Brief Interventions During Busy Student Health Visits:
Applying Motivational Interviewing Skills and Strategies

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Objectives

• Describe Motivational Interviewing principles and techniques to decrease high-risk drinking and other risky behaviors.

• Describe practical strategies to implement Brief Motivational Interventions on campuses.

• Discuss ways to motivate high-risk drinkers who are in denial, ambivalent about change, or pre-contemplative.

• Discuss ways to think reflectively and respond to high-risk students’ comments with effective reflections.

• Discuss specific strategies you will use to incorporate brief alcohol interventions into your everyday work with college students.
Brief Intervention

- Who are you?
- What do you need to know?
- What do you need to do?
Clinical Prevention

“The role of the physician is to amuse the patient while nature cures the disease…”

Voltaire
Brief Alcohol Interventions in Clinical Practice

Top 5 Clinician Tools

1. Summary of Patient’s Drinking Level
2. Drinking Likes and Dislikes
3. Discussing Life Goals
4. Risk Reduction Agreement
5. Drink Tracking Cards


Words and “Pearls” for Providers

**A**lcohol- quantity, frequency, heavy

**B**lackouts / Brain

**C**oncerned / Confidentiality

**E**njoy

**N**ot enjoy

**D**o: patient-clinician plan

**S**upport / self-efficacy

If you don’t occasionally have a patient get upset with you, you are probably not doing a thorough enough job of talking about alcohol or other risky behaviors…
Overview of Training Content

- College student substance use
- “Traditional” interventions
- Goals of interventions
- Stages of change and Motivational Interviewing
Substance Use Data from Monitoring the Future Study (2009 report)

- Alcohol is still the primary drug of choice
  - Past year
    - 82% report any alcohol use
    - 67% report having been drunk
  - Past month
    - 69% report any alcohol use
    - 45% report having been drunk
College Student Drinking

Academic Year Drinking Pattern

DelBoca et al., 2004
Trajectories of “Binge Drinking” During College

Mean score for 5+ drinks in a row in past two weeks by frequent heavy drinking trajectory group

Source: Schulenberg & Maggs (2002), *Journal of Studies on Alcohol*
Substance Use Data from Monitoring the Future Study

- Any illicit drug
  - 35% report past year use
  - 19% report past month use

- Marijuana
  - 32% report past year use
  - 17% report past month use

- Any illicit drug other than marijuana
  - 15% report past year use
    - 6.7% Vicodin
    - 6.5% Narcotics other than heroin
    - 5.7% Amphetamines
    - 5.1% Hallucinogens
    - 5.0% Tranquilizers
  - 7% report past month use
Tobacco vs. Other Drugs

More students reported past year use of any illicit drug (35%) than did past year use of cigarettes (30%)
Alcohol and Drug Use Disorders

**Past year prevalence:**
- Alcohol abuse: 12.5%
- Alcohol dependence: 8.1%

Only 3.9% of full-time college students with an alcohol use disorder received any alcohol services in the past year

Spectrum of Intervention Response

None

Mild

Moderate

Severe

Thresholds for Action

Primary Intervention

Brief Treatment

Specialized Treatment

Prevention
Overview of Training Content

- College student substance use
- “Traditional” interventions
- Goals of interventions
- Stages of change and Motivational Interviewing
Annual Alcohol-related Consequences in US

- 100,000 Deaths
- 3 Million Years of Potential Life Lost (YPLL)\(^1\)
- $185 Billion financial costs
- Highest rates of problems, AUDs: 18-29 year olds \(^2\)
- College Students ages 18-24 \(^3\)
  - 1800 deaths: unintentional EtOH-related injuries
  - 2.8 Million DUIs
  - 500,000 unintentional injuries
  - 600,000 assaults
  - 400,000 unprotected sexual encounters (100,000 no consent)

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What if Alcohol Abuse...
...were a Novel Virus on Campuses?

H1N1

H1N1

ever only!

August 2009 - February 2010
2-3 Million College Students sampled

- 4 deaths
- 94,000 ILI cases
- 169 hospitalizations

August 2009 - February 2010
College Students 18-24 years old

- 1,000 deaths
- 350,000 injuries
- 250,000 unprotected sexual encounters
- 1,600,000 DUIs
- >100,000 suicide attempts

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2. American College Health Association, March 5, 2010
Influenza Like Illnesses (ILI) Surveillance in Colleges and Universities Project   www.acha.org/ILI_Surveillance.cfm
# H1N1

## Common Sense Prevention

<table>
<thead>
<tr>
<th>1. Use alcohol hand gel smartly (often).</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Avoid social and sexual contacts with people if you’re sick.</td>
</tr>
<tr>
<td>3. Avoid sharing your germs.</td>
</tr>
<tr>
<td>4. Don’t forget your flu shots!</td>
</tr>
</tbody>
</table>

| 1. Use alcohol smartly (not often and in moderate amounts). |
| 2. Avoid social and sexual contacts with people if you’re drunk...or you will get sick. |
| 3. Avoid sharing your “drink till you’re drunk” attitude. Rather: “Go for the Buzz, not the Fuzz” |
| 4. Forget the “shots!” |
Rankings of 25 USPSTF-Recommended Clinical Preventive Services

<table>
<thead>
<tr>
<th>Rank</th>
<th>Service</th>
<th>Preventable Burden</th>
<th>Cost Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Daily aspirin use</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Childhood Immunizations</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Smoking Cessation</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol Screening &amp; Brief Intervention</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Colorectal Cancer Screening &gt;50 yo</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Hypertension screening &amp; Rx &gt;18 yo</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Influenza Immunization &gt;50 yo</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Lower: Screening for Cervical and Breast Cancer, Chlamydia, Nutrition, Vision, Cholesterol, Osteoporosis

1= Lowest
5= Highest

US Preventive Services Task Force (USPSTF)
Advisory Committee on Immunization Practices (ACIP)
National Commission on Prevention Priorities
http://www.prevent.org/content/view/43/71


Summary of Recommendation

The U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.

Rating: B Recommendation.

Rationale: The USPSTF found good evidence that screening in primary care settings can accurately identify patients whose levels or patterns of alcohol consumption place them at risk for increased morbidity and mortality. Good evidence exists for brief behavioral counseling interventions in reducing alcohol consumption that are sustained over 6- to 12-month periods or longer. The USPSTF found some evidence that interventions lead to positive health outcomes 4 or more years post-intervention but limited evidence that screening and behavioral counseling reduce alcohol-related morbidity. The evidence on the effectiveness of counseling to reduce alcohol consumption during pregnancy is limited; however, studies in the general adult population show that behavioral counseling interventions are effective among women of childbearing age. The USPSTF concluded that the benefits of behavioral counseling interventions to reduce alcohol misuse by adults outweigh any potential harms.

