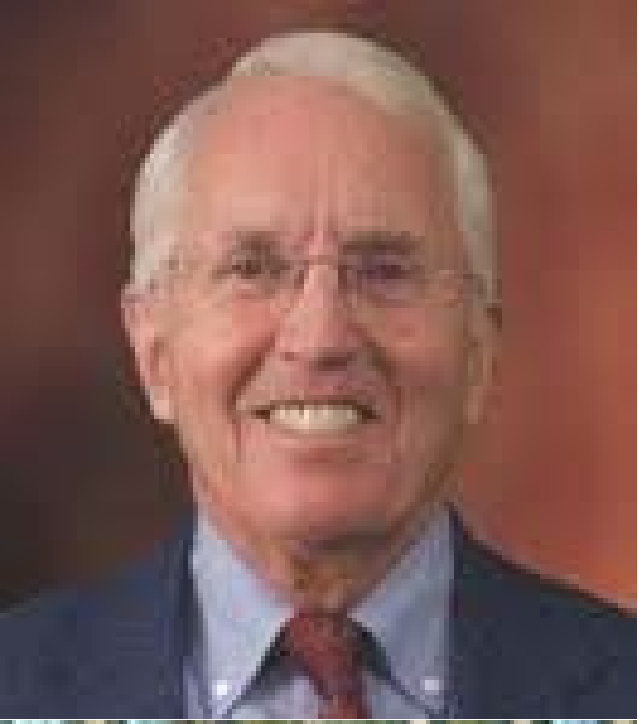
Introduction and Overview

- This presentation focuses on the screening process for alcohol and drug abuse patients.
- The first step in this process is to determine whether or not the patient recognizes the need for change in his/her behavior.
- The next step is to interview the patient to determine whether he/she describes behaviors predictive of alcohol or drug abuse and then to ask specific questions that will further describe the nature of the problem.
- Accordingly, this presentation will progress through material in the following order:

“A patient’s substance use is not the problem, but rather a symptom of underlying issues that may be the cause of why they started using in the first place...”

Clinical Evaluation: Screening

- Introduction and Overview
- Stages of Change
- Facts about Change
- FRAMES: Brief Intervention for Alcohol Problems
- Differences between Screening and Assessment
- Screening for Substance Use
- Questions? Comments?
- DSM 5: Screening/Assessment (Time dependent)
- Treatment Options and Modalities (Time dependent)



Prochaska & DiClemente

- The Stages of Change were developed by psychologists Prochaska and DiClemente in the 1980s in an effort to capture the change process of cigarette smokers in treatment.

- It has since been used to characterize changes in other addictive disorders including alcoholism.

Prochaska & DiClemente: Stages of Readiness to Change

- Pre-contemplation
- Contemplation
- Determination/Preparation
- Action
- Maintenance
- Relapse and Recycle
- Termination or Graduation

Prochaska & DiClemente: Stages of Readiness to Change

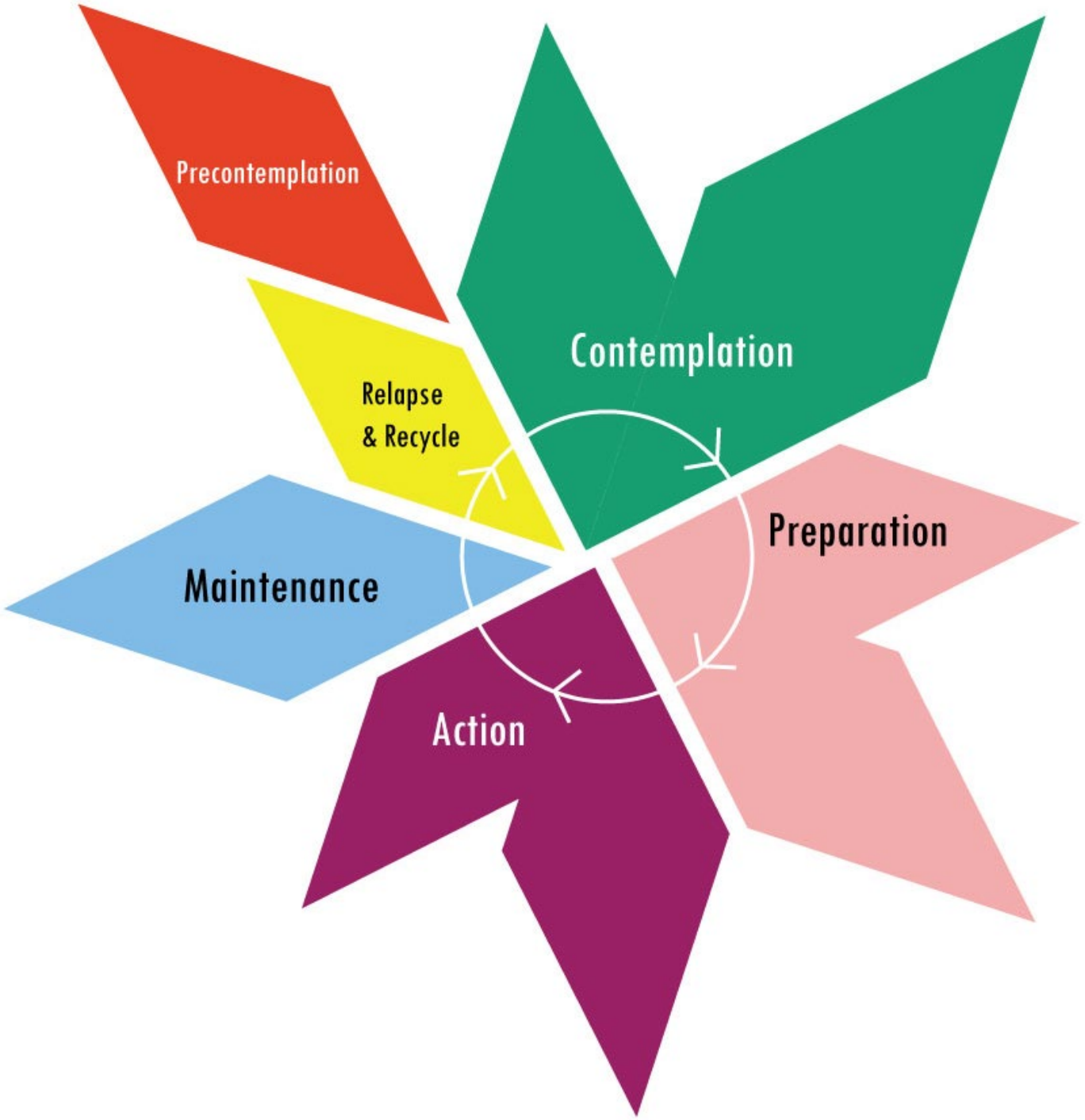
Stage	Description
• Pre-contemplation	• Not considering change • Do not see their behavior as a problem
• Contemplation	• Ambivalent about change • Acknowledge that there may be a problem

