Nebraska Collegiate Consortium to Reduce High-Risk Drinking

Skill Building Workshop July 30, 2013

Brief Motivational Interventions to Reduce Substance Abuse and Other Risky Behaviors in College Students

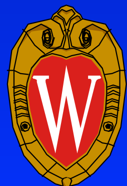
Paul Grossberg, M.D.
Clinical Professor Emeritus
Department of Pediatrics
University of Wisconsin School of Medicine and Public Health

- Disclosure:
  I have no financial relationships to commercial interests.

Objectives

- Discuss how to integrate the evidence-based principles and methods of motivational interviewing into brief interventions with college students-- in clinical, counseling, and student affairs settings.

- Formulate at least two specific strategies you will use in your everyday professional work to motivate college students with risky behaviors who are in denial, pre-contemplative, or resistant about change, with the goals of improving health and academic retention and success.

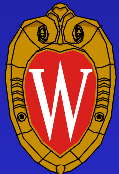


Assumptions

- Helping students change behavior is not easy; it is inherently different from the more directive / prescriptive approach to treating “medical diseases”.

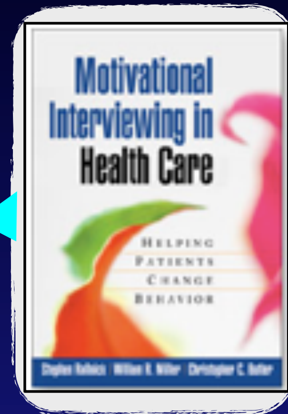
- Whether formally trained in motivational interviewing or not, we are all already using some form of brief motivational interventions with our students, and our skills will continue to improve with practice.

- These evidence-based communication skills, while studied extensively for substance abuse, are applicable to almost all clinical, counseling, and professional work on campus.



Summary: Motivational Interviewing for Behavior Change

- Strong Evidence of Effectiveness, powerful impact
- Simple but not easy: practice → effectiveness
- College Health, Counseling, Campus Professionals
  - Reflect on evidence and own students; read
  - YOU decide best strategies for you
  - Student patients / clients teach you what works:
    - resistance or “glazed” look → try different strategy
    - college students often ready to make changes
- Every Rx is simple “bridge” to brief alcohol conversation
- Clinical teams follow-up, QI, student/campus outcomes, safety



Experiential
- Feedback
- Role-plays
- Simulations
- Norms graphs
- Music, lyrics
- Animations
  - Slides
  - Videos
- EHR prompts

See one, Do one, Teach one !
-- Ancient Medical Training Proverb

See one, Do one hundred, Teach one !

The UHC Mission and Vision

Mission: The UHC promotes the health and well-being of the University of Nebraska community through quality care and education.

Vision: We envision a contemporary Health Center focused on excellence, connected with students, supportive of the academic mission, and committed to the health and wellness of the University community.

Clinical Prevention in College Health

Your work with students… 'teachable' moments…

Disease Onset

Clinical Diagnosis

No Disease

Asymptomatic Disease

Symptoms - Illness

Primary

Remove Risk Factors

Secondary

Early Detection

and Treatment

Tertiary

Reduce Complications

Critical screening point

"What we see depends mainly on what we look for" –John Lubbock

Slide adapted from James Schaus, MD

The New York Times
Wednesday, December 19, 2012

College Students ages 18-24, United States

- 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

Rankings of 25 USPSTF-Recommended Clinical Preventive Services

Rating: B Recommendation.

		Preventable Burden	Cost Effective
1	Daily aspirin use	5	5
2	Childhood Immunizati	5	5
3	Smoking Cessati	5	5
4	**Alcohol Screen g & Brief Intervention**	**4**	**5**
5	Colorectal Cancer Screening >50 yo	4	4
6	Hypertension screening & Rx >18 yo	5	3
7	Influenza Immunization >50 yo	4	4

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

5= Highest
1= Lowest

- tobacco use
- unhealthy diet
- physical inactivity
- risky alcohol use

In the US, about 37% of morbidity and mortality is related to four unhealthy behaviors.

Mokdad AH, Marks JS, Stroup DF, et al. Correction: actual causes of death in the US, 2000. *JAMA* 2005; 293: 293-4.

100,000 Deaths
$185 Billion
3 Million YPLL

Maciosek MV, Coffield A … Goodman MJ, Solberg LI. Priorities Among Effective Clinical Preventive Services: … lysis. *Am J Prev Med.* 2006 Jul;31(1):52-61
Solberg LI, Maciosek MV, … uce alcohol misuse ranking its health impact and cost effectivenes…
http://www.prevent.org/content/view/…

Rankings of 25 USPSTF-Recommended Clinical Preventive Services

Rating: B Recommendation.

		Preventable Burden	Cost Effective
1	Daily aspirin use	5	5
2	Childhood Immunizations	5	5
3	Smoking Cessation	5	5
4	**Alcohol Screening & Brief Intervention**	**4**	**5**
5	Colorectal Cancer Screening >50 yo	4	4
6	Hypertension screening & Rx >18 yo	5	3
7	Influenza Immunization >50 yo	4	4

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

5= Highest
1= Lowest

- **U.S. Preventive Services Task Force 2006**
- **NIAAA**
- **Institute of Medicine**
- **American Academy of Pediatrics**
- **Advisory Committee on Immunization Practices**
- **World Health Organization**
- **National Commission on Prevention Priorities**
- **American Society of Addiction Medicine**
- **American College of Surgeons**
- **Canadian Task Force on Preventive Care**

Maciosek MV, Coffield AB, Edwards NM, Flottemesch TJ, Goodman MJ, Solberg LI. Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis. *Am J Prev Med.* 2006 Jul;31(1):52-61

Solberg LI, Maciosek MV, Edwards NM. Primary care intervention to reduce alcohol misuse ranking its health impact and cost effectiveness. *Am J Prev Med.* 2008;34(2):143-52

http://www.prevent.org/content/view/43/71

Brief Interventions in Medical Settings

Sampling of over 200 studies in the medical literature

Community Primary Care

Wallace (1988); Israel (1996); Fleming (1997, 1999); Ockene (1999); Senft (1997); Curry (2003); Grossberg (2004); Blow (2006); Thijs (2007); Anderson (2007); Guth (2008); Anstiss (2009); Abramowitz (2010); Addo (2011); Botelho (2011) Ackerman (2011); Botelho (2011); Wilson (2011).

Obesity and Weight Loss: Pollak (2007-11); West (2007); Barlow (2007); Aspy (2008); McDoniel (2010); Cox (2011)

Cardiovascular Risks, Smoking, CVA, DM: Greaves (2008); Gillam (2010); Lai (2010); Hettema (2010); Watkins (2011);

Medication Adherence: Cheng (2007); Parsons (2007); Shea (2008); Julius (2009); Heffner (2010); Heisler (2010);

Emergency Medicine: Bernstein (1997); Maio (1997); Mello (2009); Field (2010); Parker (2010); Walton (2010); Schwan (2011); Pedersen (2011); Vaca (2011); Havard (2011). Academic ED SBIRT Research Collaborative (2007, 2010). Asthma: Borrelli (2007); Weinstein (2011). Riekert (2011); Prescription Drug Abuse: Zahradnik (2009).

Adolescents

Monti (1999); Knight (2005); McCambridge and Strang (2004, 2008); Sampl (2001); Colby SM (2005); Walker (2006); Winters (2001, '05, '07); Stein (2006); Stern (2007); D'Amico (2006, 2008); Monti (2007); Olson (2008); Naar-King (2009); Pollak (2009); Perrin (2010); Spijkerman (2010); Tripodi (2010); Walton (2010); Mason (2011); Taveras (2011); Audrain-McGovern (2011); Tripp (2011); Jensen (2011).

College Students

Baer (1992); Marlatt (1998, 2001); Borsari and Carey (2000); Larimer (2001); Murphy (2001, 2004); Feldstein (2007); Tollison (2008); LaBrie (2007, 2008); Cimini (2009); Walters (2009); Collins (2009); Schaus (2009); Fleming (2010) Grossberg (2010); Harris (2010); Murphy (2010); Kulesza (2010); Dermen (2011); Kazemi (2011).

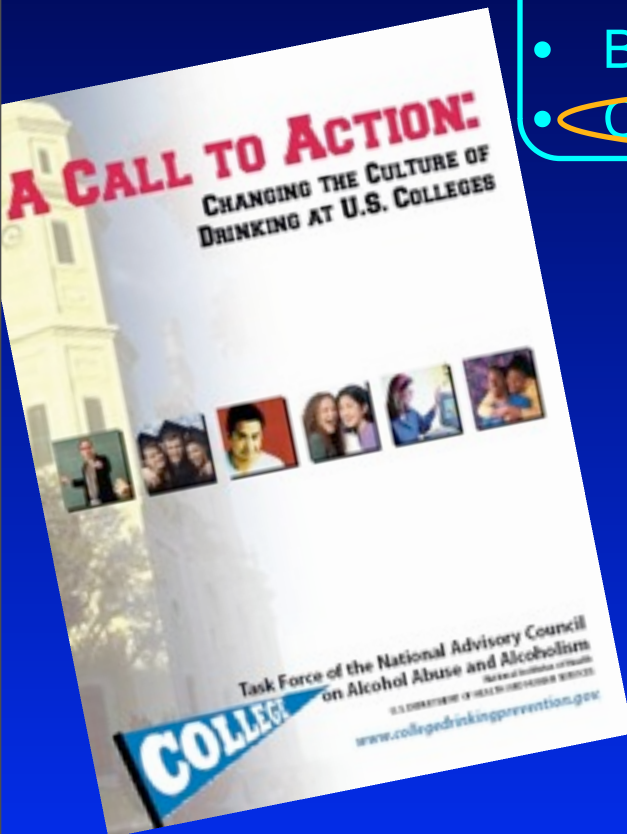
Meta-analyses and Systematic Reviews: most studies- positive outcomes.
Bien (1983); Kahan (1996); Wilk (1997); Poikolainen (1999); Foxcroft (2002); Whitlock (2004); Beich (2003); Johnson (2003, 2008); Fager and Melnyk (2004); Rubak (2005); Betholet (2005); Resnicow (2006); Maciosek (2006); Carey (2007); Kaner (2007, 2009); Solberg (2008); Riper (2009); Jenkins (2009); Olsen (2010); Lai (2010); Siegers and Carey (2010); Hettema (2010); Macgowan (2010); Wachtel (2010); Smedslund (2011); Jensen (2011) Williams (2011); McQueen (2011).

NIAAA
National Institute on Alcohol Abuse and Alcoholism

Task Force Report Recommendations

Tier 1: Evidence of Effectiveness Among College Students

- Brief Motivational Enhancement Interventions (BMI)
- BMI + Cognitive-Behavioral Skills + Norms clarification
- Challenging Alcohol Expectancies



Tier 2: Evidence of Success With General Populations That Could Be Applied to College Environments

Tier 3: Evidence of Logical and Theoretical Promise, But Require Comprehensive Evaluation

Tier 4: Evidence of Ineffectiveness

Originally published April 9, 2002
Used with permission

University of Central Florida
Brief Intervention RCT

High-Risk Drinking 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. Alcohol Screening and Brief Intervention in a College Student Health Center: A Randomized Controlled Trial *Journal of Studies on Alcohol and Drugs*, Supplement No. 16, June 2009

College Health Intervention Projects (CHIPs)

- A 5-year study (2004-2009), 5 campuses in U.S./Canada, NIAAA-funded
  - University of Wisconsin-Madison
  - University of Wisconsin-Stevens Point
  - University of Wisconsin-Oshkosh
  - University of Washington
  - University of British Columbia
- Randomized Control Trial, n=986 high-risk drinkers
- Brief Intervention: 2 clinician visits (15-20 min.) in 4 weeks.
- Outcomes (1 year post-study) in intervention group:
  - Significant **reduction in drinks in past 28 days**
  - Significant **reduction in problems/ harms** from alcohol (RAPI*)
  - **Blackouts**: strong correlations with harms, ER visits
  - **Heavy drinking days** independently correlated with any injuries

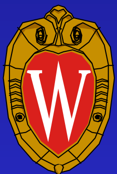
* RAPI: Rutgers Alcohol Problem Index- 23- items

Fleming MF, Balousek SL, Grossberg PM, Mundt, MP, Brown DD, Wiegel JR, Zakletskaia LI, Saewyc EM. Brief Physician Advice for Heavy Drinking College Students: A Randomized Controlled Trial in College Health Clinics. *J Stud Alcohol Drugs*. 2009 Jan; 71(1):23-31.

Brief Alcohol Interventions in Clinical Practice

Top 5 Clinician Tools [1]

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

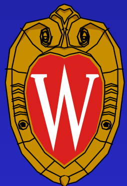


[1] Grossberg P, Halperin A, MacKenzie S, Gisslow M, Brown D, Fleming M. Inside the Physician's Black Bag: Critical Ingredients of Brief Alcohol Interventions. *Substance Abuse* 2010 Oct; 31(4):240-250.

Brief Intervention "Pearls"

A*lcohol- quantity, frequency, heavy*
B*lackouts / Brain*
C*oncerned / Confidentiality*

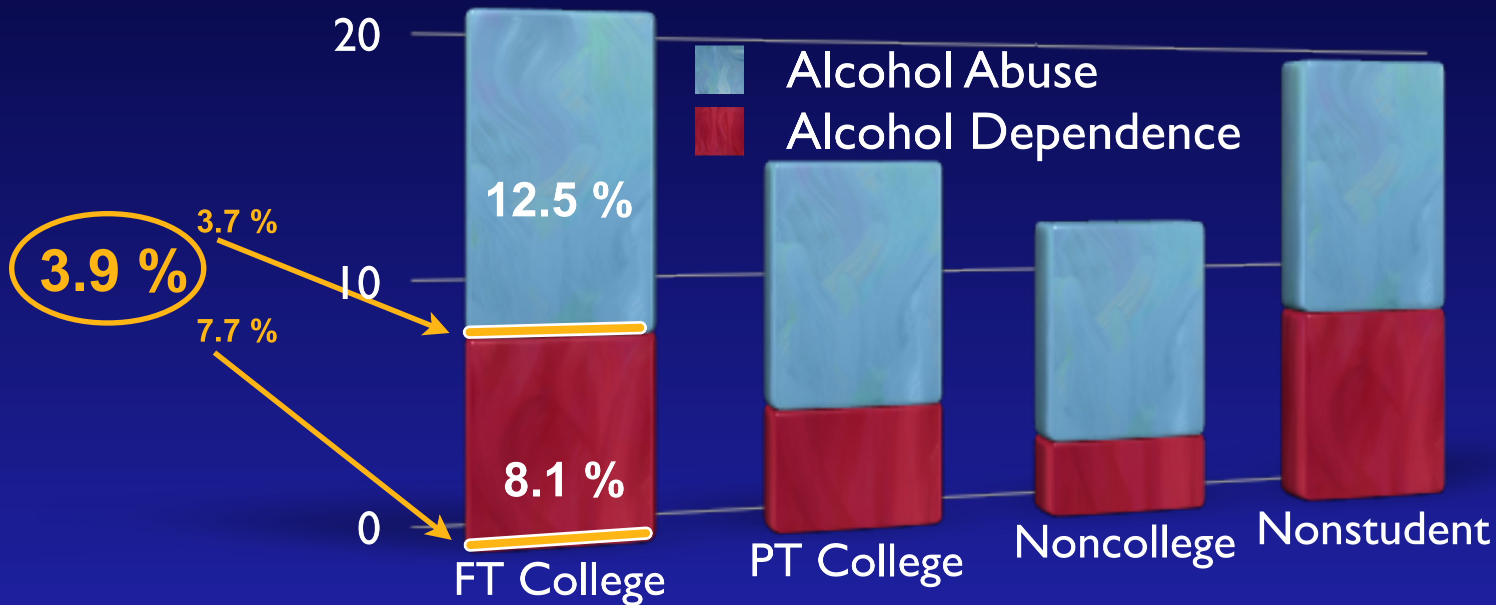
E*njoy*
N*ot enjoy*
D*o: patient-clinician plan*
S*upport / self-efficacy*



If you don't occasionally have a student (or parent) get upset with you, you are probably not doing a thorough enough job of talking about alcohol or other risky behaviors…

About _20_% of full-time U.S. college students have an Alcohol Use Disorder…
____% received alcohol services in past year

Only 3.9 % of full-time college students with an Alcohol Use Disorder received any alcohol services in the past year



96 % with AUDs receive no alcohol services
Of these, 2% perceived need for care

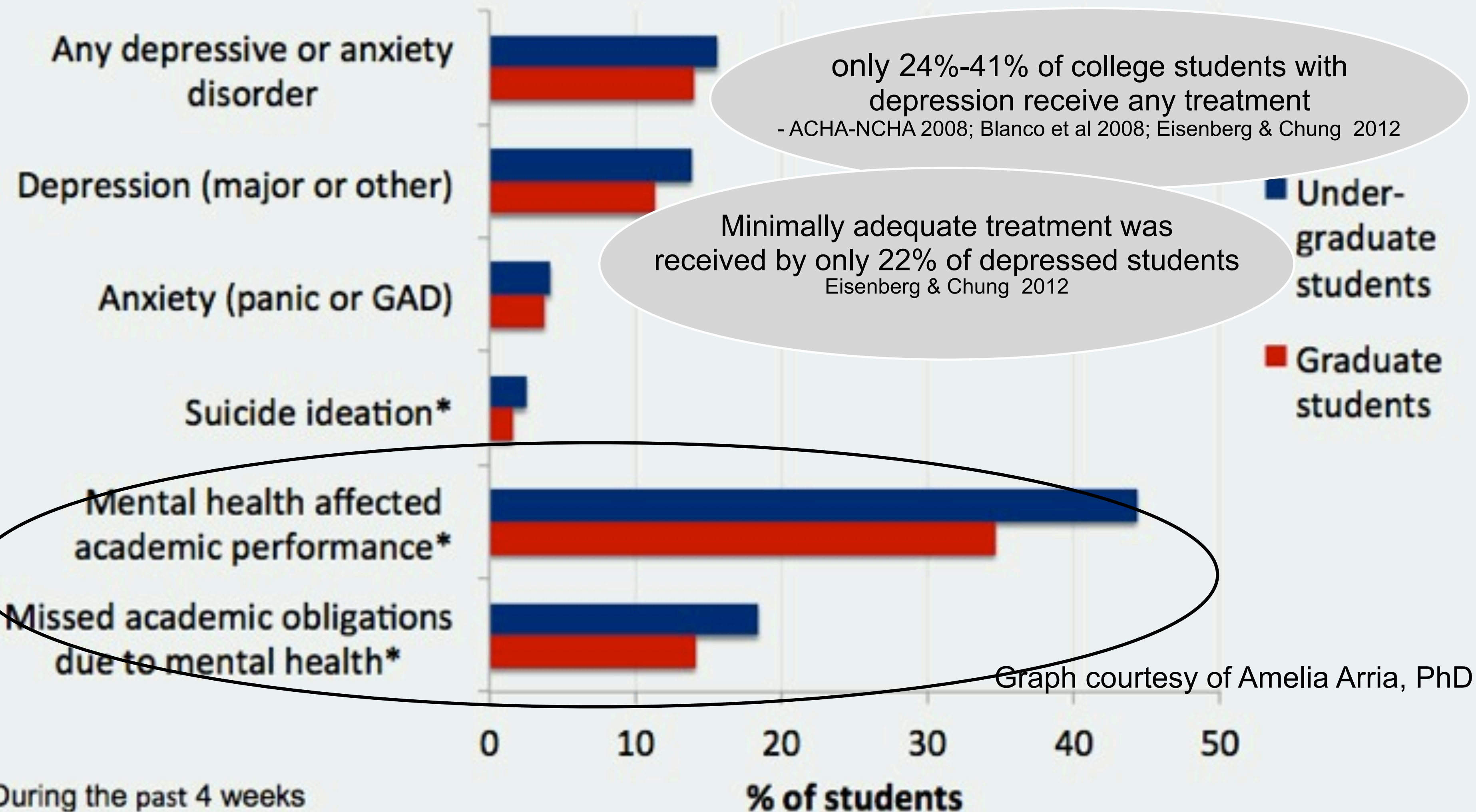
Wu L-T, Pilowsky D, Schlenger W, Hasin, D. Alcohol Use Disorders and the Use of Treatment Services Among College Age Young Adults. *Psychiatr Serv.* 2007 February; 58(2): 192–200.