Institutes:
- U.S. Preventive Services Task Force 2006
- NIAAA
- Institute of Medicine
- WHO
- American Society of Addiction Medicine
- American Academy of Pediatrics
- American College of Surgeons
- Canadian Task Force on Preventive Care

Other Organizations:
- American College of Surgeons
- Canadian Task Force on Preventive Care
Brief Interventions in Medical Settings
At least 100 studies in the medical literature

Community Primary Care
- Wallace (1988)
- Israel (1996)
- Fleming (1997, 1999)
- Ockene (1999)
- Senft (1997)
- Curry (2003)
- Grossberg (2004)

Adolescents
- Monti PM, 1999
- Knight JR et al (2005)
- Sampl S (2001)
- Colby SM et al (2005)
- Walker DD (2006)
- Stern SA (2007)
- D'Amico EJ (2006)

College Students
- Baer et al (1992)
- Borsari and Carey (2000)
- Larimer et al (2001)
- Schaus et al (2009)
- Fleming et al (2009)

Personalized feedback, MI
All influenced drinking and alcohol-related problems

Meta-analyses show most studies have positive outcomes
Over 32 clinical trials studied
- Bien (1983)
- Kahan (1996)
- Wilk (1997)
- Whitlock (2004)
Significance of Primary Care Brief Intervention RCT in Adults

- **TrEAT** found long term reductions in:
  - Alcohol use
  - Emergency Department visits
  - Alcohol harm
  - Alcohol costs

- **Primary care physicians** did the intervention
- Effects lasted up to **4 years** after intervention
- Few minutes of clinician-patient discussions can have powerful impact on health care


Brief Negotiated Intervention
Emergency Department Visits

14 Academic EDs
7,751 pts screened
1,132 high risk enrolled
ED providers trained

Brief Intervention

- Time-limited counseling strategies
- Clinician-directed, patient-centered
- Based on Motivational Interviewing (MI)
- Focus on changing behaviors
  - Alcohol “Other” Clinical Interventions
  - Tobacco, STI, obesity, hypertension, compliance with medication and other medical advice.

- Harm reduction paradigm

- SBIRT: Screening, Brief Intervention, and Referral to Treatment
SBIRT Reimbursement and Performance Measures

- CMS and AMA
  - 2008: CPT codes and Medicare reimbursement
- Joint Commission (JCAHO) performance measures
  - 2009: SBIRT draft requirements
  - 2010: 6-month pilot testing phase
Using the NIAAA Clinician’s Guide

A note to Instructors:

This slide show is a companion to the NIAAA's Clinician's Guide. To order free copies of the Guide, or to download the full-text PDF, visit www.niaaa.nih.gov/guide.

NIAAA introduces a new free online training resource: Video Cases based on the Clinician’s Guide

• Free CME/CE credits offered by Medscape.com
• For details and links, visit www.niaaa.nih.gov/guide
What’s the Same, What’s New in This Update

Same approach to screening and intervention
- The approach presented in the original 2005 Guide remains unchanged.

Updated and new supporting materials
- Updated medications section (pages 13-16)
- Medication management support (pages 17-22)
- Specialized alcohol counseling resource (page 31)
- Online resources at www.niaaa.nih.gov/guide (listed on page 27)
- New patient education handouts: see pages 26-27 and online at www.niaaa.nih.gov/guide
Case 1: Hypertension

“John”, a 25 year old MBA student with essential hypertension, presents for his first visit to student health for refill of his blood pressure medication, having just moved to Madison for grad school. He stopped smoking 4 years ago and is still not smoking. Weight increased 5 lbs. in past year. BP: 136/88, BMI: 31
STEP 1: Ask About Alcohol Use

Prescreen:
*Do you sometimes drink beer, wine, or other alcoholic beverages?*

- If NO… the screening is complete.
- If YES…

“Sure, doc. Mostly beer.”
If YES…

Ask the screening question about heavy drinking days:

**How many times in the past year have you had...**

- **5 or more drinks in a day? (for men)**
- **4 or more drinks in a day? (for women)**

Oh, about twice a week

Tip: It may be useful to show patients the **Standard Drinks** chart on page 24.
What’s a Standard Drink? (page 24)

- In the U.S., a standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons).
STEP 1 (continued):
Is the Screening Positive?

Positive Screening=
- 1 or more heavy drinking days, or...

*For patients given the AUDIT, start here:*
Positive Screening=
- AUDIT score of ≥ 8 for men
  ≥ 4 for women
John's AUDIT = 16

<table>
<thead>
<tr>
<th>Questions</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td>Monthly or less</td>
<td>2 to 4 times a month</td>
<td>2 to 3 times a week</td>
<td>4 or more times a week</td>
</tr>
<tr>
<td>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or 6</td>
<td>7 to 9</td>
<td>10 or more</td>
</tr>
<tr>
<td>3. How often do you have 5 or more drinks on one occasion?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>4. How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>5. How often during the last year have you failed to do what was normally expected of you because of drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>8. How often during the last year have you been unable to remember what happened the night before because of your drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>9. Have you or someone else been injured because of your drinking?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
STEP 1: Is the Screening Positive?

If **NO** then…

- Advise staying within these limits:

  **Maximum Drinking Limits**

  For healthy **men up to age 65**—
  - no more than 4 drinks in a **day** AND
  - no more than 14 drinks in a **week**

  For healthy **women** (and healthy **men over age 65**)—
  - no more than 3 drinks in a **day** AND
  - no more than 7 drinks in a **week**
STEP 1: Is the Screening Positive?

If **NO** then...

*In addition…*

- Recommend **lower limits or abstinence** as medically indicated for patients who...
  - take **medications** that interact with alcohol
  - have **health conditions** exacerbated by alcohol
  - are **pregnant** (advise abstinence)

- Express **openness to talking** about alcohol use and any concerns it may raise

- **Rescreen** annually
STEP 1: Is the Screening Positive?

If **YES** then...

- Your patient is an at-risk drinker. For a more complete picture of the drinking pattern, **determine the weekly average**:
  - On average, how many **days** a week do you have an alcoholic drink?
  - On a typical drinking day, how many **drinks** do you have?

**Weekly Average**

- Fri & Sat: 6 or 8 beers
- 2 weekdays: 3 or 4 beers
- 18 - 24
STEP 1: Is the Screening Positive?
If **YES** then...

- Record the following:
  - heavy drinking days in the past year and
  - the weekly average

Tip: Download preformatted Progress Notes and templates from NIAAA at [www.niaaa.nih.gov/guide](http://www.niaaa.nih.gov/guide) - see materials listed on page 27
STEP 2: Assess for Alcohol Use Disorders (AUDs)

Determine if there is—

- a maladaptive pattern of alcohol use

- causing clinically significant impairment or distress
STEP 2: Assess for Alcohol Use Disorders (AUDs) cont’d

It is important to assess the severity and extent of all alcohol-related symptoms to inform your decisions about management.

The Guide presents a list of symptoms adapted from the DSM-IV, Revised.

Sample assessment questions are available online at www.niaaa.nih.gov/guide
STEP 2: Assess for AUDs (cont’d)

Determine whether, in the past 12 months, your patient’s drinking has *repeatedly* caused or contributed to:

- ✓ Risk of bodily harm
- ✓ Relationship trouble
- □ Role failure
- □ Run-ins with the law

If YES to **one or more** your patient has **Alcohol Abuse**

In **either case**, proceed to assess for **Dependence** symptoms.
STEP 2: Assess for AUDs (cont’d)

Determine whether, in the past 12 months, your patient has...

☐ not been able to stick to drinking limits (repeatedly gone over them)
☐ not been able to cut down or stop (repeated failed attempts)
☐ shown tolerance (needed to drink a lot more to get the same effect)
☐ shown signs of withdrawal (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
☐ kept drinking despite problems (recurrent physical or psychological problems)
☐ spent a lot of time drinking (or anticipating or recovering from drinking)
☐ spent less time on other matters (activities that had been important or pleasurable)

If Yes to **three or more** your patient has

⇒ **Alcohol Dependence**
STEP 2: Assess for AUDs (cont’d)

Does the patient meet the criteria for alcohol abuse or dependence?