Prochaska & DiClemente: Stages of Readiness to Change

Stage	Description
• Determination/ Preparation	• Committed to change • Have made a decision to change
• Action	• Involved in change • Actively implementing a plan

Prochaska & DiClemente: Stages of Readiness to Change

Stage	Description
• Maintenance with Relapse Cycle & Recycle	• Behavior Change • High confrontation level new behavior • Undesired Behaviors
• Termination or Graduation	• Change is very stable • Problem behavior is resolved



A Stage Model of the Process of Change Prochaska and DiClemente

- DiClemente, C.C. (1993). Changing Addictive Behaviors: A Process Perspective. American Psychology Society, 2(4), 101-106.

Facts About Change

- Change is a natural process
- Brief counseling can speed up the change process
- Faith, hope, and efficacy are important elements
- It helps to have other supports
- Counselors do matter
- Empathy is not merely having had a similar experience
- People engage in change talk and resistance talk

Interview Skills

- Micro-counseling
- Motivational Interviewing

SUD Continuum

Occasional Substance Use

Disease of Addiction

Patients are frequently reluctant to share for 4 common reasons

- They are embarrassed
- They do not want to be judged
- They do not want to be denied or forced into treatment
- They do not want to be reported or arrested.

Disarming the patient should be done on paper as well!!!

On the form…

“In order to optimize your substance abuse assessment today we need to ask a few personal questions. Be assured all of the information remains confidential and will NOT be reported to anyone else including other family members or law enforcement.”

Micro-counseling Skills

- Allen E. Ivey EdD, ABPP Distinguished University Professor, (Emeritus) University of Massachusetts, Amherst and Professor, Counselor Education (Courtesy Appointment University of South Florida, Tampa

Micro-counseling

- Micro-counseling is an analysis of counseling skills that looks carefully and in great detail at the elements of the counseling relationship.
- Regardless of the aims and methods of a counseling relationship, understanding its micro-elements helps counselors improve their counseling effectiveness.

Counseling Microskills

- Basic foundational skills involved in effective helping relationships
- Foundational tools on which success of interventions with clients may depend
- Help create necessary conditions for positive change to take place
- Aid in establishing rapport with clients
- Constructs: empathic understanding, genuineness & acceptance

Attending and Attending Behavior

- Attending
  - Counselor's interest in the patient demonstrated by eye contact, body posture and accurate verbal following.
- Attending Behavior
  - Encourages patient disclosure
  - Active Listening

Allen E. Ivey, 1994.

Attending Skills

- Good Communication involves more than just verbal contact – much communication takes place nonverbally.
- Clients rank nonverbal gestures and presentation and body language as the most important alliance building factors.
- Non-verbal attending communicates your interest, warmth and understanding. Can include eye contact, body position, and tone of voice.

Eye Contact

- Good eye contact conveys interest, confidence and involvement in client's story.
- Clients with difficulty of closeness, eye contact can be a vehicle of change.
- Should be natural breaks in eye contact; ebb & flow as you listen to client's story.
- Essential to be sensitive to differences in how eye contact is expressed in Native culture.

Body position

- Facing client: open, relaxed, & attentive posture
- Don’t cross your arms or legs
- Don’t sit behind desk or other barrier
- Slightly lean in with upper body toward client
- Let client decide physical distance, by offering to let them arrange the chairs to their comfort level
- Be mindful of you own personal space too

Vocal Tone

- Pitch, pacing, and volume all have an effect on client response to counselor
- Voice can help create a soothing and anxiety-regulating atmosphere for the client.
- Learn to use voice as a therapeutic tool.
- **Verbal underlining:** increased vocal emphasis to certain words or phrases-helps convey a sense of empathetic understanding.

