Alcohol Clinical Training Project

IMPLEMENTATION AND EVALUATION REPORT:

APPENDICES

Supported by the National Institute on Alcohol Abuse and Alcoholism (NIAAA)
R25 AA013822

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Appendices

Appendix A. Joint Materials

1. Snapshot of ACT website
2. Publication/Presentation
3. Marketing – Journal Advertisement sample

Appendix B. Curriculum Materials

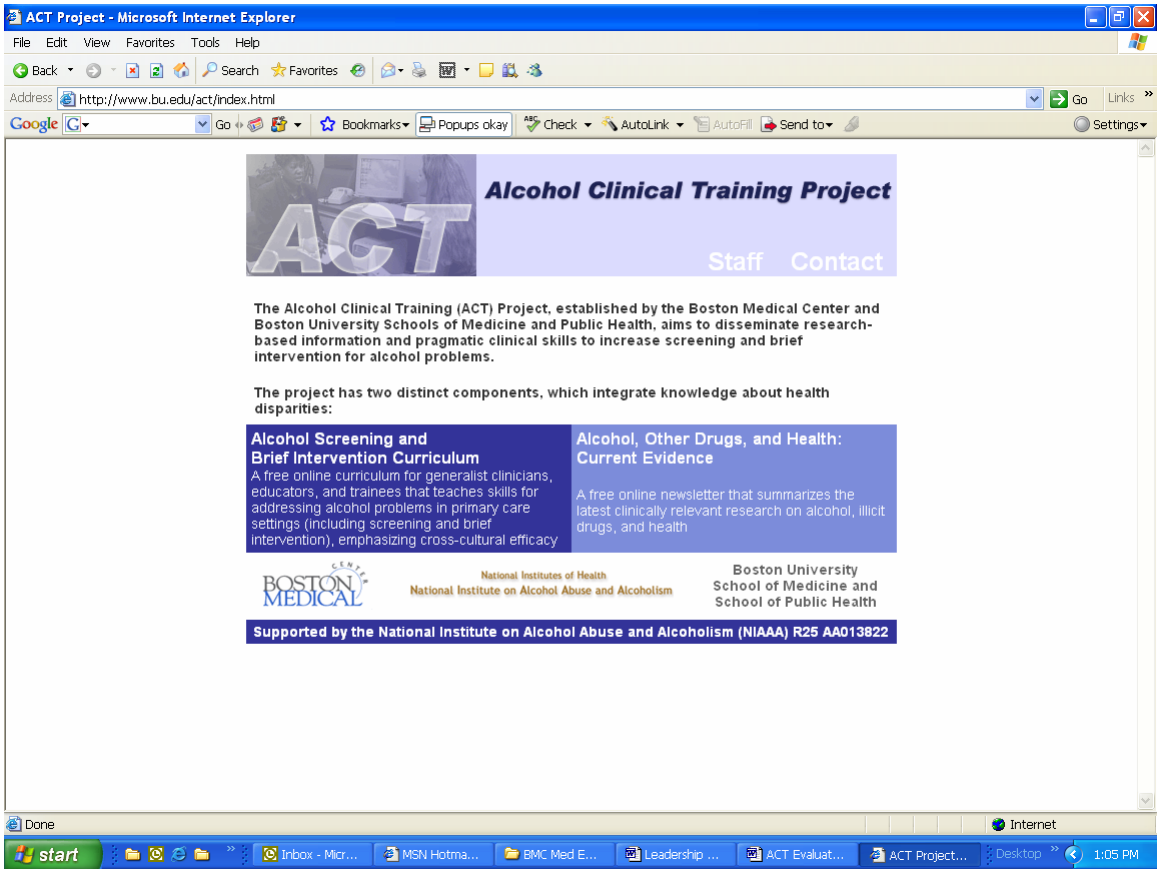
1. Curricula
    - ACT Core Curriculum
    - Related Curriculum: Health Disparities/Cultural Competence
    - Related Curriculum: Pharmacotherapy Curriculum
2. Educational Tools
3. Publications/Presentations
4. Marketing – Curriculum Postcard

