

Problem Drinking
Screening and Counseling
in New Mexico:
A Handbook for
Health Care Providers



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Problem Drinking Screening and Counseling in New Mexico: A Handbook for Health Care Providers

Objectives: The objective of this handbook is to provide primary care providers in New Mexico with a concise resource that details screening procedures, risk assessment, referral, treatment, enhancing motivation to change a health behavior, alcohol use in special populations, and reimbursement and coding procedures for problem drinking screening. The handbook also provides materials and resources for the provider to use in their practice.

The expected outcome of this handbook is that New Mexican primary care physicians will have a clearer understanding of alcohol use, abuse, and dependence, and will learn how to screen for and treat problem drinking.

Target Audience: Primary Care Physicians and Physician Assistants

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TABLE OF CONTENTS

I. Introduction	1
II. Screening	5
III. Risk Assessment and Referral	12
IV. Treatment	13
V. Enhancing Motivation to Change with a Brief Interview . . .	18
VI. Special Populations	21
VII. Reimbursement and Coding	24
VIII. Resources	29
IX. Bibliography	33
X. Continuing Medical Education Questions	36

APPENDIX

Alcohol Abuse, DSM-IV Diagnostic Criteria	46
Alcohol Dependence, DSM-IV Diagnostic Criteria	47
Standard Drink Definition	49
Quantity-frequency questions	49
CAGE Questions	50
PRIME-MD Questions	50
RAPS4-QF Questions	51
CRAFFT Questions	51

Chapter 1

Introduction



Primary care physicians are the crucial first contact for the vast majority of problem drinkers. There is compelling evidence that even brief interactions with physicians and other providers can have a positive impact on their harmful alcohol use (Kristenson, 1983). Screening and intervention for problem drinking is recommended for all adult and adolescent patients and can take place during a visit for acute medical problems or with a health maintenance exam. Screening with standardized questionnaires with demonstrated utility in clinical settings is highly recommended.

The intent of this handbook is to provide practical information, resources, and a menu of brief strategies to help practitioners interact with their patients on the topic of problem drinking in ways that make it more likely that these people will examine their potentially harmful behavior and make positive changes.

A number of randomized clinical trials have demonstrated the efficacy of brief (5-15 minutes) outpatient counseling for non-dependent problem drinkers. The US Preventive Services Task Force (1996) in its recommendations for screening of adults and adolescents for problem drinking cites a study in which patients receiving counseling experienced fewer hospitalizations and 50% lower mortality after 5 years.

The need for counseling is further intensified by changes over the last few generations in patterns of alcohol use: drinking begins at increasingly earlier ages, the odds of dependence has increased, and in women, drinking patterns and rates of dependence have become more similar to those of men (Grant, 1997).

What is a safe level of drinking? For most adults, moderate alcohol use—up to two drinks per day for men and one drink per day for women and older people—causes few if any problems. One drink equals one 12-ounce bottle of beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of 80-proof distilled spirits.

However, certain people should not drink at all.

- Women who are pregnant or trying to become pregnant
- People who plan to drive or engage in other activities that require alertness and skill (such as using high-speed machinery)
- People taking over-the-counter or prescription medications that can interact with alcohol
- People with medical conditions that can be made worse by drinking
- Recovering alcoholics and individuals of any age who cannot restrict their drinking to moderate levels
- People younger than age 21

Source: National Institute on Alcohol Abuse and Alcoholism [NIAAA] and USDA Dietary Guidelines (5th edition, 2000).

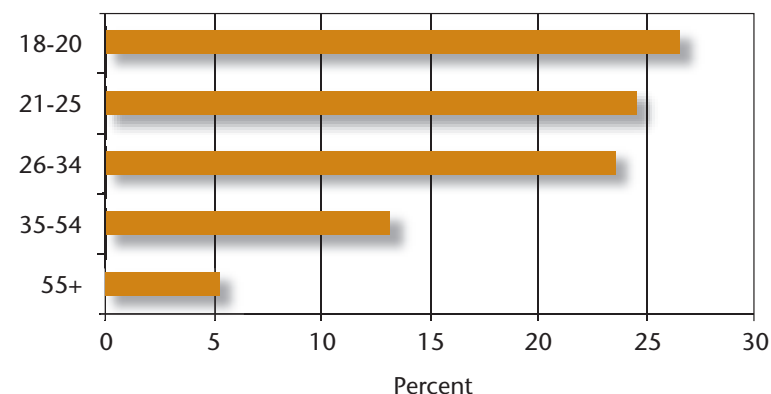
The majority of Americans drink moderately or not at all. According to data on US adults from the National Health Interview Survey for the year 2000, 39% of those over 18 were identified as abstainers (no drinking in the last year) and 43% were light drinkers (an average of three or fewer drinks per week in the last year). An additional 13.5% were at or below the recommended maximum described above. This still leaves a significant percentage of Americans (4.5%) who meet the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994) criteria for alcohol abuse or alcohol dependence or put themselves at risk on occasion through the misuse of alcohol. These individuals would benefit from timely interventions to improve their own health, and their success at changing drinking behavior could help reduce the enormous negative impact of alcohol on the public's health. This handbook will give you the tools to get you started.

Binge Drinking in New Mexico

Binge drinking, the consumption of five or more alcoholic drinks on one occasion, results in acute impairment and contributes to adverse health effects associated with alcohol consumption such as motor vehicle crashes, falls, alcohol poisonings, suicides, and intimate partner violence (Chitritzh, 2001; Smith, 1999; Stinson and DeBakey, 1992). Data on

binge drinking in New Mexico, from the Behavioral Risk Factor Surveillance System (BRFSS) 2002, is in the figure below. The BRFSS survey is a random-digit telephone survey administered by the New Mexico Department of Health Office of Epidemiology. The sample size ranged from 3,248 in 2000 to 4,678 in 2002. Those not providing information on alcohol consumption were dropped from the analysis.

Prevalence for Binge Drinking* by Age New Mexico, 2002



Source: BRFSS
* 5 or more drinks on one occasion

New Mexico is similar to the rest of the nation in terms of prevalence of binge drinking. However, patterns of alcohol use within New Mexican sub-populations vary significantly.

- Men accounted for over 82% of all binge-drinking episodes, and they were 3.5 times more likely as women to report binge drinking in the past 30 days (23.0% vs. 6.4% in 2002).
- Between 1998 and 2002, there was an 18% decrease in prevalence of binge drinking among 18 to 20 year olds.
- Between 1998 and 2002, there was a 33% increase in binge drinking among those 55 years and older.
- Between 1997 and 2002, the prevalence of binge drinking among non-Hispanic Whites remained stable; among Hispanics, the prevalence increased; among Native Americans, the prevalence decreased.

- Among 1,396 DUI (driving under the influence) offenders convicted in Bernalillo County and interviewed 5 years after their first conviction, 61% of the women and 70% of the men reported a lifetime diagnosis of alcohol dependence (Lapham, 2001).
- In 2002, on average, a non-Hispanic White binged 8.9 times, a Hispanic 16.6 times, and a Native American, 17.4 times.
- 13.6% of binge drinkers consume alcohol once or fewer times per month.
- Of those individuals who reported binge drinking in the past 30 days, 11.6% also reported driving under the influence of alcohol in the same past 30 days.
- For those who self-reported both binge drinking and DUI in the past 30 days, 36.2% were non-Hispanic White, 50.3% were Hispanic, and 4.1% were Native American.
- 15.8% of the binge drinking/DUI group was alcohol-dependent.

Health care professionals are in an excellent position to reduce binge-drinking episodes. The under-reporting of alcohol consumption coupled with the irregular binge drinking behavior of some individuals underscores the importance of **asking routine questions** relating to alcohol consumption.