Questioning

- Primary skills that allows counselors to collect important and specific information about clients.
- Questions allow us to make an accurate assessment of the client's issues and guide and focus the client to make effective use of time.
- Used inappropriately, can impede communication and block client disclosure.
- Do not drill client with questions.

Open and Closed Questions

- **Open Questions:**
  - Cannot be answered in a few words.
  - Offer encouragement, and the patient will speak more freely.
- **Closed questions:**
  - Focuses the dialogue.
  - Tends to turn the focus on the professional and away from the patient.

Allen E. Ivey, 1994.

Open Questions

- Elicit fuller and more meaningful responses, by encouraging client to talk at greater length.
- Typically begin with what, how, could, would, or why, and are useful to help begin an interview, to help elaborate the client's story, and help draw out specific details.
- With open questions the client can choose the content and direction of the interview/session.

Closed Questions

- Elicit a “yes/no” type of response.
- Too many closed ?’s can cause shut down and become passive, tend to sit back and wait for next ? to answer.
- Begin with open (general) and move to closed (specific) to obtain specific details.
- Refrain from moving too quickly into closed questions unless unable to obtain info otherwise

Patient Observation Skills

- Nonverbal behavior: 85% of communication
- Verbal behavior: key words
- Discrepancies in patient's Communication:
  - Mixed messages
  - Contradictions
  - Conflicts
  - Incongruities

Allen E. Ivey, 1994.

Encouraging, Paraphrasing, and Summarizing

Reflecting Feelings

- **Reflecting Feelings**
  - The patient's feelings, either stated or implied, as expressed by the counselor

- Feelings of patient can be:
  - Non-verbal
  - Verbal

Reflecting Meaning

- Finding the deeply held thoughts and feelings underlying life experience
- Paraphrase is to thoughts as reflection is to feelings
- Breaks down complex behaviors into parts
- Do not repeat the client’s exact words

Empathy

- Empathy
  - Understanding what the patient is experiencing and putting oneself in the patient's place
- Functions of empathy
  - Builds a firmer relationship with patient
  - Enables counselor to better understand patient's behavior
- Common problems with conveying empathy
  - Language and cultural differences between patient and counselor

Motivational Interviewing

William R. Miller, PhD

Stephen Rollnick, PhD

History

- William Miller originally developed Motivational Interviewing to increase the motivation of patients with issues related to alcohol problems to change behavior.
- As part of that process, Miller found that approaching patients with a modified patient-Centered approach increased the impact of the interview.
- What has evolved is a communication style and focus that increases patients' motivation to work on their problems.

Motivational Interviewing (MI)

“If motivational interviewing is a way of being with people, then its underlying spirit lies in understanding and experiencing the human nature that gives rise to that way of being.

How one thinks about and understands the interview process is vitally important in shaping the interview”.

Motivational Interviewing (MI)

- Patient-centered approach
- Increases patient's response to screening and assessment and adherence to treatment
- Improves treatment outcomes by enhancing motivation to change

Rationale

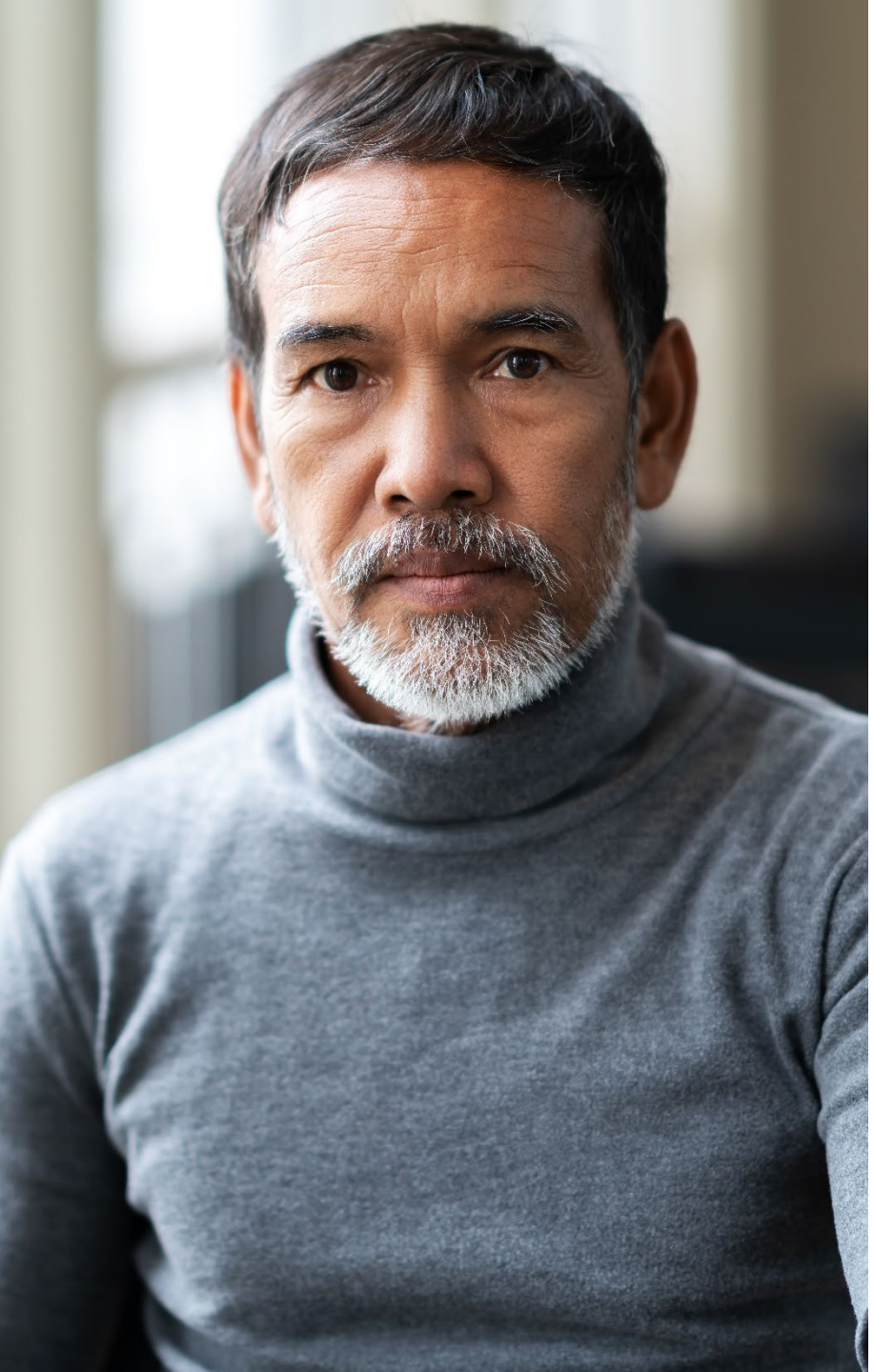
- Clinicians commonly think that they are already practicing Motivational Interviewing when they screen, assess, and treat.