Appendix C. Newsletter Materials

1. Snapshot Pages on www.alcoholandhealth.org
2. Journals Reviewed
3. Sample Research Summary
4. Sample PDF Issue
5. Summary of Results from Survey of *AHCE* Subscribers
6. Marketing – Newsletter Postcard

Appendix A. Joint Materials

1. SNAPSHOT OF ACT WEBSITE



2. PUBLICATION/PRESENTATION

Research Society on Alcoholism, Chicago, IL, July 2007

DISSEMINATING ALCOHOL RESEARCH AND CLINICAL TRAINING FOR GENERALIST PHYSICIANS USING THE WEB

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Aims: The Alcohol Clinical Training (ACT) Project (www.actproject.org) aims to (1) disseminate clinically relevant alcohol research, and (2) teach clinical skills to address unhealthy alcohol use in primary care settings.

Methods: (1) A free online newsletter, published every two months, summarizes the latest clinically relevant research on alcohol and health. Each issue (at www.alcoholandhealth.org) includes expert physician commentary, educator tools (e.g., journal club presentation to teach critical appraisal of alcohol research; a "grand rounds-type" presentation), and opportunities to earn continuing education credit. (2) A free online curriculum for clinician educators (at www.mdalcoholtraining.org**)** covers alcohol screening and brief intervention skills, emphasizing cross-cultural efficacy. Health disparities and pharmacotherapy curricula supplement the core curriculum. Evaluation is by user surveys; web statistics; formative data from resident, faculty, and practicing physicians; and a controlled study testing the effect of in-person faculty development on teaching the curriculum.

Results: (1) About 1500 people subscribe to the newsletter, including addictions counselors (20%), physicians (14%), and social workers (10%). Most consider addictions as their specialty and focus on clinical care and/or education. In October 2006, the site had 38,447 "hits." Of 168 respondents to a recent survey, all were satisfied with the newsletter's content. (2) The curriculum site receives up to 8000 hits/month, and all components are rated highly. Physicians who attended (at a national meeting) a 3-hour workshop on the curriculum were more likely than control physicians who received only the curriculum's web address to report curriculum use 3 months after the workshop (79% of 19 intervention physicians vs. 44% of 9 control physicians; P=0.07). The frequency of teaching increased significantly more in intervention physicians across all domains tested (e.g., teaching about alcohol screening, eliciting patient health beliefs). Most (84%) intervention physicians completed an individual teaching project with the curriculum.