96 % with AUDs receive no alcohol services
Of these, 2% perceived need for care

Of college students with untreated mental health problems, a majority (65%) had positive beliefs about treatment effectiveness, about half of whom (45%) perceive a need for help

Eisenberg D, Speer N, Hunt JB. Attitudes and Beliefs About Treatment Among College Students With Untreated Mental Health Problems. *Psychiatric Services* 63:711–713, 2012; doi: 10.11 76/appi.ps.201100250

Current mental health problems in college students



Source: Eisenberg, Golust, Golberstein, & Hefner. (2007). Prevalence and correlates of depression, anxiety, and suicidality among university students. *American Journal of Orthopsychiatry.* 77(4):534-542.

Discontinuous College Enrollment: Associations With Substance Use and Mental Health

Amelia M. Arria, Ph.D.
Kimberly M. Caldeira, M.S.
Kathryn B. Vincent, M.A.
Emily R. Winick, B.A.
Rebecca A. Baron, B.A.
Kevin E. O'Grady, Ph.D.

Psychiatric Services in Advance, December 3, 2012; doi: 10.1176/appi.ps.201200106

- Independent predictors of college retention problems
  - depression symptoms
  - depression diagnosed while in college
  - substance use
- Critical importance of Screening and Intervention
- "Screening for drug use, heavy drinking, and depression, especially in first year, might be useful for identifying students at risk for temporary withdrawal or dropout"

High-risk drinkers earn lower grades and are less likely to be engaged with faculty [1].

Nonmedical stimulant users spend less time studying, skip classes more often, and earn lower grades [2].

Photo courtesy of Amelia Arria, PhD

[1] Pascarella et al, 2007; Porter and Prior, 2007.

[2] Arria AM, O'Grady KE, Caldeira KM, Vincent KB, Wish ED. (2008). Nonmedical use of prescription stimulants and analgesics: Associations with social and academic behaviors among college students. *Journal of Drug Issues.* 38(4), 1045-1060.

ACHA NCHA II
American College Health Association
National College Health Assessment

Institutional Data Report, Spring 2012
N= 99,066, 27% mean response rate
141 institutions

Percent of college students reporting using Rx drugs not prescribed to them in past 12 months

	Antidep	Erectile	PainKillers	Sedatives	Stimulants	TOTALS used 1 or more
%	3	0.9	7.5	3.7	7.5	14.8

Brief Interventions Underutilized in Primary Care

- Most MDs don't ask young adults (18-39) about drinking [1]
  - 67% saw MD in past year; only 14% of at-risk were asked
  - 18-25 y.o. (most at-risk) were least asked (34%)
- Pediatricians' screen ~63-80% of teens for ATOD, sexual behavior [2]
- Most college health clinics don't screening effectively
  - 2004: 32% screen, 12% standardized, mostly CAGE [3].
  - 2011: 56% screen, 44% std, only 20% AUDIT/other recommended[4]
- PCP conversations with patients about alcohol use: [5-7]
  - often hesitancy, lack of clarity, avoiding opportune moments
  - very infrequent use of reflections, support/affirm statements

[1] Hingson RW, Hereen T, Edwards EM, Sailtz R., Young adults at risk for excess alcohol consumption are often not asked or counseled about drinking alcohol. *J Gen Intern Med.* published online 21 Sept 2011.

[2] Halpern-Felscher et al. Preventive Services in a Health Maintenance Organization: How well do pediatricians screen and educate adolescent patients? *Arch Pediatr Adolesc Med.* 2000;154:173-179

[3] Foote, J. A national survey of alcohol screening and referral in college health centers. *Journal of American College Health*, Jan-Feb 2004; 52: 149-158

[4] *Winters, K., et al. Screening for Alcohol Problems Among 4-Year Colleges and Universities. JACH. 2011;59(5):350-357*

[5] Beich A, Gannik D, Malterud K. Screening and brief intervention for excessive alcohol use: qualitative interview study of the experiences of general practitioners. *BMJ*. 2002;325:870-2.

[6] McCormick KA, Cochran NE, Back AL, Merrill JO, Williams EC, Bradley KA. How primary care providers talk to patients about alcohol: a qualitative study. *J Gen Intern Med.* 2002;17:315-26.

[7] Bradley KA, Epler AJ, Bush KR, et al. Alcohol-related discussions during general medicine appointments of male VA patients who screen positive for at-risk drinking. *J Gen Intern Med.* 2006;21:966-72.

Counseling by “Non-Specialists” on Campus

- “Non-specialists” talk with many more college students with problems (alcohol, substances, depression, anxiety, etc.) than specialized counselors, therapists, physicians or other clinicians do.
- You don’t have to be a counselor to use counseling skills.
- Relatively little formal counseling training can impact college students’ drinking, reducing risks and harm.
- **Brief: 2-5 minutes**
- **Opportunistic:** unplanned; behavior risks usually not stated upfront
- Effectiveness more related to **style** of brief interaction than to content.

Clinicians' Usual Advice about 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...

... can re-connect with the patient by saying something like:

"So, what do you make of that?"...

" I can help you solve this for yourself "

Clinician goal: Improving guiding skills while suppressing the natural instinct to direct

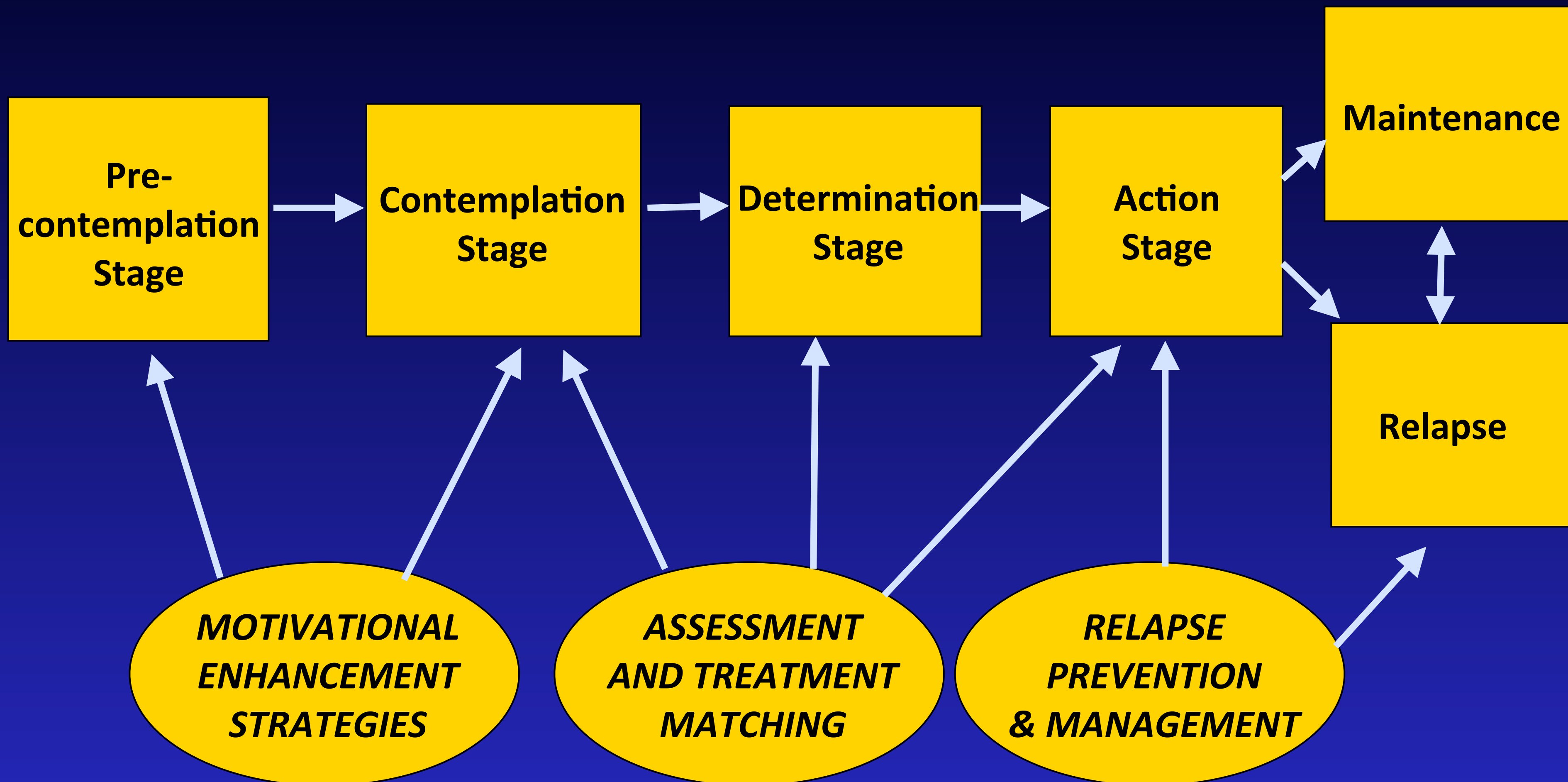
Student Ambivalence

Change **Don’t change**

Change

or at least:
“I’ll think about it…”

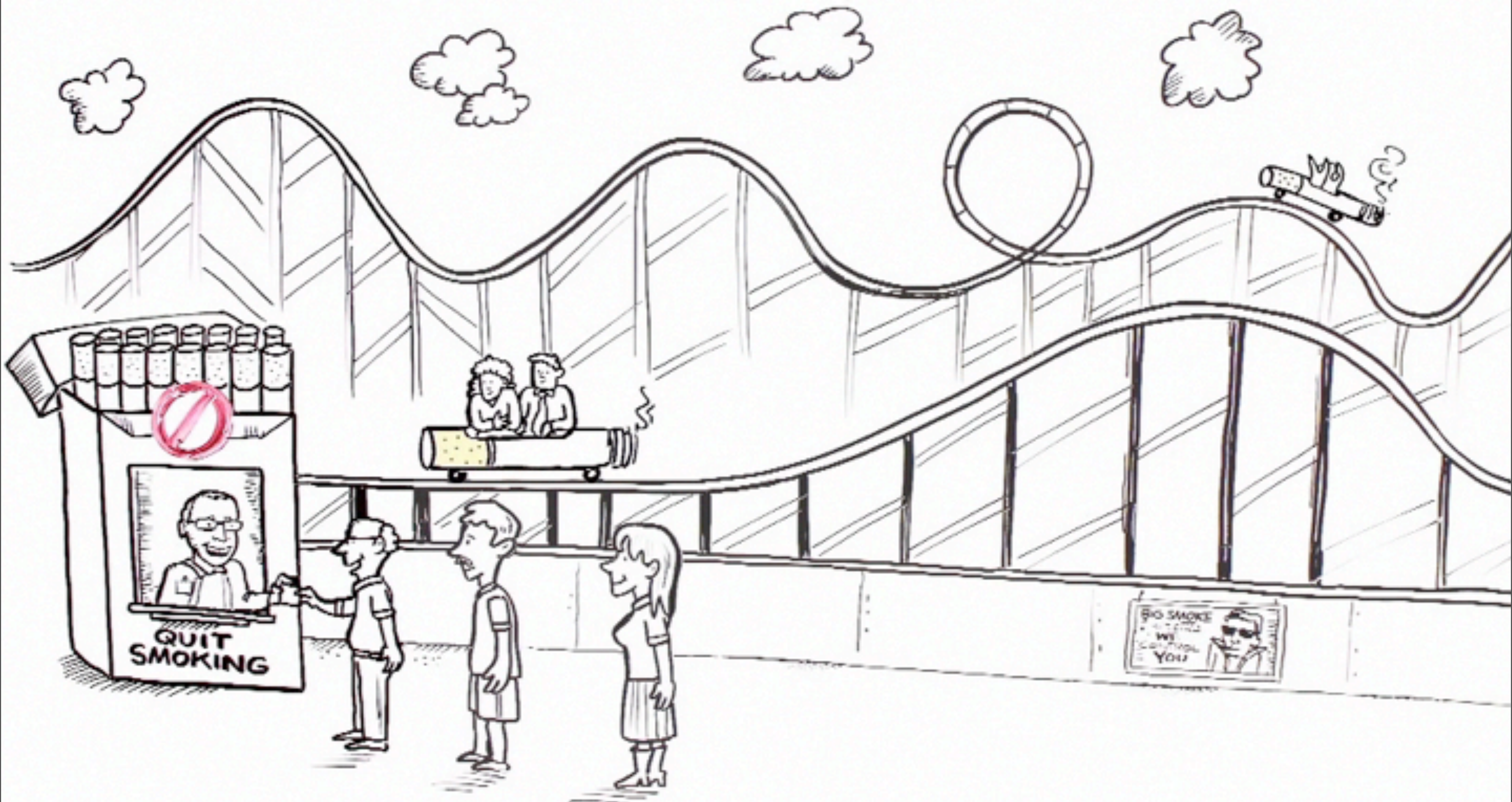
Stages of Change[1] Intervention Strategies



[1] Prochaska & DiClemente 1982, 1992

Slide adapted from Jason Kilmer, Ph.D.

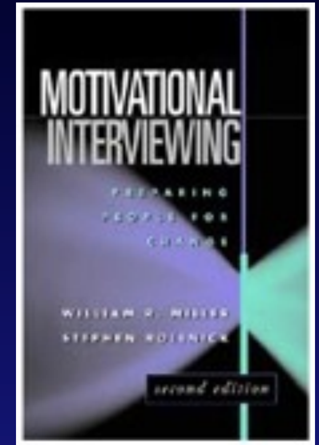
Helping Patients Change Behaviors: Diagnosing Stages of Change



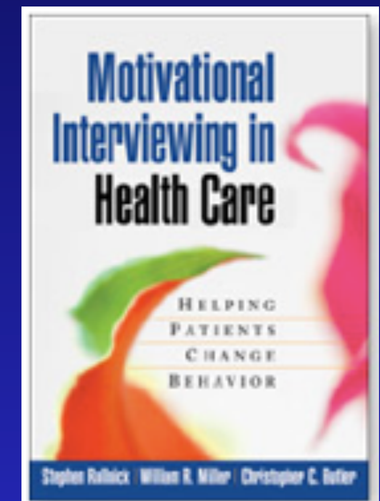
What is the single best thing you can do to stop smoking? Written, narrated, produced by Mike Evans, MD, Associate Professor of Family Medicine and Public Health, University of Toronto. YouTube video, Canadaptt Project, Peter Selby, PI.

Motivational Interviewing
Basic Principles

(Miller and Rollnick, 1991, 2002, 2008)



1. **R**oll with Resistance
2. **E**xpress Empathy
3. **D**evelop Discrepancy
4. **S**upport Self-Efficacy



Rollnick S, Miller WR, Butler CC. Motivational Interviewing in Health Care: Helping Patients Change Behavior. Guilford Press 2008.

