At-Risk Drinking and Alcohol Dependence Management

VOLUME 3

FOUNDATIONS
FOR INTEGRATED CARE
Behavioral Health Solutions for Primary Care.

Foundations for Integrated Care

LEARNING MAP

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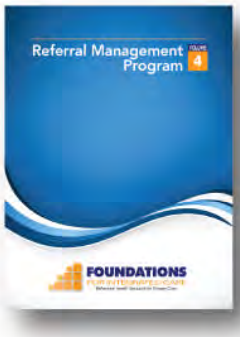

Additional Resource Materials

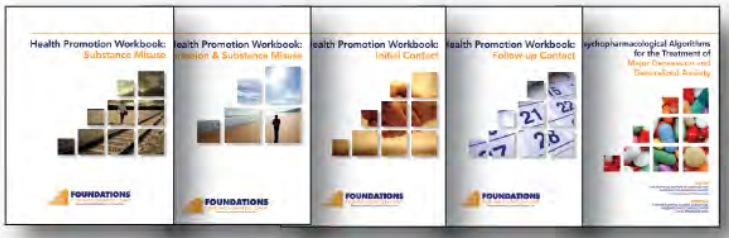

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Table of Contents

CHAPTER 1

Using This Training Manual

This training manual will provide you an overview of an evidenced-based management of at-risk drinking and alcohol dependence in the context of patients identified in a primary care setting. The manual will serve as an ongoing reference guide. The target audience is behavioral health providers working in a primary care setting (integrated care providers), although the content may also be helpful for other members of the primary care team or providers wishing to better understand successful practices for primary care treatment of common mental health disorders. The first manual in this series **"Building a Strong Foundation"** lays the groundwork for integrated care treatment. This manual will build on the concepts and steps presented in the initial manual, thus presumes the reader has a basic understanding of initial manual content.

It is important to remember that this manual serves as a launching point; the training provided in this manual will not, in itself, result in expertise in the treatment of alcohol misuse. It is expected that additional training will be required for all but the most experienced clinicians. Potential sources for additional training have been included in this manual to assist you in identifying potential opportunities for developing expertise in algorithm-appropriate skills.

As studies show that individuals demonstrate a higher level of retention when they can review their own notes later, if you are using this manual as part of a group training session, you are encouraged to make notes directly on the manual pages both to expand the content and to allow for increased future utility. The following icons are used as visual guides throughout this manual:

Graphic Icons/Cues		
		
Key Points Course content that plays an important role in the overall learning experience.	**Practice Dialogue** Course content that contains dialog that is best practiced by speaking the text aloud.	**Check it Out** Course content specific to Health Technician level staff.
		
Practice Discussion Course content that depicts typical patient interactions, best practiced as a role play.	**Procedure / Steps** Course content that illustrates step-by-step instructions, procedures, or protocols.	**Tips: Learning** Course content that provides useful tips for enhancing the overall learning experience.

CHAPTER 2

At-risk Drinking and Alcohol Dependence Management

This manual outlines a collaborative or integrative care model for the management of adults with at-risk drinking or alcohol dependence who are actively enrolled in primary or medical subspecialty care. This program consists of two distinct treatment options. The first focuses on prevention and health promotion, targeting individuals with at-risk drinking. The second focuses on the treatment of alcohol dependence. It is important to recognize that your program can choose to do one or both of these algorithms. The model incorporates the use of a Behavioral Health Provider (BHP) who provides expertise in mental health and substance abuse (MH/SA) assessment, who is skilled as a patient motivator and educator, and who is well versed in the delivery of algorithm -based management strategies. The treatment algorithms are a set of decision rules aimed at reducing variability in treatment and maximizing patients' ability to achieve a full remission and highest level of function. This manual outlines the role of the Behavioral Health Provider, the assessments for alcohol use and associated problems, strategies for successful implementation of the role, guidelines for the assessment and management of high -risk patients, and the treatment algorithms.

Learning Objectives

Completion of this training program will build clinical skills and achieve the following objectives:

- Understand the theoretical framework for assisting patients seen in primary care to achieve success in reducing or eliminating unhealthy alcohol consumption
- Learn basic skills in delivering a brief alcohol intervention
- Learn basic skills in managing patients suffering from alcohol addiction
- Learn how to effectively use telephone visits to enhance treatment outcomes
- Learn the utility of using structured assessments to facilitate symptom measurement, tracking patient outcomes, and allow for program evaluation

Basic Definitions for this Training Manual

The clinical program outlined by this manual covers a broad spectrum of severity. The severity of alcohol use is very important in developing the treatment plan. Thus a good starting point is to define the terms that will be used in this program. **Addiction** or **dependence** refers to a medical disorder characterized by loss of control, preoccupation with the substance, continued use despite adverse consequences, and physiological symptoms such as tolerance and withdrawal. The term "dependence" as used in the official DSM IV manual often leads to semantic confusion with "dependence" in the pharmacological sense, which is a normal response to repeated use of many different types of medications, including drugs for the treatment of hypertension, depression and pain. Thus many clinicians prefer the term "addiction" when referring to "dependence" as defined in DSM IV.

In addition to the syndrome of addiction, some adults engage in problem, abusive, or **at-risk substance** use in which use of a substance is at a level that either has already resulted in adverse medical, psychological, or social consequences or substantially increases the likelihood of such problems, but not to a degree that meets the criteria of addiction. Because at-risk use often does not lead to some of the classic symptoms of addiction, such as employment or legal problems, individuals and practitioners may underestimate the risks associated with at-risk use. However, due to the risks, problem and at-risk use do represent an appropriate target for screening and intervention. Other terms you may hear relating to at-risk drinking are harmful drinking, excessive drinking, problem drinking, or abusive drinking. For purposes of clarity we will stick to the term at-risk drinking but you should feel free to use the term that your patient feels is less stigmatizing or pejorative.

While the distinction between addiction and at-risk use may not always be clear, we will use these two categories to differentiate the recommended treatment plan. We will provide some guidelines for how to make this distinction later in the training.

Clinical Presentation		Initial Treatment Plan
At-risk use	⇨	Brief Intervention
Addiction	⇨	Medical Management

In addition to these categories of problematic substance use, individuals may also consume substances at levels of **low risk** or be considered **abstainers**. Adults in these categories drink within recommended drinking guidelines (see below), are able to employ reasonable limits on alcohol consumption, and do not drink when driving a motor vehicle or boat, or when using contraindicated medications.

Abstinence typically refers to no use of a substance in the previous year. Approximately 30-40% of adults are abstinent for alcohol use. If a patient is abstinent, it is useful to ascertain if there is a previous history of excessive use. Some individuals are abstinent because of a previous history of alcohol or drug problems. Some are abstinent because of recent illness, while others have lifelong patterns of low risk use or abstinence. Patients who have a previous history of alcohol or drug problems may require preventive monitoring to determine if any new stresses could exacerbate an old pattern. They should clearly be praised and supported for their continued commitment to responsible drinking. In addition, a previous history of abuse or dependence may increase the risks for developing other mental health problems in late life, such as depressive disorders or cognitive problems[4].

Recommended Drinking Limits

- Drinking no more than an average of
  - 2 standard drink/day for men <65 years old
  - 1 standard drink/day for women of all ages
  - 1 standard drink/day for everyone 65 and older
- No binge drinking (5+ in one day for men and 4 + drinks in one day for females and men over 65)
- No drinking while taking certain medications or in patients with certain illnesses

CHAPTER 3

Background and Evidence Base

Untreated or under-treated at-risk drinking and alcohol addiction continue to be major public health concern that leads to significant personal morbidity and significant societal burden in lost days of employment, increased utilization of medical services and increased mortality. Alcohol misuse and addiction are leading causes of disability worldwide, [5] yet no more than 15% of alcohol dependent individuals are actively engaged in treatment. [6] Typically, less than a third of individuals with alcohol dependence seek treatment in a specialty addiction program and many if not most don't fully engage in treatment [7]. This disparity in treatment participation exists even though patients self-report a desire to cut down and a readiness to change drinking behaviors. [8] As such, improving the access and delivery of effective treatment for at-risk drinking and addiction/dependence can have a major public health impact.

Involving primary care providers in the diagnosis and treatment of patients with a range of behavioral health disorders can reduce disability, pain, somatic complaints, and the burden of care on families. It may also have profound economic effects, given that such patients experience more medical illnesses, prolonged recovery periods from illnesses, greater disability, longer hospital stays, and a higher number of medical complications than other patients do.

Thus, the treatment of behavioral health disorders, including substance misuse, may reduce the high utilization of medical services and the economic strain that they currently place on the health care system.

Over the last two decades, significant advances have occurred in the treatment of at-risk drinking and addiction, including the demonstrated efficacy of pharmacotherapy and the refinement of individual psychotherapies such as brief alcohol interventions (BAIs). However, these treatments are underused. Because of the evidence and public health consequences, the US Preventive Services Task Force recommends screening for alcohol misuse and treatment as appropriate [9]. In the next few paragraphs, we provide an overview for some of the evidence for brief alcohol interventions and medical management of addiction.

Screening

In 1990, a seminal Institute of Medicine report noted that the majority of individuals who suffer due to alcohol misuse are not alcohol dependent.[1 7] Since then, there has been consensus among experts that alcohol screening should identify the entire spectrum of alcohol misuse, from at-risk drinking to alcohol addiction [18][19]. You may also recognize this effort as Screening, Brief Intervention, and Referral to Treatment or SBIRT. The term SBIRT refers to a public health initiative to bring screening and brief interventions to primary care. In your role as a Behavioral Health Provider in primary care, you will be delivering "SBIRT" but will also extend your efforts beyond this and build on the SBIRT model.

Interventions for at-risk drinking

Over the last two decades, there have been several controlled clinical trials to evaluate the effectiveness of early identification and secondary prevention using BAIs for treating at-risk drinking. A number of large randomized controlled trials of BAIs with younger and older adults have found significant differences between treatment and control groups in reducing alcohol use. The following are key examples of these studies. The World Health Organization Project (AMETHYST Study) was undertaken in 10 countries, including the United States.[10] Male (n=1 ,362) and female (n=299) subjects recruited from hospitals, primary care clinics, work sites, and educational settings were randomly assigned to three conditions: control, simple advice, or brief counseling. At the six-month follow-up, there were significant effects of both interventions on various alcohol consumption measures for male subjects, with approximately 25% reduction in daily consumption in the treatment groups compared with the control group.

The Trial for Early Alcohol Treatment (Project TrEAT) was a randomized clinical trial to test the effectiveness of two 15-minute BAI sessions and two follow-up telephone calls with at-risk drinkers in primary care settings. [11, 12] A total of 482 males and 292 females were randomized into a control (n=382) or intervention group (n=392). At the 12-month follow- up, there was a significant reduction in alcohol use, in episodes of binge drinking, and infrequency of excessive drinking in the treatment group compared with the control group. The relative difference in alcohol use between the groups was 19% for alcohol consumed, 15% for binge drinking, and 24% for excessive drinking. Drinking, health care costs, and medical care utilization were all improved two years post randomization in the intervention group relative to the control group. [13]

Given that many primary care populations are older, trials that focus on older adults are particularly relevant. The effects of BAI among the elderly appear to be even more robust with relative differences in drinking of 33%, relative differences in binge drinking of 55% and relative differences of excessive drinking of 72% compared to the control group [11].

Treating Addiction or Dependence in Primary Care

While a number of controlled clinical trials and meta-analyses suggest that brief alcohol interventions (BAIs) with primary care patients with at-risk drinking are efficacious there is little evidence that BAIs improve outcomes or access to specialty care for alcohol dependent patients [14]. Willenbring et al. demonstrated an Integrated Outpatient Treatment (IOT) program led to greater reductions in drinking compared to a group simply offered an appointment to specialty care [15]. IOT treated alcoholism as a chronic disease using a medical model relating reductions in alcohol use to health rather than focusing specifically on a goal of abstinence. More recently, two small open treatment studies of naltrexone in primary care demonstrated the potential effectiveness of adding pharmacotherapy to treat alcohol dependence in primary care settings [16, 17].

The principles developed in the IOT model and the availability of efficacious pharmacotherapy provides the background for Alcohol Medical Management in primary care. Over the last decade, a growing body of literature has supported the efficacy of pharmacotherapies using a psychosocial platform. For this program we have adopted the Medical Management program developed by NIAAA as the psychosocial component of this program [18]. The goal of Medical Management (MM) is to provide a basic, minimal form of clinical intervention supporting pharmacotherapy and reduction in drinking. In this way, the model is well suited to primary care, where frequent visits or group therapy sessions are often not practical. MM is also similar to the IOT model in that it promotes collaboration and integration with the patient's overall health care and focuses on functional improvement as well as behavior change. A recent randomized trial of MM in primary care showed equal rates of abstinence, better rates of treatment engagement and lower rates of heavy drinking compared to referral to specialty care (unpublished to date). Of particular note is that while pharmacotherapy for addiction is promoted it isn't necessary that patients agree to take medication in order to benefit. The MM model has a component like IOT that allows management of patients who do not chose to take medication. Taken as a whole, the literature is very supportive of treating alcohol addiction within primary care.

Conceptual framework for treatment of at-risk drinking and addiction
This At-Risk Drinking and Alcohol Dependence Management program is designed to overcome some of the barriers that influence treatment outcomes for at- risk drinking and alcohol addiction. Specifically, the program facilitates care for patients with lower perceived need of care, for those with preferences for care outside of specialty care, and for those with privacy concerns or preferences for non-group participation. Moreover, the program directly builds on recent evidence suggesting that Medical Management in combination with Naltrexone had the best outcome in the NIAAA COMBINE trial [19] and on the system of care as outlined by the National Institute of Health *(http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/cliniciansguide.html).*

Another influencing factor in treating addition is the known chronic episodic nature of the disease. These characteristics suggest that more flexible, extended treatment interventions are needed to better address the characteristics of this disorder.[20] One such approach is the Chronic Care model [21] which specifies: regular, extended contact between patients and service providers; interventions to increase patient confidence and skills to manage chronic conditions (e.g., goal setting, identification of barriers to reaching goals, development of plans to overcome barriers); links to community resources; the use of accurate and timely patient data to monitor progress and guide interventions; and provision of support to facilitate self-management. The benefits of regularly recording symptom severity and behaviors (i.e. measurement based care) on health outcomes has also been stressed by other investigators, [22, 23] possibly because it serves as a prompt to maintain behavior change efforts.

Why focus on pharmacotherapy and specifically why Naltrexone for alcohol addiction?
This question was best answered by the Institute of Medicine, which suggested that intervening for alcohol dependence with pharmacotherapy in primary care settings may be an effective way to address the gap between treatment need and access [30, 31]. This report highlighted the need to think beyond a single model of care, emphasizing the importance of having multiple models in which the broader spectrum of patient needs can be addressed. The IOM report also suggested the need to develop alternatives to existing treatments, not as a mechanism for replacing or improving existing models of care, but to be complementary. Currently, there are only three FDA-approved pharmacotherapies available for the treatment of alcohol dependence: Disulfiram, Naltrexone, and Acamprosate.