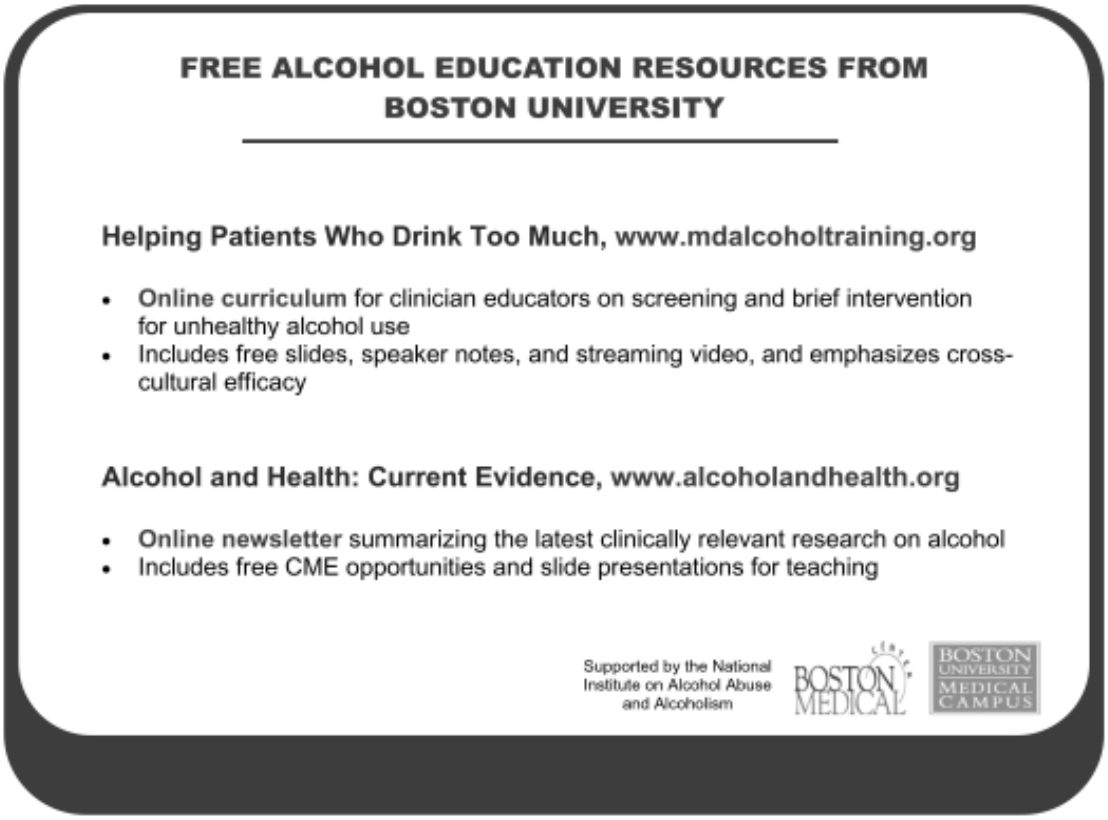
Conclusions: An online newsletter can reach many clinicians with the latest relevant alcohol research. An online alcohol curriculum can reach many physician educators, and in-person training increases alcohol-related teaching. These results suggest that the web is an effective dissemination tool but that additional efforts are needed to increase use of alcohol research and evidence-based practices by generalist physicians. (Support from R25 AA13822)