- What makes Motivational Interviewing a unique counseling approach is how its skills are employed by clinicians

- Motivational Interviewing requires attention to timing issues, specific strategies, application methods, and maximizing the effectiveness of these skills

Two Phases of MI Assist in Screening, Assessment, and patient Change

- Building motivation for reliable assessment and significant change
  - Open-ended questions
  - Affirmation
  - Reflections
  - Summary
- Strengthening commitment to change
  - Build on the patients' motivation
  - Resolve to change; (change talk)



Basic Principle of Motivational Interviewing

- Express empathy
- Develop discrepancy
- Roll with resistance (now called dancing with discord)
- Support self-efficacy and optimism
- Avoid argumentation and direct confrontation

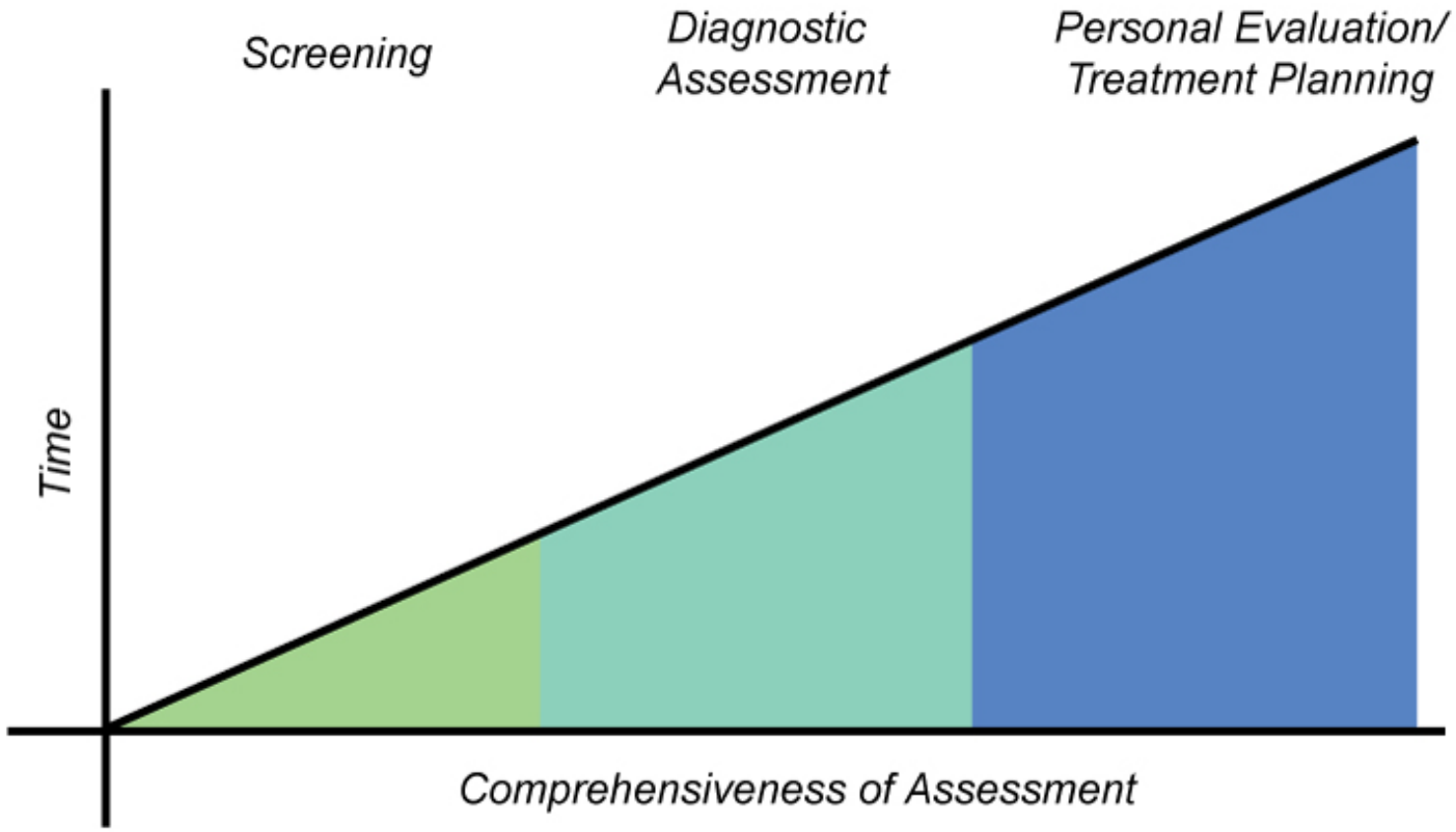
Motivational Interviewing

- Fundamental Approach
  - Collaboration
  - Evocation/suggestion
  - Autonomy/self rule
- Four Principles
  - Express empathy (not sympathy)
  - Dance with discord
  - Develop discrepancy
  - Dance with Discord
  - Support self-efficacy

Brief Intervention for Alcohol Problems

- Six common elements of brief intervention (FRAMES) (Miller & Sanchez, 1993):
- F - Feedback of personal risk
- R - Responsibility of the patient
- A - Advice to change
- M - Menu of ways to reduce drinking
- E - Empathetic counseling style
- S - Self-efficacy of the patient

Differences Between Screening and Assessment



Differences Between Screening Goals and Assessment Goals

- Screening: Designed to reflect likelihood of presence of substance abuse

- Assessment: Designed to provide a broader range of information on degree, kind, causes for, and possible treatments of the abuse

Differences in Screening Goals and Assessment Goals

- Screening instruments: Typically brief, require yes or no answers, can be administered by non-experts, and are obvious in their intent.

- Assessment instruments: Generally, are more time consuming, can require more complex historically-based information, benefit from use by experienced/ trained evaluators, and are not always obvious in intent.

Screening for Substance Abuse

- Identifying Possible Substance Use Disorder
  - Behavioral Observation: Observing the patient
  - Collateral Informants: Eliciting information from friends, other providers, corrections, public records, and spouse/relatives
  - Laboratory Tests: Are laboratory tests consistent with patient/collateral reports?
  - Self-Report Screening Measures
    - CAGE/ CAGE-Adapted to Include Drug Use
    - RAPS4 (QF)
    - MAST and MAST II
    - T-ACE
    - TWEAK
    - SBIRT
    - AUDIT

CAGE (AID)