If NO: patient is still at risk for developing alcohol-related problems. Go to Steps 3&4 for At-Risk Drinking page 6

If YES: Your patient has an alcohol use disorder. Go to Steps 3&4 for Alcohol Use Disorders page 7
AT-RISK DRINKING
(no abuse or dependence)

STEP 3: Advise and Assist

- State your conclusion and recommendation clearly

Consider using the chart on page 25 to show increased risk. See page 29 for advice considering recommendations.

“I strongly recommend that you cut down (or quit), and I’m willing to help.”
**WHAT’S YOUR DRINKING PATTERN?**

<table>
<thead>
<tr>
<th>Based on the following limits—number of drinks:</th>
<th>HOW COMMON IS THIS PATTERN?</th>
<th>HOW COMMON ARE ALCOHOL DISORDERS IN DRINKERS WITH THIS PATTERN?</th>
</tr>
</thead>
<tbody>
<tr>
<td>On any <strong>DAY</strong>—Never more than 4 (men) or 3 (women) – and – In a typical <strong>WEEK</strong>—No more than 14 (men) or 7 (women)</td>
<td>Percentage of U.S. adults aged 18 or older*</td>
<td>Combined prevalence of alcohol abuse and dependence**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Never exceed the daily or weekly limits</strong></th>
<th>72%</th>
<th>fewer than 1 in 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2 out of 3 people in this group abstain or drink fewer than 12 drinks a year)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Exceed only the daily limit</strong></th>
<th>16%</th>
<th>1 in 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>(More than 8 out of 10 in this group exceed the daily limit <em>less than once a week</em>)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Exceed both daily and weekly limits</strong></th>
<th>10%</th>
<th>almost 1 in 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>(8 out of 10 in this group exceed the daily limit <em>once a week or more</em>)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Not included in the chart, for simplicity, are the 2 percent of U.S. adults who exceed only the weekly limits. The combined prevalence of alcohol use disorders in this group is 8 percent.

** See page 5 for the diagnostic criteria for alcohol disorders.
Case 1: Hypertension

- **MD:** As your physician, I am concerned about your drinking. The recommended limits for men are no more than 4 drinks a day, and 14 drinks a week. But with your blood pressure and medication, you should be well below that, or even consider abstaining. What’s a realistic amount you can cut down to?

- **John:** I think I could stick to 3 or 4 beers max on Fridays and Saturdays, and try for 2 or 3 on those couple of nights during the week.

- **MD:** That’s a great improvement. You mentioned your wife’s not happy about your drinking. How has drinking affected your relationship...

...and how supportive do you think she’ll be with these changes you are going to make?
STEP 4: At Followup: Continue Support

REMINDER: At each visit—
• document alcohol use, and
• review goals

✓ Obtain the drinking quantity and frequency at followup visits

Tip: Download Progress Notes from www.niaaa.nih.gov/guide -- see materials listed on Page 27
This pocket guide is condensed from the 34-page NIAAA guide, Helping Patients Who Drink Too Much: A Clinician’s Guide. Visit www.niaaa.nih.gov/guide for related professional support resources, including: patient education handouts; preformatted progress notes; animated slide show for training; materials in Spanish.

Or contact: NIAAA Publications Distribution Center PO. Box 10686, Rockville, MD 20849-0686 (301) 443–3860 www.niaaa.nih.gov

Updated 2005 Edition

A POCKET GUIDE FOR Alcohol Screening and Brief Intervention

WHAT’S A STANDARD DRINK?

A standard drink in the United States is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents as well as the number of standard drinks in common consumer sizes for each beverage. These are approximate, since different brands and types of beverages vary in their actual alcohol content.

<table>
<thead>
<tr>
<th>BEVERAGE</th>
<th>STANDARD DRINK</th>
<th>APPROXIMATE NUMBER OF DRINKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 oz. of MALT LIQUEUR</td>
<td>12 oz.</td>
<td>12</td>
</tr>
<tr>
<td>8-9 oz. of TABLEWATER</td>
<td>12 oz.</td>
<td>3.2</td>
</tr>
<tr>
<td>12 oz. of 100% MALT LIQUEUR</td>
<td>12 oz.</td>
<td>12</td>
</tr>
<tr>
<td>750 mL (25-oz. bottle) of 80-proof SPIRITS (hard liquor)</td>
<td>12 oz.</td>
<td>12</td>
</tr>
<tr>
<td>1.5 oz. of 50-proof SPIRITS (hard liquor)</td>
<td>1 oz.</td>
<td>1</td>
</tr>
</tbody>
</table>

HOW TO SCREEN FOR HEAVY DRINKING

Ask: Do you sometimes drink beer, wine, or other alcoholic beverages?

Ask the screening question about heavy drinking days

How many times in the past year have you had...

One standard drink is equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

Is the answer 1 or more?

Your patient is at-risk drinker. For a more complete picture of the drinking pattern, determine the weekly average.

• On average, how many days do you have an alcoholic drink?
• On a typical drinking day, how many drinks do you have?

Weekly average

Recommend heavy drinking days in context for controls, for patients whose diagnosis matches established risk factors, or are pregnant.

Remove alcohol.

• Advise staying within those limits:

Maximum Drinking Limits
For healthy men up to age 65—no more than 4 drinks in a day and 14 drinks a week. For healthy women and healthy men age 66 or older—no more than 3 drinks in a day and 12 drinks a week. Recommended lower limits or abstinence as indicated for controls, for patients whose diagnosis matches established risk factors, or are pregnant.

Remain sober.

• On average, how many days do you have an alcoholic drink?
• On a typical drinking day, how many drinks do you have?

Weekly average

Record heavy drinking days in context for controls, for patients whose diagnosis matches established risk factors, or are pregnant.

• Yes
• No

Next, determine if there is a maladaptive pattern of alcohol use, causing clinically significant impairment or distress.

How to Assess for Alcohol Use Disorders

STEP 1 Ask About Alcohol Use

STEP 2 Assess For Alcohol Use Disorders

Determine whether, in the past 12 months, your patient’s drinking has repeatedly caused or contributed to:

• risk of health harm (drinking and driving, operating machinery, etc).
• relationship trouble (family or friends).
• role failure (interference with work, school obligations).
• run-ins with the law (arrests or other legal problems).

If yes to one or more, your patient has alcohol dependence.

In one case, proceed to assess for alcohol dependence.

Determine whether, in the past 12 months, your patient has:

• not been able to cut down or stop (expansion of failed attempts).
• not been able to stick to drinking limits (expands gone out on their own). 0
• shows tolerance (needed to drink a lot to get the same effect).
• signs of withdrawal (nervousness, sweating, or insomnia when trying to quit or cut down).
• kept drinking despite problems (seemingly physical or psychological problems).

If yes to one or more, your patient has alcohol dependence.

In one case, proceed to assess for alcohol dependence.

STEP 3 Advise and Assist

How to Conduct a Brief Intervention

STEP 4 At-Risk Drinking (no abuse or dependence)

• State your conclusion and recommendation clearly and relate it to medical concerns or findings.
• Gauge readiness to change drinking habits.

Is patient ready to commit to change?

• Restore your concern.
• Encourage reflection.
• Address barriers to change.
• Encourage to set a goal.
• Help set a goal.
• Provide educational materials (e.g., how-niaaa.org/wp).

STEP 5 At-Risk Drinking (abuse or dependence)

• Acknowledge that change is difficult.
• Support positive change.
• Restate goal and risks.
• Consider option for treatment.
• Encourage to set a goal.
• Help set a goal.
• Provide educational materials (www.niaaa.gov/wp).

STEP 8 At Followup: Continue Support

After completing initial assessment and action, consider a trial of medically managed withdrawal to help set a goal.

Is patient ready to meet and sustain drinking goal?