Chapter II Screening



Step 1: Ask about Drinking

All patients should be asked quantity-frequency questions routinely before or during an office visit. A description of a standard drink can precede the questions. We recommend that practitioners review Chapter V for ideas on how to conduct a successful consultation on alcohol use, whether or not the patient has completed a screening instrument.

STANDARD DRINK	
12 ounces of beer	8-9 ounces of malt liquor
12 ounces of wine cooler	1.5 ounces of 80 proof spirits
3-4 ounces of fortified wine	1 ounce of 100 proof spirits
5 ounces of table wine	2-3 ounces of cordial, liqueur, or aperitif

Quantity-frequency questions.

1. On average, how many days a week do you drink alcohol?
2. On a typical day, how many standard drinks do you have?

Multiply the answers to 1 and 2

If the answer equals **more than 7 drinks for female** or **more than 14 drinks for male** patients, the patient is **at risk** for developing alcohol-related problems; administer the CAGE, PRIME-MD, or RAPS4-QF (or CRAFFT if your patient is an adolescent).

3. What is the maximum number of drinks you had on any given day in the past month?

If the response is **more than 3 drinks for female** or **more than 4 drinks for male** patients, the patient is **at risk** for developing alcohol-related problems; administer the CAGE, PRIME-MD, or RAPS4-QF (or CRAFFT if your patient is an adolescent).

Step 2: Administer the CAGE, PRIME-MD, RAPS4-QF or CRAFFT questions if any of the following are true.

- The quantity-frequency questions indicate at-risk drinking.
- The patient drinks and is pregnant or trying to conceive.
- The patient is over age 65, frail, or taking medications that interact with alcohol.
- The physical exam reveals suspect injuries (e.g. cigarette burns or evidence of frequent falls).
- The patient has certain symptoms, such as abdominal pain, GI bleeding, memory loss, or insomnia.
- The patient is under 21 years of age.

Brief Screening Instruments. The diagnostic standard for alcohol abuse and dependence in the DSM-IV (Appendix) (American Psychiatric Association, 1994) requires a lengthy interview and is not practical for routine office use. This guide recommends one of four brief screens. It takes less than two minutes to administer each of these brief screens.

1. The four-question CAGE questionnaire (Mayfield, 1974; Ewing, 1984) has been the most popular screening instrument in the primary care setting with good sensitivity for alcohol abuse and dependence (74-89% and 79-95%, respectively). However, the CAGE is less sensitive for early problem or heavy drinking, has a lower sensitivity and specificity among young persons, and is less appropriate for use among pregnant women because it focuses on alcohol dependence.
2. The questions on the PRIME-MD (Spitzer, 1994) screen are similar to CAGE questions with the exception that the last question replaces “drinking in the morning” with a query about binge drinking in the last month. This helps improve the sensitivity of PRIME-MD to 81% (specificity 91%) and enhances the instrument’s value with respect to early problem or heavy drinking. However, the PRIME-MD has lower sensitivity and specificity among young persons.
3. The RAPS4-QF (Rapid Alcohol Problems Screen 4-Quantity-Frequency) appears to be more sensitive than the CAGE (while maintaining good specificity) for identifying alcohol dependence and alco-

hol abuse across gender, ethnic, and service utilization groups in the general population. The RAPS4-QF may be the instrument of choice for brief screening for alcohol use disorders, both in clinical populations and in the general population (Cherpitel, 2002).

4. The CRAFFT questions were designed specifically for use with adolescents in the outpatient medical office setting (Knight, 1999).

CAGE Questions.

- C** Have you ever felt that you should **CUT DOWN** on your drinking?
No...go to next question.
Yes...ask has this occurred during the past year?
- A** Have people **ANNOYED** you by criticizing your drinking?
No...go to next question.
Yes...ask has this occurred during the past year?
- G** Have you ever felt bad or **GUILTY** about your drinking?
No...go to next question.
Yes...ask has this occurred during the past year?
- E** Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (**EYE-OPENER**)
No.
Yes...ask has this occurred during the past year?

Positive screen if one or more “yes” answers to “in the past year” questions.

PRIME-MD Questions.

- During the past month have you thought you should **CUT DOWN** on your drinking of alcohol?
- During the past month has anyone **COMPLAINED** about your drinking?
- During the past month have you felt **GUILTY** or upset about your drinking?
- Was there ever a single day in which you had **FIVE OR MORE DRINKS (four or more for women)** of beer, wine or liquor?

Positive screen if two or more “yes” answers.

The RAPS4-QF Questions.

- R** During the last year have you had a feeling of guilt or remorse after drinking? (**REMORSE**)
- A** During the last year 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/BLACKOUTS**)
- P** During the last year have you failed to do what was normally expected from you because of drinking? (**PERFORM**)
- S** Do you sometimes take a drink in the morning when you first get up? (**STARTER/EYE-OPENER**)
- Q** During the last year have you had five or more drinks (four or more for women) on at least one occasion? (**QUANTITY**)
- F** During the last year did you have a drink as often as once a month? (**FREQUENCY**)

Positive screen if one or more “yes” answers to any of the first four questions (RAPS4) OR BOTH of the last two (QF).

CRAFFT Questions.

- C** Have you ever ridden in a **CAR** driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- R** Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
- A** Do you ever use alcohol or drugs while you are by yourself, **ALONE**?
- F** Do you ever **FORGET** things you did while using alcohol or drugs?
- F** Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
- T** Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

Positive screen if two or more “yes” answers.

Step 3: Decide to perform physical examination (Step 4) or to provide feedback on assessments alone (Step 5).

Any person who receives a positive score on a brief screening instrument should receive feedback on their assessment in a manner designed to enhance motivation for change.

- If the practitioner suspects physical impairment from the use of alcohol or physical dependence on alcohol...**Proceed to Step 4.**
- If the practitioner does not have time to conduct a physical examination or suspects the problem may not be advanced enough to yield physical signs or symptoms... **Proceed to Step 5.**

Step 4: Perform a physical examination and order laboratory tests for those who screen positive.

A thorough history and physical examination with specific laboratory tests can help identify those with more severe dependence. **Common symptoms** of those with alcohol problems include sadness, anxiety, sleep disturbance, and cognitive impairment. **Organ systems** likely to be impaired by alcohol include the gastrointestinal system (bleeding, liver failure), cardiovascular system (hypertension, arrhythmia), hematopoietic system, endocrine system (sexual functioning, hormonal balance) and the central nervous system. Heavy drinking also can cause acute alcoholic myopathy and glucose or electrolyte imbalances. Look for the following **physical signs** of chronic alcohol misuse:

hypertension, signs of alcohol withdrawal (withdrawal-induced hypertension, tachycardia, tremor, hyperreflexia, nausea, diaphoresis, sweaty palms, auditory hallucinations and paranoia), rhinophyma, palpable liver, gynecomastia, testicular atrophy, and peripheral neuropathy, sixth nerve palsy and ataxia with memory impairment (Wernicke-Korsakoff’s syndromes).

Laboratory studies that are often abnormal in alcohol-dependent individuals include blood or breath alcohol, serum gammaglutamyl transpeptidase level (GGT), mean corpuscular volume, serum aspartate aminotransferase and alanine aminotransferase level (AST, ALT), serum high density lipoprotein cholesterol level, mild thrombocytopenia, and carbohydrate deficient transferrin level). To evaluate liver function, obtain

a liver profile. A complete blood count (CBC) and liver profile will cover the basics for liver disease, bleeding, and nutritional anemia. Severe alcohol dependence is fairly easy to recognize. Symptoms of severe dependence include evidence of intoxication at the time of the appointment or an alcohol odor, obsessive or compulsive alcohol use, frequent blackouts, out-of-control drinking, driving while intoxicated, and continued use of alcohol despite health, psychological, family, or legal problems.