CAGE (AID) Questionnaire

- (Ewing, 1984) - A cut point of 1 detects about 90% of those with alcohol-related disorder, with 48% false positives.
- Have you ever felt you should Cut down on your drinking or drug use?
- Have people Annoyed you by criticizing your drinking or drug use?
- Have you ever felt bad or Guilty about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

RAPS4

RAPS4 & RAPS4-QF

- (Cherpitel, 2002) – Sensitivity better than CAGE with good specificity; addition of QF questions outperforms the CAGE for alcohol abuse at a cut point of 1 across a wide range of groups.
- During the last year have you had a feeling of guilt or Remorse after drinking?
- … has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? (Amnesia)
- …have you failed to do what was normally expected from you because of drinking? (Perform)
- Do you sometimes take a drink in the morning when you first get up? (Starter)
- ---QF of consumption of alcohol (Quantity and Frequency)

Michigan Alcohol Screening Tool (MAST)

- Do you feel you are a normal drinker? (2)
- Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking? (1)
- Do you ever feel guilty about your drinking? (1)
- Do friends or relatives think you are a normal drinker? (2)
- Are you able to stop drinking when you want to? (2)
- Have you ever attended a meeting of Alcoholics Anonymous? (5)
- Has drinking ever created problems between you and your wife, husband, a parent, or other near relative? (2)

Michigan Alcohol Screening Tool II (MAST II)

- Have you ever gotten into trouble at work because of drinking? (2)
- Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? (2)
- Have you ever gone to anyone for help about your drinking? (5)
- Have you ever been in a hospital because of drinking? (5)
- Have you ever been arrested for drunken driving while intoxicated or driving under the influence of alcoholic beverages? (2)
- Have you ever been arrested, even for a few hours, because of other drunken behavior? (2)

Alcohol-Screening Instruments for Pregnant Women

T-ACE

- Tolerance: How many drinks does it take to make you feel high?
- Have people Annoyed you by criticizing your drinking?
- Have you ever felt you ought to Cut Down on your drinking?
- Eye Opener: Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Alcohol-Screening Instruments for Pregnant Women II

TWEAK

- Tolerance: How many drinks can you hold?
- Worried: Have close friends or relatives Worried or complained about your drinking in the past year?
- Eye Opener: Do you sometimes take a drink in the morning when you get up?
- Amnesia: Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
- Cut Down: Do you sometimes feel the need to cut down on your drinking?