Motivational Interviewing *"Spirit"*

- Collaborative
  - active, cooperative conversation, partnership
  - joint decision-making process
- Evocative
  - evoke from patients that which they already have
  - elicit patient's own good reasons to change
- Honors Patient Autonomy
  - "there is something in human nature that resists being coerced and told what to do. Ironically, it is acknowledging the other's right and freedom not to change that sometimes makes change possible." (Rollnick, Miller, Butler, 2008)

Motivational Interviewing

Methods: O A R S

Ask permission first
MI is more like “pulling” rather than “pushing”

Open Questions not “yes/no”

Affirm patient’s positives/values/character

Reflective Listening statements

understand content and meaning

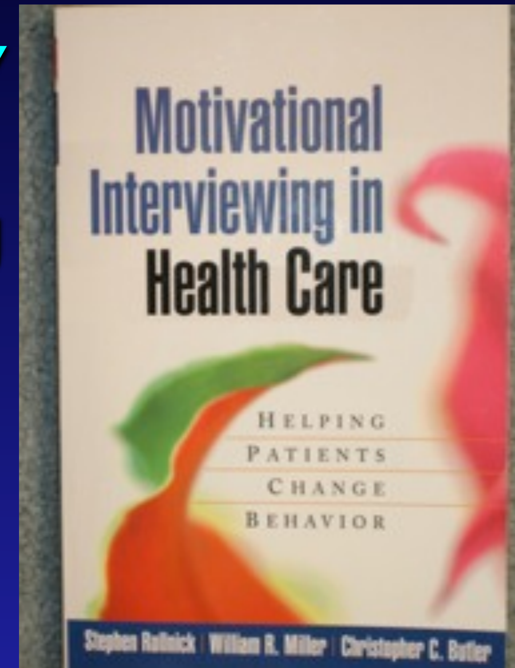
Summarize main points, then shift

Summarize periodically, demonstrating you’re listening

Clinical Prevention in Practice

- "If your time is limited, you are better off asking patients [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 *patient [student]* rather than you who should be voicing the arguments for behavior change."
  - Rollnick S, Miller WR, Butler CC. Motivational Interviewing in Health Care: Helping Patients Change Behavior. Guilford Press 2008.



Journal of Consulting and Clinical Psychology
2004, Vol. 72, No. 6, 1050–1062

Copyright 2004 by the American Psychological Association
0022-006X/04/$12.00 DOI: 10.1037/0022-006X.72.6.1050

A Randomized Trial of Methods to Help Clinicians Learn Motivational Interviewing

William R. Miller, Carolina E. Yahne, Theresa B. Moyers, James Martinez, and Matthew Pirritano
University of New Mexico

One-time workshop + self-study, manual, videotapes ≠ proficiency
Clinician self-report of MI skills ≠ proficiency in observed practice
Practice feedback is key component

showed modest gains in proficiency. Posttraining proficiency was generally well maintained throughout follow-up. Clinician self-reports of MI skillfulness were unrelated to proficiency levels in observed practice.

N=140 licensed substance abuse professionals, Randomized Trial
2-day Clinical Workshop (W), audiotape samples pre/post training over 1 year

- Workshop only ⟶ skills back to baseline at 4 months
- W + feedback
- W + coaching
- W + feedback + coaching ⟶ proficiency + improved client responses
- Control

Barriers to implementing screening and brief intervention

- Time
- Training
- Terror of the “yes” response (referrals?)
- Triage (diseases v psychosocial issues)
- Treatment reimbursement
- Translational: “system,” EHR, MA/RN/staff

Dissolving Barriers to Implementation

- **Time**
  - Screening: routine, prior to clinician, or counselor, or advisor time
  - BRIEF Intervention, based on MI principles:
    - very brief: 1-2 minutes, by clinician, MA/RN, other staff
    - **brief: 2-5 minutes, within context of reason for visit**
    - brief-ish: 5-15 minutes: explore “change talk”, decisional balance
  - Multiplier effect: BI, repeated over time at follow-up visits
  - Few minutes, primary care/other student relationship = powerful impact
  - **How** you talk about behavior more important than time/content
  - Time saved avoiding “directive” statements and plans
- **Training**
  - Skills simple, improve with practice; students teach you what works
  - “I can help you solve this for yourself”
    - places onus of behavior change on the student where it belongs
    - more effective than direct advice

Dissolving Barriers to (continued)

- Ever try cocaine, even once? ...When?
- Any sexual relationships with anyone besides your girlfriend/boyfriend/partner?
- Anyone close to you hurt you or push you to do something you'd rather not do?

- **Terror of the "yes" response**
  - Improved history/dx, outcomes, satisfaction, patient safety
  - SBIRT: screening, brief intervention, and referral to treatment
  - Referrals, follow-ups, summarize and move on
- **Triage (diseases v psychosocial issues)**
  - Alcohol / drug co-morbidities with common diseases
  - Enhanced hx, diff dx, adherence to medication and treatment plans
- **Treatment reimbursement**
  - CPT codes, medicare reimbursement, JCAHO performance measures
- **Translational**
  - Unique clinicians, entire team, support staff, EHR, administration
  - Quality Improvement: PDSA (Plan-Do-Study-Act) cycles, others

Nursing Clinical Interventions

- ...I see your AUDIT screen here. I wonder if we might look at your drinking a bit?
  - *I don't have a drinking problem!*
- I wouldn't dream of saying that you do! From your initial answers, I'd like to discuss drinking a bit more, in terms of how it affects your health. [statement, avoiding persuasion]
  - *OK...*
- Could you start by telling me how alcohol fits into your average day? [open]
  - *I don't really bother with drinking much. Too much else to do!* ...[reflection]
- Drinking's not the first thing in your mind. [reflection]
  - *No, it's not; I like a few beers after classes with my fraternity buddies.* ...[reflection]
- It helps you relax. [reflection]
  - *Yes, after classes all day you need to unwind.*
- What else do you like about drinking? [open]
  - *It's fun, social, great way to to meet people.*
- What don't you like about drinking? [open]
  - *My doctor says it's why I get stomach pains, and she gives me the lecture to cut down... plus blackouts suck...*
- Well, I'm certainly not here to lecture you. What do YOU think about your stomach pains and blackouts? [open, avoiding persuasion]
  - *Well after this last time, I can see her point and I oughta cut down. But that's not so easy...*

adapted from: Littlejohn C, Holloway A. Nursing interventions for preventing alcohol-related harm. *British Journal of Nursing* 2008. 17(1):53-59

"30-Seconds" Brief Intervention in Clinical Visits

A
clinician or staff

B
student

- 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 boyfriend 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 said to drink less"]*
  - Why? *["Well too much of that's not good either"]*
  - I agree. What did you do? *["I stopped going out on Thursdays"]*
  - How did you feel *["better"]...*
- Weight listed as part of vital signs: 15-30 seconds
  - What do you think about your weight? *["I've been trying to lose some"]*
  - Why? *["My clothes don't fit right and I don't like the way I look..."]*

Student 1: James

- James is a 19 year old majoring in art education whose grades have been falling in the past year. He is referred to you (student health clinician, counselor, academic advisor, other student affairs staff) due to concerns expressed by a professor ("sleepy in class, forgets assignments, seems out of it").
- He has a history of 3 incidents in his res hall last year (drinking, marijuana, behavioral issues and a broken wrist). His parents recently called the Dean of Students' office to complain ("there's too much partying all the time, and he's not studying").
- While waiting at your office, he seems annoyed and upset that he has to be there...

Rolling with Resistance: Reflections

- A: “Drinking and marijuana sure got you into trouble, so it’s important to cut down and get back on track.”
- B: “Sucks to be here; the last thing you wanted to do today was talk to a (<u>doctor, counselor, dean)</u> about drugs.”
- C: “Your parents must care about you, but you’re an adult and you wish they’d let you make your own decisions.”
- D: “You’re upset that your parents have been bugging you and called the Dean of Students’ office.”

- Which of the above reflections to James’ situation is <u>**not**</u> consistent with motivational interviewing?

Student 1: James: Rolling with Resistance and Open Examples

- "James, is it OK if we talk a little more about your drinking? ("OK") I'm concerned that it's been part of your decreased energy level, falling asleep in class, and falling grades. I can't tell you what to do; you're the one who decides. You can choose to make changes in your drinking and smoking, but that's really up to you.
- Rather, I'd like to find out what you think about drinking and weed after the problems this semester and maybe together we can come up with some ways to avoid these kinds of situations in the future. You're welcome to talk with me any time, and you may find talking with a counselor would be helpful (it's confidential)...Many students have found that personally very worthwhile. What do you think?"
- "I'd like you to know that we (this Clinic, Department, the rest of the faculty) would like to help you stay here, do well, and graduate. How should we proceed from here?"...

Student 1: James
Developing Discrepancy (between goals and behavior)

- "You enjoy drinking with your friends, but it has affected your grades and gotten you into trouble at school and at home. *[reflection]*
  - What do you think about that?... *[open]*
  - Compared with your friends, are you a light, medium, or heavy drinker?"

- "You've talked about your art career or perhaps grad school. *[reflection...open]*
  - If you keep drinking at this level, how do you think that might affect those plans?
  - How would you feel if your younger brother found out you were smoking weed?
  - How would that affect him?... What would you say to him?"

- *[for those in denial or highly resistant: "I'm fine, drinking's not a problem"]*
  - "You enjoy drinking and don't think reducing it would work for you *right now*..."
  - "How would you know if you *were* having a problem?"
  - "What are your worst fears about what *might* happen if you don't change?"
  - "What would have to happen for you to make a change?"
  - "Sounds like there are no bad things about drinking for you" *[amplified reflection]*

Student 1: James

Rolling with Resistance

- Student: “I don’t really have a problem or need to cut down”
- Staff: “Hmm, help me out here, James...

  I’m concerned about your broken wrist, the hole in the wall in your dorm, and the fact that your girlfriend won’t talk to you, plus your parents are on your case...

  It seems to me that the alcohol has contributed quite a bit to this situation... What do you think?”

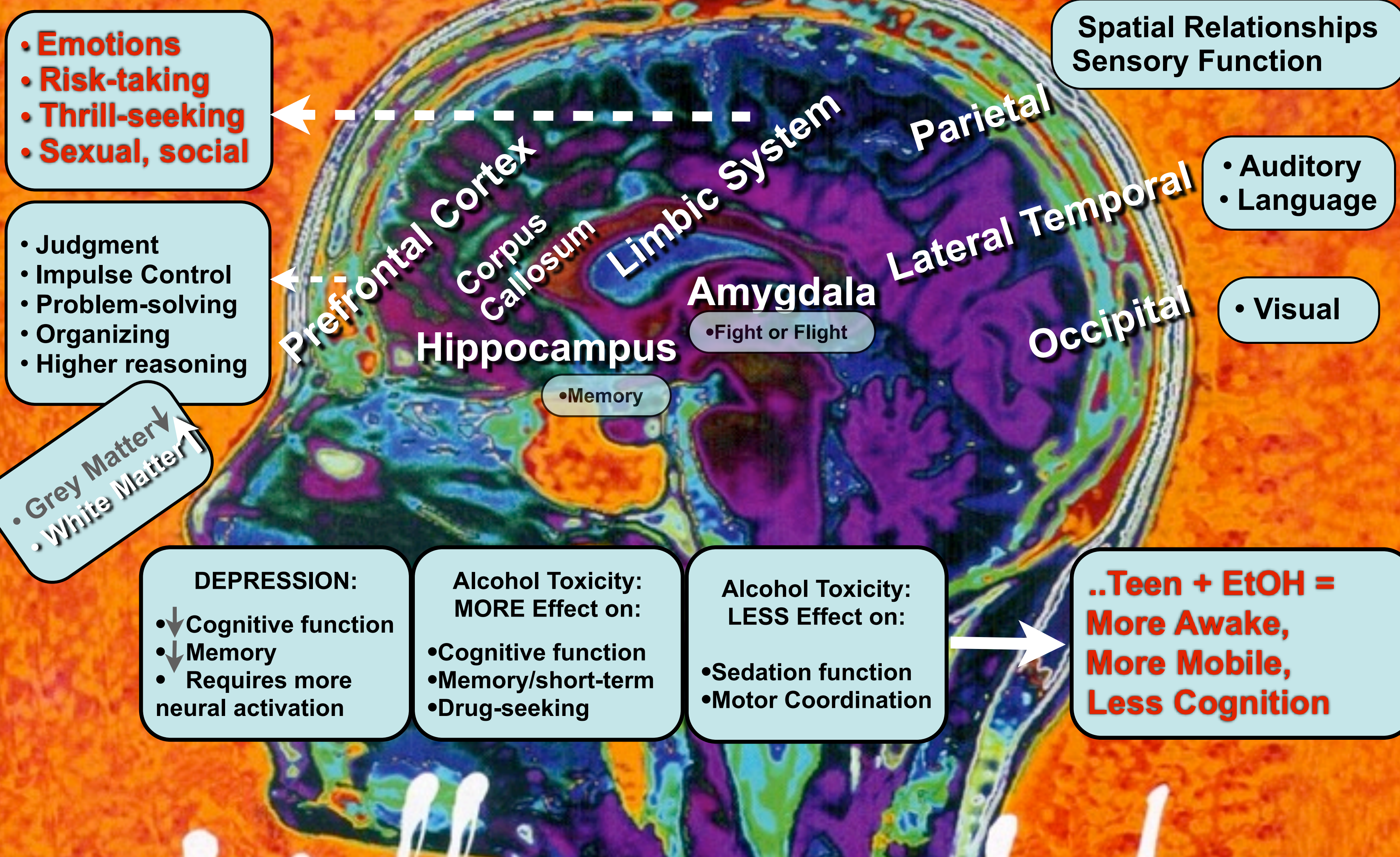
  [summary; agenda setting; asking]

The Interpersonal Process of Motivation

Role Play Exercise : High-Risk Drinking

- Conversation A
- Conversation B

20% of men between 18 - 35 consume 70% of all the beer sold in the US



well connected...

Earlier Bingeing---

by age 25...

-Increased risk Alcohol Use Disorders
-Longer term impairments: cognitive, process emotions, facial expressions

Parent Interventions to Reduce High-Risk Drinking

- Parent interventions are effective; high school ⟶ college

Power of Parenting
Nebraska Colleges

NCC
NEBRASKA COLLEGIATE CONSORTIUM TO REDUCE HIGH-RISK DRINKING

Drinking at College | Communication | Relationships | RESOURCES | Contact Us

Useful Resources for Parents of Students

Nebraska Collegiate Consortium (NCC) *(website)*
This website provides support for campuses across Nebraska who are committed to reducing high-risk drinking.

Year One College Alcohol Profile (CAP) *(website)*
The CAP is a quick and confidential online survey to get personalized feedback on student alcohol use. It was created with input from students and originally designed for .

Advice for Parents *(Adobe Reader PDF file)*
A summary of this website's topics, challenges, and strategies parents can use to discuss alcohol use with their sons and daughters.

Birthday Celebration Advice *(website)*
The Parents Association offers some great information and advice to help parents understand the dangerous rituals and traditions that surround birthdays in college.

Your Kids Are Drinking *(website with video/audio)*
NET Television and NET Radio combine efforts to present this project focusing on the problems associated with underage drinking. It includes a locally produced television special, a televised panel discussion of the problem, and a three-part NET Radio series.

Binge *(website with video/audio)*
This NET News production looks at young adults drinking too much, too fast. Hear from law enforcement, university officials, and bar owners trying to change lives before it's too late. It includes a locally produced television special, video extras, a NET Radio series, and other web resources.

Power of Parenting *(Adobe Reader PDF file)*
Learn how you can coach your sons and daughters to success.

Parent Interventions to Reduce High-Risk Drinking

- Parent interventions are effective; high school ⟶ college
- Parent-child communication "messages" improve with:
  - perceived expertise (gives good advice)
  - perceived trustworthiness (looks out for teen's best interests)
  - perceived parent availability and accessibility
- Most effective communication styles:
  - showing empathy and understanding
  - staying calm and relaxed, avoiding conflict
  - using self-disclosure
  - being direct, responsive, supportive, clear and understandable

Turrisi R. (2011). Conducting Parent Interventions to Reduce High-Risk College Student Drinking. Behavioral Health and Prevention Research. The Pennsylvania State University.

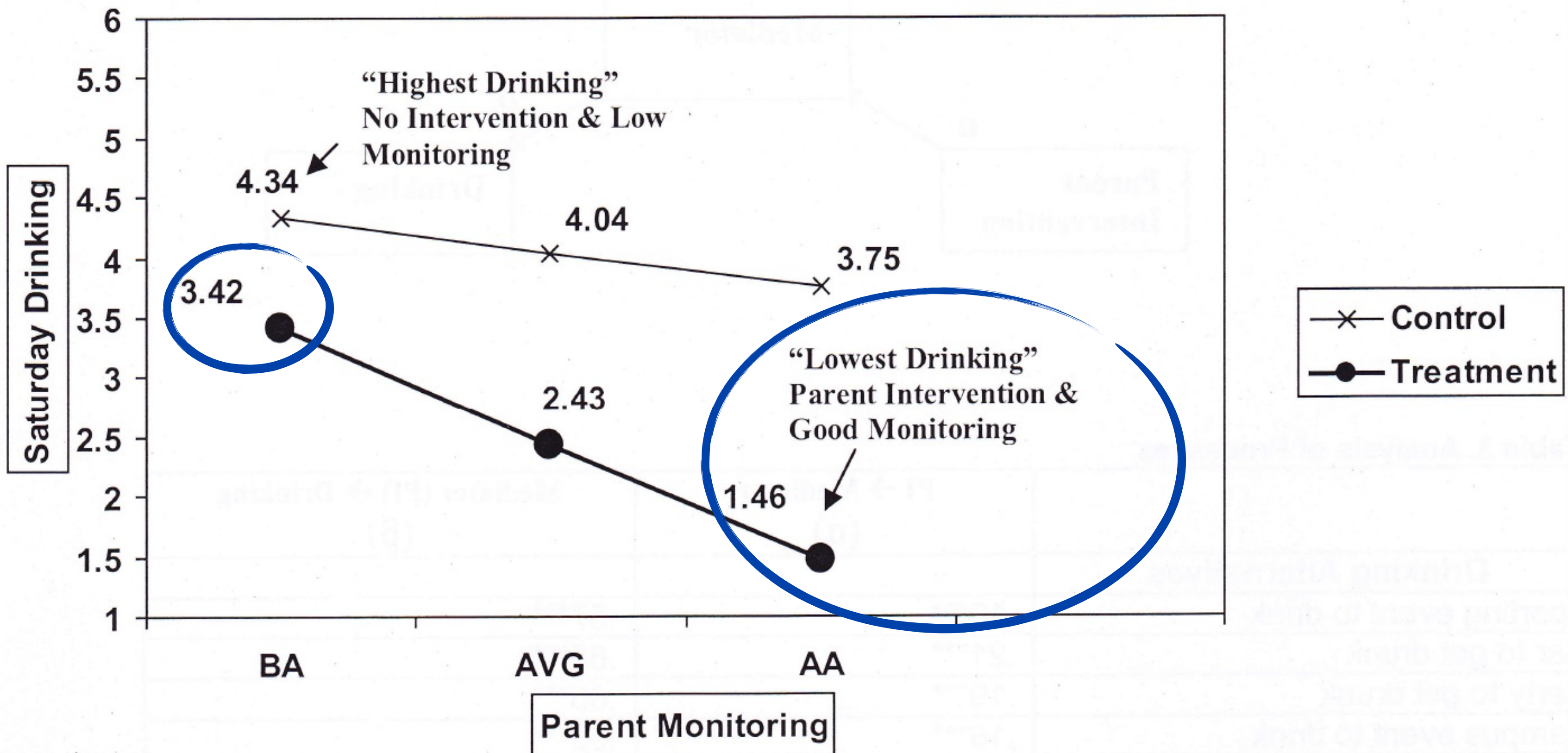
Donovan E, Wood M, Frayjo K, Black RA, Surette DA. A randomized, controlled trial to test the efficacy of an online parent-based intervention for reducing the risks associated with college-student alcohol use. Addict Behav. 2012 Jan; 37(1):25-35 Epub 2011 Sep 10.