3. MARKETING- JOURNAL ADVERTISEMENT SAMPLE

SGIM

FORUM

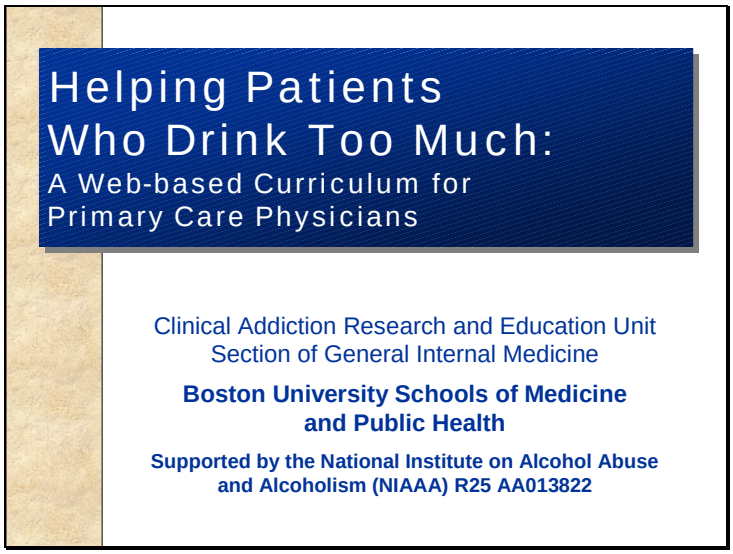
Classified Ads



Appendix B. Curriculum Materials

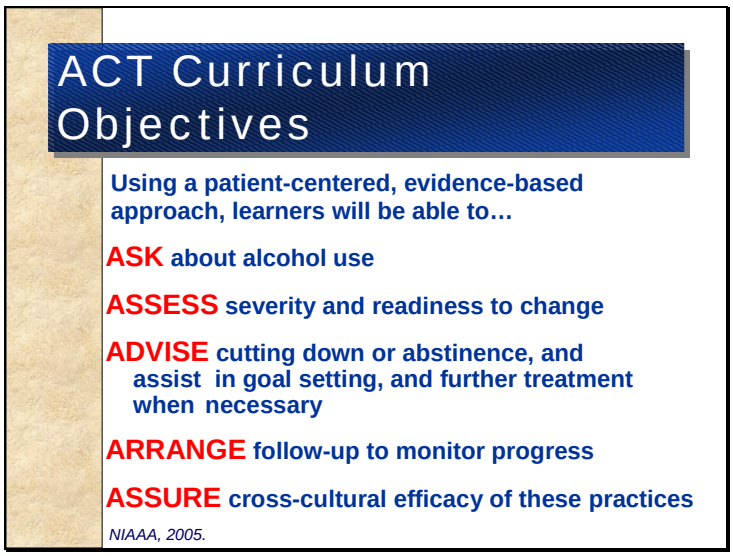
1. CURRICULA : Core Curriculum

Slide 1



Helping Patients Who Drink Too Much. This web-based curriculum for primary care physicians was developed at the Boston University Schools of Medicine and Public Health with support from the National Institute on Alcohol Abuse and Alcoholism.

Slide 2



The objectives of this talk are as follows:
Using a patient-centered, evidence-based approach, learners will be able to:
ASK about alcohol use; ASSESS severity and readiness to change; ADVISE cutting down or abstinence, and assist in goal setting, and further treatment when necessary; ARRANGE follow-up to monitor progress; and ASSURE cross-cultural efficacy of these practices
We will present a practical approach to identifying and managing unhealthy alcohol use in this approximately 45 minute presentation. Trigger video cases will be used to promote discussion and demonstrate some ways to use these strategies in practice.

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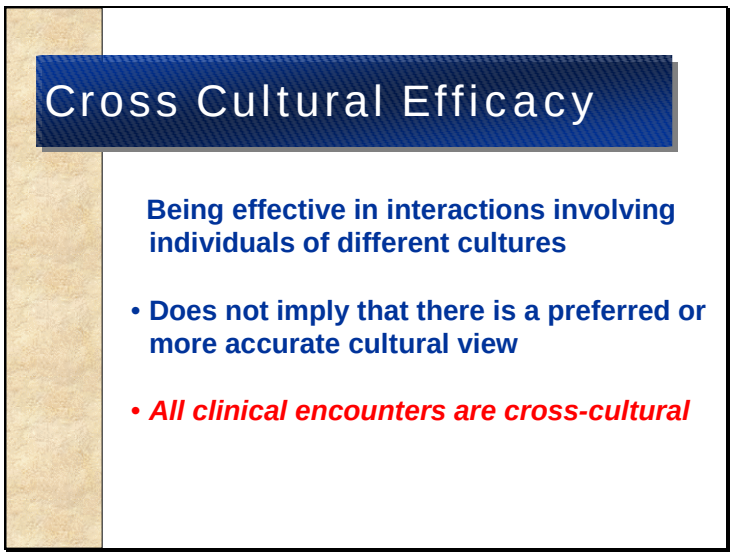
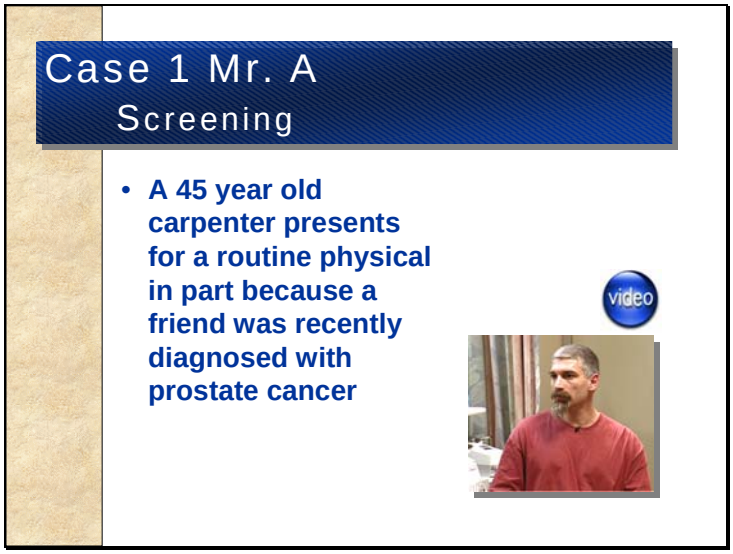