SBIRT

- SBIRT is an evidence-based approach to identifying patients who use alcohol and other drugs at risky levels with the goal of reducing and preventing related health consequences, disease, accidents and injuries. Risky substance use is a health issue and often goes undetected.

- MEN: How many times in the past year have you had 5 or more drinks in a day?
  - None
  - 1 or more

- WOMEN: How many times in the past year have you had 4 or more drinks in a day?
  - None
  - 1 or more

SBIRT

- Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

- How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?
    - None
    - 1 or more

AUDIT

- The Alcohol Use Disorders Identification Test (AUDIT) should be administered to adult patients who screen positive on the pre-screening for alcohol use. Side one contains the screening questions and side two contains instructions on scoring and interpreting the AUDIT.

Substance-Related Disorders in DSM-5

- The DSM-5 chapter on Substance-Related and Addictive Disorders includes 10 substance-related disorders:
  - Alcohol-Related Disorders
  - Caffeine-Related Disorders
  - Cannabis-Related Disorders
  - Hallucinogen-Related Disorders
  - Inhalant-Related Disorders
  - Opioid-Related Disorders
  - Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
  - Stimulant-Related Disorders
  - Tobacco-Related Disorder
  - Other Substance-Related Disorders.

Substance Use Disorders

- Almost all substance-related disorders in DSM-5 include:
  - Substance use disorders
  - Substance intoxication
  - Substance withdrawal
- Almost all specify that the substance use disorders be rated mild, moderate, or severe.
- Exceptions include:
  - Caffeine-Use Disorders: no severity ratings
  - Hallucinogen-Use Disorders: no intoxication or withdrawal
  - Inhalant-Use Disorder: no intoxication
  - Tobacco-Use Disorder: no intoxication