Naltrexone, an opioid antagonist, has been used successfully in the treatment of alcohol dependence (e.g. Volpicelli et al. 1992 and O'Malley et al., 1992) and is safe and well tolerated [32-34]. Naltrexone use leads to fewer heavy drinking days, reduced rates of relapse, briefer relapse periods, and reduced drinking during relapse periods. Of note, as with most medications not all studies have been positive and there are likely patients who will not benefit from a single treatment, [35 2]; however, Naltrexone remains a recommended treatment for alcohol dependence.[36] Furthermore, more recent studies [37, 38] and meta-analyses [39, 40] continue to support the conclusion that Naltrexone is efficacious in reducing alcohol use among individuals who are alcohol dependent. Acamprosate is also FDA approved though the evidence supporting an effect is modest and thus Acamprosate should be used as a second line agent until more information is known about in whom these medications are most effective.

A word about beliefs and goals

An important aspect of engaging patients in treatment is the attitudes and beliefs patients have that may limit the effectiveness of the intervention. The stages of change concept is particularly useful in understanding the needs of at-risk drinkers and those with dependence in the context of primary care as these patients have fewer alcohol related problems than persons who have chosen to seek specialty addiction care and thus may have greater ambivalence (pre-contemplative stage) for reducing their alcohol use. In pilot data collected from at-risk drinkers, 55.6% felt no need to change their drinking habits and only 16.7% considered their drinking a problem. Patient attitudes and beliefs may account for a great deal of the variability in access and response to treatment. Motivational Interviewing and care management strategies have the potential to address these issues through education, motivation, and support.

Therapeutic goals are another seemingly tricky area for most providers. Most often providers and programs set the goal of treatment as abstinence. There are at least two confounds with this philosophy. First, for those without an addiction, the program goal should include responsible drinking as a desirable outcome in many patients. Responsible drinking is another term for low risk drinking as defined earlier. It is true that in certain patients (those on certain medications, those with uncontrolled hypertension, etc) it would be best to consider abstinence even if they don't have an addiction. However, for someone who is excessive drinker (3-4 standard drinks per day) and is in relatively good health, the goal may only be to reduce to 1-2 standard drinks per day. The second difficulty with a program goal of abstinence is that it is the program's goal and not necessarily the patient's goal. It is important in patient-centered treatment to understand and work with the patient's goals and motivation.

It is true that for patients with an addiction, abstinence should be the recommended goal; however, if the patient is resistant to this recommendation, roll with the resistance (principle of Motivational Interviewing). Working with the patient's goal even if it isn't your recommendation will give you a better chance at ultimately achieving abstinence.

Using the telephone as part of the intervention

Interventions utilizing the Foundations framework often assist the primary care provider (PCP) by using frequent contacts and educational methods. While this type of intervention seems to bring significant benefits relative to usual care, the use of a Behavioral Health Provider (BHP) dedicated to the primary care practice is practical only for larger group practices that generate a sufficient caseload to employ a BHP, and not for smaller practices. Moreover, it is not clear that a face -to-face intervention, which is implied in most interventions, will overcome existing logistical issues that patients face in attending visits. To this end, we emphasize a combination of face-to-face and telephone visits. The leading principle is that the visit itself is more important than the visit location/type. Please review the section on using the telephone or videoconference in the Foundations manual.

CHAPTER 4

Motivational Interviewing

Motivational interviewing is an effective way of engaging with patients about behavior change. As this manual is targeted on helping the patient change a specific behavior (drinking), the use of motivational interviewing is particularly well suited. A description of motivational interviewing is included in the Foundations manual. Briefly, motivational interviewing is patient-centered and directive but non-confrontational style of interaction that developed out of the addictions field, where the goal is to strengthen motivation and commitment to change by addressing ambivalence. Ambivalence is far more common in the primary care setting as the patients who are strongly committed to treatment are likely already engaged in specialty care and thus not a target for your interventions. Patients with at-risk drinking who may not identify any problems related to their drinking are also more likely to express ambivalence regarding changing their level of alcohol use.

Thus, developing an effective, non-judgmental way of talking with the patient about this ambivalence is a skill or communication style any behavioral health provider working in primary care should cultivate.

Don't be fooled into thinking that Motivational Interviewing is simple or a skill that you can easily develop. Motivational interviewing expertise takes time and much practice, and it is recommended that you seek additional training and supervision. A formal training is recommended, but good references for further reading include *Motivational interviewing: preparing people for change*, by Miller & Rollnick and *Motivational Interviewing in Health Care: Helping Patients Change Behavior*, by Rollnick, Miller, and Butler.

CHAPTER 5 Steps of At-risk Drinking and Alcohol Dependence Management

The preceding discussions have focused on the foundations of at-risk drinking and addiction management in a primary care setting - the "why" and the "who". The remainder of the manual will discuss the implementation of the program. Again, this manual provides an introduction to core competencies; however, you are strongly encouraged to seek out additional training to increase your effectiveness in meeting your program goals.

The first 3 steps, identifying patients, conducting the initial assessment and triage and treatment planning are mentioned briefly below and discussed in more detail in the first manual, **Building a Strong Foundation**. Beginning with Step 4, there are two distinct management protocols. These will be discussed, focusing on essential elements and core competencies. The protocol is based on successful research trials. Based on the patient's presentation and needs, deviations from the protocol may make sense clinically; thus following protocol may serve as a framework rather than a script. However, providers should be mindful when deviating from the evidence. This underscores the importance of evaluating treatment progress for the patient as well as the program over time.

PROGRAM ? DECISION

A clinical program can choose to only deliver the brief intervention program for at-risk drinking or the medical management program for addiction. These two programs do not have to be linked; however, if only one program is delivered, it important to consider in detail any additional hand-offs that would be required between teams of providers.

Patient Tracking
Before beginning the At-Risk Drinking and Alcohol Dependence Management program, you need to establish a mechanism to document and track patient contacts and information. As this is a population-based and time-limited approach, the caseload of a BHP may be high and will be constantly evolving. A tracking mechanism that allows for increased efficiency and promotes delivery of measurement-based care is preferred. If you will be keeping a file outside of the medical chart for tracking purposes, for example an Excel spreadsheet, Word document, or Access database, check with your facility regarding charting regulations.

Identifying Patients on the PC Team

For a complete discussion on how to get referrals from primary care (PC) as well as a discussion on marketing to primary care staff, please refer to Volume 1, "Building a Strong Foundation." Of note, at-risk drinking and alcohol dependence are topic areas that many clinicians feel uncomfortable addressing or areas that they may not be as knowledgeable. You may need to focus more attention in helping all the primary care staff understand this topic and in particular the issue of at-risk drinking as a target of intervention. Providers may not realize that non-dependent drinking has an impact on health and that the intervention for these patients is not complex.

As a review, referral mechanisms that have been successful for integrated programs include:

- Direct referral from providers (via telephone, walking the patient down the hall to you, consult, fax etc)
- Self (patient) – referral
- Referral based on positive standardized screens, such as the AUDIT-C
- Routine review of available records

To receive referrals, your goal is to be available and accessible to both the PC staff and the patients. Some keys to success are:

- Be visible to the PC staff– go to team meetings, walk around the clinic during non-patient hours when PCPs are in their offices
- Keep an open door and an open schedule
- Be helpful with "problem" patients
- Develop handouts, reminders and resource material for PCPs and patients
- Provide feedback to PCPs about successes with their patients

STEP 2 Initial Contact and Baseline Assessment

For a complete discussion on the Baseline Assessment, please refer to "Building a Strong Foundation." The goals in Step 2 are to:

- Confirm with the patient the reason for the hand-off from primary care
- Build rapport with the patient
- Complete a baseline assessment utilizing standardized questionnaires

Keys to success include:

- Be prepared!
    - Review available information and patient chart if available
    - Have resources on hand
- Create a positive experience for the patient
- Remember that you do not need to know everything there is to know about a patient at this time but gather enough information to make an informed decision about next steps
- Balance the use of structured questionnaires with clinical skill and knowledge

From the very first contact, it is extremely important to create a positive experience for the patient. Good communication skills, including active listening, empathy, patience, flexibility, and a positive conviction that the patient can get better are qualities that cannot be scripted. These practices contribute to the development of good rapport, trust, and a positive therapeutic alliance, which in turn foster the patient's adherence to your recommendations. The primary aims of each of your contacts is to engage the patient in a non -threatening interaction, communicate that a commitment to help the patient feel better, and encourage them toward accomplishing the goal of responsible drinking.

The assessment of alcohol use

It is very important to move away from descriptive terms such as a "six pack" or a "fifth" and use standard drinks as a language when talking with patients and colleagues. The reason is two-fold; For patients colloquial language can be a way of minimizing their drinking. "I just drink a shot at night" or a "glass" of wine. When the shot is really half a glass and the glass of wine is an 8oz water glass. The second principal reason is clarity with patients and colleagues. A "six pack" of beer is not very helpful unless you know whether the cans are 6 oz, 8oz, 12oz, 16 oz, or 40 oz.. All of these sizes are used for six packs and differ greatly in the volume of alcohol consumed. The chart below provides an overview of standard drinks. It is also important to not spend enormous amounts of time with patients trying to get this down to the exact amount. Most of us cannot remember what we ate or drink yesterday much less a month ago. What you will mostly get from patients are approximations and guesses. This doesn't mean they are lying to you but is reflective of the fact that we don't monitor our intake daily. (Just try to remember how many ounces of coffee or soda you have each day.)

Sometimes asking the patient what alcohol they buy and then how long it takes to finish it can be your best approximation. For example a “pint” of liquor in 2 days is about 5-6 standard drinks per day.

Large Volume Containers		
Beer Containers	**# Standard drinks**	**Total**
(1) pint	1 standard drink (actually 1.3)	16 oz
(1) quart	3 standard drinks (actually 2.6)	32 oz
(1) gallon	11 standard drinks (approx)	128 oz
(1) pony keg (at 12 oz cups)	102 standard drinks	7.75 gallons
Wine Containers (based on 12% abv)	**# Standard drinks**	**Total**
(1) bottle (750ml)	6 standard drinks (approx)	25 oz (approx)
(1) large bottle (1.5 L)	12 standard drinks (approx)	50 oz (approx)
(1/2) gallon	13 standard drinks (approx)	64 oz
(1) 12 oz Wine Cooler	1.5 standard drinks	

Liquor Containers (based on 40% abv, 80 proof)	# Standard drinks (approx)	Total
(1) 750 ml bottle commonly called a “fifth”	17 standard drinks	25 oz (approx)
(1) 500 ml bottle commonly called a pint	11 standard drinks	16.9 oz
(1/2) gallon	43 standard drinks	64 oz

STEP 3 Triage Decision and Treatment Recommendations

The goals in Step 3 are to:

- Make a triage decision based on the collected information
- Communicate the findings and the plan to the PCP

At this point, you have completed a baseline assessment with the patient. Next, the information collected, along with your clinical judgment, is used to determine if the patient is best treated in specialty mental health care or within integrated care in the primary care setting. Patients with at-risk drinking are much more likely to engage in treatment that is delivered within the primary care setting. Those with alcohol dependence who don’t have concurrent drug abuse, psychosis or other symptoms of severe complications can either be treated in primary care or specialty care. Ideally this decision should be the patient’s, but local resources and your level of expertise with the addiction treatment component will also play a factor in your decision to offer these services.

PROGRAM ? DECISION

Program decision: not all programs will offer treatment for alcohol dependence. This is something you need to think about carefully remembering that a lot of patients with alcohol dependence do not want to participate in group therapy options or residential care options. Flexible open access treatment in the primary care clinic is not only a viable option for many but also will lead to greater engagement and better outcomes than if the patient just won’t go to specialty care. And, yes, you can make a difference for these patients.

Offering treatment

Treatment decisions are based on assessment scores and clinical judgment, but also patient and PCC preference. Once you determine primary care based treatment is a good fit for the patient, talk with the patient about the service. If they are interested, schedule a time for your first visit or if the patient will be working with another member of the integrated care team, ask for the best time to reach the patient and best telephone number. If the patient is not interested, discuss alternative options.

Example of presenting your treatment plan:

> *"Based on what we spoke about today, what I'd like to do is work with you and your primary care provider over the next few months to improve (symptoms to work on). We will meet every few weeks for about 20 to 30 minutes – you can come in or we can talk over the phone. How does that sound to you?"*

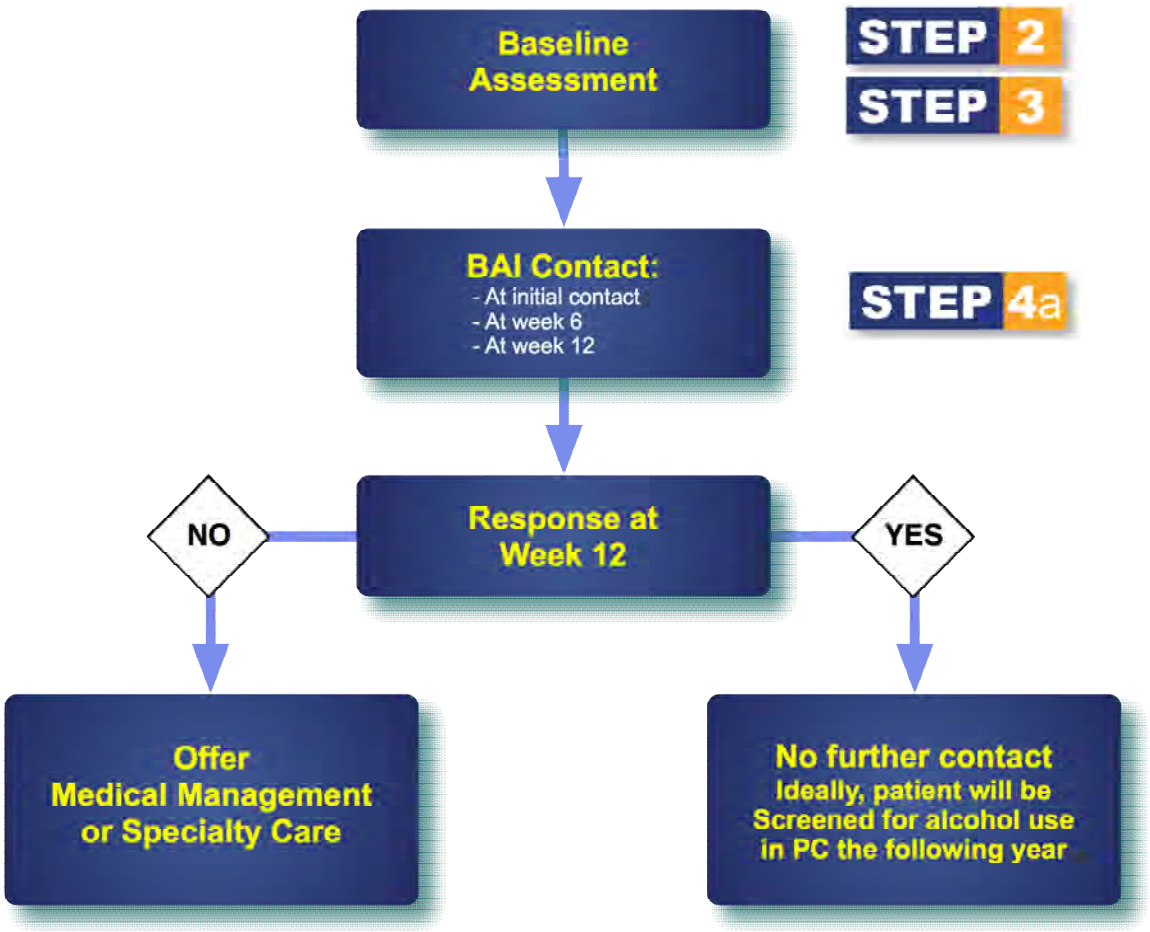
Communicating the Results
You should communicate the outcome of the baseline assessment to the patient's primary care provider in the form of a progress note (see Clinician Resources Volume for an example). Depending on provider preferences, additional communication may be appreciated in the form of in-person follow-up, telephone or secure email. For a more thorough discussion on collaborating with PCPs, please refer back to Volume 1.