• Acknowledge that change is difficult.
• Support efforts to cut down or abstain.
• Relax drinking to upcoming obstacles.
• Consider if referral is needed.
• Assess patient for readiness.
• Encourage to set a goal.
• Help set a goal.
• Provide educational materials.

STEP 9 After Followup: Continue Support

REMINDER: Discontinue alcohol use and review goals at each visit.

Was patient able to meet and sustain drinking goal?

• Acknowledge and support continued adherence.
• Reinforce sustained abstinence.
• Recognize dependence issues.
• Avoiding or reducing medication for alcohol-dependent patients who are enrolled in treatment.
• Address coexisting disorders—medical and psychiatric—assisted.

• Support and reinforce continued adherence.
• Consider case with medications, as appropriate.
• Maintain medications for alcohol dependence for at least 5 months and as clinically indicated.
• Test treating nicotine dependence.
• Address coexisting disorders—medical and psychiatric—assisted.

PREScribing Medications

The chart below contains excerpts from page 16 of NIAAA’s Helping Patients Who Drink Too Much: A Clinician’s Guide. It does not provide complete information and is not meant to be a substitute for the patient package inserts or other drug information used by healthcare providers. For patient information, visit www FDA.gov/medwatch.

<table>
<thead>
<tr>
<th>NALTREXONE</th>
<th>DOLITRIUM</th>
<th>ACAMPROSATE</th>
<th>DOPAMINE</th>
<th>CONTRAINDICATIONS</th>
<th>PRECAUTIONS</th>
<th>SERIOUS REACTIONS</th>
<th>EXAMPLES OF DRUG INTERACTIONS</th>
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<tr>
<td>Naltrexone (Duodopa®, Velves®)</td>
<td>Dolitrinum (Abused®)</td>
<td>Acamprosate (Camplor®)</td>
<td>DOPAMINE</td>
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<td>Examples of Drug Interactions</td>
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<td>Action</td>
<td>Oral medication, working to reduce or discontinue drinking in response to drug therapy.</td>
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Note: Which is not a medication should be prescribed and in whom amount is a matter between individuals and their health-care providers. The prescribing information provided here is not a substitute for a prescriber’s judgment in individual circumstances and the NIAAA accepts no liability for the use of such information by anyone other than the provider. January 2007
NIAAA Introduces…

**Free Interactive Web-based Training**

- Four engaging, 10-minute video cases, plus a 20-minute tutorial
- Free CME/CE credits through Medscape.com

Online technology brings training to your desktop

Meet the patients:
- …four heavy drinkers at different levels of severity and readiness to change
- …seen in a variety of settings

Experts offer insights and ask what you would do in each situation

Realistic video scenarios show the Clinician’s Guide in action

For details and links, visit www.niaaa.nih.gov/guide
To order free copies of the Guide, Pocket Guide, or the CD, contact NIAAA…

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Rockville, MD 20849-0686

**By phone** 301-443-3860

**Online** [www.niaaa.nih.gov/guide](http://www.niaaa.nih.gov/guide)
Do you enjoy a drink now and then? Many of us do, often when socializing with friends and family. Drinking can be beneficial or harmful, depending on your age and health status, and, of course, how much you drink.

For anyone who drinks, this site offers valuable, research-based information. What do you think about taking a look at your drinking habits and how they may affect your health? Rethinking Drinking can help you get started.

“Sometimes we do things out of habit and we don’t really stop to think about it. This made me think about my choices.”

“It emphasized that drinking is not bad in and of itself—it’s how much you’re doing it and how it’s affecting your life.”

“I thought the strategies for cutting down were really good. It gives you tools to help yourself.”

These are comments from social drinkers who reviewed the Rethinking Drinking booklet in focus testing. We welcome your comments on the booklet and this Web site as well. Send us an email.
Binge Drinking by UW-Madison Students

- “In an average 2-week period, you bingeed more often than 90% of other US college students...”
- What are your thoughts about that?”

Number of binges in past 2 weeks

- **None**: 53%
- **1**: 15%
- **2**: 12%
- **3**: 7%
- **4**: 6%
- **5**: 3%
- **6**: 2%
- **7**: 1%
- **8+**: 1%

“twice a week” (4x in 2 weeks)

American College Health Association
National College Health Assessment (ACHA-NCHA)
UW-Madison representative sample, Spring 2006, N=787
National Reference Group Data Report, N=93,727
Marijuana Use by UW-Madison Students

American College Health Association
National College Health Assessment (ACHA-NCHA)
UW-Madison representative sample, Spring 2006, N=787
National Reference Group Data Report, N=93,893

• “This month you smoked weed more often than 93% of other US college students...
• What are your thoughts about that?”

“once a week”
4x per month

UW-Madison National

Never Not now 1 - 2 3 - 5 6 - 9 10 - 19 20 - 29 Daily

Number of days in past month
“Partying” Perceptions Nationally

American College Health Association
National College Health Assessment (ACHA-NCHA)
National Data Report, Spring 2006
N= 94,806, representative sample

Number of drinks at last “partying/socializing”

- Actual Self-report
- Perceived “typical” student
The majority of high-risk drinking college students “mature out” of problematic patterns as they move through their 20s…

Why do we care?
Well connected... by age 25...
Neurodevelopment: Booze, Brains, Behavior

- Dopamine increase: response to natural rewards (food/music), drugs of abuse
- Motivational circuitry rapidly expanding
  - Novel experiences, risky/impulsive behaviors, motivation to repeat
  - Soaring levels of sex hormones, overriding interest in sex
- Inhibitory mechanisms developing slower; synapses needing more time
- Frontal cortex still “under construction” until early to mid 20’s
- Alcohol: damage to frontal areas, hippocampus, amygdala, more severely
  - Functional MRI studies: impaired processing of emotions, facial expressions
- Earlier bingeing: long-term cognitive impairment (memory, visual, spatial)

Patient Ambivalence

Change
Change
Change

Don’t change
Don’t change
Don’t change
Clinicians’ Usual Advice about Health Behavior Change

- It’s not very effective
- We do it anyway (we’ve been trained to)
- It lowers our anxiety

If we go into “giving advice mode”, or sound like we’re lecturing, we can re-connect with the patient by saying something like:

“So, what do you make of that?”...
“If your time is limited, you are better off asking students why they would want to make a change and how they might do it rather than telling them that they should. It is the student rather than you who should be voicing the arguments for behavior change.”

Overview of Training Content

- College student substance use
- “Traditional” interventions
- Goals of interventions
- Stages of change and Motivational Interviewing
What is Harm Reduction?

- The optimal outcome following a harm reduction intervention is abstinence.
- Any steps toward reduced risk are steps in the right direction.
How are these principles implemented in an intervention with college students?

- Legal issues are acknowledged
- Strategies for abstainers
- If one makes the choice to use, skills are described on ways to do so in a less dangerous and less risky way.
- A clinician or provider must elicit personally relevant reasons for changing.
  - This is done using the Stages of Change model and Motivational Interviewing.
Overview of Training Content

- College student substance use
- “Traditional” interventions
- Goals of interventions
- Stages of change and Motivational Interviewing
The Stages of Change Model

- Precontemplation
- Contemplation
- Preparation/Determination
- Action
- Maintenance
Stages of Change in Substance Abuse and Dependence: Intervention Strategies

1. Precontemplation Stage
2. Contemplation Stage
3. Action Stage
4. Maintenance of Recovery Stage
5. Relapse Stage

- **MOTIVATIONAL ENHANCEMENT STRATEGIES**
- **ASSESSMENT AND TREATMENT MATCHING**
- **RELAPSE PREVENTION & MANAGEMENT**
Motivational Interviewing: A Definition

- Motivational Interviewing is a
  - Person-centered
  - Directive
  - Method of communication
  - For enhancing intrinsic motivation to change by exploring and resolving ambivalence
What is resistance?