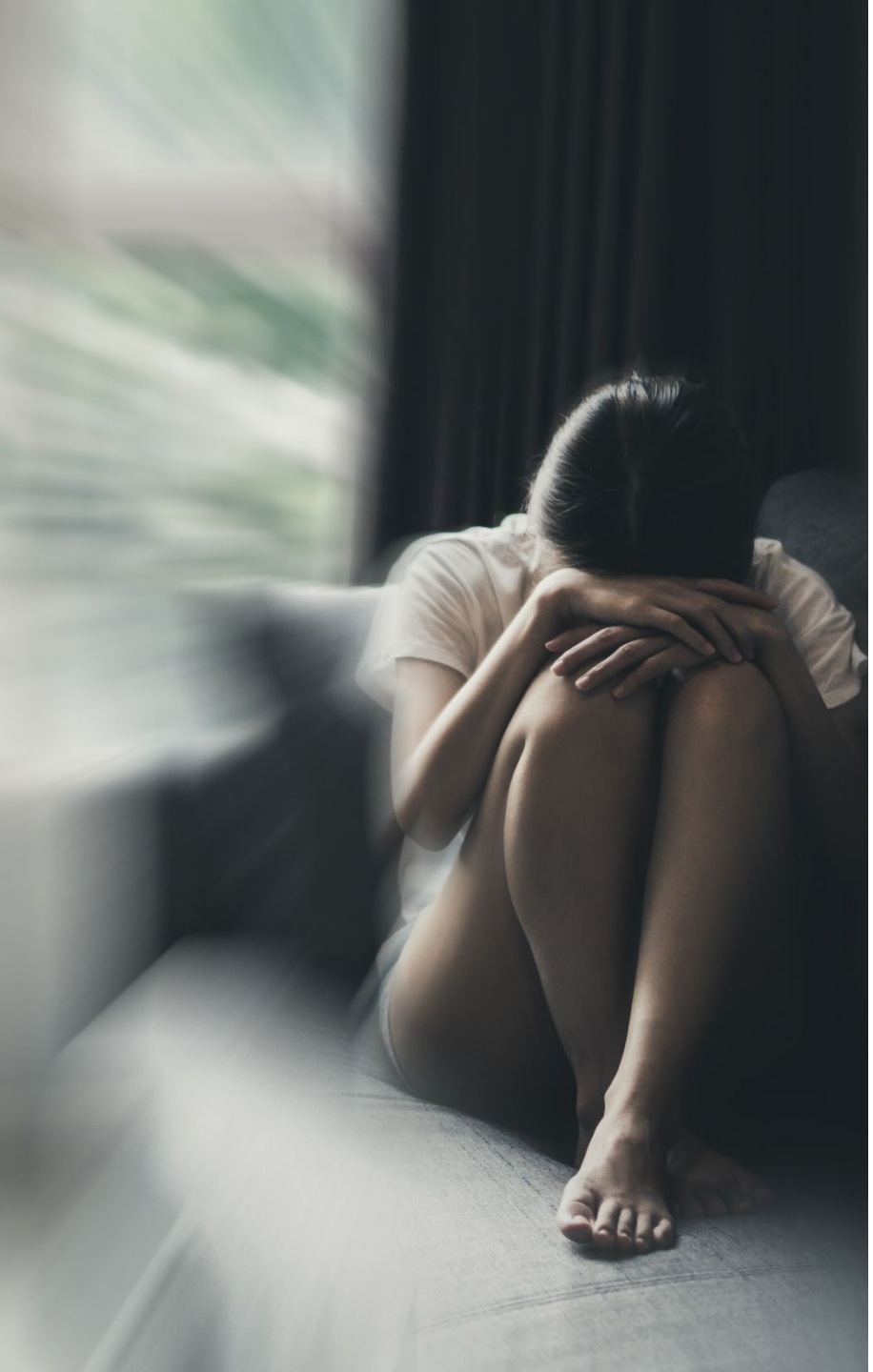
Alcohol Use Disorders

- Alcohol-Related Disorders include:
  - Alcohol Use Disorders (mild, moderate, and severe)
  - Alcohol Intoxication
  - Alcohol Withdrawal
  - Unspecified Alcohol-Related Disorder

The distinction between alcohol abuse and dependence has been eliminated in DSM-5.

Alcohol Use Disorders

- **Mild** Alcohol Use Disorder
  - **2-3 symptoms** present
- **Moderate** Alcohol Use Disorder
  - **4-5 symptoms** present
- **Severe** Alcohol Use Disorder
  - **6 or more symptoms** present



Alcohol Use Disorder

Alcohol use disorder is a **problematic pattern of alcohol use** leading to **clinically significant impairment or distress**, as manifested by:

- at least 2 of 11 listed symptoms
- occurring within a 12-month period.

Symptoms of Alcohol Use Disorder

- Often taking alcohol in larger amounts or over a longer period than intended
  - “Even when I go out to a bar or a party having resolved to drink no more than three beers or spend no more than two hours, by the end of the evening I discover I’ve consumed 10 beers over four hours.”
- A persistent desire or unsuccessful efforts to cut down or control alcohol use
  - “Time and again, I’ve tried to control my drinking, but I’ve never been able to do so.”
- Spending a great deal of time in activities necessary to obtain alcohol, use alcohol, or recover from its effects
  - “Alcohol takes up a lot of time in my life, what with getting the money to buy it, spending time at bars consuming it and talking to friends, and then getting over whatever hangover I might have developed from my drinking.”

Symptoms of Alcohol Use Disorder

- Craving, or a strong desire or urge to use alcohol (New Symptom)
  - “When I haven’t been drinking for a day or two, I’ll begin to experience strong craving for alcohol, which stays with me until I take a drink to get rid of the craving.”
- Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home
  - “It will sometimes happen that my drinking makes it impossible for me to go to work or take care of my family. This makes me feel terrible, but I still do it. Why?”

Symptoms of Alcohol Use Disorder

- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol
  - “Even though I have a tendency to become angry and, sometimes, violent when I’ve been drinking, I continue to drink and then to suffer the consequences of my anger and fights.”
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use
  - “I used to like to dance and visit with my friends and family but since I’ve started to drink so much, I’ve given up almost everything that doesn’t involve drinking.”
- Recurrent alcohol use in situations in which it is physically hazardous
  - “I’ve had three OWIs, and have been in two accidents because of my drinking in which I was pretty seriously injured. But every time I am able to drive, I’ve been drinking.”

Symptoms of Alcohol Use Disorder

- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol
  - “Even though I almost always get very depressed after I’ve been drinking for some time, I continue to drink. I don’t know why. It doesn’t make sense to me.”

Symptoms of Alcohol Use Disorder

- Tolerance
  - A need for markedly increased amounts of alcohol to achieve intoxication or desired effect, or a markedly diminished effect with continued use of the same amount of alcohol
- Withdrawal
  - The characteristic withdrawal syndrome for alcohol, or alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms

- Note: Physical withdrawal from drugs like alcohol and benzodiazepines can be life threatening. Medical support/ management must take priority!

Alcohol Use Specifier Changes

- DSM-IV:
- Physiologic dependence specifier
  - With physiologic dependence
  - Without physiologic dependence

DSM-IV specifier of with or without physiologic dependence has been deleted from DSM-5

- DSM-5:
- Severity specifier:
  - Mild
  - Moderate
  - Severe
- Patient status specifier:
  - Early remission
  - Sustained remission
  - Controlled environment

Questions? Comments?

- Stages of Change
- Facts about Change
- Interview Skills: Micro-Counseling Skills and Motivational Interviewing
- FRAMES: Brief Intervention for Alcohol Problems
- Differences between Screening and Assessment
- Screening for Substance Abuse
- DSM-5 (Time dependent)
- Treatment Options and Modalities (Time dependent)