STEP 4 Providing Clinical Services: Initiating At-risk Drinking and Alcohol Dependence Management

The next two sections (Steps 4A and 4B) provide the core of the treatment program. It is assumed at this point you have made a clinical decision about whether or not the patient has an addiction. Don't worry if you learn about more problems later, you can always change the treatment plan. For patients who appear not to have an addiction but are drinking excessively, start with Step 4a. If it is clear that the patient has alcohol addiction then start with Step 4b.

STEP 4a Intervention for At-Risk Drinking

If you are at this point, you have decided that your patient drinks excessively but doesn't endorse symptoms of dependence. Your goal is to engage the patient in an open dialogue about their drinking, educate him or her on the benefits and risks of his or her particular pattern of drinking, recommend either abstinence or responsible drinking with the patient's input valued, and leave open the door for further dialogue in the future. The process is outlined in the figure below.



General Instructions for Administering the Brief Alcohol Intervention
You will follow the general guidelines that include "setting the scene," use of structured workbooks to facilitate the intervention, and the use of follow-up contacts to enhance patients' motivation to change and meet their drinking goals. Two different workbooks are used: one for the initial contact (Health Promotion Workbook— Initial Contact) and one for the week 6 follow-up contact (Health Promotion Workbook— Follow-up Contact). Both workbooks are found in the Patient Materials manual.

The workbooks: The workbooks contain opportunities for you and the patient to complete sections on identifying future goals, triggers and reasons for drinking, and reasons to cut down or quit. The workbooks prompt you and the patient to negotiate a drinking contract and provide the patient with drinking diary cards for self-monitoring. Review the workbook content with the patient and complete based on the patient's responses. It is anticipated that many of these contacts will be completed over the telephone due to patient preference. If the session is done by telephone, mail the workbook along with a cover letter to the patient (initial and week 6 contacts).

The purpose of both workbooks is to provide you with a **guide** of key points to address with patients. It is critical to elicit key issues from patients. But you will likely not talk about every item in each section. The elements in each workbook should be conceptualized as ways to stimulate patients to think of their specific concerns and issues, rather than as an exhaustive list to be covered. Each part of the workbook, however, should to be addressed at some point. The workbooks are described in more detail in the Step-by-Step Instructions section.

Preparing for the Initial Brief Intervention Contact
Preparation for the initial contact includes the completion of a patient chart review (if available). The following information should be reviewed and pertinent details noted.

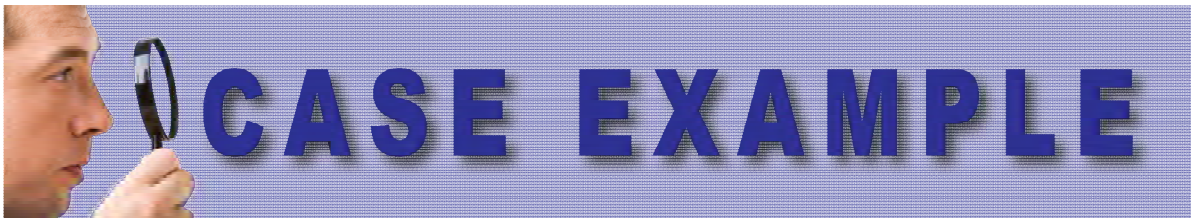
1. Results from the initial assessment
2. PCP and other relevant clinical notes
3. History of psychiatric and medical conditions
4. List of current medications
5. History of use of psychotropic medications, including tolerance and response
6. Recent laboratory and neuroimaging reports. In particular look for anemia, evidence of liver disease, evidence of diabetes, and evidence of cardiovascular disease. All of these medical problems are directly worsened by excessive alcohol use and will provide key “leverage” points with the patient

Setting the Scene
In introducing the BAI, approach patients in a manner that is non-confrontational and uses Motivational Interviewing principles. When introducing the BAI to patients, you should adhere to the following guidelines:

- Establish a supportive setting conducive to the intervention
- Begin by introducing yourself
- If appropriate, thank patients for completing the alcohol screen and/or Baseline Assessment
- Explain the screening results
- Explain that a workbook will be used as part of the program, and will be given or mailed to them after the contact
- Explain to patients that the workbook is theirs to keep and to refer to as often as they would like

The Intervention
The entire intervention should take no longer than 20-30 minutes/session. Remember this isn't specialty care and often the patient isn't looking to have a long conversation. At the end of the initial intervention, you provide the patient with a brief summary of the discussion points and the decision made regarding drinking goals. Make an appointment with the patient for the next follow-up contact. Finally, you should encourage the patient to use the workbook and the drinking diary cards, and to call you with any questions or concerns.

Follow-up Contacts
Follow-up contacts can enhance the ability of patients to meet their goals. However, research on BAIs indicates that many people make changes in their drinking without completing scheduled follow-up contacts. Indeed, an ambivalent patient may be less likely to make a constructive behavior change with frequent, unwanted visits. If a patient is not willing to make a change, schedule a brief check in weeks to months from now. A follow-up is an opportunity to provide a "check -up" on progress toward meeting drinking goals and to review barriers, risky situations (situations that may lead to binge drinking), and strategies for change.



Mr. Fowler is a 61 year old Caucasian male who comes to his annual PCP check-up with Dr. Jones. During the visit, Dr. Jones uses the AUDIT-C to screen for alcohol misuse and the screen is positive. Dr. Jones decides to walk Mr. Fowler to your office. After explaining your role, you and Mr. Fowler agree to complete a baseline assessment to get a better idea of how he is doing.

Baseline Assessment results (Step 2): Mr. Fowler reports trouble sleeping and feeling lonely. His PHQ-9 = 6. He denies any symptoms of anxiety. He reports drinking 5 -6 (12oz) beers daily "for years" and denies any problems related to alcohol use.

ROS: Hypertension.

Medications include: atenolol 50mg daily (dosage was increased from 25mg to 50mg in the past 2 months).

You notice Mr. Fowler's alcohol use is above the recommended limits and so decide to review his recent lab work. The lab results are unremarkable with the exception of slightly lower RBCs- 4.19L (range 4.20-6.10) and slightly elevated MCV (average volume of red blood cell) - 99.7H (range 81.0-99.0).

Plan: You tell Mr. Fowler that you would like to speak with him again to discuss his alcohol use and how it may be impacting his health. He says "I am happy to speak with you again but I don't see any problem with my alcohol use so not sure it is necessary." He agreed to a phone call next week and you set up a time.

Initial BAI Contact: You contact Mr. Fowler by telephone. *"Mr. Fowler, I know you said alcohol use is not a problem for you, we are interested in helping you avoid any bad health consequences from alcohol use."*

You introduce the workbook and he is agreeable to speaking with you. Mr. Fowlers identifies his goals for the next 6 months-1 year: 1) "continue to hang out with my friends" & 2) "stay healthy."

You review his blood work results collected at his Primary Care appointment and discuss the impact of alcohol on the body, specifically in relation to difficulty sleeping, hyper tension and RBCs (anemia). Although he does not meet clinical criteria for anemia, his reduced RBCs and use of alcohol put him at increased risk for anemia. Since Mr. Fowler tends to drink more when he is at the VFW with his friends, he agrees to limit his alcohol intake to 3 (1 2oz) beers per occasion and will have a non-alcoholic beverage in-between his beers.

Treatment agreement: Mr. Fowler will limit his alcohol intake to no more than 3 (12oz) beers daily and will log his daily intake in workbook using the Alcohol Diary Cards.

Week 6 Contact
The structure of the week 6 Contact is very similar to the initial contact. Background information is not collected, but patients are asked about any new medical conditions or medication changes since the previous contact. In addition, alcohol consumption during the week preceding the current contact is recorded. The Health Promotion Workbook—Follow-up Contact (provided in the Patient Materials Manual) is completed at week 6. This workbook is very similar to the Initial Contact workbook (provided in the Patient Materials Manual) although the focus is more heavily on supporting any changes that have been made in drinking behavior and helping to problem solve any difficulties that may have arisen when trying to cut down on alcohol consumption

Week 12 Contact
At week 12, perform a monitoring contact and make a clinical decision as to future follow-up. There is no workbook associated with this contact.

If the patient has met his/her therapeutic goals and/or is drinking below at-risk drinking levels by week 12, the contacts can be ended and a recommendation made to the PCP to screen for alcohol misuse again the following year. If the week 12 monitoring contact indicates that the patient is still not meeting his/her therapeutic goals, the patient is offered Medical Management or a referral to specialty care, such as an outpatient addiction recovery program (see the Referral Management Manual). Alternatively, the patient may not be agreeable to more treatment and should be offered an open door to return at any point in time in the future. Continuing to provide brief interventions when the patient is not motivated to change is not likely to be of any benefit and will take up your time.

Concurrent alcohol management and Depression/Anxiety Management
Patients who present with symptoms of depression or anxiety prior to or during their participation in the alcohol misuse program should be evaluated for enrollment in the depression program and the two treatments delivered concurrently. The depression program has more frequent contacts than those scheduled in the alcohol misuse program. Therefore, practically speaking, the concurrent delivery of both programs results in some contacts addressing depression symptoms alone, while other contacts address both depressive symptoms and alcohol monitoring.

Clinical Notes
Part of your role is to communicate the outcome of your clinical contact to the PCP. This may be accomplished through the documentation in your clinical note, but may also include additional communication (i.e. in-person, by telephone, via secure email). The format of your clinical notes, and the route of communication to the PCP, is expected to be highly specific to site, provider, and your own preferences.

Health Promotion Workbooks: Step-by-Step Instructions Health Promotion Workbook—Initial Contact

This section contains instructions regarding how to review the Health Promotion Workbook— Initial Contact (found in the Patient Materials manual – workbook section) with patients, keeping in mind the basic tenets of Motivational Interviewing. Due to the uniqueness of each patient and their reactions to the materials covered, it will be necessary for you to be able to deal with responses in a flexible manner. The review of Motivational Interviewing in Building a Strong Foundation serves as a guideline on how to react and respond to patients.

However, throughout the instructions, there are general reminders or suggestions of ways to respond to some of the more frequent patient responses. It is important to review the entire manual in depth in order to be familiar with all aspects of it. Also, as you read this section of the manual, it is helpful to follow along with the corresponding sections of the workbook. After completing the manual with the patient (either in person or by telephone) make sure the patient takes the original home with them or mail it to them. The workbook is theirs not yours. We do not recommend keeping a copy of the workbook. Please remember this is meant to be brief not extensive or exhaustive. You do not want to turn the patient off to what you have to say. With each section some general time limits are suggested.

Part 1. Identifying Future Goals (usually 2 minutes but not more than 5):

Talking about the patient's goals is important for several reasons. First, it helps establish rapport with the patient. Second, it helps you understand what is important to the patient and establishes a context for thinking about the role of drinking in the patient's life. In addition, having the patient voice current goals helps orient his or her attention to the future and to possible positive changes, which sets the stage for the BAI and generally provides increased motivation for the individual to change.

- **Key Points:**
    - Discuss how the person would like his/her life to improve and be different in the future. This awareness of the discrepancy between what patients desire in their life and how their current drinking behavior may negatively impact those goals.
    - It is important for you to elicit from the patient the goals that are most important to them, rather than covering all areas listed in the workbook. You are listening for what it is they value, what is meaningful for them. Thus, starting with an open-ended question may be helpful initially to understand what is most relevant for the patient. Further querying may help generate additional goals in other domains that the patient did not think of right away. For example, a patient may say right away that they want to find a better job, but also mention that they would like to lose weight when asked if they have any goals around their health.
    - When patients respond by stating they have no goals, give some examples, such as maintaining their current health/independence, improving a chronic health problem, or maintaining contact with family or friends.
- **Dialogue Example:**

    "What are some of your goals right now for the next three months to a year?"

    "What goals do you have in terms of your physical and emotional health, your activities and hobbies, your relationships and social life, your financial situation or other parts of your life?

    "How would you like your life to improve?"

Part 2. Summary of Health Habits (usually 1 minute but not more than 3):

The next section of the workbook includes a brief review of the patient's health behaviors including exercise, nutrition, tobacco use, and alcohol use. This information could be derived from screening and pre-assessment or from the patient during this contact.

- **Key Points:**
    - Summarize information on other health behaviors including exercise, nutrition, and tobacco use *first*.
    - Confirm regular drinking habits with patient, including number of drinking days per week, drinks per day, drinking binges in the past 3 months, and whether they experienced any withdrawal symptoms on days when not drinking. Be sure to ask in a way that will provide you information on standards drinks rather than information reflective of what the patient considers a drink. The patient's idea of a drink may be very different from an actual standard drinks size. Standard drink information is also provided in the next section (part 3).
    - After reviewing the alcohol section of the health habits portion of the workbook, ask the patient if there are any health behaviors with which they would like help. Generally, patients will not indicate alcohol use as a targeted health behavior. This gives you the opportunity to move the patient toward a discussion about alcohol.
- **Dialogue Example:**

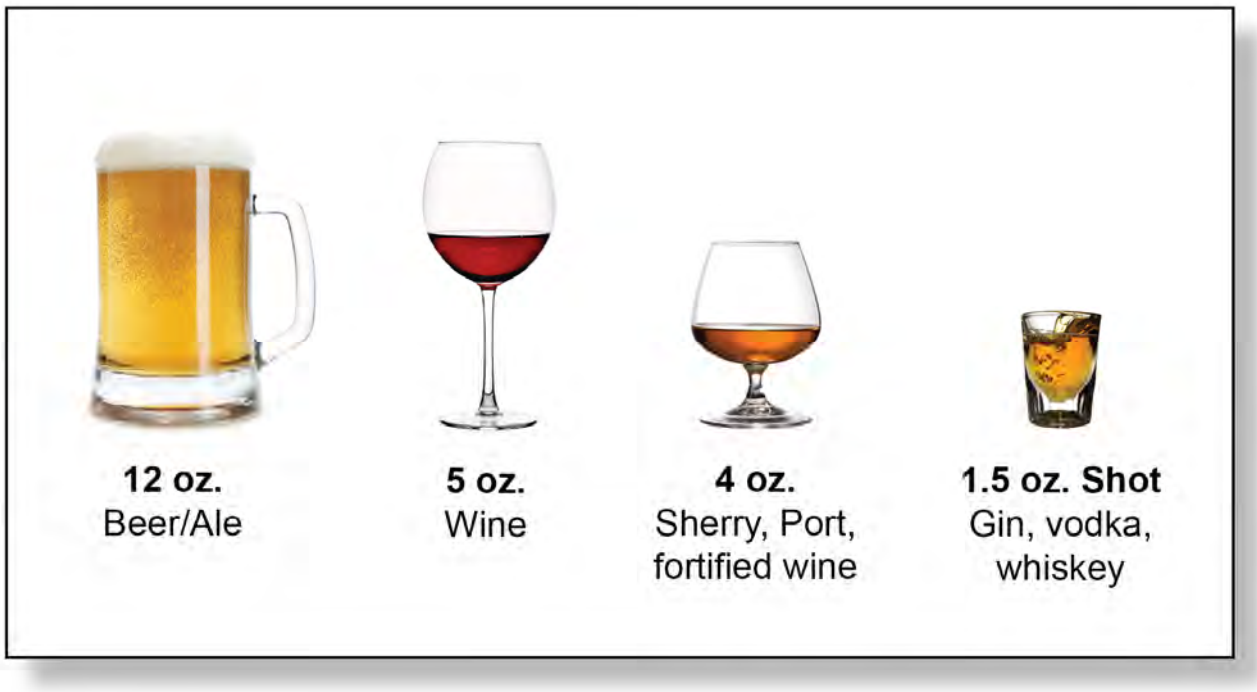
    "Let's review some of the information about your health behaviors and habits. When we spoke initially, you indicated that you had about # drinks in past week. Is this still about right"

    "I'm pleased that you are interested in exercise and nutrition. That's great! These are important areas. I can set up a time for you to talk with the nutritionist (or other). Right now, I'd like to discuss your use of alcohol with you."

