising patients about recommended drinking limits. The extant research that has been conducted on sexual orientation and alcohol-related care has specifically focused on utilization of specialty addictions treatment, rather than on screening and brief intervention (Allen and Mowbray, 2016; McCabe et al., 2013).

In the current study, we aimed to examine patterns of alcohol use as well as receipt of alcohol screening and brief intervention during routine clinical care in a representative sample of sexual minority and heterosexual respondents. Given prior nationally representative research, we hypothesized that lesbian and bisexual women would report greater unhealthy alcohol use than heterosexual women but did not expect to observe parallel disparities among men. Given lack of any prior research on alcohol screening and brief intervention in clinical settings, we did not have *a priori* hypotheses about sexual orientation differences with respect to these outcomes.

2. Methods

2.1. Data

The data for this secondary analysis are from the 2014 Behavioral Risk Factor Surveillance System (BRFSS) survey. Coordinated by the Centers for Disease Control and Prevention (CDC), the BRFSS is administered to probability-based samples of non-institutionalized adults over the age of 18 within all states and territories. Each year, the CDC issues a mandatory standardized core questionnaire and various optional modules from which the states and territories can elect to supplement their core surveys. Of the optional modules in 2014, the two of principal interest for this investigation were the Sexual Orientation and Gender Identity (SOGI) module (administered by 20 states) and the Alcohol Screening and Brief Intervention (ASBI) module (administered by 19 states). Eight states − Hawaii, Indiana, Kansas, Kentucky, Minnesota, Montana, New York and Wisconsin − chose to administer *both* of these modules in 2014, and their samples formed the basis of the present analyses (total N = 65,265). Because the ASBI module was only administered to respondents who reported having a healthcare checkup in the past two years, individuals who did not have a checkup in the past two years (weighted 15.9%, n = 9420) and individuals who indicated “don’t know” or refused to answer (n = 842) were excluded. Additionally, because this investigation focused on sexual minority status, respondents missing data on sexual orientation (n = 838 missing, 168 other, n = 402 don’t know, n = 821 refusals) were excluded. Lastly, 4974 individuals were excluded due to early termination of the survey. The analytic sample thus included 47,800 persons. All surveys are administered through computer-assisted telephone interviews, and the CDC uses complex sampling methodology to gather samples from both landline and cellular telephones. Further information about the BRFSS survey, methodology, and response rates is available through the CDC (2015a,b).

2.2. Sexual orientation

The key independent variable of sexual orientation was gathered from the SOGI module, in which respondents are asked “Do you consider yourself to be: 1-straight, 2-lesbian or gay, 3-bisexual.”

2.3. Alcohol use

Four alcohol use measures were taken from the core survey from which the CDC calculates variables of alcohol consumption. First, respondents were asked, “During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?” From this item, the CDC calculated a dichotomous variable for *any alcohol use* in the past 30 days. Second, a measure of *risky drinking* was defined as adult men who on average had > 2 drinks per day or adult women who had > 1 drink per day, based on weekly drinking limits defined by the National Institute on Alcohol Abuse and Alcoholism (14 drinks/week for men or 7 drinks/week for women; NIAAA, 2007). Third, heavy episodic drinking was defined as men who report ≥5 drinks on one occasion in the last 30 days and women who report ≥4 drinks on one occasion in the last 30 days (NIAAA, 2007). Fourth, a summary measure of *any unhealthy alcohol use* was defined as respondents who either met criteria for risky drinking or any heavy episodic drinking in the last 30 days.

2.4. Alcohol screening and brief intervention

Additional variables were taken from the 5-item ASBI module. The ASBI module focuses on receipt of screening and brief intervention from healthcare providers during a healthcare visit. Because the ASBI module measures alcohol screening and brief interventions occurring in healthcare settings, only respondents who indicated having visited a healthcare provider for a routine checkup in the last two years were asked the ASBI questions. In the context of their last checkup, respondents were asked five questions to which they responded yes or no: (1) “were you asked in person or on a form if you drink alcohol;” (2) “did the healthcare provider ask you in person or on a form how much you drink;” (3) “did the healthcare provider specifically ask whether you drank [5 for men/4 for women] or more alcoholic drinks on an occasion” (*alcohol screening questions*); (4) “were you offered advice about what level of drinking is harmful or risky for your health;” and (5) “were you advised to reduce or quit your drinking” (*brief intervention questions*). The BRFSS skip logic had only respondents who answered ‘yes’ to any of the first three screening questions administered the fifth question. The first three questions reflected receipt of alcohol screening and the last two questions assessed components of brief intervention that are commonly offered as brief alcohol counseling interventions tested in randomized controlled trials (Solberg et al., 2008).

2.5. Socio-demographic variables

Respondent characteristics that were included as covariates in this study were age coded into four categories of 18–29, 30–44, 45–64, and > 65 years; race/ethnicity coded into five categories of non-Hispanic white, African American/black, other race, multiracial, and Hispanic; and education coded into four categories of < high school diploma, high school diploma, some college, and a college degree or higher. Marital status was coded into a three-category variable of being married or in an unmarried partnership, formerly married (including separated, divorced, and widowed individuals), and never married. Employment status was coded into a four-category variable of employed, unemployed, retired, and out of the workforce; the latter category included individuals who reported being homemakers, students, or unable to work. Veteran status was included as a dichotomous variable and was defined as individuals who indicated that they “ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit.”

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