Treatment Options

Detoxification

Pharmacological maintenance

Outpatient: extended and intensive

Partial hospitalization

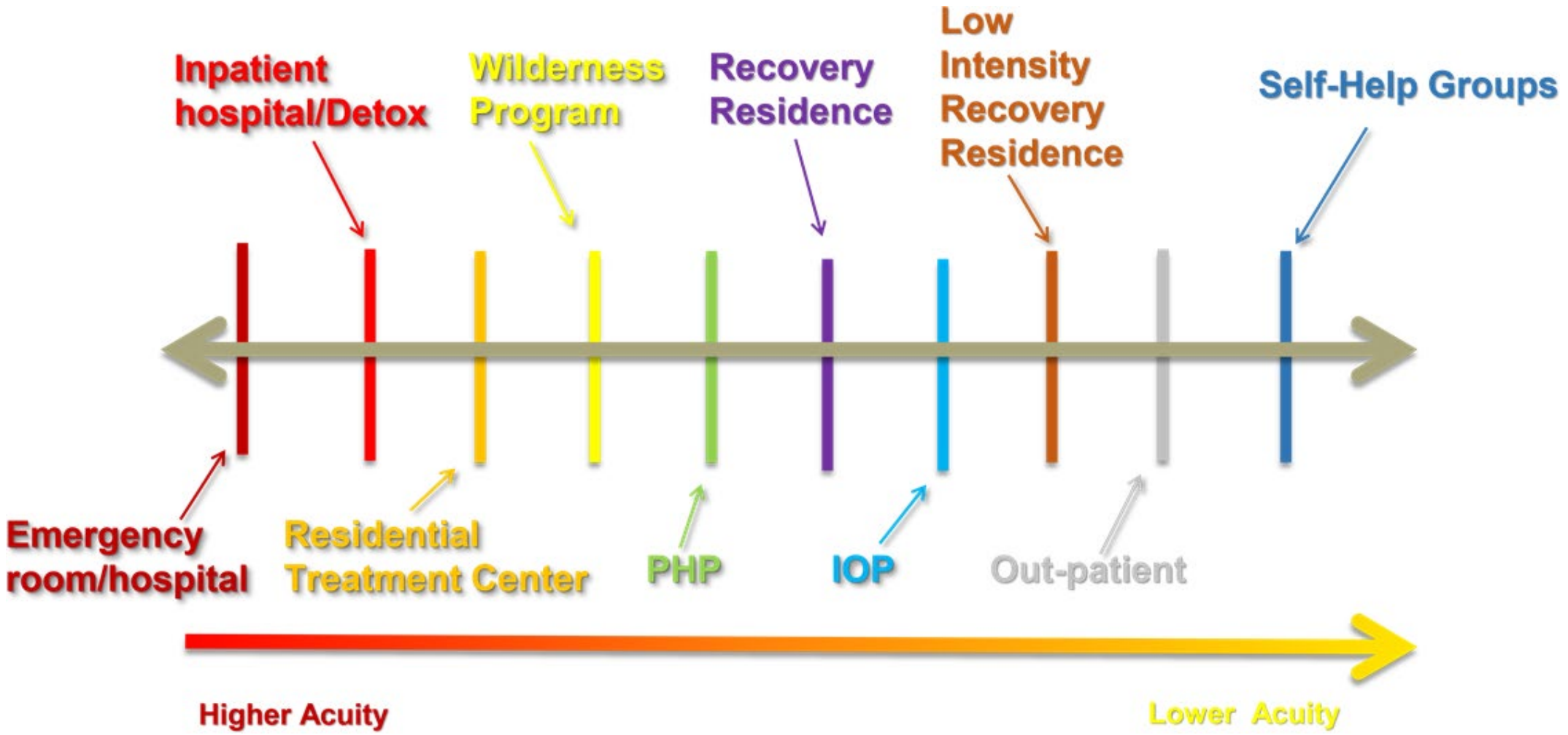
Inpatient/residential

Continuing Care, RSS, and/or community-based support groups

Evidence-Based Treatments for Alcohol Abuse

- Motivational Enhancement Therapy
- Cognitive-Behavioral Coping Skills Therapy
- Twelve-Step Facilitation Therapy
- Community Reinforcement
- Behavioral Couples Therapy
- Pharmacologic Treatments
  - Anxiolytics
  - Opioid Replacement (MAT)

Continuum of Care



Evidence-Based Psychosocial Treatments for Alcohol Abuse

- Motivational Interviewing (MI)
  - Heightens motivation to stop abusive drinking by providing patient objective feedback on its likely impact on health and quality of life.
- Cognitive-Behavioral Coping Skills Therapy (CBCST)
  - Identifies situations that represent substantial risk for continued abusive drinking, then helps develop both the skills to cope with those risky situations and the self efficacy to believe that changes in drinking can actually be made successfully.

Evidence-Based Psychosocial Treatments for Alcohol Abuse

- Twelve-Step Facilitation Therapy (TSF)
  - Prepares patient with a SUD to benefit from the rigors of involvement with Alcoholics Anonymous.
- Community reinforcement approach (CRA)
  - Provides SUD patient access to community resources and personal reinforcers contingent on maintenance of sobriety and other prescribed behavioral changes.
- Behavioral couples therapy (BCT)
  - Addresses both abusive drinking by the alcoholic spouse and the associated troubled couple interactions that often accompany abusive spousal drinking.

Evidence-Based Pharmacologic Treatments for Alcohol Abuse

- Anxiolytic (e.g., Buspar)
  - Lead to short-term reductions in alcohol consumption in alcohol dependent individuals suffering from depression.
- Medicated Assisted Treatment(e.g., Naltrexone or Suboxone) and calcium bisacetyl homotaurine (Acamprosate/ Campral)
  - Reduce craving following detoxification and thereby increase likelihood of continued abstinence/ recovery process.

Thoughts, ideas, questions?