Turrisi R, Ray AE. (2010). Sustained parenting and college drinking in first year students. *Developmental Psychobiology*, 52:286-294

Turrisi R, Jaccard J, Taki R, Dunnam H, Grimes J. (2001). Examination of the short-term efficacy of a parent-based interveniton to reduce college drinking tendencies. *Psychology of Addictive Behaviors: Special Issue on Understanding Binge Drinking*, 15:356-372.

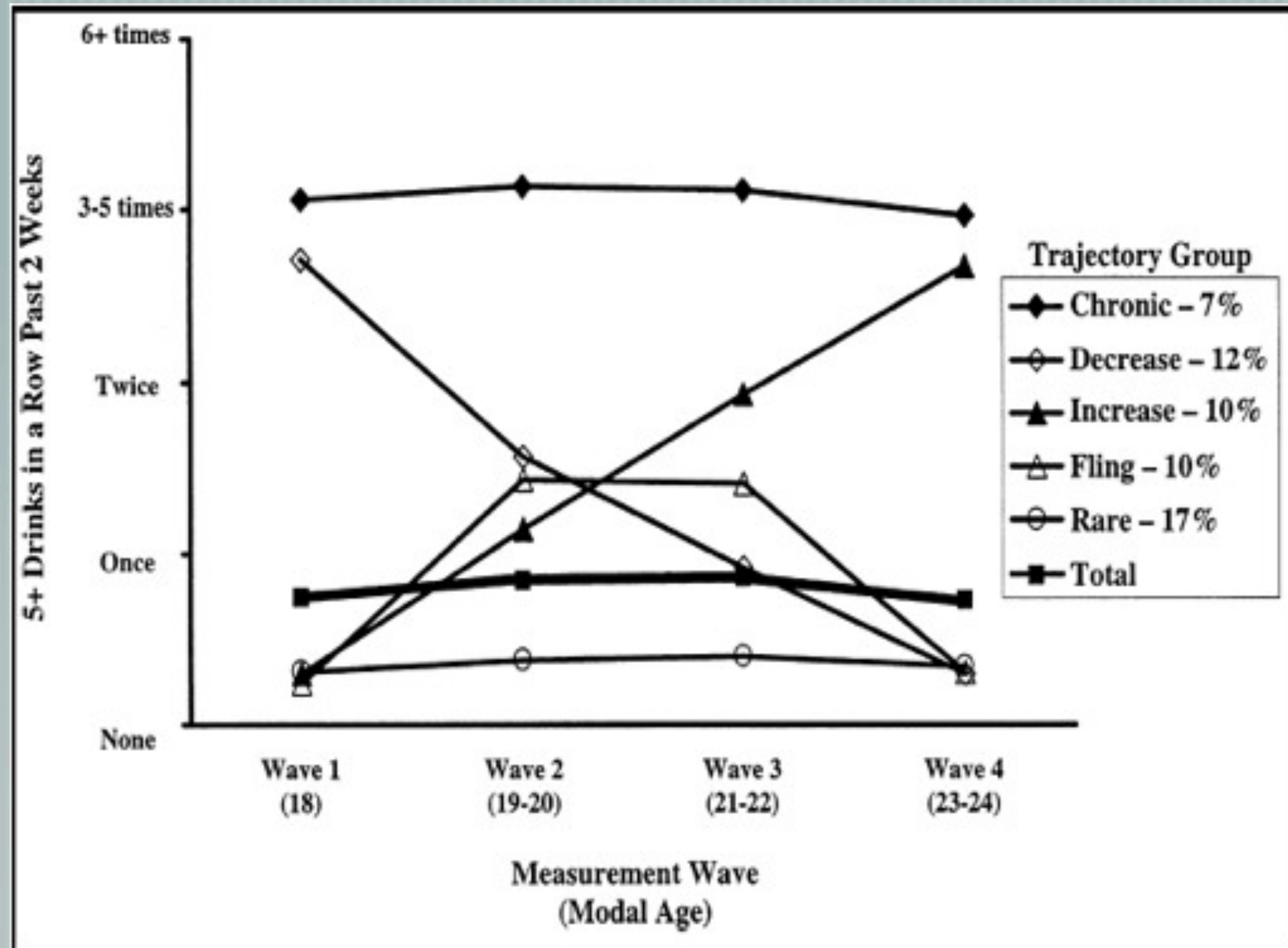
Parental Monitoring Outcomes

Interaction of Positive Monitoring and Group (Treatment v Control) for Saturday Drinking



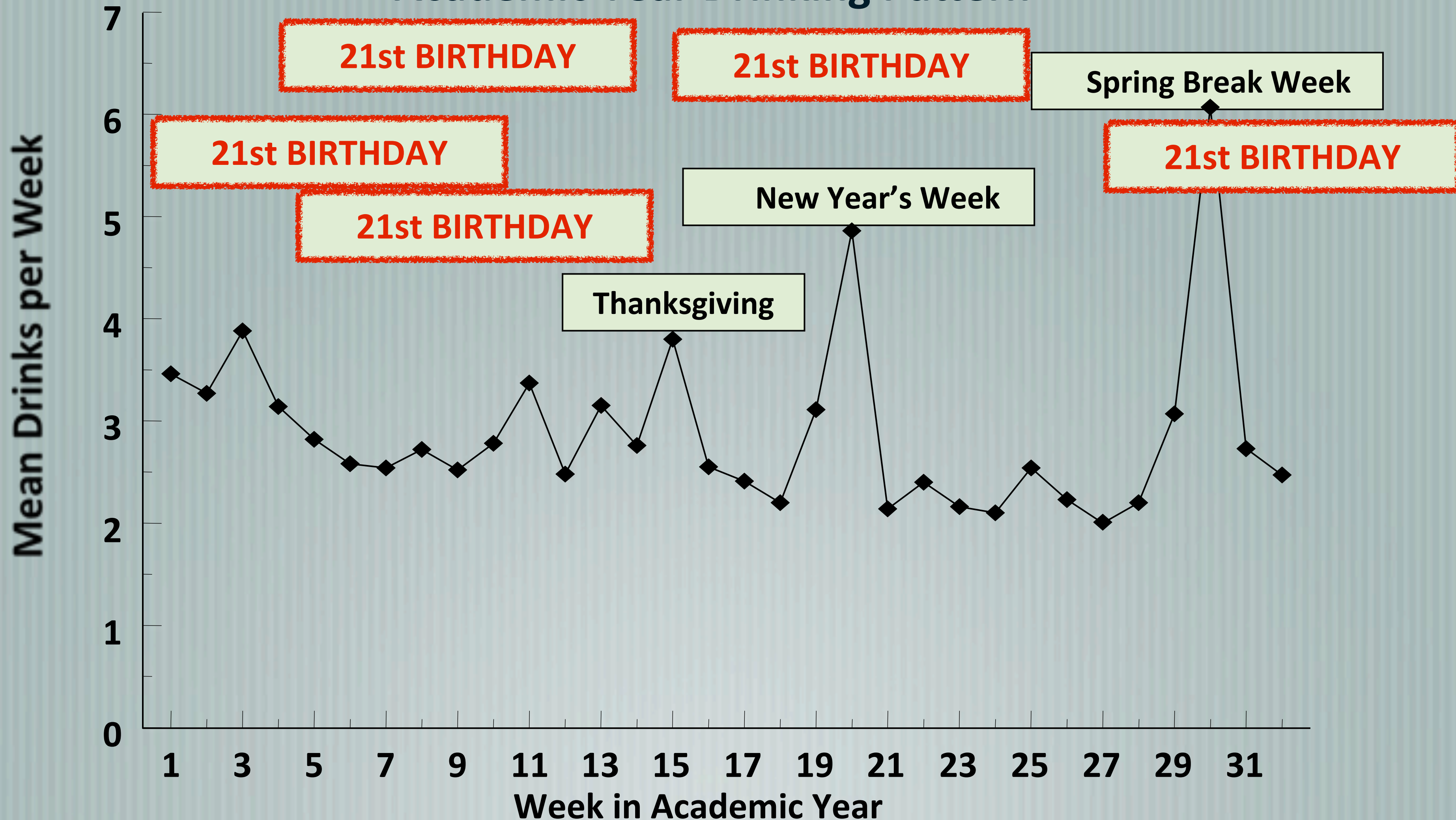
Trajectories of "Binge Drinking" During College

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



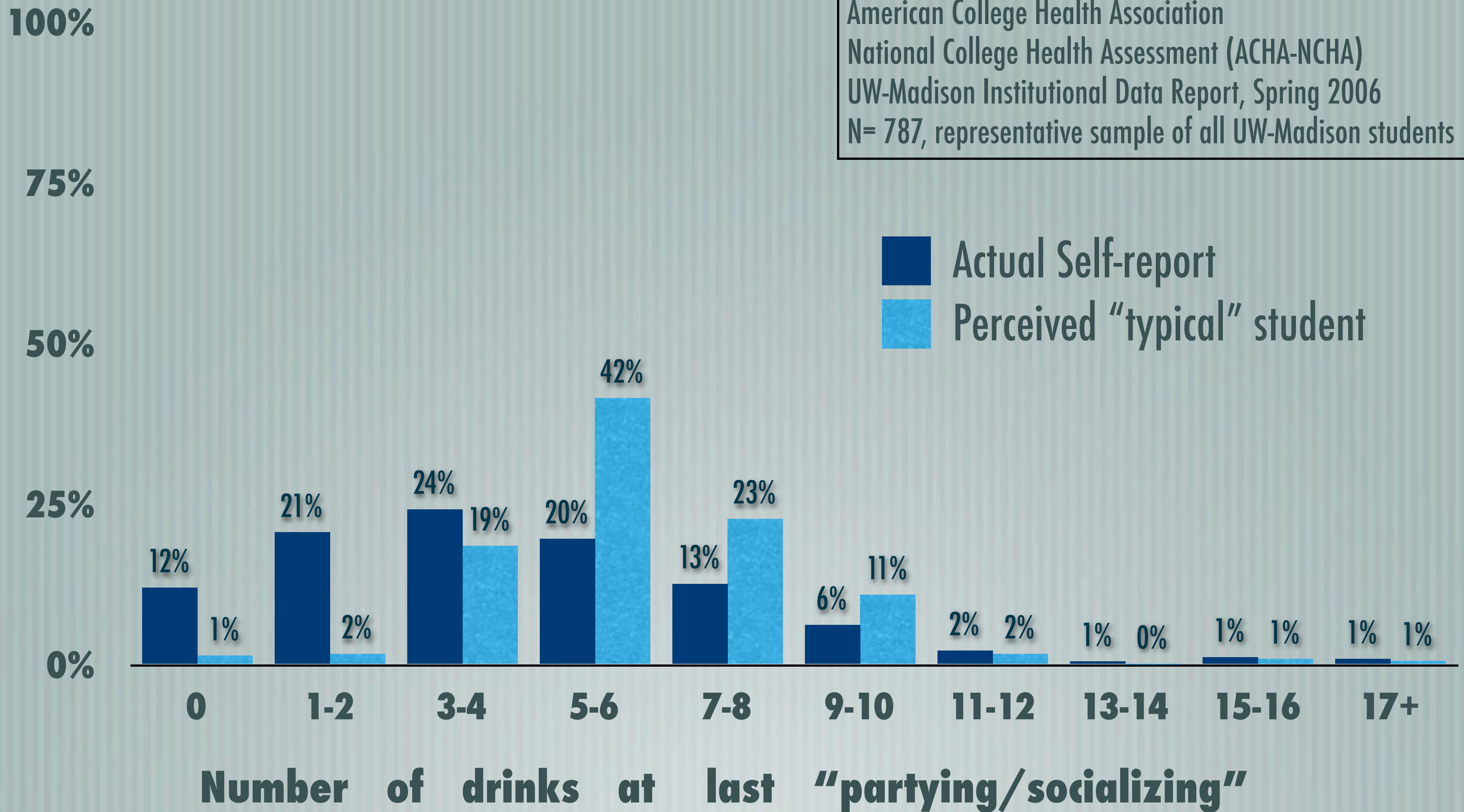
Source: Schulenberg & Maggs (2002), *Journal of Studies on Alcohol*

College Student Drinking



DelBoca et al., 2004

"Partying" Perceptions at UW-Madison



High-Risk Drinking at NCC campuses

- “Average” student
- Fraternities and Sororities
- Athletes
- Perceptions v Reality