Part 3. Standard Drinks (usually 1 minute but not more than 3).

This discussion focuses on the equivalence of alcohol content across various beverage types. This concept provides the context for a discussion of sensible drinking limits.

- **Key Points:**
    - The following examples are roughly equivalent in alcohol content:



- Encourage the patient to *measure* their usual drink to compare to the alcohol content of standardized drinks so that they have a more realistic view of their usual drinking behavior.

- For those patients who have difficulty stating how many drinks they consume, focus on quantity purchased and how long it lasts.

- Alcohol is alcohol. Some patients may think that they do not use alcohol because they "only drink beer or wine." Some people view "hard" and "soft" alcoholic beverages as different in their effects.

- Briefly review standard drinks. Avoid disputes about picky details regarding the alcohol content of specific beverages.

- **Dialogue Example:**

  "Did you know that if you measure the amount of alcohol that you are drinking, these beverages all contain the same amount of alcohol?" (Describe the figures).

Part 4. Types of Drinkers in the U.S. Population (usually 1 minute but not more than 3):

The purpose of this section is to introduce the idea that patients' alcohol use can be related to their physical and emotional health, and that their level of drinking can put them at risk for more health- related problems.

This includes providing feedback on national averages for patterns of drinking (including abstainers, light drinkers, moderate drinkers, at-risk drinkers, and alcohol abusers) and providing brief psychoeducation on the common consequences of drinking.

- **Key Points:**
  - Ask the patient to identify his/her pattern of substance use/abuse.
  - Highlight the information provided in the chart on the negative outcomes of drinking and national averages for alcohol use patterns as appropriate. It may be helpful to first ask what the patient understands the negative consequences can be for their level of use. You can then reinforce what knowledge they already have and add any additional information to help put their drinking into context.
  - This section may evoke a number of strong reactions from patients (argumentativeness, minimizing, concern, tearfulness, embarrassment, hostility, and so on).
  - It is important to avoid creating additional resistance. It is very important to "roll with" patients' resistance or reluctance to further examine their drinking behavior in an empathetic manner.

- **Dialogue Examples:**

  "This chart talks about the different types of drinkers. There are 4 types of drinkers: abstainers or light drinkers, moderate drinkers, at-risk drinkers and those that have alcohol abuse or dependence. Most people, over 80%, are abstainers/light drinkers or moderate drinkers. Another 10% or so are drinking above the recommended limits, which we talked about, putting them at risk for negative health outcomes, and then about 5% or so have problems around their drinking and they are also at risk for negative health outcomes. Based on what we have talked about, where would you say you best fit in these categories? What do you know about the possible negative effects of that level of drinking? Is it okay if I tell you about some other common health consequences you may or may not have known about?"

  "The national guidelines recommend that men your age drink no more than (fourteen/seven drinks per week; no more than two/one per day). Where do you think your drinking falls in terms of that recommendation?." (Remember that the guidelines are 2 drinks/day for men below age 65, 1 drink/day for women and men above 65).

  "From what you've said, I can see that you do not see yourself fitting into the at-risk and problem drinking category. Is it alright if we look at some of the things that happen to others who are considered more than a light drinker? " (If patient agrees, describe this from the chart.)

Part 5. Pros and Cons of Drinking (usually 5 minute but not more than 8):

This section addresses reasons for drinking and weighs the positives and negatives of drinking. This is particularly important in those with ambivalence about change. It is helpful for you to understand both the positive and negative role of alcohol in the context of the patient's life, including coping with loss and loneliness. This section is also designed to facilitate the patient's understanding of the potential social, emotional, and physical consequences of drinking. Prior to asking about the negative effects, first ask about the positive effects of drinking. This helps acknowledge to the patient that you understand there may be some benefits, and makes it easier to then address the negative consequences. Please note, for patients who are already using "change talk" it may be counterproductive to focus on the good things they would forego. This pros-cons strategy should be used selectively.

- **Key Points:**
    - Ask the patient to indicate positive effects of his/her drinking to identify the top 3 (Think MI – acknowledge the reasons for the status quo).
    - Ask the patient to identify the top three negative effects of drinking on his/her physical health, emotional social/well being and relationships. Try to use the patient's own words for their distress, for example they may say they are depressed, stressed out, emotionally overwhelmed, etc.
    - If the patient has difficulty coming up with negative effects, ask if you can mention some common effects of drinking that other people sometimes experience.
    - Some patients may experience problems in physical, psychological, or social functioning even though they are drinking below cut-off levels.
- **Dialogue Examples:**

    "What are some of the things you like about drinking? And what are some of the negative experiences that you have had as a result of your drinking?

    "How has drinking impacted your life?"

    Again, it is much more powerful if these example come from the patient, but if they are unable to articulate any, you may provide some examples: *"Have you had any difficulty with…?" or "Some people say they have problems with … Have you had difficulty with …?"*

    "How has (or could) drinking interfered with reaching the goals you described earlier?"

It should be noted that some patients might also begin to recognize that their drinking is problematic. Try to elicit self-motivational statements with evocative questions (e.g., *"In what way does this concern you?"*; *"What do you think would happen if you continue drinking at your current level?")* Eliciting self-motivational statements is reviewed at the end of this section.

Part 6. Reasons to Quit or Cut Down your Drinking (usually 5 minute but not more than 8):

This is a discussion of how changing drinking levels could have important benefits for the individual. Some patients may experience problems in physical, psychological, or social functioning even though they are drinking below cut-off levels. This section reviews the potential social, emotional, and physical benefits of changing their drinking. This is important information for you to use in MI reflections back to the patient.

- **Key Points:**
    - Patients identify the top three positive effects of controlling or reducing his/her drinking.
    - If the patient can't identify positive effects, ask if you can provide examples of common positive effects that other people mention.
    - It is helpful to think back to what the patient identified as important to them or as their future goals, and tie in how they could better reach these goals via alcohol abstinence/reduction.
    - Maintaining independence, physical health, and mental capacity can be key motivators.
    - Be careful not to promise miracles or cures. Alcohol use is often a component of health problems, not the sole etiology.
    - Focus efforts on eliciting self-motivational statements (see the end of this section for more information).
    - Strategies that are useful include developing social opportunities that do not involve alcohol, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.
- **Dialogue Example:**

    "What do you think might be some of the positive effects if you were able to reduce/stop drinking?"

    Tie it in to future goals that were discussed: *"You mentioned that you really wanted to develop better relationships with your kids. Do you think reducing your drinking would help with this goal? How so?"*

Give examples from the list of common benefits if the patient is unable to identify multiple benefits: *"Do you think you may (sleep better, be happier, see improvement in your job performance etc.)"*

"Of the benefits we talked about, what would you say are your top 3?"

Part 7. Drinking Agreement (usually 3 minute but not more than 5):

Agreed upon drinking limits are particularly effective in changing drinking patterns. The purpose of this section is for the patient to choose a goal (moderation or abstinence) and to complete the agreement.

- **Key Points:**
    - After giving guidance on abstinence vs. cutting down, complete the contract. Patients decide which goal they prefer: abstinence or moderation. Patients are asked to sign the agreement when they receive the workbook.
    - Ask the patient to rate his/her confidence that he/she will be able to adhere to the contract on a scale from 0 to 10. Ask why the patient is at that number rather than a 0. This will elicit from the patient a positive response on why they will be able or want to abstain or cut back. You can then strengthen/highlight those reasons when reflecting it back.
    - If patients are reluctant to sign contracts, try to determine the reason for their reluctance and alleviate their concerns if possible.
    - Patients who have a serious health problem or take medications that interact with alcohol should be advised to abstain.
    - Some patients may be appropriate candidates for reducing their drinking to below recommended limits.
    - Provide guidance by recommending a low level of alcohol use or abstinence. Remember, you may have to negotiate "up," so start low.
    - The prescription-type form contains a space to write what you have negotiated with patients:
        - stop or cut down on drinking
        - when to begin
        - how frequently to drink
        - for what period of time
    - Remind the patient to keep in mind the negative consequences of drinking, the benefits of reducing/abstaining from alcohol, and the reasons they identified for reducing/abstaining from alcohol.

- Be sensitive to patients' reactions, including concern, embarrassment, defensiveness, minimization of drinking problems, or hostility. It is very important to "roll with" patients' resistance or reluctance to further examine their drinking behavior and to avoid disputes. Patients who are resistant to accepting the provided drinking guidelines should be encouraged to consider cutting down their current level of drinking. Allow the patient to "take the lead" in moving forward while continuing to have follow up visits.

- **Dialogue Examples:**

  "I would suggest that you drink no more than three days no more than one standard drink on any drinking day. What do you think about that level of alcohol use?"

  "I see that you like to have a bottle of beer each night with dinner. I would not be concerned about that affecting your health as long as you drink no more than one 12 oz bottle of beer a day. What are your thoughts on that.

  "I am concerned about your hypertension and how difficult you say this is to control. Given this, I would recommend that you abstain from alcohol now. What do you think of this recommendation?"

  "It is up to you to decide if you should do anything about your drinking. I would still like to review the rest of the workbook with you. You may find some of it to be helpful, and if you decide to make some changes this might be useful. Just take what you can use, and leave the rest."

  "What changes would you like to make to your drinking? Would you be interested in cutting back, or abstaining? What I would like to do now is write down your goal (what patient decides is a reasonable change). When you get this workbook in the mail, you can review what we agreed upon."

  "I will be sending you the workbook that we just completed together. I would like you to look through it and use it to help you get through hard days during your abstinence/reduction of alcohol use so you can keep your goals in mind."

Part 8. Handling Risky Situations (usually 5 minute but not more than 8):

This section is only done if there is change talk and the patient identifies the desire to cut down or quite. This section is often not done for those with ambivalence on their first visit. Social isolation, boredom, and negative family interactions can present special problems for patients. This section is aimed to help patients identify situations and moods that are related to drinking too much alcohol and to identify some individualized cognitive and behavioral coping alternatives.

- **Key Points:**
    - Work with patients to develop strategies for dealing with issues such as social isolation and negative family interactions.
    - It is important to encourage patients to come up with their own alternatives and to provide the minimal guidance necessary.
    - Remind patients that the intervention is concerned with their unique situations by providing individualized feedback.
    - Review at least one roadblock and solution, and review the rest as you have time. Role-playing specific stressful situations can be helpful. The role-play exercises will vary depending on patients' particular situations.
    - Remember, motivation to change occurs as the perceived benefits of change outweigh their reasons for drinking (the barriers to change).
- **Dialogue Example:**

    "*You mentioned the following situations as risky for you: Let's talk about some ways to get through them. What are some of your ideas?"*

    "You've said that one of the reasons you drink over recommended limits is that since you retired and your wife died you have nothing to occupy your time and that you are lonely. You also have said that you and your wife used to play cards at the senior center. Have you thought about going back to the senior center to start doing some of the things you liked to do there?"

    "Sometimes quitting or cutting back on drinking involves making some very difficult decisions, like deciding not to get together with certain friends or not going to certain places like the bar or club. What could you participate in that could be just as rewarding for you."

    "You say that you drink because you enjoy meeting your friends at the bar. Have you considered other places that you could meet these friends or how you might meet some new friends?"

Step 9. Contact Summary (usually 2 minute but not more than 4):

The summary should include a review of the contact, including a review of the agreed upon drinking goals, a discussion of the drinking diary cards (calendar) to be completed for the next six weeks, and the recommendation to refer back to the workbook materials given to patients during intervention contacts.

- **Key Points:**
    - The tone of the summary should be empathetic, encouraging, and positive.
    - Review the diary cards. Tell patients that you have additional cards when these are filled.
    - Make a final effort to elicit self-motivational statements.
    - Schedule an appointment for the brief follow-up contact three weeks later.
    - Thank patients for their time and their patience.
- **Dialogue Example:**

    "We've covered a lot of material today and you've done really well in identifying how alcohol has been affecting your health and how continued drinking above limits can make your health conditions worse. You have a good plan for cutting down on your drinking. I know that you can reach your goal of drinking no more than one drink a day."

    "Sometimes people have days when they drink more than they think they will. Just record the number of drinks you had on the drinking diary card. Don't be discouraged. Start over the next day following the limits we set together."

*The "Health Promotion Workbook—Initial Contact" should be sent to the patient with a cover letter

Health Promotion Workbook—Week 6 Follow-up Contact

This section contains instructions regarding how to review the "Follow-Up Workbook" (found in the Patient Materials Manual workbook section) with patients. In general, the same tenets of Motivational Interviewing should be used for the follow-up contact, including being as flexible and supportive as possible. After the initial contact with the patient is completed, more emphasis can be placed on alcohol consumption and consequences of alcohol consumption.

The purpose of the follow-up contact is multifaceted. Foremost, it is a way for you to can show concern about the patient. Follow-up contacts allow you to emphasize your concern about a patient's health and the consequences of their alcohol consumption. The contacts also serve the function of assisting patients in monitoring their behaviors. This needs to be done in a compassionate and helpful manner. A paternalistic or confrontational approach is counter-productive and needs to be avoided. The follow-up contacts are also an opportunity to support patients' efforts at changing their behavior. Finally, these contacts are an opportunity to give direction or advice on how to maintain or improve upon the patients' goals.

Part 1. Purpose of Today's Contact:

It is important to explain to patients why the follow-up is being done. This part of the intervention builds rapport and establishes the tone of the contact.