- Resistance is verbal behaviors
- It is expected and normal
- It is a function of interpersonal communication
- Continued resistance is predictive of (non) change
- Resistance is highly responsive to style of the provider
The Spirit of Motivational Interviewing

- Motivation for change is elicited from the individual, and not imposed from without.

- It is the student’s task, not the provider’s, to articulate and resolve his or her ambivalence.
Direct persuasion is not an effective method for resolving ambivalence.

The style is generally a quiet and eliciting one.

The provider/clinician is directive in helping the individual to examine and resolve ambivalence.
The Spirit of Motivational Interviewing

- Readiness to change is not an individual trait, but a fluctuating product of interpersonal interaction.

- The relationship is more like a partnership than expert/recipient roles.
Four Principles of Motivational Interviewing

- Express Empathy
  - Research indicating importance of empathy

- Develop Discrepancy
  - Values and goals for future as potent contrast to status quo
  - Student must present arguments for change: provider declines expert role
Four Principles of Motivational Interviewing

- Roll with Resistance
  - Avoid argumentation
  - Confrontation increases resistance to change
  - Labeling is unnecessary
  - Provider’s role is to reduce resistance, since this is correlated with poorer outcomes
  - If resistance increases, shift to different strategies
  - Objections or minimization do not demand a response
Four Principles of Motivational Interviewing

- **Support Self-Efficacy**
  - The student we’re working with is responsible for choosing and implementing change
  - Confidence and optimism are predictors of good outcome in both the provider and the person he or she is working with
OARS: Building Blocks for a Foundation

- Ask Open-Ended Questions
  - Cannot be answered with yes or no
  - Provider does not know where answer will lead
    - “What do you make of this?”
    - “Where do you want to go with this now?”
    - “What ideas do you have about things that might work for you?”
    - “How are you feeling about everything?”
    - “How’s the school year going for you?”
Exercise: Open-ended Questions in Response to students’ comments:

• Spring break was awesome. It’s made it kind of tough to get things rolling academically again.

• My roommate sucks. That’s the bottom line.

• I know I’m not the smartest person in my class, and sometimes I wonder if I should even be in college right now.

• I get depressed every winter, but nothing has seemed to help. Sometimes I wonder if I should look into medication, but I don’t want to get better “artificially.”

• I know my partner doesn’t treat me the way I’d like, but I don’t want to wind up alone by breaking up…

• My parents want me to go home this weekend, but I really want to hang out here. Makes me feel like I’m letting them down somehow.
OARS: Building Blocks for a Foundation

- **Affirm**
  - Takes skill to find positives
  - Should be offered only when sincere
  - Has to do with characteristics/strengths
    - “It is important for you to be a good student”
    - “You’re the kind of person that sticks to your word”
Listen **Reflectively**

- **Effortful process: Involves Hypothesis Testing**
  - A reflection is our “hypothesis” of what the other person means or is feeling

- **Reflections are statements**
  - Student: “I’ve got so much to do and I don’t know where to start.”
  - Provider: “You’ve got a lot on your plate.”
  - Student: “Yes, I really wish things weren’t this way” or... “No, I’m just not really motivated to get things started.”

- “Either way, you get more information, and either way you’re receiving feedback about the accuracy of your reflection.” (p. 179, Rollnick, Miller, & Butler, 2008)
Reflective Listening: A Primary Skill

- “Hypothesis testing” approach to listening
- Statements, not questions
- Voice goes down
- Can amplify meaning or feeling
- Can be used strategically
- Takes hard work and practice
Hypothesis Testing Model

1. What speaker means
2. What speaker says
3. What listener hears
4. What listener thinks speaker means
Types of reflections...

“I’ve been feeling stressed a lot lately...”

- Repeating
  - “You’ve been feeling stressed.”

- Rephrasing
  - “You’ve been feeling anxious.”

- Paraphrasing
  - “You’ve been feeling anxious, and that’s taking its toll on you.”

- Focusing on emotional component
  - “And that’s taking its toll on you.”
Reflection

My partner won’t stop criticizing me about my drinking.

Your partner is concerned about your drinking.

-- or --

And that annoys you.

-- or --

It feels like your partner is always on your case.
Amplified Reflection

I don’t see any reasons to change my drinking...I mean, I just like drinking alcohol.

*Sounds like there are no bad things about drinking for you.*
Motivational Interviewing Strategies

- Double-Sided Reflection

Student: I’ve been drinking with my friends in my room. My parents are always lecturing me about it. They’re always saying that it makes my depression worse.

Provider: Sounds like you get a hard time from your parents about how drinking affects your depression.

Student: Yeah... I mean, I know that it affects my mood a little, but I don’t drink that much and when I do, I really enjoy it, you know?
Motivational Interviewing Strategies

- Double-Sided Reflection

Provider: What do you enjoy about drinking?

Student: I like the fact that it helps me chill out with my friends.

Provider: So on the one hand you enjoy drinking because you feel that it helps you chill out with your friends, and on the other hand it you’ve noticed that it has some effect on your mood.
Exercise: Respond with Reflections to students’ comments:

• Spring break was awesome. It’s made it kind of tough to get things rolling academically again.

• My roommate sucks. That’s the bottom line.

• I know I’m not the smartest person in my class, and sometimes I wonder if I should even be in college right now.

• I get depressed every winter, but nothing has seemed to help. Sometimes I wonder if I should look into medication, but I don’t want to get better “artificially.”

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• My parents want me to go home this weekend, but I really want to hang out here. Makes me feel like I’m letting them down somehow.
OARS: Building Blocks for a Foundation

- **Summarize**
  - Periodically to...
    - Demonstrate you are listening
    - Provide opportunity for shifting
Building Blocks for a Foundation

Strategic goal:

- Elicit Self-Motivational Statements
  
  - “Change talk”
  
  - Self motivational statements indicate an individual’s concern or recognition of need for change
  
  - Arrange the conversation so the individual makes arguments for change
Ambivalence

- “I need to lose some weight, but I’m too tired to exercise at the end of the day.”
- “I should quit smoking, but I just can’t seem to do it.”
- “I mean to take my medicine, but I keep forgetting.”
  - Look for “but” in the middle...
  - When the practitioner takes up the “pro” side, the patient could fill in the other side of the argument

Rollnick, Miller, & Butler, 2008
Provider Strategies for Eliciting Self-Motivational Statements

- **Decisional Balance Exercise**
  
<table>
<thead>
<tr>
<th>Continuing the Status Quo</th>
<th>Making a Change</th>
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</table>

- **Using Extremes**
  
  - “What concerns you the most?”
  - “What are your worst fears about what might happen if you don’t change (or keep going the way you’re going)?”

Miller & Rollnick (1991)
Provider Strategies for Eliciting Self-Motivational Statements

- **Strategies to Elicit Them**
  - **Looking Back**
    - “Think back to before this issue came up for you. What has changed since then?”
  - **Looking Forward**
    - “How would you like things to turn out for you?”
    - “How would you like things to be different?”
    - “What are the best results you can imagine if you make a change?”
  - **Exploring Goals**
  - **Asking Provocative Questions**

Miller & Rollnick (1991)
Listen for Change Talk: Themes

- **D: Desire**
  - “I wish I could lose some weight”
  - “I like the idea of getting more exercise”

- **A: Ability**
  - “I might be able to cut down a bit”
  - “I could probably try to drink less”

- **R: Reasons**
  - “Cutting down would be good for my health”
  - “I’d sure have more money if I cut down”

- **N: Need**
  - “I must get some sleep”
  - “I really need to get more exercise”

*Examples from and/or adapted from: Rollnick, Miller, & Butler (2008)*
Listen for Change Talk: Themes

- Commitment is a form of change talk
  - “I will...”
  - “I intend to...”