Step 5: Provide screening results in a motivational manner.

The aim of the feedback is to provide patients with their personal results from alcohol screening instruments (RAPS4-QF, CAGE, etc.) in a way that maintains a sense of collaboration, enhances the impact of the information, increases the individual's buy-in, and minimizes resistance or defensiveness.

How To Do It:

Ask the patient's permission to go over their screening results.

"I'd like to spend a couple of minutes going over some information that might be interesting to you, if that would be okay..."

If permission is given, explain the context.

"There were a few questions you answered when you first came into the office. Those questions were developed to screen people for possible health risks related to drinking. The results might be interesting to you, but it is really up to you to decide what to do about them."

Provide information in an objective, nonjudgmental way. Remain neutral. Do not interpret the results for patients beyond giving them enough information to interpret the results themselves. For example, "This test does not diagnose drinking problems, but can give a sense of who may or may not develop problems in the future." Let patients draw their own conclusions. Depersonalize the results as much as possible. For example, "People who score in this range [indicating the patient's score] run a moderate risk for developing alcohol-related problems in the future," instead of, "Your score indicates you've got a drinking problem."

Ask for the individual's response to the information.

"What do you make of this?"

Listen to and reflect the response.

"This is hard to believe."

"This makes sense to you."

"This is surprising/troubling (etc.) information for you."

"You're not sure what to make of this..."

"You're not convinced this is accurate (etc.)..."

Summarize and ask.

"Where does this leave you now?"

Proceed with a brief intervention or a specialized treatment referral (Chapter IV), or leave the door open for further discussion.



Chapter III

Risk Assessment and Referral



A positive screen indicates with high probability that your patient is engaging in harmful or hazardous use of alcohol or is alcohol-dependent. The physical examination and laboratory tests will help you make that determination. If questions remain, you may decide to refer the patient for further assessment or you may wish to review the alcohol abuse and alcohol dependence criteria provided in the Appendix to help you determine the severity of your patient's level of alcohol problems. Keep in mind that individuals may engage in risky drinking (i.e., outside the safe guidelines) without meeting the criteria for alcohol abuse or dependence. After the assessment, proceed with a brief intervention or referral. For those with less severe alcohol problems, a brief intervention (Chapter IV) is a good first approach. The Institute of Medicine and others have suggested that patients with severe problems should receive specialized treatment.

Brief interventions are appropriate for persons who are socially stable, have no other psychiatric disorders except mild depression and do not have symptoms of severe dependence. Brief intervention techniques are useful to learn and master as they are helpful in dealing with all sorts of behavioral health problems in your practice from substance abuse to helping patients remember to take their medications. Remember, you can initiate a brief intervention with or without pharmacotherapy and, at any point in the process, still refer the patient to specialized services if you think it necessary.

Specialized treatment services should be considered for patients with a lack of social support, severe psychosocial problems, dependence on other drugs of abuse besides nicotine, and untreated psychiatric disorders. For these patients, ongoing brief interventions by the primary care physician, while not a substitute for intensive treatment, are especially helpful in engaging and motivating patients to seek and remain in treatment (Rubin, 1996).

Chapter IV

Treatment



Brief Intervention

- Step 1:** Advise the patient by providing feedback related to their screening results, then ask them what they make of the results. If they respond by telling you they think they should reduce or stop drinking, agree with them. If not, advise them they should consider reducing or stopping drinking. Use the motivational techniques described in Chapter V to increase the effectiveness of brief interventions (Miller and Sanchez, 1994).
- Step 2:** Let the patient know that making choices about drinking means deciding each day whether or not to drink, and if so, what the limits will be.
- Step 3:** Advise that people who are able to abstain from alcohol for a short period (two weeks) are more likely to achieve their long-term goal. Ask them if they would like to try abstinence. If not, negotiate a short-term goal within the low-risk drinking limits.
- Step 4:** Offer materials to facilitate change, for example, the NIAAA patient workbook, "Alcohol Risk Assessment and Intervention, Patient Workbook for Quitting or Cutting Down," listed in Chapter VIII. Basic guidelines in the patient workbook include:
- Take stock of your drinking patterns by completing the exercises in the workbook.
 - Whether your ultimate goal is abstinence or cutting back, quit drinking for 2 weeks. Learn about the limits of low-risk drinking and set your personal goal.
 - Use a diary for at least 3 months and keep accurate track of your progress. Practice the methods that either you or others have used previously to succeed.
- Step 5:** Ask the patient to return with the completed workbook in 2 to 4 weeks. Reinforce the patient's responsibility and ability to make changes.

Step 6: In future sessions, review the patient’s progress toward their goals since the last visit. If the patient has not been successful, explore what happened and reassess the patient’s motivation (Chapter V). If the patient has forgotten the workbook or it is incomplete, go through the points briefly and ask them to fill in some of the answers. Encourage the patient to talk about barriers to their progress. Reinforce the message that you believe they can do this, but it is their responsibility. Schedule another follow-up visit to monitor progress.

Specialized Treatment Referral

Those with substantial risks — severe alcohol dependence, multiple drug use, other psychiatric problems or life crises — should be referred for specialized treatment. Many people with severe problems also benefit from a support group. Abstinence should be recommended as well. Compliance with a treatment referral is enhanced if you make the referral while the patient is in the office. Referral resources are listed in Chapter VIII.

Follow-up care is critical for patients who have been referred to specialized treatment. It ensures that the patient has acted on the referral and entered treatment. It also allows the patient to update you on their progress and will give you valuable information about the health needs of the patient and other family members. Most importantly, your expressed concern can help motivate the patient to quit drinking.

Pharmacotherapy

There are currently two medications licensed for the treatment of alcohol use disorders, disulfiram (Antabuse®) and naltrexone (ReVia®).

Disulfiram is considered an aversive agent because it causes unpleasant effects after alcohol ingestion. It interferes with the metabolism of alcohol by inhibiting the enzyme aldehyde dehydrogenase. When a person drinks after taking disulfiram, acetaldehyde builds up in the blood and causes extreme discomfort, headache, tremor, blood pressure changes, nausea, vomiting, and other symptoms. Disulfiram does not affect craving for alcohol and is best used in highly motivated patients. Disulfiram can cause liver damage and should be used only with patients who are highly motivated to quit drinking, as compliance is often a problem, and who feel

that this medication is needed as an “insurance policy” against the urge to drink. It should be used for only 3 months and liver enzymes should be monitored monthly. The dose is 250 mg/day by mouth. Evidence for efficacy is mixed. Disulfiram is contraindicated for patients with portal hypertension, diabetes mellitus, heart disease, or a history of stroke. If prescribed, remind the patient to avoid all medications and foods containing alcohol including mouthwash, flaming desserts, certain sauces used in cooking, deodorant, and aftershave lotions containing alcohol.

Naltrexone is an opiate antagonist and blocks brain opiate receptors. This reduces the high induced by alcohol and may also reduce the craving for a drink. No ill effects are suffered if a person drinks while taking naltrexone. It is recommended that naltrexone be used as an adjunct to standard psychosocial treatment. The usual dose is one to two 50 mg tablets orally per day for up to 3 months. Common side effects are nausea, light-headedness, and increased sexual desire. High doses can cause liver damage. The main contraindications are severe liver disease and concurrent use of opiate medications (for chronic or acute pain).