- **Key Points:**
    - Let the patient know you will be reviewing their alcohol consumption since the last time you saw them.
    - Inform the patient that you will be reviewing their experiences with adhering to their drinking goals including successes and any obstacles.
- **Dialogue Example:**

    "Thank you for taking my call today. The reason I wanted to talk to you was for us to see how you are doing with the goals you set around your alcohol use. I would like to review with you how much you are currently drinking and look at your drinking goals to see if you want to change them in any way or if you need any further help in maintaining your goals."

Part 2. Review of Alcohol Use:

This section is used to review patients' alcohol consumption since their last contact. You have two sources of information for this section: the patient's drinking diaries and self -report. The purpose of reviewing their current drinking is to better assess and assist patients. This review is not meant to be punitive or confrontational. It is important to be non-judgmental in terms of whether patients met or did not meet their goals. Reviewing drinking habits can be enlightening for patients in terms of realizing how much they are drinking or how well they are doing in cutting down.

- **Key Points:**
    - If patients have completed their drinking diaries, review them and summarize for the patients the amount they are drinking. Translate the drinking records to standard drinks when necessary.
    - Look for trends in drinking patterns since the last contact.
    - Ask about drinking over the past week and record this in the workbook.

- **Dialogue Example:**

  "Did you find using the drinking diary cards useful? Do you have them handy to look at now? Let's look at them."

  "Now let's talk about last week. How do you think you did overall? Did you have any drinks this past week?"

Part 3. Review of Changes in Alcohol Use:

This discussion focuses on patients' efforts to change. First, make observations about whether there were changes in drinking based upon diary information. Then patients will indicate if they believe they are meeting their goals. Finally, this is the opportunity for you to listen to patients about what it was like to try cutting down. It is important that you focus on successes as well as struggles. Listening at this point will be crucial in developing ideas on how to improve or maintain the established goals.

- **Key Points:**
  - Establish if there has been any change in alcohol consumption since the last contact based upon diary records.
  - Get a feel from patients about their goals and if they feel they are meeting their goals.
  - Listen to patients tell how they achieved their goals or struggled with achieving their goals. Provide positive encouragement for their successes.

- **Dialogue Example:**

  "Based on the last week of drinking, it looks like you have decreased your drinking since the last time we spoke. That's impressive. How do you think you are doing in terms of the goal you set for yourself?"

  "Based on the last week of drinking, it looks like you have increased your drinking since the last time we spoke. How does your current drinking match with the goal you have for yourself?"

  "What was it like to think about or try changing your drinking patterns? Did you find it hard or easy?"

Part 4. Consequences of At -Risk and Problem Drinking:

This section addresses reasons for drinking and weighs the positives and negatives of drinking. This is particularly important because you need to understand both the positive and negative role of alcohol in the context of the patient's life, including coping with loss and loneliness. This section is also designed to facilitate patients' understanding of the potential social, emotional, and physical consequences of drinking. Linking changes in drinking to changes in other aspects of life is important for maintaining behavioral change. It provides a climate in which patients can obtain greater clarity of how alcohol is or could be negatively affecting their lives. During your dialogue with patients you can begin to understand what changes are occurring in their lives relative to their drinking.

- **Key Points:**
    - Review the positive and negative effects of drinking the patient stated at the previous contact.
    - Ask the patient to indicate what he/she now considers positive effects of his/her drinking to identify the top 3 (Think MI – acknowledge the reasons for the status quo).
    - Ask the patient to identify the current top three negative effects of drinking on his/her physical health, emotional social/well being and relationships. Try to use the patient's own words for their distress, for example they may say they are depressed, stressed out, emotionally overwhelmed, etc.
    - If the patient has difficulty coming up with negative effects, ask if you can mention some common effects of drinking that other people sometimes experience.
    - Some patients may experience problems in physical, psychological, or social functioning even though they are drinking well below cut-off levels.
    - Some patients may minimize the contribution of alcohol to their problems. Listen, don't argue. Look for opportunities to point out potential relationships between drinking and disability. If pointing out a relationship, ask the patient if you can make an observation. Frame it as a question "Do you think your drinking could be related to ….?" This will help to minimized any potential resistance.
- **Dialogue Examples:**

    "What are some of the things you like about drinking? And what are some of the negative experiences that you have had as a result of your drinking?"

    "We spoke last time about how drinking affects your sleep. Have you noticed any change in your sleep since then?"

    "How has drinking impacted your life?"

Again, it is much more powerful if these example come from the patient, but if they are unable to articulate any, you may provide some examples: "Have you had any difficulty with…?" or "Some people say they have problems with … Have you had difficulty with…?"

"How has (or could) drinking interfere with reaching the goals you described earlier?"

Part 5. Reasons to Quit or Cut Down on Drinking:

This section focuses on an individual's motivation for change. Maintaining behavioral changes can be very difficult, as anyone who has tried to diet well knows. While there may have been some very important things in patients' lives that make them initially decide to try to cut down on their drinking, those reasons may get lost over time and lead to lapses back to old habits. Moreover, some patients may take weeks to months to come to the decision modify their behavior. Thus, some individuals may not come up with any reasons for change during the initial contact, but may identify some reasons at the follow-up contact. During this time with patients, it is crucial to listen for the things that are important to them in their lives and how alcohol may be affecting these things. The goal is to link the things that are important for the patient to the effects of alcohol. This section reviews the potential social, emotional, and physical benefits of changing their drinking.

- **Key Points:**
    - When appropriate, link reduction in alcohol use to maintaining health, independence, and function.
    - Highlight positive changes and improvements that have already occurred.
    - Strategies that are useful include developing social opportunities that do not involve alcohol, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.
- **Dialogue Example:**

    "You indicated that you are still mostly concerned about your health. As we discussed, cutting back on your drinking is one positive thing you can do that may improve your health. You have been doing a really good job of cutting back on your drinking and I would encourage you to continue with your goal."

    "Last time we spoke, I suggested that drinking may be affecting your overall health. Have you given this any further thought?

    "What do you think might be some of the positive effects if you were able to reduce/stop drinking?"

    Tie it in to future goals that were discussed: "You mentioned that you really wanted to develop better relationships with your kids. Do you think reducing your drinking would help with this goal? How so?"

Give examples from the list of common benefits if the patient is unable to identify multiple benefits: "Do you think you may (sleep better, be happier, see improvement in your job performance etc.)

"Of the benefits we talked about, what would you say are your top 3?"

Part 6. Drinking Agreement:

Agreed-upon drinking limits are particularly effective in changing and maintaining drinking patterns. The purpose of this section is for patients to choose a goal (moderation or abstinence). The goal can be the same as that established in the prior contact(s) or it can be a new goal. Reaffirming goals that have been achieved is also important.

- **Key Points:**
  - Give guidance on abstinence vs. cutting down. Complete the contract. Make sure to allow patients to decide which plan they prefer.
  - Ask the patient to rate his/her confidence that he/she will be able to adhere to the contract on a scale from 0 to 10. Ask why the patient is at that number rather than a 0. This will elicit from the patient a positive response on why they will be able or want to abstain or cut back. You can then strengthen/highlight those reasons when reflecting it back.
  - Patients who have serious health problems or take medications that interact with alcohol should be advised to abstain.
  - Others may be appropriate candidates for reducing their drinking to below recommended limits.
  - Provide guidance by recommending a low level of alcohol use or abstinence. Remember, you may have to negotiate "up," so start low.
  - The prescription-type form contains a space to write what you have negotiated with patients**:**
    - Stop or cut down on drinking
    - When to begin
    - How frequently to drink
    - For what period of time
  - Remind the patient to keep in mind the negative consequences of drinking, the benefits of reducing/abstaining from alcohol, and the reasons they identified for reducing/abstaining from alcohol.
  - If patients are reluctant to sign contracts, try to determine the reasons for their reluctance and alleviate their concerns if possible.

- Be sensitive to patients' reactions, including concern, embarrassment, defensiveness, minimization of drinking problems, or hostility. It is very important to "roll with" patients' resistance or reluctance to further examine their drinking behaviors in a straightforward and empathetic manner. Avoid disputes over these guidelines and suggest that they continue to monitor for benefits and consequences of drinking. Never try to force your opinions about drinking limits when they are directly in conflict with those of the patient.

- **Dialogue Examples:**

  "You last set a goal of cutting back to eight drinks per week, I would suggest that you now consider no more than three days per week, with no more than one standard drink on any drinking day. With this in mind what would you like to set as your new goal?"

  "Now that you have cut down to two drinks every day, what do you think about a new goal?"

  "When we talked last time, we had set a goal of one drink per day As you found out, trying to moderate drinking is sometimes harder than eliminating alcohol altogether. Perhaps you might try abstinence as a goal for the next several months. What do you think? What would you like to set as your new goal?"

Part 7. Ways to Cope with Risky Situations

Social isolation, boredom, and negative family interactions can present special problems. This section is aimed at helping patients identify situations and moods that are related to drinking too much alcohol, and to identify some individualized cognitive and behavioral coping alternatives.

- **Key Points:**

  - Work with patients to develop strategies for dealing with issues such as social isolation and negative family interactions.

  - Discuss the strategies that were used since the last time you spoke.

  - Probe for mood or anxiety problems and, if present, consider additional treatment.

  - Review at least one roadblock and solution, and review the rest as you have time. Role playing specific stressful situations can be helpful. The role-play exercises will vary depending on patients' particular situations.

- Remember, motivation to change occurs as the perceived benefits of change outweigh patients' reasons for drinking (the barriers to change). Thus the amount of time and energy needed to address each risky situation cannot be greater than the time and energy it takes to drink.

- **Dialogue Example:**

  "You described encountering a risky situation (put in patient's words), let's talk about how you felt you handled it and if/what you need to do differently." If patient successfully handles the situation provided positive encouragement. If patient had difficulty, praise them for t heir efforts and help them to come up with a plan to handle the situation next time.

  "You stated that getting together with friends is an important part of the reason you drink. Can you think of some ways you can get the companionship you want but in a setting that does not involve drinking? Are there activities that you enjoy that don't involve drinking?"

  "You said that you tried going to a senior center and church but you didn't feel like you fit in. Are there any other places that you would enjo y going to?"

Part 8. Contact Summary:

The summary should have a review of the contact, including a review of the agreed upon drinking goals, a discussion of the drinking diary cards (calendar) to be completed for the next several weeks, and the recommendation to refer back to the workbook materials given to the patient during the intervention contacts. This is also the appropriate time to discuss when the next contact, if one, will occur.

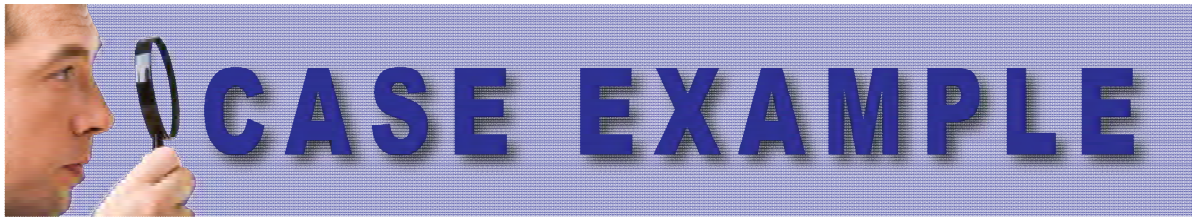
- **Key Points:**

  - The tone of the summary should be empathetic, encouraging, and positive.
  - Review the diary cards. Tell patients that additional cards are available when these are filled.
  - Make a final effort to elicit self-motivational statements. o Make an appointment for the next contact.
  - Thank patients for their time and their patience.

- **Dialogue Example:**

  "We've covered a lot of material today and you've done really well in identifying how alcohol has been affecting your health and how continuing drinking above limits can make your health conditions worse. You have a good plan for cutting down on your drinking. I know that you can reach your goal of drinking no more than one drink a day."

  "Sometimes people have days when they drink more than they think they will. Just record the number of drinks you had on the drinking diary card. Don't be discouraged. Start over the next day, following the limits we set together."



Week 3 Contact- PHQ = 4. Mr. Fowler has been able to stick to his goal of 3 (12 oz) beers daily; however, reports cravings and urges for alcohol. Rationale for pharmacotherapy with naltrexone 50mg daily (including the risks and benefits of this medication) to assist with reducing the urge/desire for alcohol is discussed with the patient. He states he will consider this option should he need assistance with reducing alcohol consumption; however, he is not interested in starting the medication at this time. Information packet on naltrexone is provided to Mr. Fowler for future reference. He is congratulated on his progress and is asked if he is interested revising his treatment agreement. Mr. Fowler agrees to drink no more than 2 (12oz) beers daily.

Recognizing and Reinforcing Motivational Statements to Enhance Commitment to Change The purpose of this section is to give you some additional examples of statements patients may make that indicate a willingness to work on reducing or stopping their drinking and, most importantly, of motivational statements that you can use to facilitate the change. The concepts underlying these statements are adapted from Miller and Rollnick.[45]

A critical aspect of the intervention is eliciting motivational statements from patients. It is your task to facilitate patients' expression of their reasons to change their drinking as well as their resolve to change. Motivational statements tend to fall into four categories: *problem recognition, expression of concern, openness to change,* and *optimism*. It is important to reinforce statements that indicate a willingness to consider change. The use of questions can help elicit motivational statements and enhance commitment to change. Each motivational statement may further help patients realize that the benefits of changing outweigh the costs.

The table below contains examples of motivational statements and evocative statements.

Type of Statement	Patient's Statement	Evocative Questions
Problem recognition	*I guess there is more of a problem than I thought.*	*What other problems have you had?*
	I never realized how much I was drinking or what the recommended drinking limits were for people my age.	*What else have you noticed or wondered about?*
	I always thought I could drink the same amount I drank when I was younger.	*How does knowing the limits change how you feel about your drinking?*
Expression of concern	*I'm a little worried about this.*	*What other concerns have you had?*
	I really feel bad about letting this happen.	*What else worries you about your drinking?*
Openness to change	*I think it's time for me to think about quitting.*	*What are some other reasons you may need to make a change?*
	I guess I need to do something about this.	*Do you have any ideas about what you can do?*
	This isn't how I want to be. What can I do?	*Well, it is different for everybody. What do you think you can do that would help?*
Optimism	*I think I can change my drinking.*	*A positive outlook is very important. Why else do you think you can succeed?*
	I'm going to overcome this.	
	Now that I've decided, I'm sure I can change.	

STEP 4b Treating Alcohol Dependence

The following guide was developed to complement the *Medical Management (MM) Treatment Manual* (USDHHS, 2004), a research manual developed for use in Project COMBINE. That research manual served as a standardized guide for delivering Medical Management (MM) treatment to patients with alcohol addiction. We have adopted this approach form primary care into a program entitled Alcohol Care management (ACM). ACM employs a series of brief counseling sessions to enhance medication adherence and abstinence from alcohol. As a brief treatment, this approach is suitable for delivery in primary care settings and is similar in concept to the care management programs developed for depressive disorders. Prior to reading this section, you should get and study the Medical Management Treatment Manual. What follows here are guidelines for implementing ACM in a primary care setting.