- Using campus norms to enhance prevention

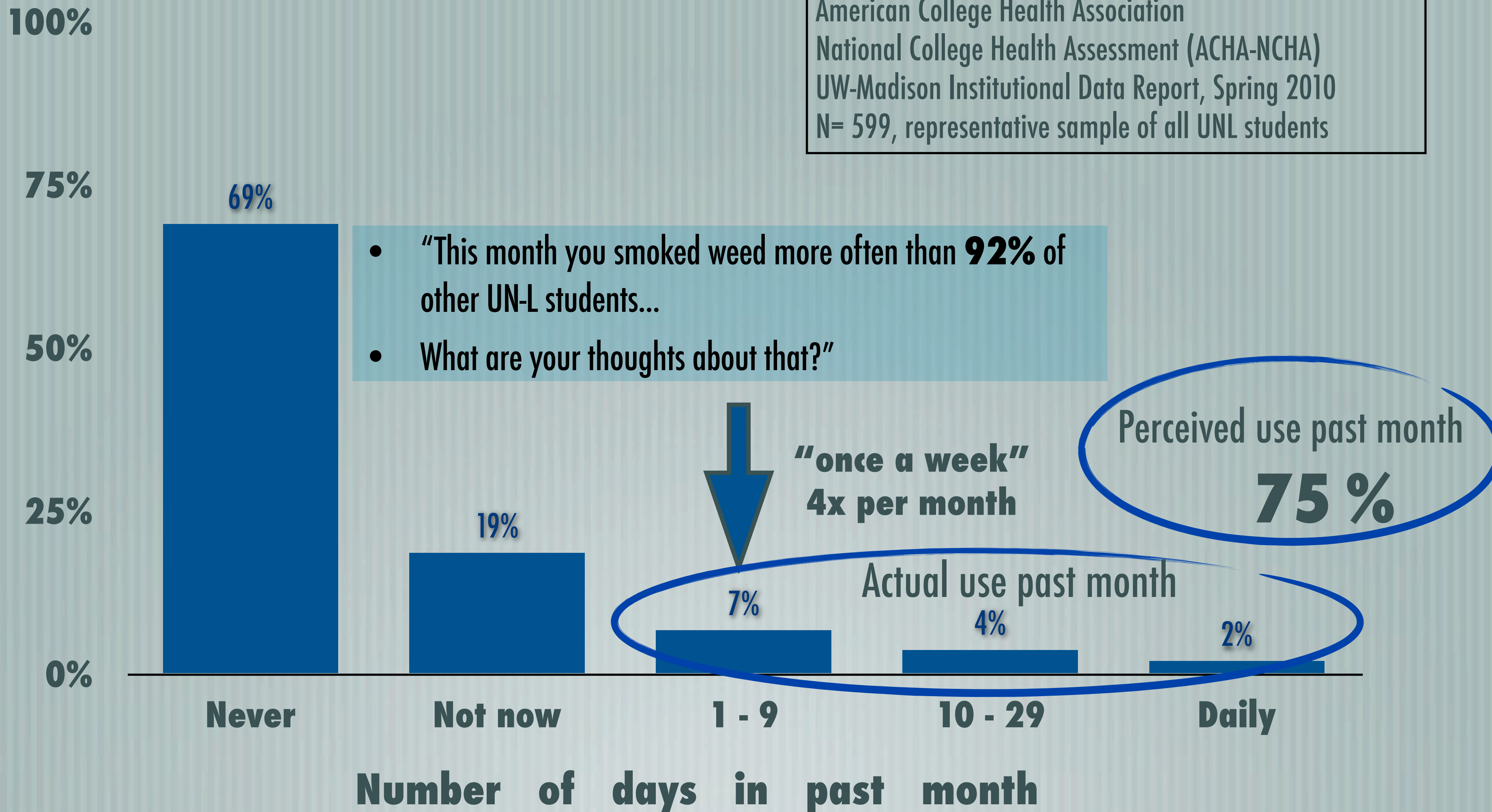
University of Nebraska- Lincoln

Student partying precautions **most of time or always:**

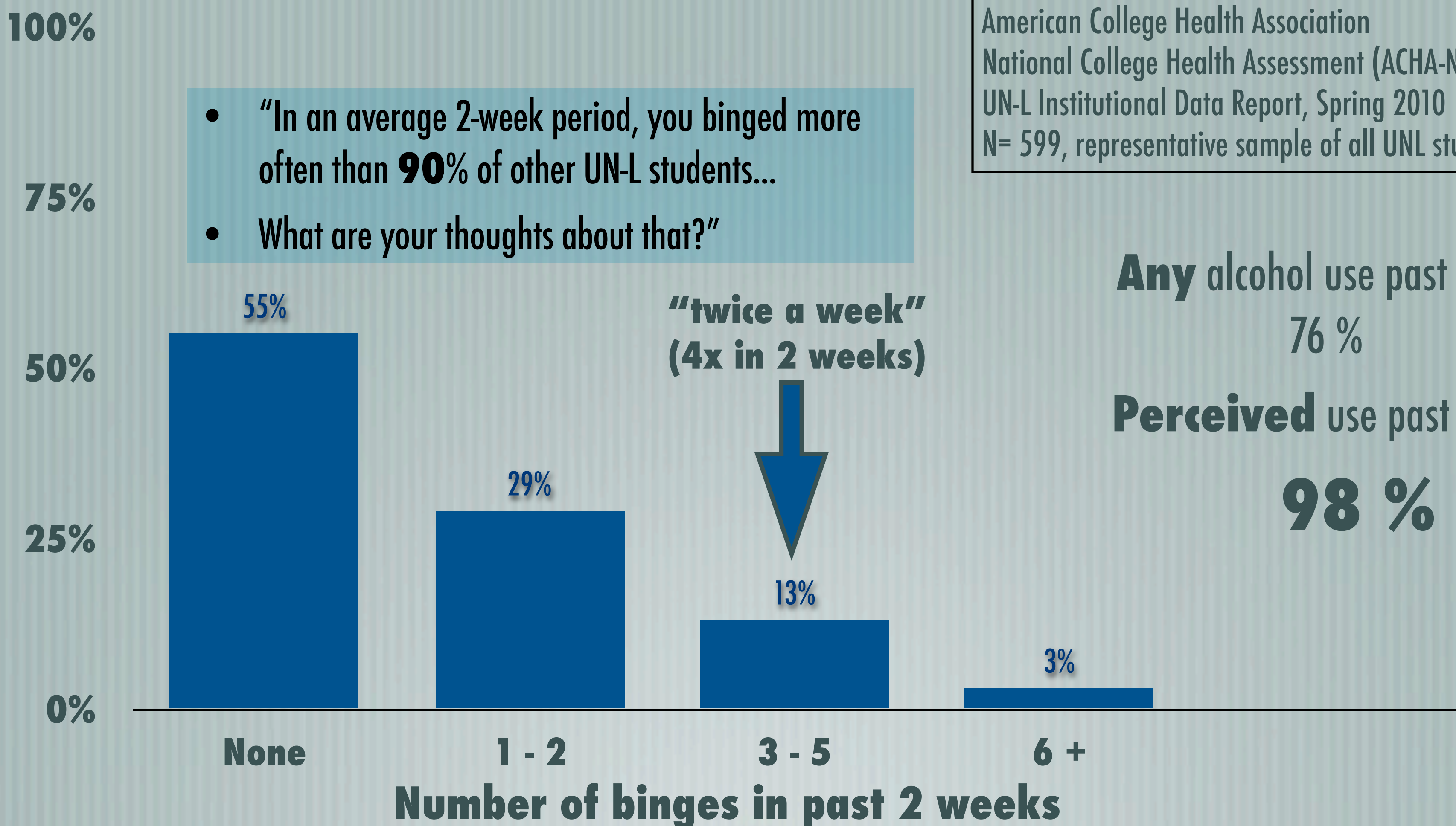
Past 12 months *Percent (%)*	Male	Female	Total
Alternate non-alcoholic with alcoholic beverages	19.8	25.2	22.6
Avoid drinking games	42.7	43.4	42.7
Choose not to drink alcohol	19.7	24.2	22.3
Determine in advance not to exceed a set number of drinks	37.9	38.5	38.4
Eat before and/or during drinking	71.9	85.3	79.5
Have a friend let you know when you have had enough	24.5	37.6	31.8
Keep track of how many drinks being consumed	62.1	70.8	67.1
Pace drinks to one or fewer an hour	22.3	34.5	29.7
Stay with the same group of friends the entire time drinking	88.4	94.4	91.6
Stick with only one kind of alcohol when drinking	51.3	55.4	53.5
Use a designated driver	84.1	91.2	87.7
Reported one or more of the above	99.0	99.7	99.2

**Students responding "N/A, don't drink" were excluded from this analysis.*

Marijuana Use by UN-Lincoln Students

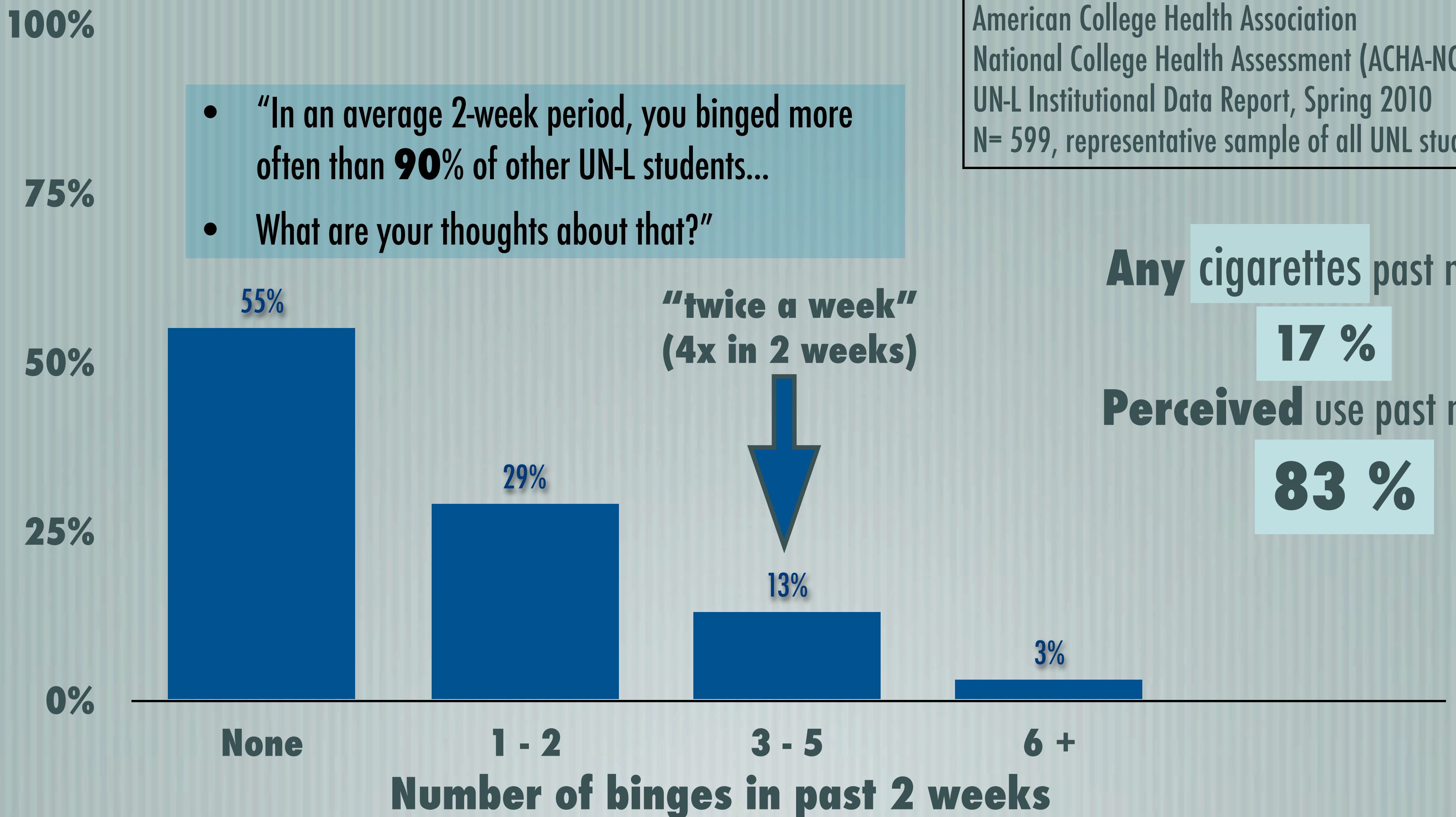


Binge Drinking: Norms and Perceptions



University of Nebraska-Lincoln

Binge Drinking: Norms and Perceptions



University of Nebraska-Lincoln

University of Wisconsin-Madison Intake Screening

- In the past 2 weeks, how often have you been bothered by the following*:
  - little interest or pleasure in doing things
  - feeling down, depressed, or helpless

Not at all	Several days	**Over half**	**Nearly daily**

- Alcohol 5/4 screen
- Emotional, physical, and sexual violence impacts health and wellness in our community. Would you like more information at your appointment?
  - ___ No ___ Yes/Maybe

* PHQ-2, first two questions of PHQ-9

Kroenke K, Spitzer R L, Williams J B. The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine* 2001;16(9): 606-613.

PHQ-9

Over the past two weeks how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
1. Feeling down, depressed, or hopeless	0	1	2	3
1. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
1. Feeling tired or having little energy.	0	1	2	3
1. Poor appetite or overeating	0	1	2	3
1. Feeling bad about yourself-or that you are a failure or let yourself/family down	0	1	2	3
1. Trouble concentrating on things such as reading a newspaper or watching TV	0	1	2	3
1. Moving or speaking so slowly that other people could have noticed. Or, the opposite-feeling so fidgety or restless that you have been moving around more than usual	0	1	2	3
1. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

UHS Alcohol Screening Question

[Men]

During the past 2 weeks, have you had **5** or more drinks containing alcohol (beer, wine or liquor) in a row on at least one occasion?

[Women]

During the past 2 weeks, have you had **4** or more drinks containing alcohol (beer, wine or liquor) in a row on at least one occasion?

No → Screen Complete

Yes → AUDIT given to patient by MA

- 8 or more: Clinician Brief Intervention as appropriate
- < 8 Support Reinforce Individualize

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

AUDIT-C

AUDIT-3

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

AUDIT-C

Consumption

Problems

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at www.who.org.

Excerpted from NIH Publication No. 07-3769 **National Institute on Alcohol and Alcoholism** *www.niaaa.nih.gov/guide*

AUDIT

Alcohol Use Disorders Identification Test

Widely tested and highly reliable screen

Sensitivity/Specificity acceptable:

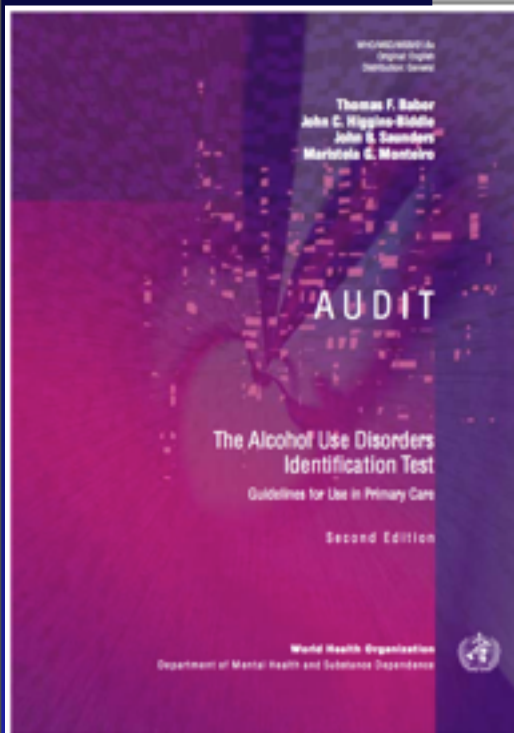
- Adults (≥ 18): score ≥ 8 M ≥ 4 F
- Adolescents (14 - 18 year olds) :
- Score ≥ 2 Problems (0.88/0.81)
- ≥ 3 Abuse/Dependence (0.88/0.77)

Reinert DF, Allen JP. The Alcohol Use Disorder Test: An update of research findings. *Alcohol Clin Exp Res*. 2007; 32(2):185-189.

Kaarne T, Aalto M, MARTTI Kuokkanen M, Seppä K: AUDIT-C, AUDIT-3 and AUDIT-QF in screening risky drinking among Finnish occupational health-care patients.*Drug and Alcohol Review* (September 2010), 29, 563–567 DOI: 10.1111/j.1465-3362.2010.00172.x

Donovan JE. Estimated blood alcohol concentration for child and adolescent drinking and their implications for screening instruments. *Pediatrics.* 2009;123(6)

SBIRT Implementation
Who and How to Screen?



Domains and Item Content of the AUDIT

Domains		Question Number	Item Content
Hazardous Alcohol Use	Consumption	1	Frequency of drinking
		2	Typical quantity
		3	Frequency of heavy drinking
Dependence Symptoms	Dependence	4	Impaired control over drinking
		5	Increased salience of drinking
		6	Morning drinking
Harmful Alcohol Use	Harms	7	Guilt after drinking
		8	Blackouts
		9	Alcohol-related injuries
		10	Others concerned about drinking

SBIRT Implementation

Who and How to Screen?

Risk Level	Intervention	AUDIT score*
Zone I	Alcohol Education	0-7
Zone II	Simple Advice	8-15
Zone III	Simple Advice plus Brief Counseling and Continued Monitoring	16-19
Zone IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20-40

*The AUDIT cut-off score may vary slightly depending on the country's drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Clinical judgment should be exercised in cases where the patient's score is not consistent with other evidence, or if the patient has a prior history of alcohol dependence. It may also be instructive to review the patient's responses to individual questions dealing with dependence symptoms (Questions 4, 5 and 6) and alcohol-related problems (Questions 9 and 10). Provide the next highest level of intervention to patients who score 2 or more on Questions 4, 5 and 6, or 4 on Questions 9 or 10.

Clinical Judgment

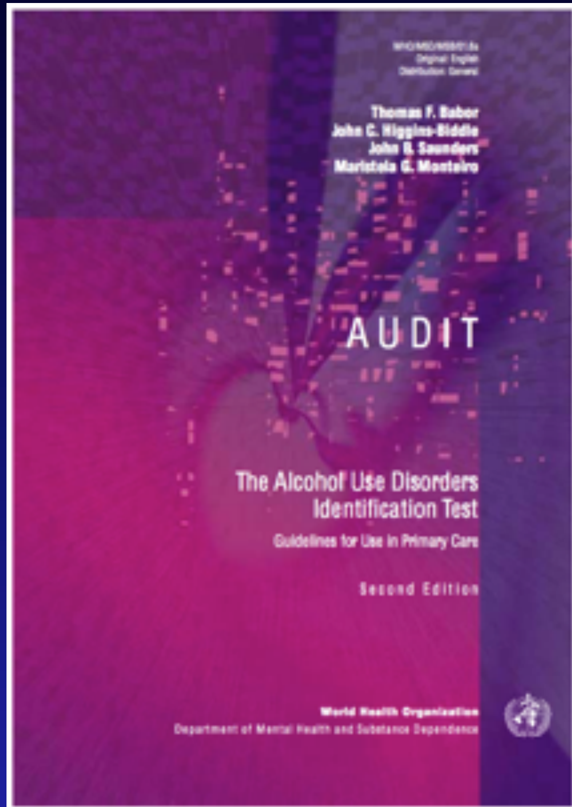
SBIRT Implementation

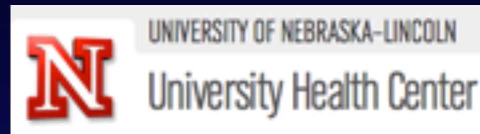
Who and How to Screen?

Elements of Brief Interventions

- Present screening results
- Identify risks and discuss conse-quences
- Provide medical advice
- Solicit patient commitment
- Identify goal—reduced drinking or abstinence
- Give advice and encouragement

SBIRT Implementation
Who and How to Screen?





Implementation Questions

Which patients will be screened?

How often will patients be screened?

How will screening be coordinated with other activities?

Who will administer the screen?

What provider and patient materials will be used?

Who will interpret results and help the patient?

How will medical records be maintained?

What follow-up actions will be taken?

How will patients needing screening be identified?

When during the patient's visit will screening be done?

What will be the sequence of actions?

How will instruments and materials be obtained, stored, and managed?

How will follow-up be scheduled?

Case 2 Women's Health Clinic Visit:

- "Carmen", a 21 year old senior in marketing presents for routine pelvic and STI check.

Risk Level	Intervention	AUDIT score*
Zone I	Alcohol Education	0-7
Zone II	Simple Advice	8-15
Zone III	Simple Advice plus Brief Counseling and Continued Monitoring	16-19
Zone IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20-40

*The AUDIT cut-off score may vary slightly depending on the country's drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Clinical judgment should be exercised in cases where the patient's score is not consistent with other evidence, or if the patient has a prior history of alcohol dependence. It may also be instructive to review the patient's responses to individual questions dealing with dependence symptoms (Questions 4, 5 and 6) and alcohol-related problems (Questions 9 and 10). Provide the next highest level of intervention to patients who score 2 or more on Questions 4, 5 and 6, or 4 on Questions 9 or 10.