In addition to the oral form of naltrexone, two pharmaceutical companies are testing long-acting, injectable formulations, Naltrel® and Vivitrex®. These formulations are undergoing clinical trials and are expected to receive FDA approval in 2005-2006. Both require monthly, intramuscular injections. The major advantage of these formulations is that they eliminate the need to take pills, ameliorating compliance problems.

Other promising medications currently in clinical trials include:

- Acamprosate (used in Europe, currently testing for approval in U.S.) is a glutamate antagonist and appears to reduce the intensity of craving after drinking cessation in high-relapse situations.
- Ondansetron is a serotonergic medication that may be helpful to treat early-onset alcoholics who respond poorly to psychosocial treatment alone or who have serotonin dysfunction.
- Topiramate may be a safe and effective treatment for alcoholism. A randomized, double-blind, placebo-controlled trial showed it to be superior to placebo at improving drinking outcomes, promoting abstinence, and reducing craving for alcohol.

It should be noted that medications used to treat depression and other psychiatric disorders that often co-occur with alcoholism may be beneficial in helping your patients stay sober.

Medical Detoxification

Patients with **physical dependence** may need to be detoxified. Although detoxification sometimes requires hospitalization, it may be accomplished safely in an outpatient setting if the patient is in good health, there is no history of alcohol withdrawal seizures or delirium tremens, and the patient is reliable. Benzodiazepines, preferably chlordiazepoxide, can be given orally in decreasing doses over a 3 to 5 day period. Optimally, it should be administered to the patient by a spouse or other family member four times a day then tapered. Patients are asked to return daily for evaluation of vital signs and to come to the emergency department if symptoms of alcohol withdrawal escalate.

It is important to classify the stage of withdrawal. Table 1 provides classification along with recommended management options.

TABLE 1: Stages of Alcohol Withdrawal

Stage	Symptoms	Management options
I	Shaking, elevated pulse, increased blood pressure, agitation	Outpatient management
II	All of stage I symptoms plus hallucinations with insight	Outpatient management if patient reverts to stage I in 3 hours
III	All of stage I symptoms plus a temperature above 38.3°C (101°F) and hallucinations without insight, or history of delirium tremens or alcohol withdrawal seizures, or pregnancy	Intensive inpatient treatment with close monitoring

The usual medications used for alcohol detoxification are benzodiazepines. One of the more common medications used is chlordiazepoxide. It is generic, has a long half-life and so self-tapers and has a wide therapeutic window. It should not be given to pregnant women, as it is teratogenic, and should not be used in those with liver failure. The latter group should receive oxazepam or lorazepam. There are several strategies

for the use of chlordiazepoxide in outpatient medical detoxification, which are listed in Table 2 below. For some individuals the combination of an outpatient medical detoxification and brief intervention is most effective.

TABLE 2: Treating Alcohol Withdrawal with Chlordiazepoxide (Librium)

Schedule	Day 1	Day 2	Day 3	Day 4
Rigid	50 to 100 mg four times daily	50 to 100 mg three times daily	50 to 100 mg twice daily	50 to 100 mg at bedtime
Flexible	50 to 100 mg every 4 to 6 hours as needed based on withdrawal symptoms*	50 to 100 mg every 6 to 8 hours as needed	50 to 100 mg every 12 hours as needed	50 to 100 mg at bedtime as needed
Front loading**	100 to 200 mg every 2 to 4 hours until sedation is achieved, then 50 to 100 mg every 4 to 6 hours as needed	50 to 100 mg every 4 to 6 hours as needed	50 to 100 mg every 4 to 6 hours as needed	None

*See Table 1, Stages of Alcohol Withdrawal.

**After initial loading, often little additional medication is needed for the second day (Prater, 1999).



Chapter V

Enhancing Motivation to Change with a Brief Interview



Motivation is partially the product of interactions with other people. It can be either **enhanced** or **undermined** by contacts with a clinician (or a friend or a family member). This chapter presents approaches and attitudes designed to tip the scale towards positive change. The efficacy of this therapeutic method is reflected in a growing body of clinical research (Burke, 2002; Dunn, 2001).

Motivation to change health behaviors depends, in part, on two perceptions:

How **IMPORTANT** is it to the individual to make the change?

How **CONFIDENT** is the individual that he or she can do what needs to be done to accomplish the change? (Rollnick, 1999).

It is normal for people to be ambivalent about both of these dimensions. Miller and Rollnick (2002) define their approach to motivational enhancement as “... a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.”

Key Components of the Motivational Style (Miller and Rollnick, 1991, 2002; Rollnick and Miller, 1995; and Miller and Moyers, 2002)

1. **Be optimistic about the possibility of change.**
2. **Express appreciation and offer praise** to patients for the positive steps they take, for their honesty, for their willingness to consider change, for showing up for consultations.
3. **Use open-ended questions** to build rapport and to direct the discussion.
4. **Listen with empathy and suspend judgment.** Make short statements that summarize what the patient is saying and feeling.
“It’s important for you to be a good parent and you’re worried your drinking might affect your kids.”

5. **Collaborate with your patient.** Step out of the “expert” role when the topic is behavior change.
“What do *you* want to do?”
“What do you think will work for *you*?”
6. **It is normal to have mixed feelings about making a change.**
Invite patients to look at the pros and cons of their current behavior as well as the pros and cons of making a change.
7. **Avoid arguments.** Arguments are hard work and are counterproductive.
8. **Develop discrepancy.** Provide opportunities for patients to see the gap between the way things are and the way they would like things to be.
9. **Use periodic summaries to clarify and reinforce what the individual is saying.**
“Let me make sure I’m getting this right...”
10. **Match your strategies to the patient’s readiness to change.**
Patients who have not decided to stop drinking are unlikely to benefit from a lecture about why they should or a discussion of referral resources.
11. **Provide information and feedback with permission.**
Ask, “Would it be okay if we talked about your use of alcohol?”
Provide information or clinical findings in a neutral, nonjudgmental way, “People with liver function results in this range are at risk for liver disease.”
Ask, “What do you make of this information?”
12. **Give advice about behavior change sparingly**, with permission, and with respect for freedom of choice. Encourage patients to come up with their own solutions.
13. **Ask for a decision to change.**
“What would you like to do about your alcohol use at this time?”
14. **Provide a menu of options.** Let patients choose what they think will work best for them.

Enhancing Motivation with a Brief Interview (Rollnick, 1999)

1. **Assess readiness for change:** “On a scale of 1-10, where “1” means not at all important and “10” means very important, how important is it for you to make a change in your drinking right now?”
2. **Ask for elaboration:** “Tell me why you picked this number.”
3. **Ask “Scaling” questions:** “What makes this a “4” for you rather than a “1”? What keeps you from having a higher number, say an “8” or a “9”? What would it take for you to move from a “4” to a “9”?”
4. **Listen, summarize and ask:** “Where does this leave you now?”
5. **Assess patient’s confidence:** “On a scale of 1-10, where “1” means not at all confident and “10” means very confident, how confident are you that you could make a change in your drinking?”
6. **Ask “Scaling” questions again:** “What makes this a “2” for you rather than a “1”? What keeps you from having a higher number, say an “8” or a “9”? How can I help you move from a “2” to a “9”?”
7. **Listen, summarize and ask:** “Where does this leave you now?”

If the patient is NOT ready to consider change:

1. **Reflect and emphasize your role as a collaborator** and your belief in personal choice and control. “It sounds like you’re not ready to think about changing your drinking right now. It’s really up to you if you want to make any future changes.”
2. **Show appreciation.** “Thanks for being willing to talk about this. I appreciate your honesty/openness/patience.”
3. **Ask,** “Would it be okay if I checked in with you again about this at your next visit?”
4. **Follow up** as appropriate.