> *Source: Pettinati, H.M., Weiss, R.D., Miller, W.R., Donovan, D., Ernst, D.B., & Rounsaville, B.J. (2004). COMBINE Monograph Series, Volume 2. Medical Management Treatment Manual: A clinical research guide for medially trained clinicians providing pharmacotherapy as part of the treatment for alcohol dependence. (DHHS Publication No. NIH 04-5289. Bethesda, MD: NIAAA*

A central feature of ACM is the worksheets (see Clinician Resources, Volume 5). The worksheets have been structured to guide each session. Follow up sessions are based on the assessment of the patient's drinking status and medication adherence status with four different scenarios: (1) patient is not drinking and is taking medication consistently, (2) patient is drinking and is taking medication consistently, (3) patient is not drinking and is not taking medication consistently, and (4) patient is drinking and is not taking medication consistently. The manual also includes brief interventions tailored based on the assessment of readiness to take medications consistently and readiness to change alcohol use.

Patient information handouts and assessment tools are referenced in the session forms and included in the patient materials manual.

Initial Treatment Session

Again it is important to note that the initial treatment session assumes that you have completed a baseline assessment and have some existing data about the patient's addiction. You will use motivational interviewing as a skill to engage, show empathy and try to tip the decisional balance toward healthy goals. The initial treatment session will likely take 60 minutes to complete. The session is composed of three general areas – gathering data, formulating a treatment plan, planning for the next visit.

Gathering Information about Drinking

The first section is gathering specific information about drinking and the consequences of drinking. Some data should be gathered before seeing the patient (see the worksheet). This includes routine laboratory studies.

If these have not been done at this point, please recommend them to the PCP or supervising clinician so that they can be available for the next visit.

In the following tables are lists of data that should be gathered or reviewed near the beginning of the first treatment session. Each item has a brief explanation for relevance to alcohol addiction

Assessment Data	Review Results and Relay Feedback
Breath Alcohol Concentration (BAC)	**.02%** *Light to moderate drinkers begin to feel some effect* **.04%** *Most people begin to feel relaxed* **.06%** *Judgment is somewhat impaired; people are less able to make rational decisions about their capabilities (e.g., driving)* **.08%** *Definite impairment of muscle coordination and driving skills. Increased risk of nausea and slurred speech. Legal intoxication.* **.10%** *Clear deterioration of reaction time and control.* **.15%** *Balance and movement are impaired. Risk of blackouts and accidents.* **.30%** *Many people lose consciousness. Risk of death.* **.45%** *Breathing stops, death occurs.*
Weight	
Blood pressure (sitting)	Blood pressure and pulse are essential vital signs for monitoring response to drinking and withdrawal from alcohol. Elevated blood pressure in individuals without a history of hypertension is a concern.
Blood pressure (standing)	
Pulse (sitting)	The pulse rate is typically elevated during withdrawal from alcohol. A high pulse differential [PD] (standing – sitting = PD), along with other objective symptoms (i.e., sweating and tremor) may indicate withdrawal from alcohol.
Pulse (standing)	

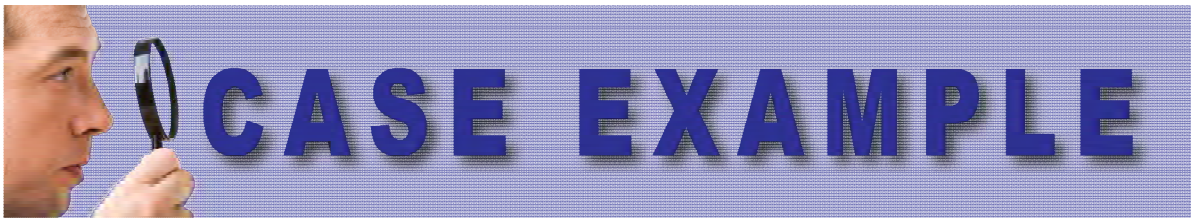
AST (SGOT)	When the liver is damaged, as happens from heavy drinking, it becomes less efficient and begins to leak enzymes into the bloodstream. The liver filters and neutralizes impurities and toxins in the blood. Elevated levels of these enzymes are general indicators of compromised liver function.
ALT (SGPT)	
GGT (GGTP)	Serum gamma glutamyl transpeptidase (GGT or GGTP) is an enzyme found in liver, blood, and brain, which is more specifically sensitive to alcohol's effects. If drinking continues, elevations of this enzyme predict later serious medical problems related to drinking, including injuries, illnesses, hospitalizations, and deaths. GGT is sensitive to recent drinking and elevations may reflect a recent heavy drinking episode.
Bilirubin	Elevated bilirubin is indicative of liver abnormality.
MCV	Mean corpuscular volume (MCV) is the average size of red blood cells. Heavy drinking causes blood cells not to have enough hemoglobin which is necessary to carry oxygen around the body and brain. Trying to make up for less hemoglobin, the blood cells grow larger. While there are no serious immediate consequences of this enlargement, it reflects harmful effects of drinking that in the long run can damage circulation and brain cells.
(Other abnormal lab values)	Alcohol has negative effects on almost every body system.

Next are a series of clinical assessments. Each is outlined below.

Gathering Patient Information about Drinking	
Assessment Data	Review results and relay feedback from the initial assessment
Drinking-related medical symptom(s) / conditions(s)	Provide handout “How Alcohol Affects Your Body” and review relevant information. (see Patient Resources, Volume 6)
Average number of drinking days per week and per occasion	The amount of alcohol and frequency of drinking are important to examine over time. The consequences of drinking can be quite serious. (Focus discussion on consequences, tying in amount and frequency as warranted.)

Consequences of drinking	Give the patient the Short Inventory of Problems (SIP) and discuss 2-3 items that the patient responded "yes." Select the three most clinically relevant items. (see Patient Resources, Volume 6) These are warning signs that your drinking is destructive to your health and/or well-being.
When you start drinking, you end up drinking more, or longer than you planned.	Review the symptoms of addiction; three or more symptoms indicate alcohol dependence. (The questions are in the left column). Advise abstinence. If lifelong abstinence is too difficult a goal to commit to at the time, recommend a brief period of abstinence to find out what it is like to live without alcohol. (Set a timeframe that the patient can agree upon.) Document the goal in a treatment agreement.
You have tried to, or wanted to, cut down or stop drinking alcohol.	
You have spent a lot of time drinking or being hung over.	
You have given up important social, occupational, or recreational activities because of alcohol use.	
You have continued to drink even though alcohol has caused, or made worse, psychological or physical problems.	
You have an increased tolerance to alcohol.	
You have experience withdrawal symptoms when you cut down or stopped drinking.	

Concurrent Medications	Review any medications the patient is taking including over-the-counter medications and supplements. Ask the patient if s/he has any concerns about the medications. Address concerns and refer to primary care provider if indicated. If the patient is female, ask about regular use of birth control and any changes in menstrual cycle.



Week 6 Contact*- Health Promotion Follow-up Workbook is conducted. PHQ = 6. Mr. Fowler has increased his alcohol intake to 4-5 beers daily and expresses interest in trying Naltrexone. Reasons for increased use are explored- his son lost his job and has temporarily moved in with Mr. Fowler, which has been a source of stress. Stress management techniques are discussed as well as ways to continue to reduce alcohol consumption. Since Mr. Fowler expressed interest in starting naltrexone, the medication is prescribed by his Primary Care Provider. Mr. Fowler is contacted in 1 week of prescribing to assess for side effects. At this time he denies any side effects, is taking naltrexone as prescribed and is tracking his alcohol intake.*

Week 12 Contact*- PHQ = 1. Mr. Fowler continues on naltrexone with no reported side effects. He has successfully reduced his alcohol intake to 2 (12oz) beers twice a week (Friday night at VFW and Sunday for Football). Mr. Fowler's blood pressure has dropped since his reduction in alcohol use. Therefore, his Primary Care Provider changed his atenolol dosage to 25mg daily. Mr. Fowler denies urges/cravings for alcohol and is not interested in further reduction of alcohol at this time. He reports trouble sleeping only "a few nights" (previously reported "almost every night") and states he is feeling less tired. Mr. Fowler declines further intervention at this time; however, he expresses appreciation for the assessments. Contact information! Clinician is provided should a need arise in the future. Naltrexone is recommended for 6 months to 1 year for optimal effectiveness. Alcohol misuse screening in 1 year is recommended.*

Assessment Data	Review Results and Relay Feedback
Breath Alcohol Concentration (BAC)	**.02%** *Light to moderate drinkers begin to feel some effect* **.04%** *Most people begin to feel relaxed* **.06%** *Judgment is somewhat impaired; people are less able to make rational decisions about their capabilities (e.g., driving)* **.08%** *Definite impairment of muscle coordination and driving skills. Increased risk of nausea and slurred speech. Legal intoxication.* **.10%** *Clear deterioration of reaction time and control.* **.15%** *Balance and movement are impaired. Risk of blackouts and accidents.* **.30%** *Many people lose consciousness. Risk of death.* **.45%** *Breathing stops, death occurs.*
Weight	
Blood pressure (sitting)	Blood pressure and pulse are essential vital signs for monitoring response to drinking and withdrawal from alcohol. Elevated blood pressure in individuals without a history of hypertension is a concern.
Blood pressure (standing)	
Pulse (sitting)	The pulse rate is typically elevated during withdrawal from alcohol. A high pulse differential [PD] (standing – sitting = PD), along with other objective symptoms (i.e., sweating and tremor) may indicate withdrawal from alcohol.
Pulse (standing)	
AST (SGOT)	When the liver is damaged, as happens from heavy drinking, it becomes less efficient and begins to leak enzymes into the bloodstream. The liver filters and neutralizes impurities and toxins in the blood. Elevated levels of these enzymes are general indicators of compromised liver function.
ALT (SGPT)	

GGT (GGTP)	Serum gamma glutamyl transpeptidase (GGT or GGTP) is an enzyme found in liver, blood, and brain, which is more specifically sensitive to alcohol's effects. If drinking continues, elevations of this enzyme predict later serious medical problems related to drinking, including injuries, illnesses, hospitalizations, and deaths. GGT is sensitive to recent drinking and elevations may reflect a recent heavy drinking episode.
Bilirubin	Elevated bilirubin is indicative of liver abnormality.
MCV	Mean corpuscular volume (MCV) is the average size of red blood cells. Heavy drinking causes blood cells not to have enough hemoglobin which is necessary to carry oxygen around the body and brain. Trying to make up for less hemoglobin, the blood cells grow larger. While there are no serious immediate consequences of this enlargement, it reflects harmful effects of drinking that in the long run can damage circulation and brain cells.

Next are a series of clinical assessments. Each is outlined below.

Gathering Patient Information about Drinking	
Assessment Data	Review results and relay feedback from the initial assessment
Drinking-related medical symptom(s) / conditions(s)	Provide handout "How Alcohol Affects Your Body" and review relevant information. (see Patient Resources, Volume 6)
Average number of drinking days per week	The amount of alcohol and frequency of drinking are important to examine over time. The consequences of drinking can be quite serious. (Focus discussion on consequences, tying in amount and frequency as warranted.)
Average number of drinks per drinking occasion	

Concurrent Medications	Review any medications the patient is taking including over-the-counter medications and supplements. Ask the patient if s/he has any concerns about the medications. Address concerns and refer to primary care provider if indicated.

	If the patient is female, ask about regular use of birth control and any changes in menstrual cycle.

Formulating a Treatment Plan

Your initial treatment plan will include 3 principal factors. First a drinking goal. This should be established the same way you established a goal for at-risk drinkers. Be prepared for the patient who wants to just cut down on their drinking. You should recommend and encourage abstinence but not insist on abstinence. The second factor is to encourage the use of pharmacotherapy for alcohol dependence. This typically means naltrexone or acamprosate. The table below has some useful hints about starting or maintaining use of medication. Remember you should discuss pharmacotherapy with your supervising clinician prior to getting a prescription. You will need to review contraindications as well. The third factor is staying connected with the patient. You cannot help the patient if you aren't in communication with the patient. If they don't want to return for a visit make sure you let them know you will call and check up on them and follow through. If there is additional time, then using the strategies in the at-risk drinking on risky situations is an excellent way of helping the patient.

Formulating a Treatment Plan	
Pharmacotherapy for alcohol dependence	**If not on medication**: Tell the patient the purpose of Naltrexone and Acamprosate. Distinguish them from medications used for detoxification. Provide information about the difference between these medications and disulfiram (Antabuse) as the patient may have negative feelings, experiences, or images about taking medications to treat alcohol dependence. Provide and review the "Addiction Medication Common Questions" handout. Provide the "Acamprosate Information Sheet" and the "Naltrexone Information Sheet" and review, focusing on efficacy, proposed mechanisms of action, potential side effects, and dosing. (For handouts, see Patient Resources, Volume 6) **If the patient is already on medication**: Identify medication prescribed for alcohol use. Ask patient what s/he already knows about the medication. Provide relevant medication (Acamprosate or Naltrexone) information sheet and review, focusing on efficacy, proposed mechanisms of action, potential side effects, and dosing. Provide and review the "Patient Instructions for Managing Side Effects" pointing out ways to cope with adverse events such as nausea, vomiting, and diarrhea. Provide the patient with contact information if s/he is concerned with any symptoms in between visits. Provide "Wallet Card" and assist in completing for relevant medication. If on Naltrexone, provide and review "Naltrexone Provider Letter." (For handouts, see Patient Resources, Volume 6)
Promoting medication taking	Provide "Rationale for Taking Medication Consistently" and review.

If the patient is on or willing to take pharmacotherapy or is taking psychotropic medications like antidepressants then you will want to also assess their general habits for taking medication. The following section outlines questions regarding medication adherence.

Based on the following types of questions, assess the level of trouble the patient has with taking medication. Using the medication adherence plan on the worksheet, identify any strategies s/he has found useful for taking medications consistently. If the patient has not had enough experience or a history of inconsistency, review the rationales for taking medication and the strategies for taking medications in the following sections.

- Have you ever been asked or tried on your own to take pills on a daily basis?
- Have you ever been asked or tried on your own to take four or more pills at one time on a daily basis?
- Have you ever been asked or tried on your own to take pills in the evening or at bedtime on a daily basis?

Suggestions for Taking Medications Consistently

- Take medications when performing daily activities such as brushing your teeth
- Keep medications in one place, such as by the bathroom sink or on the kitchen counter
- Take medications with morning coffee
- Take medications while watching a particular TV show that is at the same time medications are to be taken
- Involve others to remind you to take your medication
- Use a device such as an alarm watch or clock that rings when it is time to take medication
- Use a medication cassette to help you organize your medications by day and time to be taken

Pros for Taking Medication

- Takes away or reduce my desire to drink
- Helps me maintain abstinence
- Reduce my urge to drink if a slip occurs
- Makes me feel more responsible
- Keeps me healthier
- Helps me experience less drinking-related consequences
- Helps me enjoy being with my friends and family
- Makes my loved ones worry less about my drinking

Rationale for Taking Addiction Medications Consistently
Medications prescribed to help you change your drinking behavior reduce your urge or desire to drink

- Research on Naltrexone showed that individuals who took the medication consistently were able to reduce their drinking more than those who did not take their medication as directed

- Medications do not work immediately. It takes several days to achieve a steady therapeutic level in your blood

- Once you have the right amount of medication in your blood, it can still take some time for the medication to have the fill effect on helping you change your drinking behavior

- The medication can only help you to maintain abstinence if you taken them consistently, as you would with blood pressure medicine or insulin.