Clinical Judgment

Motivational Interviewing

Methods: O A R S

Ask permission first
MI is more like "pulling" rather than "pushing"

Open Questions not "yes/no"

Affirm patient's positives/values/character

Reflective Listening statements
understand content and meaning

Summarize main points, then shift

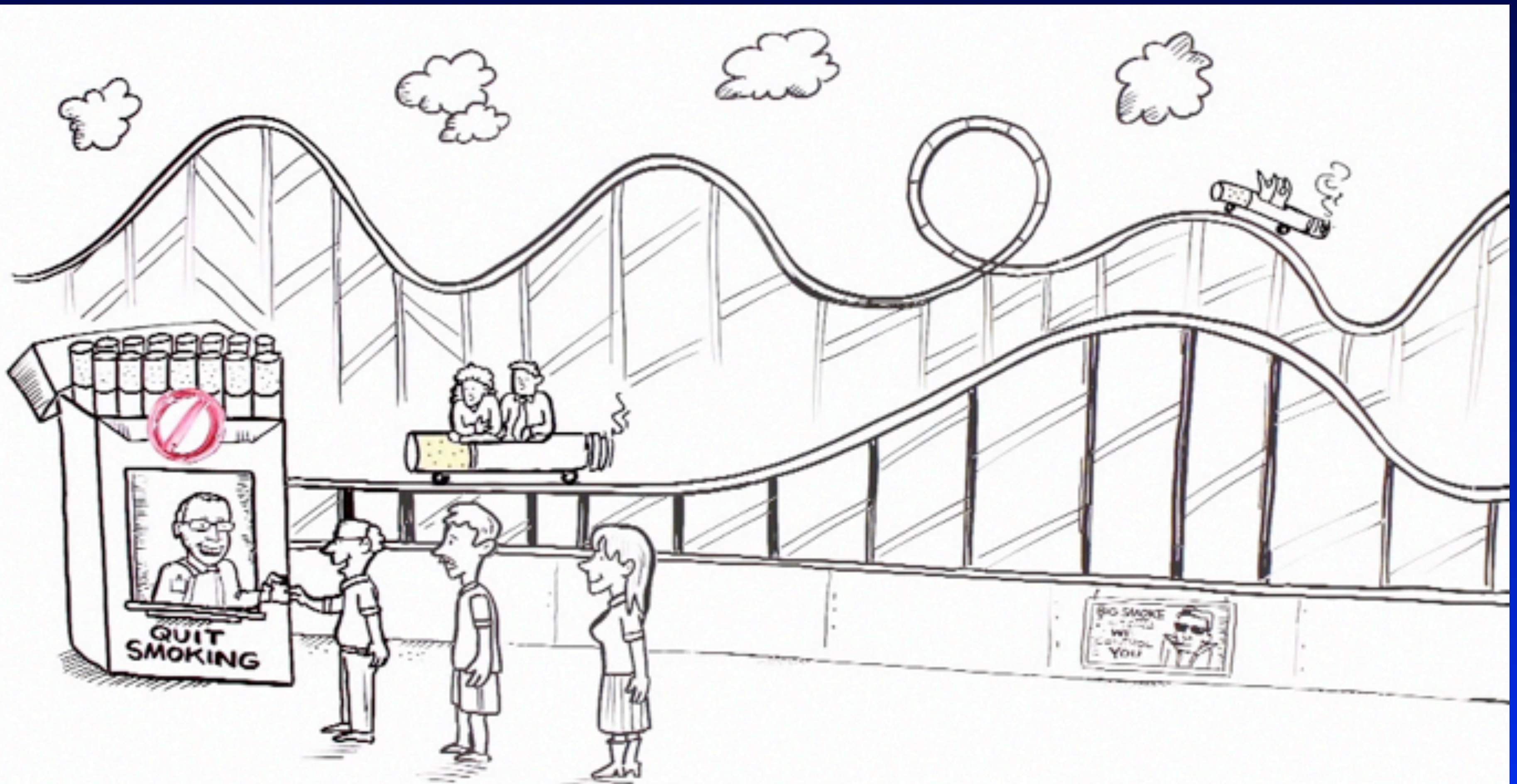
Summarize periodically, demonstrating you're listening

Reflective Listening:
A Critical Primary Skill

Exercise:
Practicing Reflective Listening

Respond with Reflections and Open Questions to these patients' comments:

Helping Patients Change Behaviors: 0 to 10 “Change Ruler”



What is the single best thing you can do to stop smoking? Written, narrated, produced by Mike Evans, MD, Associate Professor of Family Medicine and Public Health, University of Toronto. YouTube video, Canadaptt Project, Peter Selby, PI.

Readiness Rulers to Elicit "Change Talk"

On a scale of 0 to 10, with 10 being the most,

How **important** is it for you to ________________________ ?

How **confident** are you that you can __________________ ?

How **willing** are you to _______________________________ ?

Why are you not a **lower number** ? Answer = "change talk"

Eliciting "Change Talk"

"Change Talk Scanning" throughout interview

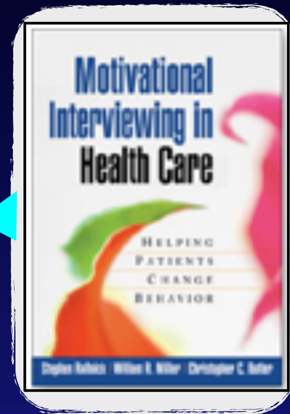
- **Listen for DARN statements**
- **D: Desire**
  - "I wish I could lose some weight"
  - "I like the idea of getting more exercise"
- **A: Ability**
  - "I might be able to cut down a bit"
  - "I could probably try to drink less"
- **R: Reasons**
  - "Cutting down would be good for my health"
  - "I'd sure have more money if I cut down"
- **N: Need**
  - "I must get some sleep"
  - "I really need to get more exercise"

"WHY" or "HOW"

- **Ask "Might" Questions:** (pre-contemplation)
  - "Do you think you might consider losing weight?"
  - "Why might you want to eat better?"

Examples from and/or adapted from: Rollnick, Miller, & Butler (2008)

Summary:
Motivational Interviewing for Behavior Change



- Strong Evidence of Effectiveness, powerful impact
- Simple but not easy: practice → effectiveness
- College Health, Counseling, Campus Professionals
  - Reflect on evidence and own students; read
  - YOU decide best strategies for you
  - Student patients / clients teach you what works:
    - resistance or "glazed" look → try different strategy
    - college students often ready to make changes
- Every Rx is simple "bridge" to brief alcohol conversation
- Clinical teams follow-up, QI, student/campus outcomes, safety

Experiential
- Feedback
- Role-plays
- Simulations
- Norms graphs
- Music, lyrics
- Animations
  - Slides
  - Videos
- EHR prompts

See one, Do one, Teach one !
-- Ancient Medical Training Proverb

See one, Do one hundred, Teach one !

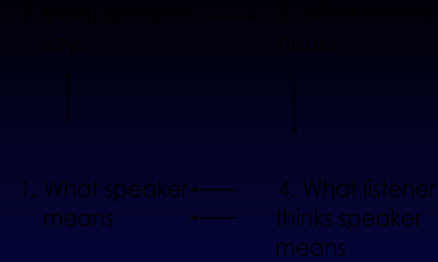
The UHC Mission and Vision

Mission: The UHC promotes the health and well-being of the University of Nebraska community through quality care and education.

Vision: We envision a contemporary Health Center focused on excellence, connected with students, supportive of the academic mission, and committed to the health and wellness of the University community.

Alcohol Expectancies

Alcohol's Biphasic Effect

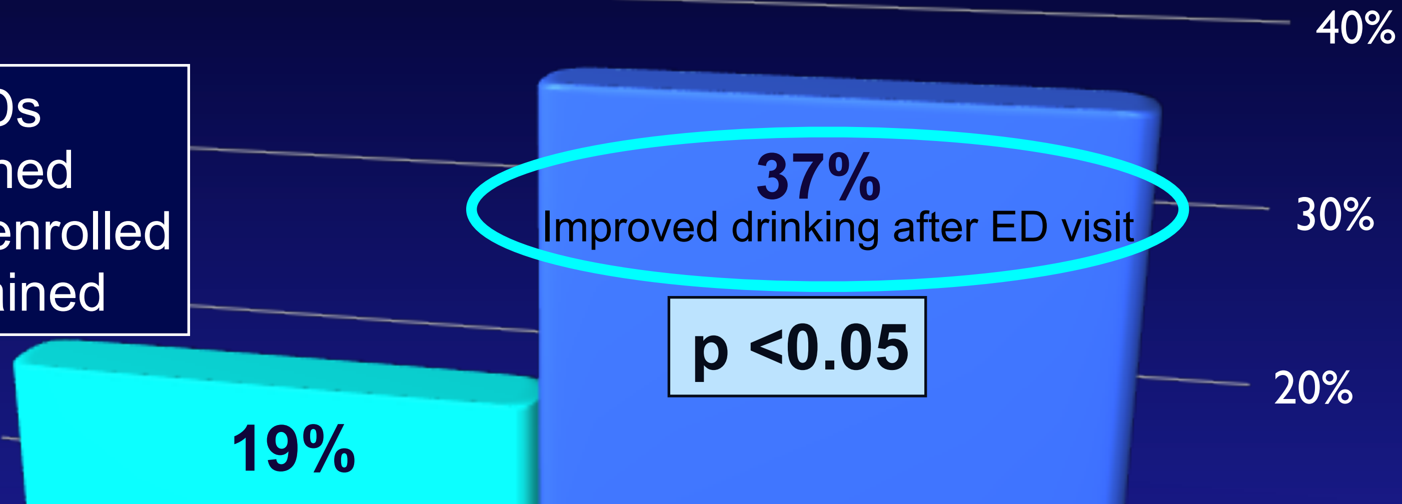


Exercise:
Respond with Reflections and Open Questions to patients' comments:

College Student Case 3: “Chris” Academic Difficulties and Fatigue

MI Consistent and MI Inconsistent Conversations

Brief Negotiated Intervention Emergency Department Visits



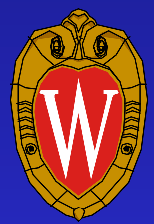
14 Academic EDs
7,751 pts screened
1,132 high risk enrolled
ED providers trained

6-, 12-month f/up: positive outcomes no longer statistically significant

"Given the success of BIs in primary-care practice, active referral to primary-care providers offers an opportunity to enhance ED interventions."

3 months post-intervention

% High-risk drinkers becoming low risk



*Academic ED SBIRT Research Collaborative, The Impact of Screening, Brief Intervention, and Referral to Treatment in Emergency Department Patients' Alcohol Use: A 3-, 6-, and 12-month Follow-up. *Alcohol and Alcoholism* Vol. 45, No. 6, pp. 514–519, 2010 Advance Access Publication 27 September 2010

*Academic ED SBIRT Research Collaborative, *Ann Emerg Med.* December 2007; 50:699-710.

Brief Intervention in Emergency Departments

- **BI: Reduced ED alcohol-related readmission rates 45% in 1 year[1]**
- Systematic Reviews: Most ED/Surgical patients participate in and complete alcohol intervention programs[2] ; others- mixed results[3]
- RCT: Reduced alcohol misuse and violence among teens[4]
- Cost-effective adjuncts to ED care with promising positive outcomes:
  - Telephone counseling[5]; hiring an alcohol counselor[6]
  - Computerized SBIRT in ED[7], plus phone call[8]
  - Post-ED text-message[9], PDA/phone apps, mailed feedback[10]

1 Schwan R, DiPatrito P, Albuisson E, Malet L, Brousse G, Lerond J, Laprevote V, Boivin JM. Usefulness of brief intervention for patients admitted to emergency services for acute alcohol intoxication. *Eur J Emerg Med*. 2011 Dec. 16 [Epub ahead of print]

2 Pedersen B, Oppedal K, Eqund L, Tonnesen H. Will emergency and surgical patients participate in and complete alcohol interventions? A systematic review. *BMC Surg.* 2011 Sep 23;11:26.

3 Field CA, Baird J, Saitz R, Caetano R, Monti P. The mixed evidence for brief intervention in emergency depatents, trauma care centers, and inpatient hospital settings: What should we do? *Alcohol Clin Exp Res*. 2010. 34(12): 2004-10.

4 Walton MA, Chermack ST, Shope JT, Bingham CR, Zimmerman MA, Blow FC, Cunningham RM. Effects of a brief intervention trial for reducing violence and alcohol misuse among adolescents: a randomized controlled trial. *JAMA*. 2010 Aug 4;304(5):527-35.

5 Mello MJ, Baird J, Nirenberg TD, Smith JC, Woolard RH, Dinwood RG. Project Integrate: Translating screening and brief interventions for alcohol problems to a community hospital emergency department. *Subst Abus*. 2009. 30(3); 223-229.

6 Bernstein E, Bernstein J, Levenson S. Project Assert: An ED-based intervention to increase access to primary care, preventive services, and the substance abuse treatment system. *Annals of Emerg Med.* 1997. 30:181-89.

7 Maio R, Shope J, Blow F, Gregor J, Zakrajsek J, Weber J, Nypaver M, A Randomized controlled trial of an emergency department-based computerized interactive program to prevent alcohol misuse among injured adolescents. *Annals Emerg Med* 1997. 45(4):420-29.

8 Vaca FE, Winn D, Anderson CL, Mik D, Arcila M. Six-month follow-up of computerized alcohol screening, brief intervention and referral to treatment in the emergency department. *Subst Abus*. 2011 Jul;32(3):144-52.

9 Parker M, Wills G, Wills J, Using mobile instant messaging to support the substance abuse problem amongst youth in South Africa. Paper presented at International Development Informatics Conference, Cape Town, South Africa. Nov 3-5, 2010.

10 Havard A, Shakeshaft AP, Conigrave KM, Doran CM. RCT of mailed personalized feedback for problem drinkers in the ED: The short-term impact. *Alcohol Clin Exp Res*. 2011 Oct 20. [Epub ahead of print]

Using the NIAAA *Clinician's Guide*

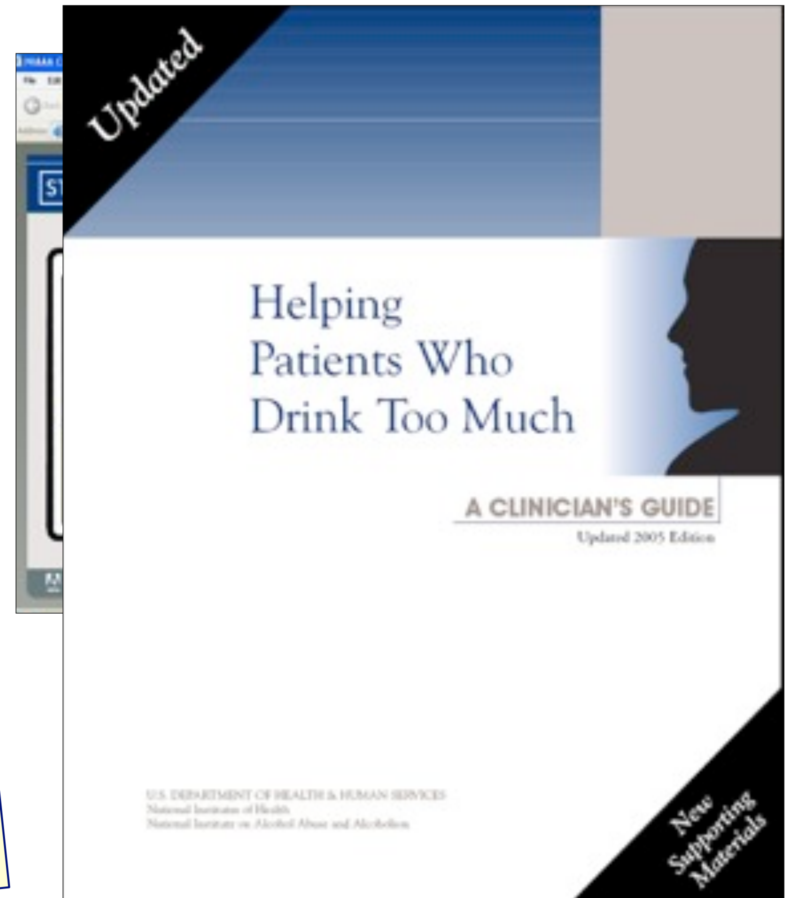
A note to Instructors:

This slide show is a companion to
the

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***



Student Health Case 4: Hypertension

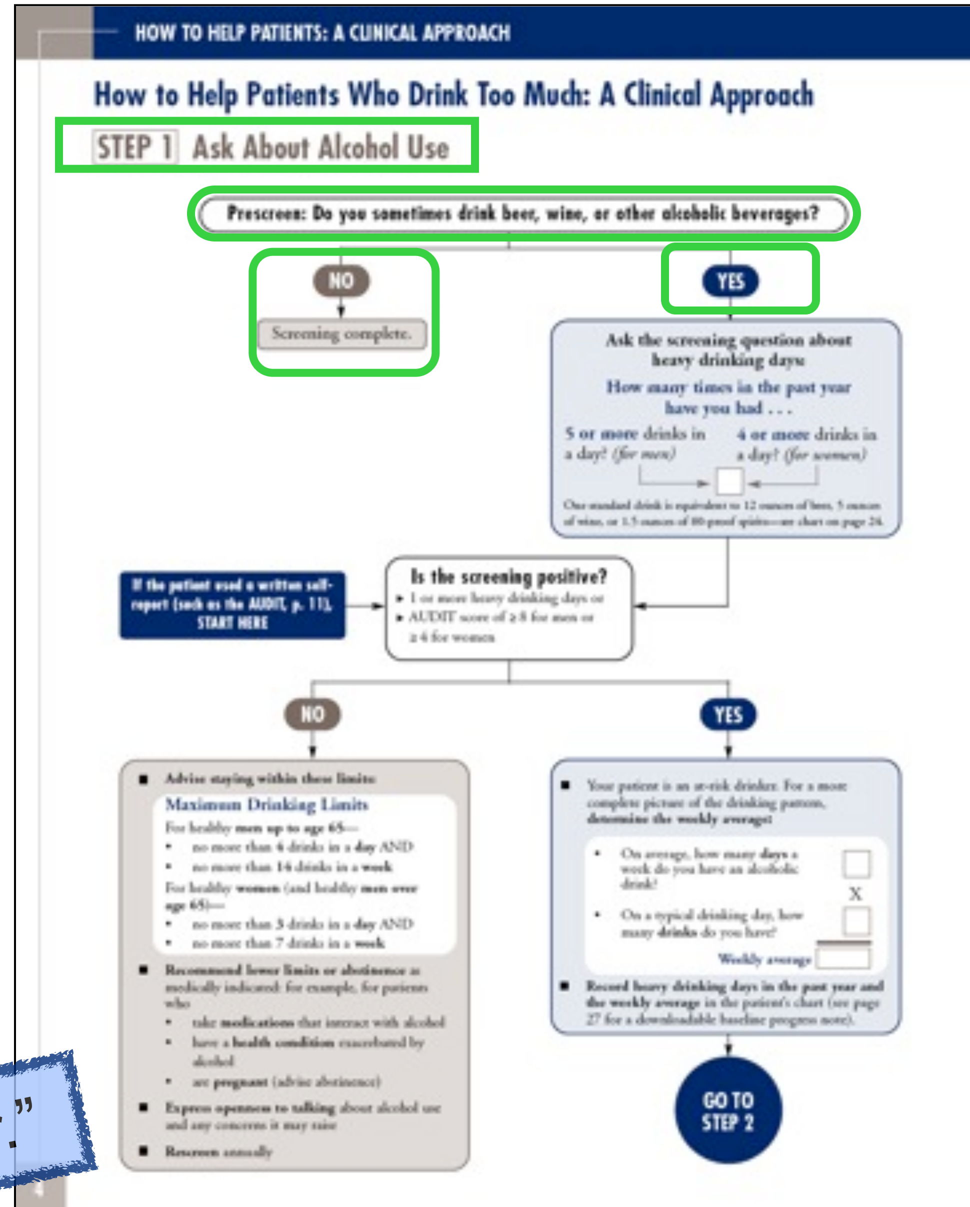
STEP 1: Ask About Alcohol Use

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.