Chapter VI

Special Populations

**Pregnancy**

There is no safe level of alcohol use during pregnancy. Alcohol use during pregnancy can cause Fetal Alcohol Syndrome and is associated with other developmental problems in the child.

1. The benefits of sobriety should be discussed.
2. It is important to emphasize hope rather than fear and health rather than sickness in working with this population.
3. Pregnant women who do not stop drinking in 2 to 3 weeks usually require more intervention such as referral to a behavioral health specialist.

Children and Adolescents

Young people should be approached taking into account their developmental level, differences in values and beliefs, peer influence, and educational concerns.

1. Signs of a young person’s misuse of alcohol include:
 - Acute change of personality
 - Decline in school performance
 - Change of peer group
 - Change of appetite and sleep patterns
2. Young people should be screened using the CRAFFT (Chapter II).
3. It is extremely important for adolescents to be assessed for co-occurring mental disorders, including suicidality.
4. Treatment should involve family members.

Geriatric Populations

Ninety percent of older adults use medications and many of these interact with alcohol. Some elderly people begin drinking in response to the stresses of aging.

1. Indications of potential problems with alcohol include:
 - Memory loss or cognitive impairment
 - Depression, anxiety, poor appetite and sleep, and nutritional deficits
 - Hypertension refractory to treatment
 - Trouble controlling blood sugar in diabetics
 - Recurrent gastritis or esophagitis
2. Brief interventions are useful and effective (Chapters IV & V).

Medical Illness

Alcohol may cause, complicate, or be comorbid with illness, or be used to deal with symptoms of illness, such as pain.

1. Treatment should include:
 - Supporting and educating patients and families about substance abuse
 - Inducing abstinence, if possible, or reduction in use
 - Limiting relapses
 - Improving the quality of life and slowing the rate of deterioration
2. Treatment of both the medical problem(s) and alcohol use in an integrated fashion in the provider office is effective.
3. Brief interventions are useful and effective (Chapters IV & V).

Psychiatric Illness

Alcohol use greatly worsens outcomes in psychiatric illness.

1. Treatment should include:
 - Stabilizing the psychiatric illness
 - Achieving abstinence, if possible, or reduction in use
 - Improving functioning across life domains, working towards positive lifestyle changes
2. Progress is frequently stepwise from engagement, to stabilization, to late recovery.

3. There frequently is a need to involve a behavioral health professional.
4. Individuals with alcohol use and depression should have both issues treated simultaneously. While depression is frequently a sequelae to alcohol use or withdrawal, alcohol is also used by some individuals in attempt to alleviate or lessen depressive symptoms. If the depression is severe, was present before the alcohol use began, or is present in the weeks after alcohol withdrawal is completed, treatment of depression should occur. This may involve medications, such as SSRI's at normal doses, a referral to psychotherapy, or both.

Rural Populations

There is virtually no difference in use of alcohol between urban and rural areas. However, be aware that rural residents may feel they have a tradition of trying to take care of problems on their own.

1. Take into account the local culture.
2. Treat those you can; refer those you cannot. Use the National Drug and Alcohol Treatment Referral Routing Service to find a listing of all treatment facilities in a 100-mile radius of a town, <http://findtreatment.samhsa.gov> (Chapter VIII).
3. Work with others in the community to avoid duplication of services.
4. Utilize self-help groups.

Emergency Department

Brief interventions do work, even in the emergency department.

1. Routinely screen for alcohol use in injured patients and document findings.
2. Provide brief interventions for patients who screen positive for alcohol problems.
3. Provide care in a professional and non-judgmental manner (Chapter V).

Chapter VII

Reimbursement and Coding



A Few Practical Suggestions

Coverage of problem drinking screening and intervention by medical practitioners may be highly variable from health plan to health plan. For health care providers who do not typically offer prolonged mental health services, the major issue will be reimbursement of extended screening/counseling time using standard CPT-4 coding for office visits or preventive examinations. In the case of screening and counseling time, it will be important to distinguish between patients with a known alcohol related medical problem (intoxication, dependence, abuse, toxicity, or medical complications of alcohol) from those at risk or future risk from problem drinking because of a current medical condition, symptom, or other risk factor.

Focusing on Alcohol Use Counseling for a Patient with an Alcohol-Related Medical Problem

Relatively brief counseling may be conveniently added to an office visit for a known alcohol-related medical problem. As described in CPT-4 guidance, if counseling dominates the visit (more than 50%), then total time spent with the patient and family – rather than other criteria – controls the level of the evaluation and management service code. Documentation of the extent of counseling must appear in the medical record. Office visit codes and their time criteria are listed below:

99201	Problem-focused office visit, new patient	10 min
99202	Expanded problem-focused office visit, new patient	20 min
99203	Detailed office visit, new patient	30 min
99204	Comprehensive office visit, new patient	45 min
99205	Comprehensive complex office visit, new patient	60 min
99212	Problem-focused office visit, established patient	10 min
99213	Expanded problem-focused office visit, established patient	15 min
99214	Detailed office visit, established patient	25 min
99215	Comprehensive office visit, established patient	40 min.

Listed below are some typical alcohol problems and a sample of ICD-9 diagnostic codes that could be chosen as a primary diagnosis. Of importance is the fact that a few health plans will reimburse certain psychiatric diagnoses (such as 291.0 to 305.0 below) only if the service is provided by a psychiatrist. Others, such as Medicare, may increase conventional patient co-payment for the visit. Codes for alcohol-related medical problems include:

265.2	Pellagra
291.0	Alcohol withdrawal delirium
291.1	Alcohol amnestic syndrome
291.2	Other alcoholic dementia
291.3	Alcoholic withdrawal hallucinosis
291.4	Idiosyncratic alcohol intoxication
291.5	Alcoholic jealousy
291.81	Alcohol withdrawal
291.89	Other specified alcohol withdrawal psychosis
291.9	Unspecified alcoholic psychosis
303.00	Acute alcoholic intoxication, unspecified
303.01	Acute alcoholic intoxication, continuous
303.02	Acute alcoholic intoxication, episodic
303.03	Acute alcoholic intoxication, in remission
303.90	Other and unspecified alcohol dependence, unspecified
303.90	Other and unspecified alcohol dependence, continuous
303.90	Other and unspecified alcohol dependence, episodic
303.90	Other and unspecified alcohol dependence, in remission
305.0	Alcohol abuse
425.5	Alcoholic cardiomyopathy
535.3	Alcoholic gastritis
571.0	Alcoholic fatty liver
571.1	Alcoholic hepatitis
571.2	Alcoholic cirrhosis
571.3	Alcoholic liver damage, unspecified
648.4	Alcoholism complicating pregnancy, childbirth, or puerperium
655.4	Suspected damage to fetus from other disease in the mother
980.0	Toxic effect of alcohol

For example, an established patient is referred to you by a local judge for driving while intoxicated. The patient is counseled about alcohol use for

7¹/₂ or more minutes during a 15 minute office visit. The appropriate CPT-4 code to choose would be 99213. Codes used for your claim would be:

**99213 Expanded problem-focused office visit, established patient:
305.0 Alcohol abuse**

Adding Problem Drinking Screening, Anticipatory Guidance, or Counseling to an Office Visit for a Condition Placing the Patient at Risk for Problem Drinking

Relatively brief counseling may also be conveniently added to an office visit for a condition which may reflect problem drinking or place a patient at increased risk for development of problem drinking behavior. Some typical “at risk” conditions and their ICD-9 diagnosis codes are listed below:

578.0 Hematemesis
578.1 Blood in stool
578.9 Hemorrhage of gastrointestinal tract, unspecified
695.3 Rhinophyma
780.79 Other malaise and fatigue
780.02 Memory disturbance
781.2 Abnormality of gait
782.4 Jaundice, unspecified, not of newborn
789.1 Hepatomegaly
789.5 Abdominal ascites
790.4 Nonspecific elevation of levels of transaminase or LDH
995.50 Child abuse, unspecified
995.59 Other child abuse and neglect
995.81 Adult physical abuse

When sequencing diagnoses for claim submission, place the condition from the above list first and a “V code” for problem drinking risk second. V codes are often not reimbursable when used as a primary or first diagnosis. Available codes include:

V11.3 Personal history of alcoholism
V61.41 Alcoholism in the family
V65.42 Counseling on substance use and abuse
V79.1 Special screening for alcoholism

For example, if an established patient with recent cognitive changes receives a CAGE questionnaire and counseling about alcohol use for

12¹/₂ or more minutes during a 25 minute office visit, the appropriate CPT-4 code would be 99214. Documentation of the extent of counseling must appear in the medical record. When sequencing diagnoses for claim submission, place the condition first and codes for problem drinking risk second. This visit could be appropriately coded:

99214 Detailed office visit, established patient:
780.02 Memory disturbance
V79.1 Special screening for alcoholism
V65.42 Counseling on substance use and abuse

Adding Problem Drinking Screening/Counseling to a Preventive “Physical Exam”

Problem drinking screening and/or counseling is typically provided as part of a preventive medicine evaluation (well-person “check-up.”) Codes for this service include:

<u>Age</u>	<u>New Patients</u>	<u>Established Patients</u>
5-11	99383	99393
12-17	99384	99394
18-39	99385	99395
40-64	99386	99396
65+	99387	99397

The counseling should be documented in the medical record. Reimbursement for these codes will not be affected by the focus of the visit on problem drinking. A Clinical Prevention Initiative (CPI) payor survey has demonstrated that most health plans cover preventive medicine codes, although there are a few which exclude it as a benefit. You may want to check with certain health plans about the availability of this benefit.



Providing Problem Drinking Screening/Counseling as a Separate Service

Counseling to prevent or address problem drinking is properly coded as preventive medicine counseling with one of the following time-specific codes:

Individual Counseling		Group Counseling	
99401	approximately 15 minutes	99411	approximately 30 minutes
99402	approximately 30 minutes	99412	approximately 60 minutes
99403	approximately 45 minutes		
99404	approximately 60 minutes		

The counseling code would be an appropriate choice when extended alcohol screening or intervention is added to prenatal care which is globally billed. The CPI survey of payors detected some health plans which cover this service, usually with a fixed dollar cap (e.g., \$500) and occasionally with a higher (e.g., 50%) co-pay. Many plans, however, exclude it as a benefit.

Providing Problem Drinking Counseling as part of Supportive Psychotherapy

When treatment for problem drinking is performed through insight-oriented, behavior modifying and/or supported psychotherapy, a separate set of codes is available. Such therapy typically increases the patient's insight (understanding of his/her emotional/mood alterations) and uses psychiatric modalities such as behavior modification techniques, supportive interactions, and cognitive discussion of reality. Codes available which are usually appropriate for mental health professionals include:

Psychotherapy Alone		With Medical Evaluation/Management	
90804	approx. 20-30 minutes	90805	approx. 20-30 minutes
90806	approx. 45-50 minutes	90807	approx. 45-50 minutes
90808	approx. 75-80 minutes	90809	approx. 75-80 minutes

Coverage of these codes is widespread among health plans with a mental health benefit, but is often subjected to payment limits and higher co-pays.

Chapter VIII

Resources



Treatment and Referral Resources – New Mexico

ASPEN BEHAVIORAL HEALTH

3800 Osuna Rd. NE, Suite 2

Albuquerque, NM 87109

Telephone: 505-342-2474

FAX: 505-342-2454

Contact: Tom Sims, Clinical Director

Email: tsims@aspenpsych.com

Provides financial assistance to inpatients

ENDORPHIN POWER COMPANY

509 Cardenas SE

Albuquerque, NM 87108

Telephone: 505-272-5062

Contact: Sam Slishman MD

Email: sam_sliselman@yahoo.com

A center and program focusing on the substance-dependent and homeless with a goal to alleviate many of the challenges faced by current emergency medical systems.

NATIONAL DRUG AND ALCOHOL TREATMENT REFERRAL ROUTING SERVICE

Website: <http://findtreatment.samhsa.gov>

Telephone: 1-800-662-HELP (4357) or 1-877-767-8432 (Spanish)

Type in the city and state and get a list of all treatment facilities in a 100 mile radius.

PRESBYTERIAN MEDICAL SERVICES (PMS)**Service Center Headquarters**

1422 Paseo de Peralta, Bldg. 2

Santa Fe, NM 87504

Website: <http://pms-healthierstate.org>Telephone: 1-800-477-7633 or 505-982-5565

FAX: 505-992-6190

Contact: Scott Wallace, CEO/Director, or Paul Nelson

Email: scott_wallace@pmsnet.org or info@pms-inc.org

Provides referrals for Artesia, Cuba, Farmington, Gallup, Hope, Mountainair, Questa, Rio Rancho and Santa Fe.

REGION 2 BEHAVIORAL HEALTH PROVIDERS, INC. (R2BHP)

2500 Camino Entrada, Suite B

Santa Fe, NM 87507

Telephone: 505-473-0334

Blanca Kampa, Medical Director

FAX: 505-473-0374

Email: bkampa@region2bhp.org**Crisis Center 24 Hour Response**

1-877-473-0380

Contact: Guillermo Brito, Ph.D., CEO/Director

Email: gbrito@region2bhp.orgor Gilbert MoralesEmail: gmorales@region2bhp.org**RIO GRANDE BEHAVIORAL HEALTH SERVICES, INC.**

2801 Missouri, Suite 22

Las Cruces, NM 88011

Telephone: 505-532-2500

FAX: 505-532-8683

24 Hour Care Coordinator Line 1-877-532-2500

Contact: Roque Garcia, CEO/Director

Serves southwestern New Mexico. Provides coordination to place patients.

Treatment and Referral Resources – National**AL-ANON/ALATEEN**Website: www.al-anon.alateen.org

Telephone: 1-888-4AL-ANON (425-2666)

Monday-Friday, 8 am to 6 pm (MST) for meeting information.

Hope and help for families and friends of alcoholics.

ALCOHOLICS ANONYMOUS

P.O. Box 459, Grand Central Station

New York, NY 10163

Website: www.aa.org

Telephone: 212-870-3400

A fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

Website: www.aa.org/default/en_about_aa.cfm?pageid=7

AA members and service committees are available to provide information about AA to professionals in health care, correctional and treatment facilities, the media, and employee assistance departments.

SMART RECOVERY®

7537 Mentor Avenue, Suite 306

Mentor, OH 44060

Website: www.smartrecovery.org

Telephone: 440-951-5357

Email: SRMail@aol.com

Face to face and online mutual help groups.

Resource Materials

“ALCOHOL RISK ASSESSMENT AND INTERVENTION, PATIENT WORKBOOK FOR QUITTING OR CUTTING DOWN”

[The College of Family Physicians of Canada]

Telephone: 905-629-0900

“AMERICAN FAMILY PHYSICIAN: INFORMATION FROM YOUR FAMILY DOCTOR” April 1, 2003

[American Academy of Family Physicians]

Website: <http://www.aafp.org/afp/20030401/1535ph.html>

“BEHAVIORAL HEALTH NEEDS AND GAPS IN NEW MEXICO”

[New Mexico Department of Health]

Website: www.health.state.nm.us

Telephone: 505-827-2613

CENTER FOR SUBSTANCE ABUSE TREATMENT

[Substance Abuse and Mental Health Services Administration]

Website: www.csat.samhsa.gov

Telephone: 301-443-8956

“HELPING PATIENTS WITH ALCOHOL PROBLEMS: A HEALTH PRACTITIONER’S GUIDE” & “POCKET GUIDE”

Website: www.niaaa.nih.gov/publications/Practitioner/HelpingPatients.htm

NATIONAL CLEARINGHOUSE FOR ALCOHOL & DRUG INFORMATION (NCADI)

The U.S. Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration’s (SAMHSA) clearinghouse.