You should also be ready for Cons for Taking Medication that may be raised by the patient. Think about what your response to these will be. Prepare an answer for the patient.

- I don't want to rely on medication
- I have negative effects including:
    - o _____
    - o _____
- I don't like to take pills
- I worry about what people will think if they know I am taking the medication
- It's inconvenient to remember to take the medication with me when I am not home

Concluding the Initial Visit
At this point you are ready to summarize and work on engaging the patient into a return visit. Remember you cannot help the patient reach a goal if you don't have a next visit. You must spend time with the patient encouraging them to engage and discussing any ambivalence toward behavior change. This is where your MI training will come in the most.

1. Summarize diagnosis briefly and recommend abstinence. If a patient is resistant to abstinence, recommend a trial period of abstinence and roll with the resistance

2. Recommend mutual-support groups as an aid to change

3. Provide literature on local mutual -support groups. (*Problem-solve obstacles to attendance as necessary.*) Refer to the Patient Resources, Volume 6 for a list of support group suggestions

4. If the patient is also seeing a therapist, support the patient in his/her effort

5. If you start or continue medications, summarize the dose and plan with the patient, include a discussion of side effects
6. Elicit and answer the patient's questions or concerns
7. Schedule next session
8. Relay how the patient can contact their provider(s) as indicated
9. Document summary of initial session (assessment, interventions provided, patient response, and plan of care)

Follow up Treatment Sessions
Follow up sessions are generally planned for weekly visits not to exceed 45 minutes in duration. As the patient gains confidence and success, sessions can be tapered to every other week or monthly. The table below contains a checklist of items to be included in your follow up sessions with the frequency of assessment.

Follow-up checklist:

Gathering Objective Information about Drinking	
Assessment Data	Review any changes from previous session. Reinforce concept that improvements in drinking and/or laboratory data are linked with abstinence or less consumption of alcohol. Reinforce importance of continuing to work toward goal.
Breath alcohol concentration (BAC)	
Weight	Collect monthly
Blood pressure (sitting)	
Blood pressure (standing)	
Pulse (sitting)	
Pulse (standing)	

AST (SGOT)	Collect monthly
ALT (SGPT)	Collect monthly
GGT (GGTP)	Collect monthly
Bilirubin	Collect monthly
Uric Acid	Collect again only if elevated at baseline
MCV	Collect monthly
Other abnormal lab values	
Average number of drinks per drinking occasion	Ask about drinking status since last appointment, as well as any other drug use and attendance at mutual support groups. Reward any positive steps. Express optimism that the patient can recover. If drinking status is unchanged or increased, or treatment goal (i.e., abstinence) has not been attained, refer to corresponding scenario based on assessment of readiness to abstain.
Assess readiness to change alcohol use if drinking continues	Assess readiness using the "Readiness Ruler" (Patient Materials manual – assessments) for alcohol use.
Pharmacotherapy for alcohol dependence	Did the patient agree to addiction-focused medication? If yes, ask about adherence, efficacy, and side effects. If not it is never too late to start particularly if the patient describes cravings or is struggling to stay abstinent.
Medication taking	Using a calendar, ask the patient to report whether or not s/he took the medication. Start from the current day and work backwards to the last appointment. Praise the patient for taking any amount of prescribed medication. If s/he skipped any doses, inquire about the reasons. Provide advice for taking medications as directed.

<table>
<tr><td>Assess readiness to take medication consistently</td><td>Assess readiness using the “Readiness Ruler” (see Patient Resources, Volume 6) for taking medication. (After assessing drinking status, refer to relevant scenario in “Promoting Outcomes.”)</td></tr>
<tr><td>Concurrent medications</td><td>Review any medications the patient is taking including over-the-counter medications and supplements.
Ask the patient if s/he has any concerns about the medications.
Address concerns and refer to primary care provider if indicated.

If the patient is female, ask about regular use of birth control and any changes in menstrual cycle.</td></tr>
<tr><td>Have you had any physical or health problems since your last visit?</td><td rowspan="4">If yes…
Identify event,
Date of onset,
Duration (days),
Pattern (isolated, intermittent, continuous),
Severity (minimal, mild, moderate, severe),
If medication related (no, dose-response, timing of onset, known drug effect, other [specify], or unknown),
Action taken (none, increased surveillance, continue, discontinue, dose reduction, dose increase, other [specify]).</td></tr>
<tr><td>Have you noticed any changes in your physical appearance since your last visit?</td></tr>
<tr><td>Have you cut down on the things you usually do because you have not felt well physically since your last visit?</td></tr>
<tr><td>Assess specific events (Administer Symptom Checklist)</td></tr>
<tr><td>Concurrent treatment</td><td>Ask about concurrent treatment, providing support for continuing. Determine if there are any scheduling conflicts or barriers to attending treatments; if so, help resolve any practical problems.</td></tr>
<tr><td>Mutual support</td><td>Ask about attendance, identify barriers and help resolve them.</td></tr>
<tr><td>Interventions for alcohol use and medication taking</td><td>Refer to “Promoting Outcomes.” (Next section)</td></tr>
</table>

Promoting Outcomes (5 to 10 minutes)
The next four sections deal with the various possible scenarios regarding drinking and medication adherence. Use these to help guide adjustments in the treatment planning.

The Patient is NOT drinking and IS taking medications consistently		
Interventions	**Patient Response**	**Changes in Plan / Recommendations**
1. Reinforce the patient's ability to follow advice and stick to the plan. Discuss how many patients have trouble achieving abstinence and taking medications consistently.		
2. Elicit feedback on success; ask the patient to tell you specifically how s/he did so well.		
3. Obtain feedback about what the patient has observed. "What have you noticed since achieving these outcomes?" Focus on the benefits of taking medications and abstaining from alcohol.		
4. Address the common, but incorrect belief that the patient can stop the medication as soon as s/he feels successful in treatment. Focus on the importance of completing treatment as prescribed to better ensure his/her continued recovery after treatment is over. Convey that ongoing sessions serve as "booster shots" for successful treatment outcomes.		
5. Review the benefits of abstinence in general terms, such as improved health, fewer drinking related problems, and the benefits of the medication.		
6. Finish the session with positive, supportive statements.		

Source: MMTM (2004), pp. 19-20, Appendix B, page B-15

The Patient IS drinking and IS taking medications consistently		
Interventions	**Patient Response**	**Changes in Plan / Recommendations**
1. Praise any small steps the patient has taken toward abstinence and/or reductions in desire for alcohol. Provide reassurance that recovery is a gradual process and that occasional returns to drinking sometimes occur along the way.		
2. Review the benefits of abstinence in general terms (e.g., general health, fewer drinking-related problems) and the benefits of medications.		
3. If early in treatment, remind the patient that medication works slowly and may not have begun to yield the full effect on reducing drinking.		
4. Identify where the patient is on the "Readiness Ruler for alcohol use" (see Patient Resources, Volume 6) and provide corresponding interventions.		
5. Finish the session with general encouragement and praise.		

Source: MMTM (2004), p. 20.

The Patient is NOT drinking and NOT taking medications consistently		
Interventions	**Patient Response**	**Changes in Plan / Recommendations**
1. Congratulate the patient for not drinking.		
2. Review the benefits of abstinence in general		

terms, such as improved health, fewer drinking-related problems, and the benefits of the medication (reduce the desire for alcohol).		
3. Identify where the patient is on the "Readiness Ruler for medication taking" (see Patient Resources, Volume 6) and provide corresponding interventions.		
4. Finish the session on a positive note with general encouragement and praise.		

Source: MMTM (2004), pp. 20-21.

The Patient IS drinking and is NOT taking medications consistently		
Interventions	**Patient Response**	**Changes in Plan / Recommendations**
1. Review the benefits of abstinence in general terms, such as improved health, fewer drinking related problems, and the benefits of the medication.		
2. Encourage the patient to give treatment a chance.		
3. Explain that although it is very difficult to give up drinking, it is a lot easier to routinely take medications as prescribed.		
4. Briefly evaluate the reasons that the patient did not take medications.		
5. Provide and review "Common Reasons for Not Taking Medications." (see page 58)		
3. Identify where the patient is on the "Readiness Ruler for alcohol use" and the "Readiness Ruler for medication taking" (see Patient Resources, Volume 6) and provide corresponding interventions.		

Source: MMTM (2004), p. 21

Helpful tips for addressing ambivalence.
The following sections deal with ambivalence toward treatment (either continued engagement or pharmacotherapy). Become familiar with these and use this as an opportunity to adjust the treatment planning process.

Readiness to Change Alcohol Use
Not ready • Probe further about the reasons for not reducing alcohol use. Assist in problem solving and provide information as indicated. • Remind the patient of specific reasons s/he sought treatment. • Review information about consequences of the patient's recent drinking behavior obtained in initial session. • Repeat points made in initial session about the general benefits of abstinence. • Encourage goal of considering information about cutting down drinking.
Unsure • Provide assurance that ambivalence is normal. • Provide and review "Pros and Cons for Drinking" information sheet (see Patient Resources, Volume 6) asking if patient can identify any additional ones. Discuss the importance of each, encouraging the patient to consider "tipping the balance" so the consequences outweigh the benefits. • Engage in problem solving to identify positive comebacks for the cons. • Encourage the patient to give abstinence a change. Convey that starting the process of abstaining from alcohol is a difficult time, but if s/he can get the process started, it should get easier as time goes by.
Trying • Praise efforts. • Convey that starting the process of abstaining from alcohol is a difficult time, but if s/he can get the process started, it should get easier as time goes by. • Explore where drinking is taking place. If at home, encourage the patient to remove alcohol from the house. If at a bar or with specific people, suggest not associating with drinking buddies and not going to bars. • Identify if there is a particular time of day that the patient drinks. If so, suggest that s/he find some other activity to distract him/her at that time. • Encourage the patient to set a goal.

Readiness to Take Medications Consistently
Not ready • Probe further about the reasons for not taking medications regularly. Assist in problem solving and provide information as indicated. • Convey that s/he may significantly improve his/her chances for sustained improvement by taking the medication. • Provide and review "Pros for Taking Medications" information sheet (see page 48), asking if patient can identify any additional ones.
Unsure • Provide assurance that ambivalence is normal. • Provide and review "Pros for Taking Medications" information sheet, asking if patient can identify any additional ones. • Have the patient identify "Cons for Taking Medications" (see page 49) and engage in problem solving to identify positive comebacks. • Ask the patient what he or she envisions for the future if he or she does not take medications consistently. • Review benefits of abstinence and encourage patient to give medication a chance.
Ready • Clarify the patient's own goals and strategies for taking medications. • Consider barriers to taking medications and problem solve ways to lower or remove them. • Identify strategies that have been successful in the past either for her/him or others. • Establish a date for starting to take medications routinely.
Trying • Praise efforts. • Acknowledge difficulties for patients taking medication for the first time. • Identify obstacles to taking medications consistently. • Provide and review "Suggestions for Taking Medications Consistently." (see page 49)

Source: MMTM (2004), p. 21, 25-28.

Common Reasons for Not Taking Medication

1. Forgets to take or loses medication
2. Worries about side effects
3. Has misinformation about medications
4. Expects instant results
5. Has never like taking pills
6. Desires to drink or “get high”
7. Tires of taking pills every day
8. Disagrees about having an alcohol disorder
9. Feels like medications are no longer needed

If any of these situations occur during treatment, please discuss them with your supervising clinician.

Charting and documenting your work
You should document the outcome of the sessions and provide this information to the PCP. The format of clinical notes, and the route of communication to the PCP, is expected to be highly specific to site, provider, and your preference. Issues related to charting and documenting your work are discussed in Volume 1.

Evaluation/Monitoring
Program level monitoring is just as important as patient level monitoring. Program level monitoring facilitates quality measurement, the ability to adjust and improve the program, and communication with all stakeholders including hospital administrators, insurance companies or others responsible for budgeting of the program. A successful program needs to be able to demonstrate success over many patients. This is only done with appropriate informatics.

For the alcohol misuse management program key parameters to monitor include:

- Number of referrals
- Proportion of referrals assessed or pending an assessment
- Proportion of patients getting a brief intervention
- Number of brief interventions/visits per patient
- Proportion of visits attended for addiction care
- Proportion of patients with heavy drinking days or abstinent days

Tracking these outcomes can be accomplished in a number of ways. There is commercially available software that facilitates the baseline assessment, progress note creation and the program level evaluation. It also assists with tracking patient’s alcohol use, for a further discussion on program evaluation and monitoring, see the Building a Strong Foundation manual.

CHAPTER 6

Alcohol Withdrawal

Alcohol withdrawal symptoms commonly occur in patients who stop drinking or markedly cut down their drinking after regular heavy use. Alcohol withdrawal can range from mild and almost unnoticeable symptoms to severe and life-threatening ones. The classical set of symptoms associated with alcohol withdrawal includes autonomic hyperactivity (increased pulse rate, increased blood pressure, increased temperature), restlessness, disturbed sleep, anxiety, nausea, and tremor. More severe withdrawal symptoms can include auditory, visual, or tactile hallucinations, delirium, seizures, and comas. Additionally, alcohol withdrawal has the potential to complicate other illnesses.

Most patients are able to reduce or stop drinking with minimal withdrawal symptoms. In patients who do experience significant alcohol withdrawal, the primary goal is to prevent the development of alcohol withdrawal delirium, which can be life threatening. This section is designed to provide you with some basic understand of withdrawal symptoms and to help identify and manage patients who are experiencing significant withdrawal symptoms. Most alcohol withdrawal can easily be managed as an outpatient and can be done in primary care.

Course of Alcohol Withdrawal Symptoms
Alcohol withdrawal symptoms are heterogeneous in terms of whether and to what degree they occur. However, the time course for withdrawal symptoms is somewhat predictable. Within zero to six hours after ceasing or markedly reducing alcohol intake, withdrawal symptoms tend to be minimal if present at all. From six to 24 hours, symptoms begin to emerge such as tremor, nervousness, malaise, palpitations, elevations in heart rate, blood pressure and temperature, sweating, nausea, anorexia, and sleep disturbances. These symptoms usually peak in severity from 24 to 36 hours and subside by 48 hours. In more severe cases, patients may experience withdrawal seizures, hallucinations, or delirium. These symptoms most often occur 36 to 72 hours after drinking cessation. Thus, in terms of evaluating a patient for withdrawal symptoms and the need for treatment, the clinician must know the time of the last drink or the time that the person dramatically reduced his/her drinking.

Patients who have not consumed alcohol for more than three to four days are not generally thought to be at risk for suddenly developing withdrawal symptoms. You need to be aware that in addition to acute withdrawal effects, alcohol can cause more enduring effects that are disturbing to patients, such as disrupted sleep patterns and changes in attention and concentration. Patients should be educated that these effects may take days or even months to reverse.

When to be concerned about Alcohol Withdrawal
There are few absolutes in terms of who will suffer alcohol withdrawal symptoms and who will not. However, as a general rule, alcohol withdrawal symptoms are more likely to occur in patients who dramatically reduce or stop their drinking after the regular use of large quantities of alcohol. Withdrawal symptoms are theorized to occur because of substantial changes in blood alcohol levels that lead to effects on the nervous system. In practical terms, this means that patients who become abstinent after daily use of more than three to four drinks per day are more at risk for withdrawal. Remember, this does not mean that patients who drink less than this will not experience withdrawal symptoms, and you should be mindful of this potential.