HOW TO HELP PATIENTS: A CLINICAL APPROACH

How to Help Patients Who Drink Too Much: A Clinical Approach

STEP 1 Ask About Alcohol Use

...you sometimes drink beer, wine, or other alcoholic beverages?

YES

Ask the screening question about heavy drinking days:

5 or more drinks in a day? (for men)

4 or more drinks in a day? (for women)

Is the screening positive?

YES

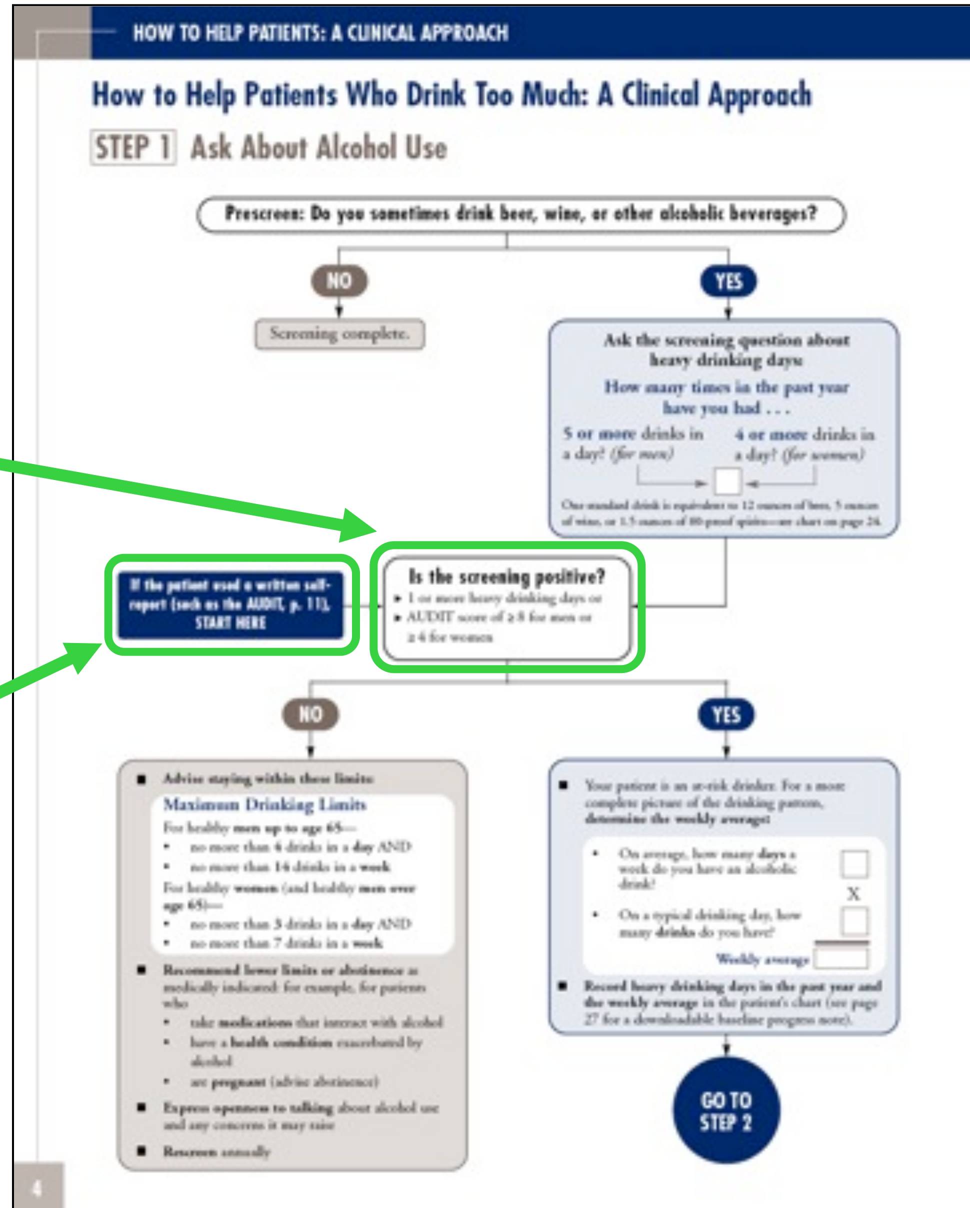
GO TO STEP 2

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



AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

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

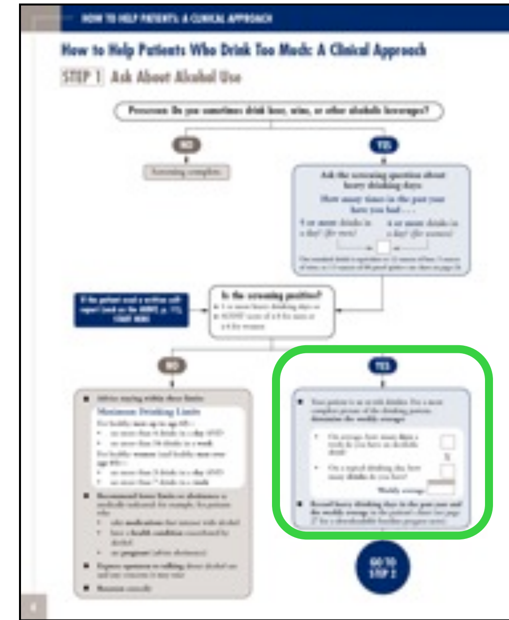
Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at *www.who.org*.

John's AUDIT = 16

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?

x

Weekly Average

4 days

Fri & Sat: 6 or 8 beers
2 weekdays: 3 or 4 beers

18 - 24

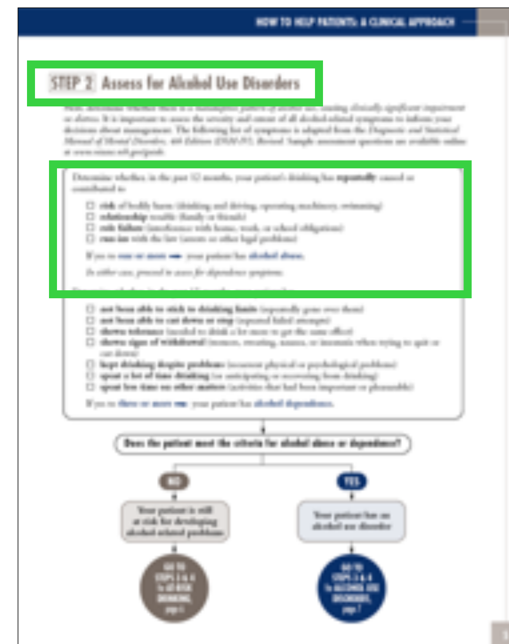
STEP 2: Assess for AUDs (cont'd)

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

Drinking and Driving

Wife Concerned



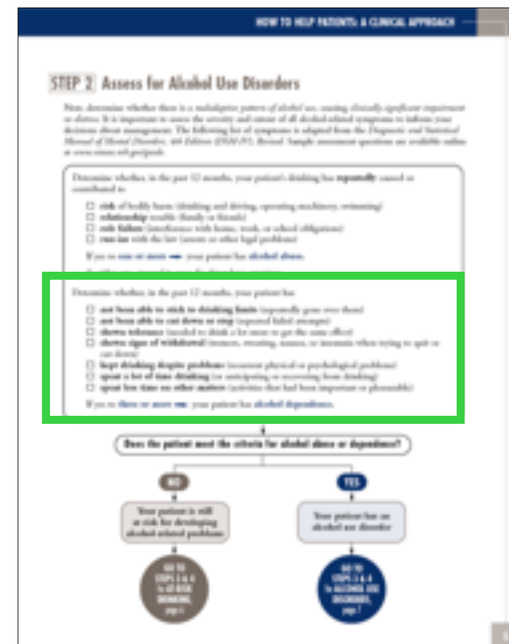
If YES to one or more ➡ your patient has Alcohol Abuse

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**

Updated

A POCKET GUIDE FOR
Alcohol Screening and Brief Intervention

Updated 2005 Edition

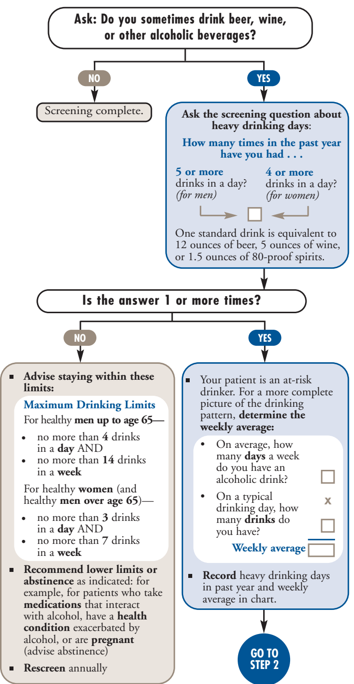
This pocket guide is condensed from the 34-page NIAAA guide, *Helping Patients Who Drink Too Much: A Clinician's Guide.*

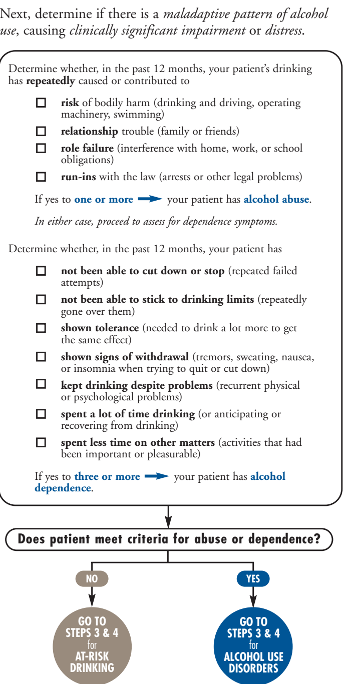
Visit ***www.niaaa.nih.gov/guide*** for related professional support resources, including:

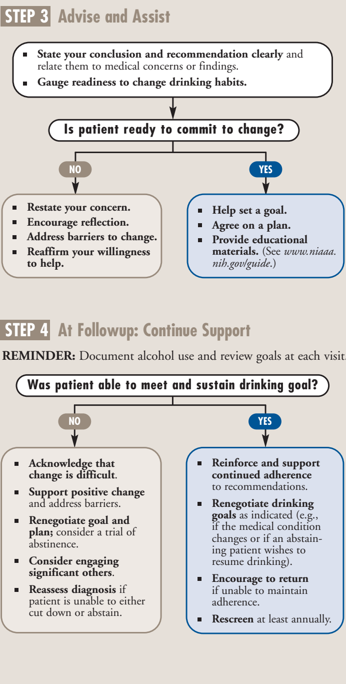
- patient education handouts
- preformatted progress notes
- animated slide show for training
- materials in Spanish

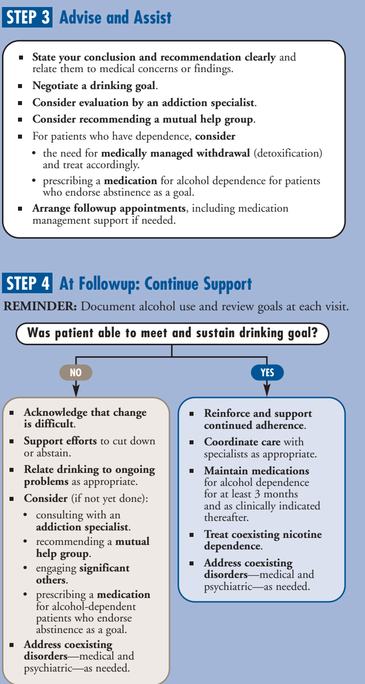
Or contact:

NIAAA Publications Distribution Center
P.O. Box 10686, Rockville, MD 20849-0686
(301) 443–3860
www.niaaa.nih.gov









To order free copies of the Guide, Pocket Guide, or the CD, contact NIAAA…

By mail

NIAAA Publications Distribution Center
P.O. Box 10686
Rockville, MD 20849-0686

By phone 301-443-3860

Online www.niaaa.nih.gov/guide

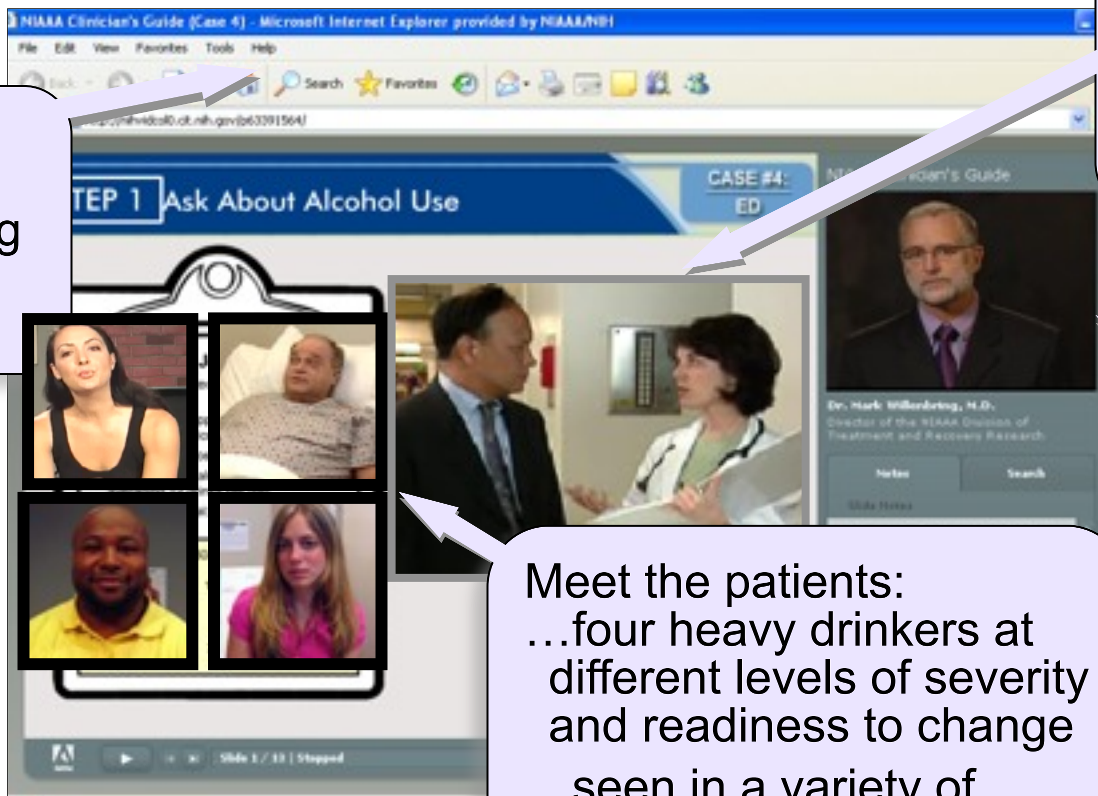
NIAAA Introduces…

Free Interactive Web-based Training

One Hour, Free CME

- **Free CME/CE credits through *Medscape.com***

For details and links, visit www.niaaa.nih.gov/guide



Online technology brings training to your desktop

Realistic video scenarios show the *Clinician's Guide* in action

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

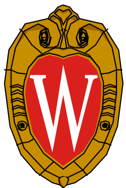
Experts offer insights and ask what you would do in each situation

Case 4: Hypertension (cont'd)

Behavioral Conversation A

Behavioral Conversation B

RETHINKING DRINKING



RETHINKING DRINKING
Alcohol and your health

Search

HOW MUCH IS TOO MUCH?
- What counts as a drink?
- Is your drinking pattern risky?
- What's the harm?

THINKING ABOUT A CHANGE?
- It's up to you
- Strategies for cutting down
- Support for quitting
- Tools & resources

QUESTIONS?
- Q & As

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.

Is your "lite" beer light in alcohol?

How strong is your mixed drink?