Cross-cultural efficacy allows clinicians to be effective in interactions involving individuals of different backgrounds or cultures than the physician. This approach values patient-physician communication that is understood and respected by both parties. The goal is for the physician to achieve understanding of the patient's practices and intentions, and for the patient to fully understand the physician's messages about prognosis, diagnosis and management.
Cross-cultural efficacy is a term that does not imply that there is a preferred or more accurate cultural view. It simply recognizes that physicians and patients have different life experiences and perspectives and therefore, that all clinical encounters are cross-cultural. Culture in this definition means much more than just race or ethnicity. Specific efforts are required to assure that both parties understand each other and an effective caring relationship can be established. These efforts can save time and be more effective than other approaches.

Slide 4



Case #1, Screening. While you watch this case, think about how you would Ask about alcohol use. Think about the good and bad characteristics of how this physician asks his patient about drinking.

The case begins in the middle of a medical history from this 45 year old carpenter who presents for a routine physical, in part because a friend was recently diagnosed with prostate cancer.

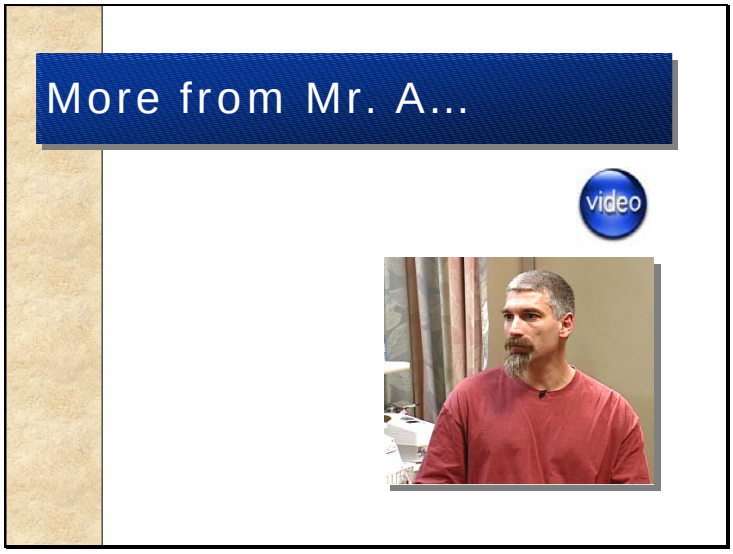
Slide 5

Is Mr. A drinking risky amounts? In epidemiologic studies, these drinking amounts have been associated with adverse consequences. These studies are similar in design to studies that inform us regarding the possible benefits of moderate drinking.
For men, amounts that risk adverse consequences are:
- more than 14 standard drinks per week or 2 per day on average or more than 4 on any one occasion

For women and people 65 years of age and older, the corresponding amounts are:
- 7 per week or 1 per day on average and 3 per occasion

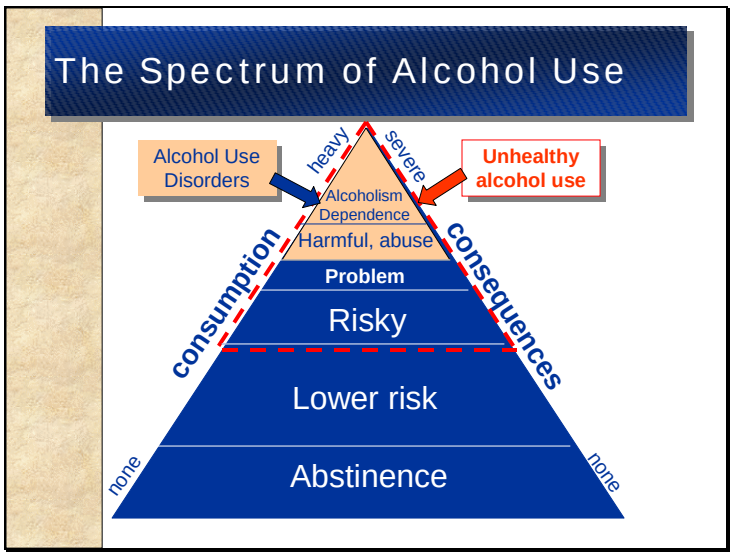
One reason why women risk consequences at lower amounts is that women have less gastric alcohol dehydrogenase and therefore absorb more alcohol per unit ingested.
Of note, the per occasion amounts place patients at risk for acute consequences such as falls and trauma. The weekly amounts, when done over time, place patients at risk for the more chronic, medical consequences, such as cancers and liver disease. Despite the fact that some consequences such as cirrhosis are generally seen at much higher amounts than these cutoffs, epidemiologic studies can detect increased risks for these disorders beginning at these amounts.