Often, the best source of information about the potential for withdrawal symptoms is the patient. Many patients have had occasions to cut down or stop drinking for one reason or another. During these times, patients may have had withdrawal symptoms and can describe them to you. In your initial session, patients are asked if they ever experienced withdrawal symptoms when not drinking. You can use this question to further probe the severity of past withdrawal symptoms and the need for treatment. Patients reporting the occurrence of alcohol withdrawal symptoms in the past are more likely to experience these symptoms again when cutting down or quitting. Patients who report the need for hospitalization for detoxification or report having had seizures are at increased risk for developing severe alcohol withdrawal symptoms.

Withdrawal Assessment and Management Algorithm
The following algorithm has been developed as an aid in determining the severity of withdrawal symptoms among outpatients and to assist in the management of those with significant withdrawal symptoms. This algorithm has been formulated by consensus and has not been empirically tested. You should rely on sound clinical judgment supplemented by the availability of a supervising clinician in cases in which you are uncomfortable or when the algorithm does not address concerns.
When screening and assessing patients in an outpatient setting, you should consider three factors in determining the potential for a patient to suffer withdrawal symptoms: quantity, timeline for reducing alcohol and history of withdrawal symptoms.

Quantity	**Infrequent or moderate drinkers** are less likely to suffer withdrawal symptoms. When symptoms do occur, they are usually mild.
Timeline for reducing alcohol: dramaticallyreducing/eliminating versus tapering	**Dramatically reducing or eliminating** alcohol consumption is likely to lead to withdrawal symptoms, but research shows that it is more effective for those with alcohol dependence or who have high craving states. Gradually **tapering** alcohol use is **not** likely to lead to significant withdrawal effects, but research shows that it is less effective in achieving reduced consumption in those who are alcohol dependent or who have high craving states.
History of withdrawal symptoms	Patients who have had **previous withdrawal symptoms** are more likely to manifest symptoms again. While some patients may be more vulnerable to withdrawal symptoms, the presence of withdrawal symptoms is a likely marker of greater severity of alcohol use.

Withdrawal Assessment

If you are concerned about withdrawal symptoms, you should complete the Clinical Institute Withdrawal Assessment – Alcohol revised (CIWA - Ar; Patient Materials manual – assessment section). The CIWA-Ar is a well - validated assessment tool for determining the severity of alcohol withdrawal. The total score on this initial CIWA -Ar will dictate the follow-up schedule. If the CIWA-Ar score is below eight, care can continue as previously determined. Under supervision from a psychiatrist, these patients may receive medication to alleviate or prevent withdrawal symptoms from occurring or progressing. If at any point the patient's total score is above 8, the patient should be referred for management in specialty care. If the CIWA score is over 15 you are strongly encouraged to consider hospitalization.

CHAPTER 7

Additional Treatment Resources

Inpatient detoxification and rehabilitation

The availability of inpatient facilities has dramatically decreased over the last decade. Inpatient detoxification is warranted for patients with complex medical or psychiatric problems or for patients who are unable to be successfully detoxified as an outpatient. It is vital to remember that detoxification is not a long-term solution for alcohol dependence and is merely an initial stop on the road to improved health. Inpatient rehabilitation or day treatments are potentially viable treatment options for patients who struggle to succeed as an outpatient. Alternatives to inpatient rehab and day treatment may need to be considered in the case of the older heavy drinker.

Factors to consider are the lack of age-specific programs and the considerable cost of these more intensive treatment settings. Some alternatives for this age group may include activities such as attending senior centers, seeking volunteer positions, and participating in other activities that are structured and don't involve alcohol consumption.

Self-help groups

There are many different self-help groups available for patients with alcohol dependence. The most widely known is Alcoholics Anonymous. These groups can be extraordinarily helpful to some patients in providing a peer support network and in providing a semi-structured program to follow when trying to reduce drinking. Self-help groups have also traditionally focused on alcohol-dependent individuals and have had abstinence as the primary goal. Therefore, the at-risk drinker or non-alcohol dependent drinker is likely to be "put-off" by the program. As many self-help groups also incorporate a philosophy of a "higher power," some persons may find this focus unappealing. The bottom line here is that self-help groups are not for everyone and should not be a requirement of treatment, especially in non-alcohol dependent patients.

Intensive outpatient programs
Intensive outpatient programs are often used during the early stages of recovery from alcohol dependence and typically involve 4 to 8-hour day programs that are attended for 3 to 5 days per week. These programs often include psycho-education, individual counseling, attendance to peer support groups, and vocational rehabilitation. Programs that have a similar intensity of service include half-way house programs, sheltered addiction programs, and other programs that combine housing with addiction services. These programs are typically geared toward younger and more severely affected patients.

Many drinkers increase their drinking because of a lac k of structured activities. Structured leisure time can be accomplished not only in intensive specialized addiction services, but through volunteer activities, part-time employment, or participation in social organizations such as community centers, churches, mosques, and fraternal organizations.

Group therapy/individual psychotherapy
Group therapy with adjunctive individual therapy or counseling has been the mainstay of community-oriented addiction programs. Group therapy tends to work best with a younger population, as these services have been predominately structured for younger adults and many counselors/therapists have not received adequate training in issues related to the elderly. In general, these more formal services should be reserved for patients who do not respond to the brief interventions.

Both intensive outpatient programs and group therapy/individual psychotherapy can involve significant costs for patients. It not uncommon for health insurance plans to provide only limited coverage for these types of programs.

CHAPTER 8

Frequently Asked Questions

How do I deal with a resistant patient?
Resistance can happen at any point during the intervention and can manifest itself in many different ways. *It is often a signal that you are not using strategies appropriate for the patient's current stage of change.* In general, the best way of responding to resistance is with nonresistance. Acknowledging the patient's disagreement, emotion, or perception allows for further exploration and discussion.

How do I respond when patients contest the accuracy, expertise, or integrity of my skills?
Sometimes patients directly challenge the accuracy of what you have said. This is most likely to occur during the feedback portions of the intervention. It is possible that patients may benefit from additional information about the material in the Health Promotion Workbooks.

For example, it may be helpful to reiterate that the material is based on studies with adults their age and to provide a little more detail to address their questions or challenges. The additional detail can also include limitations of the material presented in the Health Promotion Workbooks. In addition, acknowledging that the information may or may not apply to them can be helpful in reducing disputes about minor details. Regardless try to diffuse this tactic as it will distract you from your treatment planning.

> *"You realize you've occasionally had some problems associated with your drinking, but you're not that badly off. It is up to you to decide how serious your problems are and whether you should do anything about them.*

Patients often claim they are not in any danger due to their drinking. This is most likely to occur at the Type of Drinkers and Pros and Cons sections.

> Example response:
> *"You are correct, I cannot say for sure if some of your current problems [or medical conditions] will get worse because of drinking. Other adults your age and gender who drink about the same as you either have some problems related to drinking or are likely to have problems in the future. No one knows for sure what will happen. You have to weigh the pros and cons for yourself and how much risk you are willing to live with."*

The patient may firmly express a lack of desire or unwillingness to change or an intention not to change. This is most likely to occur at the Drinking Agreement and Plan sections.

> Example response:
> *"That is completely up to you. You should do what you feel is best. If you feel differently in the future or run into some problems, you may find the Health Promotion Workbooks to be helpful. I would still like to follow up with you in several weeks to see how your health is."*

It is important to avoid the arguing trap in this situation. However, you still should review all of the materials with patients. Thus, you may wish to state the following:

> Example response:
> *"What I would like to do is to go through the rest of the Health Promotion Workboook to give you an idea about what is in it. You've told me what you plan to do, and that is OK with me. What I would like you to do is to consider whether any of this may be helpful to you and to tell me what you don't think is helpful about the workbook."*

Does the patient need to become completely abstinent to be successful?

Success is up to the patient and the goals that they establish. You should not put yourself in the situation of judging whether the patient has failed or succeeded. Changes in behavior are very complex and not as black and white as success/failure.

Helping establish achievable goals should be your goal. It is true that abstinence should be the goal you recommend in patients with abusive or dependent drinking or when patients suffer from other health problems such as hypertension or pulmonary disease that are exacerbated by even moderate drinking. However, in the absence of alcohol related problems or chronic medical problems, the goal may only be to get the at-risk drinker to become a moderate drinker.

How do I deal with a really heavy drinker?
Heavy drinking is associated with greater risks to patients and therefore requires greater attention. Consider treating this person as if they have an addiction and consider pharmacotherapy or other alternative treatments.

What do I do when someone returns to drinking after having been successful at reducing or quitting?
The response is to be empathetic. The initial goals are to re-engage patients, to schedule follow- up contacts, and to assess their needs. To structure this time you should use the "Follow-up Workbook." (see Patient Resources, Volume 6)

Example response:

> *I am glad you can talk about this with me. You say that you have increased your drinking. Let's talk about the success you had in cutting down before and whether you want to set a new drinking goal for yourself.*

When is drinking OK?
This question is often asked in the context of hearing about the beneficial effects of alcohol on cardiovascular disease. Studies have strongly suggested but not proven that modest drinking can reduce the risk of cardiovascular disease. Most of these studies have studied relatively healthy people in their 50s and 60s. There are no studies that show that increasing or initiating drinking because you have cardiovascular disease is a helpful or wise thing to do. In general, adults who are otherwise healthy should enjoy alcohol in a responsible manner. However, if there are chronic medical problems or if the person is taking medications that are affected by alcohol, then abstinence may, in fact, be the better choice.

How can family members be helpful?
Involvement of family can be helpful in terms of supporting patients' goals. However, as with any mental health condition, one needs to be aware of confidentiality. For further discussion on confidentiality, please read on. As for including family in the treatment contacts, we would recommend that the majority of time be spent with the patient alone. If patients then want to review the goals with their family members, this can be done at the end of contacts. Allowing a family member to enter the contact at the end also allows for engagement in the treatment plan rather than limiting the contact to a personal health review.

If family members are to be involved, there are a number of ways that they can be supportive or included in the treatment. Family members can help remove alcohol from the residence, assist in filling in diaries, and be empathetic to patients' goals.

You should exercise caution in having the family member monitor alcohol use as this can be taken by the patient as being overly parental. However, in more cognitively impaired patients, or in patients that want this level of involvement, this may, in fact, be reasonable.

How do I get other providers to refer patients or to support the need for treatment?
When working in settings such as outpatient mental health clinics, primary care offices, or other medical sub-specialty clinics, it is important that all the providers support the need for screening and intervention. Otherwise, patients will not be referred to you for treatment and your credibility will be undermined in terms of establishing drinking goals. However, at times this is difficult as the idea of identifying patients without demonstrated illness and conducting treatment is sometimes counter to modern medicine. This can be particularly difficult for some providers to embrace, as there is more and more evidence of beneficial effects of moderate drinking. Unfortunately, many providers conceive of moderate drinking as something less than heavy drinking i.e. less than 3 – 4 standard drinks per day or something less than alcohol dependence. Fortunately, there is an increased awareness of the need for preventive medicine and for targeting preventive interventions. A good example would be conducting cholesterol screening and treating those with elevated levels as a way to prevent cardiovascular disease several years later.

The practical implication of this issue for you is the need to reach out to the primary care team ahead of time, spending time educating and negotiating how brief interventions or medical management will be conducted in a particular clinic. These discussions should address intervention goals and ways to communicate findings (either through progress notes or verbal communication). You could also share successful patient outcomes from other providers that you have worked with.

Are there any special confidentiality issues about patients who drink?
You should exercise extreme caution regarding the release of medical records either verbally or in written form. You should not release medical records without written consent consistent with the requirements of their health care system. This may arise when family members call to ask about patients or step in at the end of contacts. You need to discuss with the patient what information can be discussed and with whom prior to any discussion with family members. You should also be clear about with whom information is shared, including the patient's PCP if this intervention is performed in a primary care setting. Similar issues and guidelines arise with employers, friends, and other health professionals. Encouraging patients to share information on their own is a separate matter.

What if the patient asks, *"Do you expect me to go to AA?"*
The answer is "no." Self-help groups can be extraordinarily important for some people but these groups are not for everyone. Many individuals may especially be "put off" by self-help groups. Moreover, for the at -risk or moderate drinkers, the idea of a self-help group may further alienate them from wanting to participate in the intervention because they do not feel they should be labeled as an "alcoholic." If patients want to go or find it helpful then you should support their attendance.

The patient seems to have a lot of depression or anxiety. How do I manage this?
The interaction between alcohol use and depression/anxiety is complex. Alcohol use can cause depression and anxiety, as well as be a reaction to the presence of depression or anxiety. Key steps include assessing the level of distress present and deciding what steps should be taken to address patient distress. Measuring symptoms of anxiety or depression can be done with any of a number of standardized instruments. This program encourages the use of the PHQ-9 for depression or the GAD7 for anxiety (see Patient Resources, Volume 6, for these assessments). This should have been part of your baseline assessment but can be repeated at any time.

In treating patients for alcohol problems, be careful to not ignore symptoms that don't meet diagnostic criteria because these depressive or anxious symptoms can have significant impact on treatment outcomes for drinking. Of particular concern here is the combination of suicidal ideation and either depression or drinking. Both depression and drinking are strongly associated with completed suicide, especially in the elderly. The presence of moderate or severe depression or heavy drinking should always be followed by questions regarding suicide risk.

A key in treating patients with more complex presentations or symptoms is to recognize your own limitations for providing care and to seek assistance through consultation or referral.

When should I refer a patient to a psychiatrist or specialty addictions program?
Some patients with more severe problems or patients who do not respond well to the recommendations found in this manual may need services found in more traditional specialty care programs. These services might include detoxification programs, group therapy, and case management or formalized psychotherapy. In addition, in patients with complex symptoms such as comorbid depression or anxiety, you may need consultative help from a psychiatrist or other mental health specialist. You should use a consulting provider to help with complex diagnostic problems or when using medications with which you are not familiar.

There are two important considerations when referring patients to other providers. First, referrals are conducted either to assist in the management of the patient or as a consultation. Thus, referrals are usually done when the patient is not meeting their goals and you are unable to provide enough or the appropriate services to meet these goals. There is generally not a need to automatically refer patients just because they meet certain criteria; for example, having concurrent depression. Second, it is important to consider who you are referring to and your continued role in patients' care. In considering referral sources for patients, remember to take into account the patient and the referral site. The patient may have special circumstances such as transportation, mobility, or financial problems that limit where they can go for care. As for the referral sources, try finding both local and regional resources that have a track record of providing appropriate care.

Finally, do not think of referral as the end point. Stay connected with the patient; continue to conduct follow-up contacts using the workbooks. This is supportive and empathetic, and gives the patient the best chance to succeed.

How can I maintain confidence that I am doing the right thing?
You should be getting regular supervision as part of your program. We encourage programs to have a psychiatrist as part of the supervision team. Seek out peers for help, go on the web, and join national trainings. All of these things will benefit you.

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