TRY THE COCKTAIL CONTENT CALCULATOR

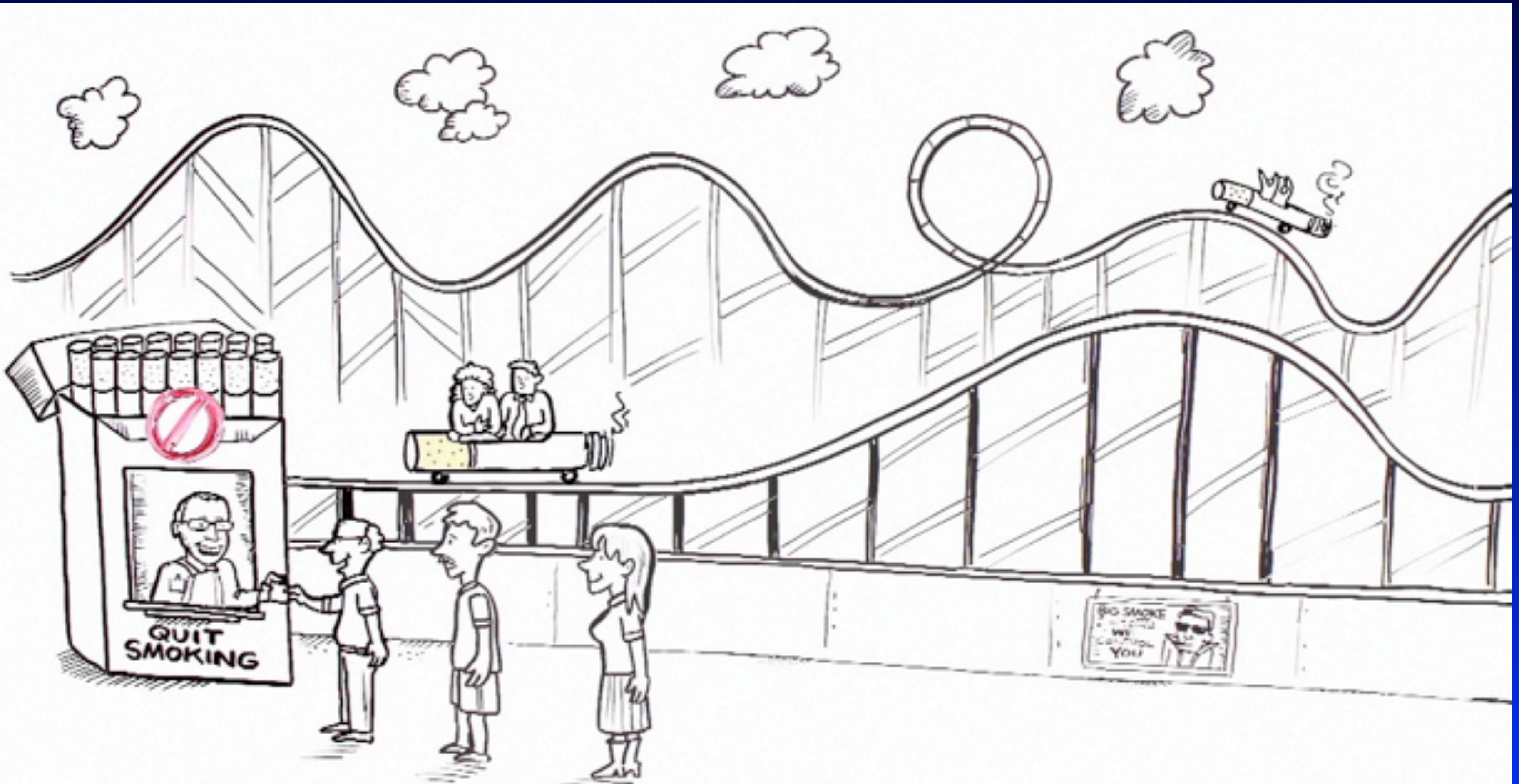
How many "drinks" are in a bottle of wine?

Quick links
- Check your drinking pattern
- See signs of a problem
- Get tools to make a change

TAKE IT with you

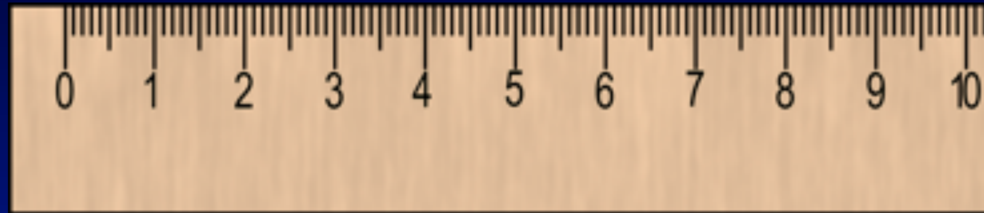
Download or order this 16-page booklet, *Rethinking Drinking: Alcohol and Your Health*

Helping Patients Change Behaviors: 0 to 10 “Change Ruler”



What is the single best thing you can do to stop smoking? Written, narrated, produced by Mike Evans, MD, Associate Professor of Family Medicine and Public Health, University of Toronto. YouTube video, Canadaptt Project, Peter Selby, PI.

Readiness to Change Rulers: Eliciting "Change Talk"



On a scale of 0 to 10, with 10 being the most,

How **important** is it for you to _______________________ ?

How **confident** are you that you can _________________ ?

How **willing** are you to ______________________________ ?

Why are you not a **lower number** ? Answer = "change talk"

Medication / Treatment Adherence

- "The Choice Triad" [1]

  -Adherence stems from patient's personal belief that:
  - 1. Something is wrong; personally want relief
  - 2. Medication may help, or may prevent future problems
  - 3. The "pros" outweigh the "cons"
    - – Patients often assess pros/cons with 3 "belief sets"
      - Efficacy: Does the drug make me feel better?
      - Cost: Is it worth it to me to take this drug?
      - Meaning: What does it say about me that I have to take this drug, or do this treatment?

> "It is much more important to know what sort of person has a disease than to know what sort of disease a person has."
>
> - Sir William Osler

[1] Shea SC. The "Medication Interest Model" An Integrative Clinical Interviewing Approach for Improving Medication Adherence--Part 1: Clinical Applications. 2008. Professional Case Management 13(6):305-315.

Medication / Treatment Adherence (continued)

- “The Choice Triad” [2] for patients: Further history
  - 1. “Target Symptom” or “Magic Pill” questions
    - “Tina, of all the worries you’ve mentioned, which one(s) do you most want help with?”

      “If I had a magic pill--and I don’t--to completely take away just one of your symptoms, which one would you want me to get rid of?”
  - 2. “Inquiry Into Lost Dreams” questions
    - “Is there anything your diabetes / depression / asthma / weight /etc. is keeping you from doing that you really wish you could do again?”
  - 3. “Envelope” and “Medication Interest” questions
    - “If I were to hand you an envelope, what would the message inside have to say for you to think more about taking this medication (or treatment)?

[2] Shea SC. The “Medication Interest Model” An Integrative Clinical Interviewing Approach for Improving Medication Adherence--Part 2: Implications for Teaching and Research. 2009. Professional Case Management 14(1):6-15.

Case 5: Men's Sexual Health Clinic Visit

- "Scott," 19 year old sophomore for STI check.
- **+** Alcohol screen. AUDIT = 14.

Case 6: Primary Care Clinic
Strep Throat Plus

College Student 7: “Rafael”
STI screen
Behavioral conversation A

Behavioral conversation B

Sexual Risk Reduction

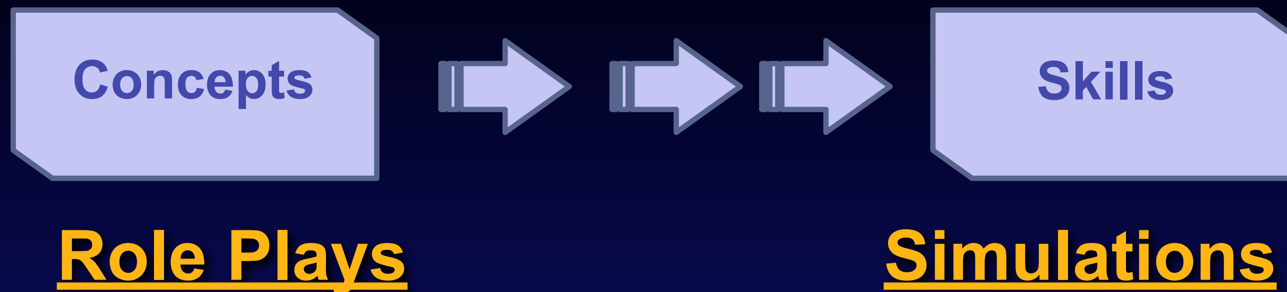
- Brief, patient-centered, interactive counseling
  - “Asking” v. “Telling”
    - What do you think about condoms?
    - Describe your experiences using them…
    - How does your partner feel about this?

Kamb, ML et al. Project RESPECT Study Group. Efficacy of Risk-Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases. A Randomized Controlled Trial. JAMA 1998; 280:1161-1167

Case 8, Wound Check: “Kevin”

Case 9, Bike Accident: “Mike”

Application of Virtual Reality Simulations



Role Plays	Simulations
▪ Few times, limited	▪ Played many times
▪ Management issues	▪ Reliable performance
▪ Player may go off script	▪ Carefully written script
▪ Judgment concerns	▪ Non-judgmental
▪ Feedback inconsistent	▪ Feedback consistent, safe, given immediately

Virtual Reality Simulation

Virtual Reality Skills Training

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, Judie Pfeifer, MEd, Stephanie Schiro, BA, Jane Banning, MSSW, and Susan Skochelak, 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 1207 simulated patient responses.

Results: A sample of 102 health care professionals (10 physicians; 30 physician assistants or nurse practitioners; 36 medical students; 26 pharmacy, physican 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 43.5 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;22:387–98.)

Virtual Reality Skills Training

Randomized Controlled Trial
N= 102 Heath Care Providers

- 10 MDs and 30 NP/PAs
- 36 Med students
- 26 NP/PA/Pharm students

N = 51
No Training

N = 51
Simulation Training
10 practices/ 3 months

Standardized Patient (SP) Testing and Scoring: Baseline and 6 Months

Virtual Reality Skills Training

SP Scores 6 months post-intervention

Student Health Primary Care Cases

- Case 10: Cholesterol follow-up
- Case 11: Uvulitis
- Case 12: STI risks and testing
- Case 13: Poison Ivy Plus
- Case 14: Ankle sprain
- Case 15: Tetracycline Med refill

- Case Analyses and Discussion.
- OARS: Open, Affirm, Reflect, Summarize
- REDS
  - Rolling with Resistance
  - Expressing Empathy
  - Developing Discrepancy
  - Supporting Self-efficacy

Case 10, Brief Nutrition Intervention: "Linda"

- Linda, a sedentary 24 year old with a BMI of 32, comes to clinic for follow-up of hypercholesterolemia. She's been trying to lose some weight and eat better but is not very motivated or talkative.

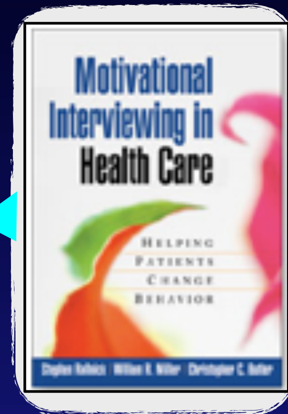
Case 15: Medication refill

John, 20 year-old junior, history major, new patient presents for med refill.

Summary Exercise: Putting OARS together

- Please respond to these statements with
  - open questions first,
  - then with reflections

Summary:
Motivational Interviewing for Behavior Change



- Strong Evidence of Effectiveness, powerful impact
- Simple but not easy: practice → effectiveness
- College Health, Counseling, Campus Professionals
  - Reflect on evidence and own students; read
  - YOU decide best strategies for you
  - Student patients / clients teach you what works:
    - resistance or “glazed” look → try different strategy
    - college students often ready to make changes
- Every Rx is simple “bridge” to brief alcohol conversation
- Clinical teams follow-up, QI, student/campus outcomes, safety

Experiential
- •Feedback
- •Role-plays
- •Simulations
- •Norms graphs
- •Music, lyrics
- •Animations
  - •Slides
  - •Videos
- •EHR prompts

See one, Do one, Teach one !
-- Ancient Medical Training Proverb

See one, Do one hundred, Teach one !

The UHC Mission and Vision

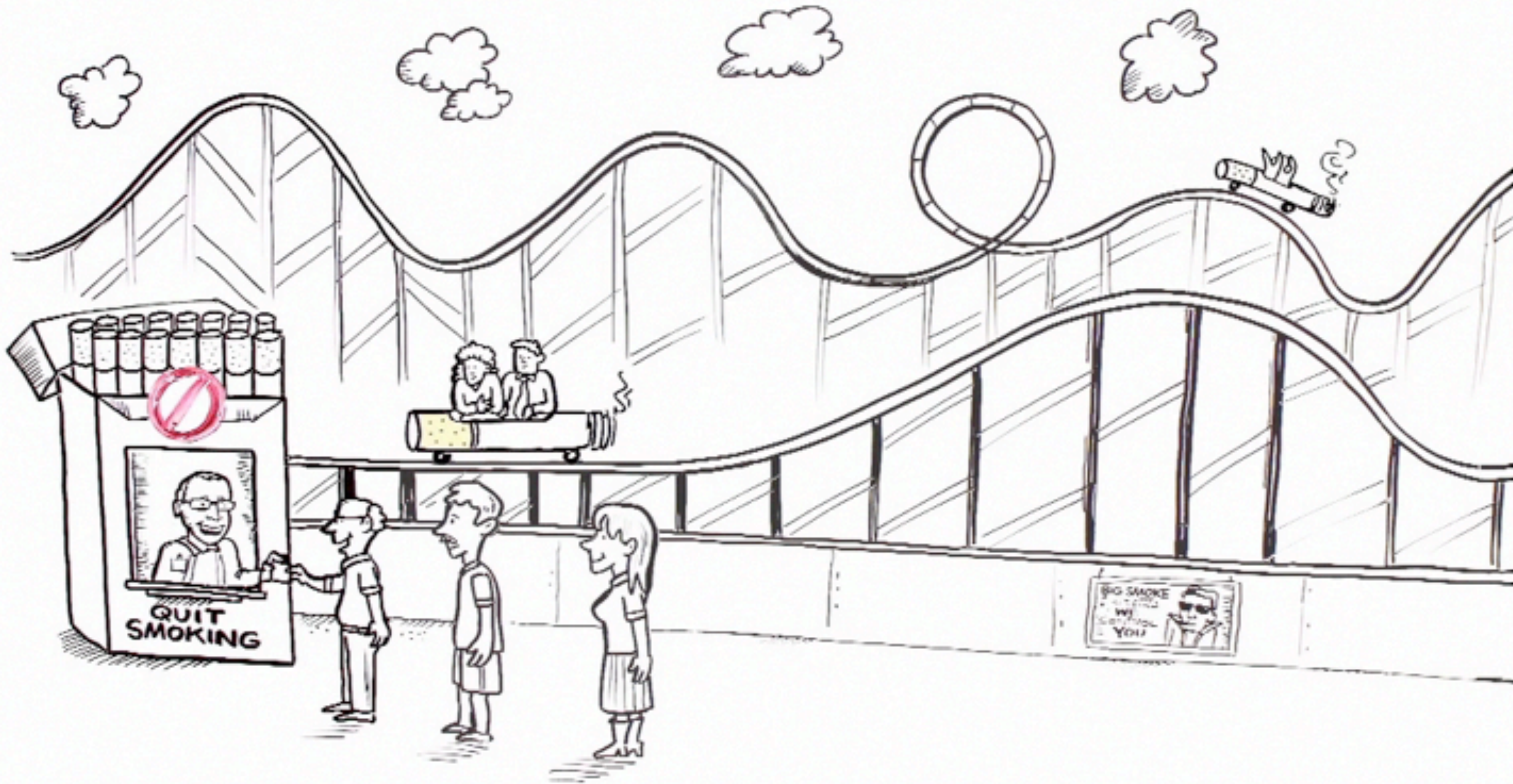
Mission: The UHC promotes the health and well-being of the University of Nebraska community through quality care and education.

Vision: We envision a contemporary Health Center focused on excellence, connected with students, supportive of the academic mission, and committed to the health and wellness of the University community.

Key Questions: What Next?

- “So what do you make of all this now?”
- “What would you like to do?”
- “What would be realistic for you?”
- “What will you do next?”

Helping Patients Change Behaviors: Reframing the Positives



What is the single best thing you can do to stop smoking? Written, narrated, produced by Mike Evans, MD, Associate Professor of Family Medicine and Public Health, University of Toronto. YouTube video, Canadaptt Project, Peter Selby, PI.

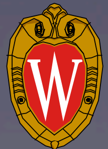
Clinical Prevention in College Health

- Every student clinical visit is an opportunity to elicit a **"motivational moment"** of prevention:
  - **Brief,** always student-centered
  - Relevant to student's reason for visit
  - Stimulate student's own efforts at improving
- Ideally, the student will verbalize the need and the plan to start changing behavior, or at least to **"think about it."**

An ounce of prevention…is a ton of work !

- Paul S. Frame, M.D.

Secondary Effects of High Risk Drinking
Learning Community (LC) Environment



Brower AM, Golde C, Allen C, Residential Learning Communities Positively Affect College Binge Drinking. 2003. *NASPA Journal* 40 (3), 132-152.

Clinical Prevention

Upstream / Downstream

...Were we to get students and their communities to feel the collective pain of problem drinking, to notice, care about, and act on behalf of others, we would need few other alcohol prevention strategies...

-- Richard P. Keeling, MD

Keeling RP. Changing the context: the power in prevention. Alcohol awareness, caring, and community. *J American College Health.* 1994;42:243-247

Thank You!

Acknowledgements

- Michael Fleming, MD
- David Brown, PhD
- Judie Pfeifer, MEd
- Jason Kilmer, PhD
- Abigail Halperin, MD
- Sara MacKenzie, MD
- Mary Gisslow, MD
- Marlon Mundt PhD
- Larissa Zakleskaia, PhD
- John Stephenson, MD
- Pat Kokotailo, MD
- James Schaus, MD
- Dale Olsen PhD
- Hilary Stathes, MEd
- Laura Boteler
- Stacey Balousek
- Stephanie Schiro
- Jennifer Wiegel

grossberg@pediatrics.wisc.edu