- Taking steps is also a form of change talk
  - “I tried a couple of days without drinking this week”
  - “I walked up the stairs today instead of taking the escalator.”

Examples from: Rollnick, Miller, & Butler (2008)
Listen for Change Talk: Themes

- Ask questions to elicit change talk
- **Desire:** “What do you want, like, wish, hope, etc.?"
  - “Why might you want to make this change?”
- **Ability:** “What is possible? What can or could you do? What are you able to do?”
  - “If you did decide to make this change, how would you do it?”

Examples from: Rollnick, Miller, & Butler (2008)
Listen for Change Talk: Themes

- Ask questions to elicit change talk
- Reasons: “Why would you make this change? What would be some specific benefits? What risks would you like to decrease?”
  - “What are the most important benefits that you see in making this change?”
- Need: “How important is this change? How much do you need to do it?”
  - “How important is it to you to make this change?”

Examples from: Rollnick, Miller, & Butler (2008)
Using a Ruler

- “How strongly do you feel about wanting to get more exercise? On a scale from 1 to 10, where 1 is “not at all” and 10 is “very much,” where would you place yourself now?

- “How important would you say it is for you to stop smoking? On a scale from 1 to 10, where 1 is “not at all important,” and 10 is “extremely important,” what would you say?

- Then, ask why a lower number wasn’t given

- The answer = change talk!

Rollnick, Miller, & Butler, 2008
Key Questions: What Next?

“So what do you make of all this now?”
“What do you think you’ll do?”
“What would be a first step for you?”
“What do you intend to do?”

Rollnick, Miller, & Butler, 2008
“30-Seconds” Brief Intervention in Clinical Visits

• Tobacco listed as part of “vital signs”: 15-30 seconds
  • It says here you smoke cigarettes [“yeah”]
  • What do you think about that? [“I should quit”]
  • Why?...[“this cough’s a drag...” “my girlfriend hates it” etc..]
  • Good for you. What would like to do? [varied responses]
  • What worked/didn’t work in the past? We’ll help you...

• Tobacco not listed in vitals: 15-30 seconds
  • Do you smoke...anything?  [cigarettes... weed...?]
  • Every day...week...month...? [observe non-verbals]
  • What do you think about that?

• Smoking link to alcohol question: another 15-30 seconds
  • Do you smoke more when you’re drinking? [“yeah”]
  • What does your girlfriend think about that? [“She’s tried to get me to drink less”]
  • What did you do? [“I stopped going out on Thursdays”]
  • How did you feel [“better”]...
Brief Intervention example without MI Principles

“Well, Tom, you drink too much. It’s bad for you and will affect your job and can mess up relationships. You might get in a serious accident, forget to use a condom and get STIs or HIV. As your doctor, I recommend that you cut down to 3 or 4 drinks when you go out with your friends.”
Motivational Interviewing
Rolling with Resistance: example 1

- **Patient:** I don’t think I have a problem or need to cut down
down.

- **Clinician:** You enjoy drinking and don’t think that reducing it would work for you right now.

  *Reflective Listening; trying to be guiding*

- **Patient:** I’m having too much fun with all my friends.

- **Clinician:** OK, so how would you know if you are having a problem with drinking?… *open*

  What are your worst fears about what might happen if you don’t make any changes in your drinking?

  …What would have to happen for you to make a change?

  …How about your friends?… *open*
Motivational Interviewing
Rolling with Resistance: example 2

- Patient: “I don’t think I have a problem or need to cut down”
- Clinician: “Only you can decide to reduce your alcohol use. I’ll help you take care of these medical problems and hopefully help you prevent more troubles with drinking, but you are in charge of what you do. How about trying to cut down for a month or so and seeing how it goes?” [guiding; asking]
Motivational Interviewing
Rolling with Resistance: example 3

- Patient: “I don’t really have a problem or need to cut down”
- Clinician: “Actually, Tom, I have to respectfully disagree. Considering your broken hand, the hole in the wall, and the fact that your girlfriend won’t talk to you, I think the alcohol has contributed quite a bit to this situation. What do you think?”
Case 2: Wound Check

- Kevin, a 21 year-old junior at UW, presents for a nurse visit to check a recently sutured wound for possible infection. He had sustained a laceration above the right ankle from his bicycle chain when he fell 2 days previously. At that time it was cleansed and sutured without problems, but for the past day or so it has been red and swollen and painful. RN asks MD to stop in.
- Exam: Afebrile, normal vitals, mild to moderate erythema and tenderness about 1 cm around sutured wound, consistent with mild cellulitis.
  - Rx antibiotic, wound monitoring and care (Friday)
Case 2: Wound Check (cont’d)

• Alcohol history:
  • MD: “It’s a weekend, and I’m giving you a prescription, and since medications often interact with alcohol, I always ask about drinking. What’s your usual alcohol intake like on the weekends?”
  • Kevin: “Oh, about 1/3 Liter of Vodka, Fri. and on Sat…”
  • MD: [calculating…] “So, let’s see, that’s about 7-8 standard drinks twice a week…”
    • ever have any blackouts?: “yes”
    • what did you think of those?: “not good”
    • FHx?: “Dad, uncles…”
    • “So, what do you think, about your drinking?”
  • Kevin: “Well, I’m much better than last year!”
Case 2: Wound Check (cont’d)

• Alcohol history (continued):
  • MD: “That’s good... but as your physician I must tell you I’m concerned about your drinking, especially with your family history...How much were you drinking last year?”
  • Kevin: “Oh, it was probably more like 1/2 L on weekend nights”
  • MD: “Glad to hear you cut that down. Now, with your wound infection, it’s important to avoid drinking this weekend. Any problems with that?”
  • Kevin: “No, I’m good”
  • MD: “How about after that?... Halloween’s in 2 weeks... What can you cut down to?”
  • Kevin: “About, hmm...1/5 Liter once or twice a week...”
  • MD: “Sounds better than 1/3 L. So, that’s about 4-5 drinks max. Let me know how it goes. And be sure to check in sooner if the wound is not improving... ”
Case 2: Wound Check (cont’d)

• 1 week later, Kevin returns for a nurse visit for suture removal. MD notices patient entering exam room with nurse, and stops in.
  • MD: “How’s it going?”
  • Kevin: “Haven’t had anything to drink; been studying a lot this week. I’m fine, doc, but I’m really worried about my buddy Mike who was in the ER last weekend getting 13 stitches. He rode his bike into a parked car after drinking...”
  • MD: “Too bad. Did he hurt his head or neck?”
  • Kevin: “No. He was lucky--just the stitches”
  • MD: “Feel free to give him my card and tell him he’s welcome to talk with me or set up an appointment”
Case 2: Wound Check (cont’d)

- 1 week later, medical assistant stops MD in hallway to say “a student wants to talk to you about something”. “Mike” [*unfamiliar name*] is at clinic for nurse appointment for suture removal...
  - Mike: “Hi. My friend Kevin told me to come and talk to you about my stitches and my drinking...”
  - Clinician: [*surprised, now remembering the connection*] “Good that you followed through on that. Tell me what happened...” [*open*]
Case 3: Bike Accident

Mike: “One of my neighbors was having a party last Friday and I had a bunch of beers and some shots. Then I needed to get going to meet some friends on State Street. I thought I was OK so I hopped on my bike, but I must have been going too fast and swerved into a parked car and hit my head. I don’t remember all that much, but it’s a good thing Susie was outside. She heard the crash and saw me bleeding and called 911.”
Case 3: Bike Accident (cont’d)

- Clinician: Sounds like you have some friends who care about you. [reflective listening; affirming]

- Mike: Yeah, they stayed with me at the ER the whole time. After the CT scan and 13 stitches in my head, I guess I’m pretty lucky.