Website: www.health.org

Telephone: 1-800-729-6686

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA)

Website: www.niaaa.nih.gov

Telephone: 301-443-3860

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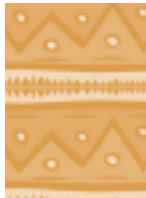
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Chapter X

Continuing Medical Education Questions



1. Which of the following is considered a “standard drink”?
- 9 oz of table wine
 - 1 oz of 100 proof spirits
 - 5 oz of beer
 - 12 oz of fortified wine

Answer

- b) 1 oz. of 100 proof spirits.

One standard drink equals:

12 ounces of beer	8-9 ounces of malt liquor
12 ounces of wine cooler	1.5 ounces of 80 proof spirits
3-4 ounces of fortified wine	1 ounce of 100 proof spirits
5 ounces of table wine	2-3 ounces of cordial, liqueur, or aperitif

2. Safe daily drinking levels are...
- ...one standard drink for women, two for men [under 65 years old].
 - ...two standard drinks for women, three for men [under 65 years old].
 - ...irrelevant as long as an individual doesn't drink before 5pm or on a week night.
 - ...applicable only as they pertain to driving. As long as your patient doesn't drink and drive, they can drink as much as they want.

Answer

- a) ...one standard drink for women, two for men [under 65 years old].

For most adults, moderate alcohol use—up to two drinks per day for men and one drink per day for women and older people—causes few if any problems.

3. Who of the following should not drink at all?
- Women who are pregnant or trying to become pregnant.
 - People with medical conditions that can be made worse by drinking and those taking over-the-counter or prescription medication that can interact with alcohol.
 - People who plan to drive or engage in other activities that require alertness and skill [e.g. air traffic controllers].
 - All of the above.

Answer

- d) All of the above.

Certain people should not drink at all:

- Women who are pregnant or trying to become pregnant
- People who plan to drive or engage in other activities that require alertness and skill (such as using high-speed machinery)
- People taking over-the-counter or prescription medications that can interact with alcohol
- People with medical conditions that can be made worse by drinking
- Recovering alcoholics and individuals of any age who cannot restrict their drinking to moderate levels
- People younger than age 21

4. Binge drinking [5 or more drinks on one occasion] is more prevalent in post-menopausal women than in college-aged males.
- True
 - False

Answer

- b) False

In the 2002 BRFSS report, men accounted for over 82% of all binge-drinking episodes and they were 3.5 times more likely than women to report binge drinking in the past 30 days (23.0% vs. 6.4%). In addition, 18-20 year olds had a 27% prevalence of binge drinking compared to 5.5% prevalence in 55+ year olds.

5. Alcohol-consumption questions should be asked...
- ...only when there is alcohol on the patient's breath.
 - ...when there is time left at the end of the visit.
 - ...routinely of all patients.
 - ...only when the patient has risk factors, e.g., they're diabetic, over 65 years old, frail, and taking scores of medication.

Answer

- c) ...routinely of all patients.

The under-reporting of alcohol consumption coupled with the irregular binge drinking behavior of some individuals underscores the importance of asking routine questions relating to alcohol consumption.

6. Screening for problem drinking includes...
- ...giving all alcohol users the CRAFFT questionnaire.
 - ...performing a physical examination and ordering laboratory tests for all alcohol users.
 - ...asking if drinking interferes with his/her life.
 - ...asking quantity-frequency questions. If these are positive, administer a brief screening instrument [CAGE, PRIME-MD, RAPS4-QF, or CRAFFT] and provide screening results to the patient in a motivational manner, accompanied, or not, by a physical exam.

Answer

- d) ...asking quantity-frequency questions. If these are positive, administer a brief screening instrument [CAGE, PRIME-MD, RAPS4-QF, or CRAFFT] and provide screening results to the patient in a motivational manner, accompanied, or not, by a physical exam.

The above outlines the steps in a brief screening intervention. The CRAFFT is a screening tool for adolescents. A physical exam and laboratory tests are for those patients in whom the practitioner suspects physical impairment from the use of alcohol or physical dependence. And finally, a key element in a beneficial therapeutic interaction is for the physician to provide information in an objective, non-judgmental way.

7. When providing screening results, it is best to...
- ...give the patient a sheet of paper with their "numbers" and let them decide what to do about them at a subsequent visit.
 - ...discuss the results and indicate if they don't stop drinking now, you may be unable to treat them any longer.
 - ...immediately deliver a strong message that they may be endangering their life.
 - ...ask permission to talk about the screening results, provide information in an objective, non-judgmental way, ask for the patient's response to the information, listen to and reflect the response, summarize their response, and ask "where does this leave you now?"

Answer

- d) ...ask permission to talk about the screening results, provide information in an objective, non-judgmental way, ask for the patient's response to the information, listen to and reflect the response, summarize their response, and ask "where does this leave you now?"

These are the steps to providing patients with personalized feedback from alcohol screening instruments in a way that maintains the sense of collaboration, enhances the impact of the information, increases the individual's buy-in, and minimizes resistance or defensiveness.

8. Most patients who drink at unsafe levels are alcohol-dependent and should only be treated/counseled in a substance abuse center.
- True
 - False

Answer

- b) False

Individuals may engage in risky drinking (i.e., outside the safe guidelines) without meeting the criteria for alcohol abuse or dependence. Brief interventions are appropriate for persons who are socially stable, have no other psychiatric disorders except mild depression and do not have symptoms of severe dependence.

9. Persons with alcohol abuse but not dependence...
- ...are often receptive to brief interventions by the physician.
 - ...most often exhibit out-of-control drinking.
 - ...are more likely to have co-morbid depression.
 - ...should be referred for specialized treatment services.

Answer

- a) ...are often receptive to brief interventions by the physician.

The National Institute on Alcohol Abuse and Alcoholism notes many studies suggesting that brief intervention can help non-alcohol-dependent patients reduce their drinking.

10. Elements of motivational interviewing include...
- ...an optimistic attitude.
 - ...arguing with the patient only if they are very resistant to advice.
 - ...not discussing the patient's drinking if you are in a bad mood.
 - ...listening for opportunities to insert educational information into the discussion.

Answer

- a) ...an optimistic attitude.

Key components of a motivational interaction include an optimistic attitude, expressing appreciation and offering praise, using open-ended questions, listening with empathy, collaborating with your patient, avoiding arguments, developing discrepancy, using periodic summaries, matching your strategies to the patient's readiness to change, providing information and feedback with permission, giving advice about behavior change sparingly, asking for a decision to change, and providing a menu of options.

11. In motivational interviewing, "scaling questions" are...
- ...asking the patient how much they weighed before they started drinking heavily.
 - ...asking the patient if their skin has undergone any changes after they started drinking heavily.
 - ...asking the patient to rate the level of importance cutting down on drinking has for them on a 1 - 10 scale and asking them what it would take for them to rate it higher.
 - ...reviewing their drinking scales every month.

Answer

- c) ...asking the patient to rate the level of importance cutting down on drinking has for them on a 1 - 10 scale and asking them what it would take for them to rate it higher.