- Clinician: You’re right; it could have been a lot worse. The sutures look pretty good, ready to come out, and you’ll see the nurse in a minute for that. So how can I help you? [open]
Case 3: Bike Accident (cont’d)

- **Mike:** Well, Kevin said you know a lot about drinking and I should talk to you.
- **Clinician:** So what do **you** think about your drinking? [open]
- **Mike:** Well, it’s gotten me into a lot of trouble lately, so I should probably cut down.
- **Clinician:** Why? [open; guiding]
- **Mike:** Well, my girlfriend broke up with me and I’ve been drinking a lot more since that happened... and now this bike accident shook me up, so I don’t know what to do.
- **Clinician:** What do you like about drinking? [open; elicit]
Case 3: Bike Accident (cont’d)

- **Mike:** It’s fun...social...relaxing...good way to meet people.
- **Clinician:** How much do you usually drink? [open]
- **Mike:** Oh, about 10 beers, weekend nights, and a couple of shots. (2 or 3 times a week)
- **Clinician:** So, that’s about 100-120 drinks a month. [guiding]
- **Mike:** Wow... never really counted ‘em up...
- **Clinician:** What do you NOT like about drinking? [open]
- **Mike:** Well, the bike accident was pretty stupid, but I, uhh... guess I sometimes get a little nasty when I drink too much, and that probably didn’t help things with my girlfriend...
- **Clinician:** So what would you like to do? [open; guiding]
Case 3: Bike Accident (cont’d)

- Mike: Well, I know I should cut down, but I like going out...
- Clinician: Sounds like on the one hand, you’re concerned about how drinking has affected your relationship with your girlfriend, and on the other hand, you enjoy alcohol when you going out...[“exactly”]. So, what would be a realistic amount you could cut down to?
- Mike: OK, well...maybe 6 or 7 beers, twice a week...
- Clinician: Over how many hours [“4 or 5”]. Sounds like a reasonable plan. Who will support you in sticking with that? [guiding]
- Mike: Susie, and Kevin I guess.
- Clinician: Great. When will you talk with them about this? [guiding]
- Mike: Tonight.
- Clinician: Good. And let me know how it goes. Thanks for stopping to talk with me. You’re welcome to make a follow up appointment anytime if I can help with this or anything else. And now I’ll let Rita know you’re ready to get rid of those stitches...
Case 3: Bike Accident (cont’d)

- Total clinic time for bike accident “detour”
  - 3.5 minutes
- Value to patient:
  - “priceless” ...
Specific Tips for Reducing the Risk of Alcohol Use

- Set limits
- Keep track of how much you drink
- Space your drinks
- Alternate alcoholic drinks with non-alcoholic drinks
- Drink for quality, not quantity
- Avoid drinking games
- If you choose to drink, drink slowly
- Don’t leave your drink unattended
- Don’t accept a drink when you don’t know what’s in it
Questions...

• When people start to lose their buzz, what do they usually do?
• Do they ever get that same buzz back?
Stimulant or “buzz” feeling

Baseline (normal activity)

Depressant effects
## Blood Alcohol Concentration

As a Function of Drinks Consumed and Time Taken to Consume

### Male 185 lbs.

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Expect: No Alcohol and Alcohol.
College Health Intervention Projects (CHIPs)

- A 5-year study (2004-2009), 5 campuses in U.S./Canada
- Randomized Control Trial, n=986 high-risk drinkers
- Designed to test the efficacy of brief clinician intervention on reducing the frequency of high-risk drinking and alcohol-related harms in college students

Principal Investigator: Michael Fleming, MD, MPH
Co-Investigators: Paul Grossberg, MD, David Brown, PhD
Funding Source: National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Binge Drinking* Among College Students Receiving Routine Care at Health Services

CHIPs Study  N= 11,329

- Wisconsin: N=5532, 65%
- Vancouver: N=1420, 55%
- Seattle: N=4377, 46%

*past 30 days

1-2 times
3-4 times
5 or more

years old
Case 4: CHIPs Study Patient

Tim, a 20 year old junior, journalism major, comes to clinic for his first CHIPs study appointment. His overview reveals:

- 128 drinks/month, about 32 per week.
- 10 binges per month
- Highest estimated BAC, past month: 0.31
- Several blackouts, regretted actions, tolerance
Binge Drinking Progression

Drinks Per Week

Fresh Soph Junior Senior

“What happened here?”

“What happened here?”
Case 4: CHIPs Study Patient: Tim (cont’d)

“Well, I came out last year, and right around then I broke up with my boyfriend and met lots of great new friends, and all they like to do is go out to the bars and drink a lot. So that’s what I did. It’s been a lot of fun…[pause] but actually when I drink a lot I can’t remember to use a condom…and I had unprotected sex a few times, so I went to the STD clinic to get tested a few days ago. I should get the results next week…”
[Reflective response]: You seem pretty worried about this, which is completely understandable; and let’s hope that the test is negative. Now what…

What can you do to avoid having to worry about this in the future?

What’s going on in your life that makes this difficult?

What’s worked for you in the past to reduce the amount that you drink?

What hasn’t worked? [open questions]

[Closed response]:

Well, for your sake, I hope the results are negative because that was certainly risky. I’m sure you know how important it is to use condoms every time. We stress this with all our patients, straight or gay; it makes no difference.
Case 4: CHIPs Study Patient: Tim (cont’d)

• Motivational conversation
  • Patient very motivated to change: 9 on 1-10 scale
  • Patient’s plan: abstinence, to avoid temptation
  • Clinician encouraged counseling to explore issues
• Follow up phone call 2 weeks later:
  • Mostly abstained
  • One occasion 4-5 drinks, no high risk sex
Case 4: CHIPs Study Patient: Tim (continued)

- Follow-up visit: 1 month later
  - Drank 5-6 drinks 3 times, once had 8 drinks with one unprotected insertive anal intercourse, followed by visit to urgent care for post-exposure prophylaxis (PEP) Rx.
  - New commitment to change. HIV and STI testing negative.
  - Plan: Referral for counseling and further follow-up
- Follow-up phone call 1 month after this visit:
  - Doing better
  - Sticking to limits
  - Very appreciative of study.
CHIPs Study: Follow-up

- Follow-up phone calls by researchers
- Detailed questions similar to baseline
  - 6 months
  - 12 months
  - 18 months
  - 24 months
- Outcomes: Substance use, health care utilization, illness, injuries, academic, legal
CHIPs Study: # Drinks in past 28 days

Baseline: 69.2 (Control), 71.9 (Treatment)
6 Months: 57.2 (Control), 52.9 (Treatment)
12 Months: 54.7 (Control), 51.7 (Treatment)

p = 0.018

CHIPs Study: RAPI* Score


**Baseline**
- Control: 15.9
- Treatment: 15.2

**6 Months**
- Control: 11.0
- Treatment: 9.7

**12 Months**
- Control: 9.1
- Treatment: 7.8

*p = 0.033*

*Rutgers Alcohol Problem Index (23-item)*
Blackouts and ED Visits

UW-Madison CHIPs Study N=954

• 1 or more ED Visits in 24 months:
  • 30% of males
  • 27% of females

• Blackout frequency same: male/female

• More blackouts → More ED visits

<table>
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<tr>
<th># of Blackouts</th>
<th>Rate Ratio (CI)</th>
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<td>0</td>
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<tr>
<td>3-5</td>
<td>1.66 (1.34-1.90)</td>
</tr>
<tr>
<td>6+</td>
<td>1.96 (1.48-2.50)</td>
</tr>
</tbody>
</table>