Examples of scaling questions include, "What makes this a "4" for you rather than a "1"? What keeps you from having a higher number, say an "8" or a "9"? What would it take for you to move from a "4" to a "9"?"

12. Primary care physicians generally should not prescribe naltrexone for treatment of alcohol problems.
- True
 - False

Answer

- b) False

The National Institute on Alcohol Abuse and Alcoholism welcomes the U.S. Food and Drug Administration announcement of an indication for use of the pharmacologic agent naltrexone (ReVia®) as a safe and effective adjunct to psychosocial treatments for alcoholism.

13. Special attention should be paid to alcohol use in certain populations, including but not limited to, pregnant women, persons older than 65 years, those with psychiatric and/or medical illnesses, and adolescents.
- True
 - False

Answer

- True

Special attention should be paid to alcohol use in certain populations, including but not limited to, pregnant women, persons older than 65 years, those with psychiatric and/or medical illnesses, and adolescents.

14. You have just completed a 30-minute follow-up visit for a 62-year-old man who complains of memory loss. On his initial visit, you ruled out most serious causes and performed a mental status exam that was normal. On this visit you discussed his normal lab results, but spent most of the time screening for and addressing his binge drinking behavior. A proper way to receive fair compensation for your time is to...
- ...bill for 99213 (Extended problem-focused office visit, established patient) with diagnosis V65.42 (Counseling on substance use and abuse).
 - ...bill for 99214 (Detailed office visit, established patient) with first diagnosis 780.02 (Memory loss), second diagnosis V79.1 (Special screening for alcoholism), and third diagnosis V65.42 (Counseling on substance use and abuse).
 - ...go back to the exam room and do a complete physical exam and then bill for 99215 (Comprehensive office visit, established patient) with diagnosis 780.02 (Memory loss).
 - ...bill for 90805 (Psychotherapy with medical evaluation/management) with diagnosis V65.42 (Counseling on substance use and abuse).

Answer

- ...Bill for 99214 (Detailed office visit, established patient) with first diagnosis 780.02 (Memory loss), second diagnosis V79.1 (Special screening for alcoholism), and third diagnosis V65.42 (Counseling on substance use and abuse)

Although the visit was planned to follow-up the problem of memory loss, the time spent on counseling for alcohol use and abuse, a contributing factor, justifies a time-based CPT-4 code. The second and third diagnoses are added to account for the counseling time.

15. To find treatment and referral options within a 100 mile radius of any community in New Mexico, open the link <http://findtreatment.samhsa.gov> and type in the community name. A map will appear with the treatment facilities highlighted and a description of what each facility has to offer.
- True
 - False

Answer

- True

The link <http://findtreatment.samhsa.gov> link provides treatment and referral options within a 100 mile radius of any community in New Mexico.

APPENDIX

TABLE OF CONTENTS

Alcohol Abuse, DSM-IV Diagnostic Criteria	46
Alcohol Dependence, DSM-IV Diagnostic Criteria	47
Standard Drink Definition	49
Quantity-frequency questions	49
CAGE Questions	50
PRIME-MD Questions	50
RAPS4-QF Questions	51
CRAFFT Questions	51

Alcohol Abuse

DSM-IV Diagnostic Criteria

A. A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

- (1) recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home
- (2) recurrent alcohol use in situations in which it is physically hazardous
- (3) recurrent alcohol-related legal problems
- (4) continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol

B. The symptoms have never met the criteria for alcohol dependence.

Alcohol Dependence

DSM-IV Diagnostic Criteria

A maladaptive pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- (1) tolerance, as defined by either of the following:
 - (a) a need for markedly increased amounts of alcohol to achieve intoxication or desired effect
 - (b) markedly diminished effect with continued use of the same amount of alcohol
- (2) withdrawal, as manifested by either of the following:
 - (a) the characteristic withdrawal syndrome for alcohol
 - (b) alcohol (or a closely related substance) is taken to relieve or avoid withdrawal symptoms
- (3) alcohol is often taken in larger amounts or over a longer period than was intended
- (4) there is a persistent desire or unsuccessful efforts to cut down or control alcohol use
- (5) a great deal of time is spent in activities necessary to obtain the alcohol, use the alcohol, or recover from its effects
- (6) important social, occupational, or recreational activities are given up or reduced because of alcohol use
- (7) the 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 the alcohol

(continued on page 48)

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal

Without Physiological Dependence: no evidence of tolerance or withdrawal

Course specifiers:

Early Full Remission

Early Partial Remission

Sustained Full Remission

Sustained Partial Remission

On Agonist Therapy

In a Controlled Environment

All patients should be asked quantity-frequency questions routinely as part of their pre-exam paperwork. A description of a standard drink can precede the questions.

STANDARD DRINK	
12 ounces of beer	8-9 ounces of malt liquor
12 ounces of wine cooler	1.5 ounces of 80 proof spirits
3-4 ounces of fortified wine	1 ounce of 100 proof spirits
5 ounces of table wine	2-3 ounces of cordial, liqueur, or aperitif

Quantity-frequency Questions

1. On average, how many days a week do you drink alcohol?
2. On a typical day, how many standard drinks do you have?

Multiply the answers to 1 and 2

If the answer equals **7+ drinks for female** or **14+ drinks for male** patients, the patient is **at risk** for developing alcohol-related problems; administer the CAGE, PRIME-MD, or RAPS4-QF (or CRAFFT if your patient is an adolescent).

3. What is the maximum number of drinks you had on any given day in the past month?

If the response is **3+ drinks for female** or **4+ drinks for male** patients, the patient is **at risk** for developing alcohol-related problems; administer the CAGE, PRIME-MD, or RAPS4-QF (or CRAFFT if your patient is an adolescent).

CAGE Questions.

- C** Have you ever felt that you should **CUT DOWN** on your drinking?
No...go to next question.
Yes...ask has this occurred during the past year?
- A** Have people **ANNOYED** you by criticizing your drinking?
No...go to next question.
Yes...ask has this occurred during the past year?
- G** Have you ever felt bad or **GUILTY** about your drinking?
No...go to next question.
Yes...ask has this occurred during the past year?
- E** Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (**EYE-OPENER**)
No.
Yes...ask has this occurred during the past year?

Positive screen if one or more “yes” answers to “in the past year” questions.

PRIME-MD Questions.

- During the past month have you thought you should **CUT DOWN** on your drinking of alcohol?
- During the past month has anyone **COMPLAINED** about your drinking?
- During the past month have you felt **GUILTY** or upset about your drinking?
- Was there ever a single day in which you had **FIVE OR MORE DRINKS (four or more for women)** of beer, wine or liquor?

Positive screen if two or more “yes” answers.

The RAPS4-QF Questions.

- R** During the last year have you had a feeling of guilt or remorse after drinking? (**REMORSE**)
- A** During the last year 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/BLACKOUTS**)
- P** During the last year have you failed to do what was normally expected from you because of drinking? (**PERFORM**)
- S** Do you sometimes take a drink in the morning when you first get up? (**STARTER/EYE-OPENER**)
- Q** During the last year have you had five or more drinks (four or more for women) on at least one occasion? (**QUANTITY**)
- F** During the last year did you have a drink as often as once a month? (**FREQUENCY**)

Positive screen if one or more “yes” answers to any of the first four questions (RAPS4) OR BOTH of the last two (QF).

CRAFFT Questions.

- C** Have you ever ridden in a **CAR** driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- R** Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
- A** Do you ever use alcohol or drugs while you are by yourself, **ALONE**?
- F** Do you ever **FORGET** things you did while using alcohol or drugs?
- F** Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
- T** Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

Positive screen if two or more “yes” answers.