1 Mundt M, College Health Intervention Projects 2010
Alcohol Screening and Brief Intervention in a College Student Health Center: A Randomized Controlled Trial

Reductions* in treatment (n=181) v. control group (n=182)

- Typical BAC
- Peak BAC
- Peak # drinks / sitting
- Average # drinks/week
- RAPI 23-item harm score
- Times drunk in typical week
- Foolish risks when drinking
- Driving after 3 or more

* (p < .05) by repeated measures analysis, 12 month outcomes

Schaus JF, Sole ML, McCoy TP, Mullett N, O’Brien MC. *Journal of Studies on Alcohol and Drugs*, Supplement No. 16, June 2009
Inside the Physician’s Black Bag: 
Top 10 “tools” used in Brief Interventions with College Students

- 1. Likes and Dislikes
- 2. Life Goals
- 3. Reducing Risk Agreement
- 4. Feedback on Binges per month
- 5. Tracking # of Drinks
- 6. Readiness to Change Scale (1-10) [“why not lower #?”]
- 7. Consequences- Overall [esp. Blackouts]
- 8. Consequences- Calories
- 9. Consequences- BAC
- 10. Alcohol Norms

Sexual Risk Reduction

- Brief Counseling comparable to longer
- Interactive Counseling is the key
- Patient-Centered Approach:
  - “Asking” v. “Telling”
  - Do you see a need for condom use?
  - Describe your experiences using them…
  - How does your partner feel about this?

Case 5: Woman’s Exam/STI Check

- Carmen, a 22 year old graduating senior presents for routine pelvic exam and STI check.
  - Asymptomatic, on OCP for 5 years, no problems
  - 8 lifetime male partners, 2 in the past 3 months, inconsistent condoms
  - Unprotected vaginal intercourse 1 month ago, worried about “risky” guy
  - New boyfriend, good relationship, wants to be tested for “clean bill of health”
- Positive routine alcohol screen (9 drinks twice a week; AUDIT=18)
- Clinician: Ever have any blackouts?
- Carmen: Yeah, lots of those.
- Clinician: What do you think about those?
- Carmen: I know it’s really bad. But it’s been like that since junior year. My whole family are alcoholics and I know I drink too much. That’s what happened that night a month ago... (tearful)
Case 5: Woman’s Exam/STI Check

- Empathic conversation about drinking, what happened, consensual v. nonconsensual, support, current boyfriend, readiness to change ( “8” on 1-10 scale).
- Patient plans for follow-up (“what do you want to do?”):
  - Reduce to 4-5 drinks max
  - Counseling Services for Alcohol Assessment and relationship
- STI test results (negative) sent via email 1 week later:
  - Reminder about counseling/alcohol issues
- 1 month later: patient in clinic for unrelated visit (sinusitis)
  - Patient reports f/up with alcohol counselor for 2 visits
  - Plan to maintain reduced intake, positive support from boyfriend, helps her stay at 3 drinks max
- Appears motivated to continue counseling
What type of things do you imagine you’ll hear that you want to reflect?
Exercise: Putting OARS together

- Please respond to these statements with open ended questions first, then with reflections
So tolerance doesn’t mean I actually handle alcohol better? Wow, that means I’m getting pretty intoxicated when I drink.

Open-ended question?

Reflection?

2. What speaker says

3. What listener hears

1. What speaker means

4. What listener thinks speaker means
Sometimes I feel like I drink too much... I mean, how normal is it to be drunk all the time?

**Open-ended question?**

**Reflection?**

1. What speaker means
2. What speaker says
3. What listener hears
4. What listener thinks speaker means
Everyone on my dad’s side of the family has a problem with alcohol...my grandma has always told me to watch out for myself, and maybe there’s something to that.

Open-ended question?

Reflection?

2. What speaker says

3. What listener hears

1. What speaker means

4. What listener thinks speaker means
Can this blood alcohol level chart be right? That’s a really high blood alcohol level!!!!

Open-ended question?

Reflection?

2. What speaker says

3. What listener hears

1. What speaker means

4. What listener thinks speaker means
After the person wouldn’t wake up, the paramedics had to come. She was hospitalized, and it really freaked everyone out.

Open-ended question?

Reflection?

2. What speaker says

3. What listener hears

1. What speaker means

4. What listener thinks speaker means
Virtual Reality Skills Training

• “Virtual Reality Simulation”
  • video, voice recognition, non-branching logic
  • interactive environment, complex social cues
    • 707 provider questions/statements
    • 1,207 patient responses

Virtual Reality Skills Training for Health Care Professionals in Alcohol Screening and Brief Intervention

Michael Fleming, MD, MPH, Dale Olsen, PhD, Hilary Statbes, MEd, Laura Boteler, BS, Paul Grossberg, MD, Judi Ffeifer, MEd, Stephanie Schiro, BA, Jane Banning, MSSW, and Susan Skocelas, MD, MPH

Background: Educating physicians and other health care professionals about the identification and treatment of patients who drink more than recommended limits is an ongoing challenge.

Methods: An educational randomized controlled trial was conducted to test the ability of a stand-alone training simulation to improve the clinical skills of health care professionals in alcohol screening and intervention. The “virtual reality simulation” combined video, voice recognition, and nonbranching logic to create an interactive environment that allowed trainees to encounter complex social cues and realistic interpersonal exchanges. The simulation included 707 questions and statements and 1,207 simulated patient responses.

Results: A sample of 102 health care professionals (10 physicians; 30 physician assistants or nurse practitioners; 36 medical students; 26 pharmacy, physician assistant, or nurse practitioner students) were randomly assigned to a no training group (n = 51) or a computer-based virtual reality intervention (n = 51). Professionals in both groups had similar pretest standardized patient alcohol screening skill scores: 53.2 (experimental) vs 54.4 (controls), 52.2 vs 53.7 alcohol brief intervention skills, and 42.9 vs 45.5 alcohol referral skills. After repeated practice with the simulation there were significant increases in the scores of the experimental group at 6 months after randomization compared with the control group for the screening (67.7 vs 58.1; P < .001) and brief intervention (58.3 vs 51.6; P < .04) scenarios.

Conclusions: The technology tested in this trial is the first virtual reality simulation to demonstrate an increase in the alcohol screening and brief intervention skills of health care professionals. (J Am Board Fam Med 2009;22:587–98.)
Virtual Reality Skills Training

Randomized Controlled Trial
N= 102 Health Care Providers
  10 MDs and 30 NP/PAs
  36 Med students
  26 NP/PA/Pharm students

N = 51
Simulation Training
10 practices/ 3 months

N = 51
No Training

Standardized Patient (SP) Testing and Scoring:
Baseline and 6 Months
Virtual Reality Skills Training

SP Scores 6 months post-intervention

- Screening: p = < .001
- Intervention: p = < .04
- Referral: NS
Brief Intervention
Post-Workshop Assessment

• Questionnaire, plus:
• What I will do differently in my everyday work with college students:

• Comments
• Contact us:

jkilmer@u.washington.edu
grossberg@pediatrics.wisc.edu