Slide 6



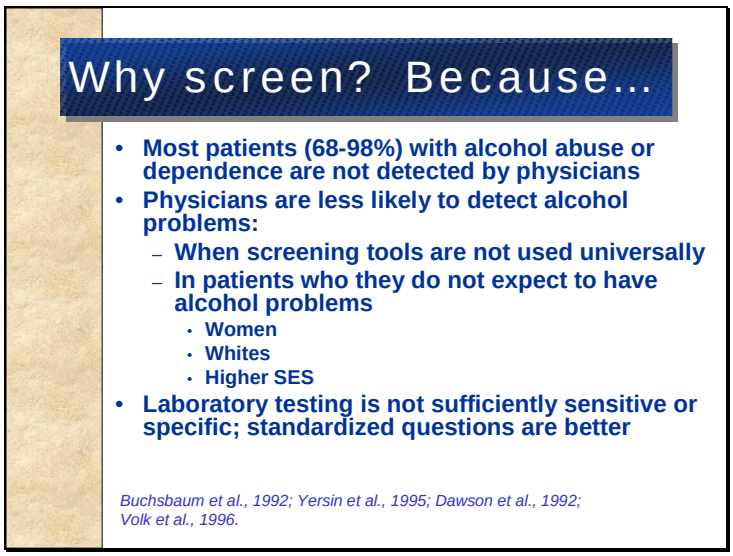
Let's hear from the patient about what he was thinking and how he viewed the physician and his line of questioning.

Slide 7



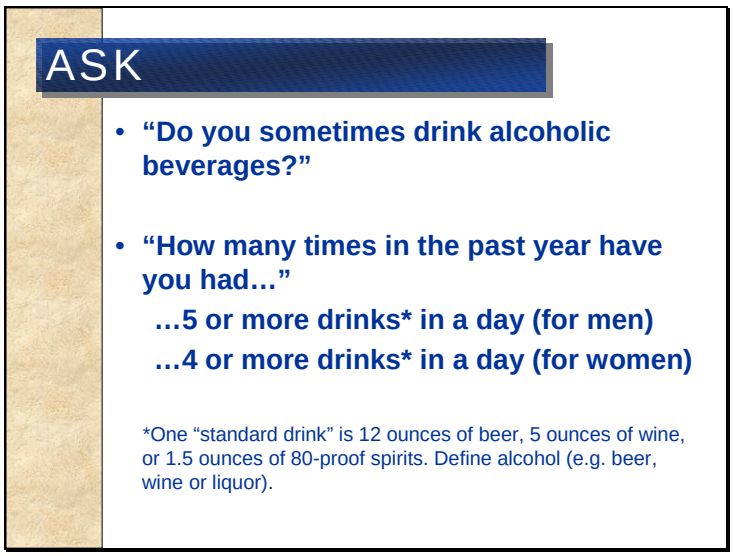
Consider Mr. A's alcohol consumption and where it fits on this spectrum of alcohol use. This is one way to think about the levels of use and unhealthy drinking that the physician was trying to identify. This depiction is adapted from a report from the Institute of Medicine. The amount of consumption is represented on the left side of the triangle, and consequences are on the right. Both increase as one moves up to the top of the triangle. In general, clinicians are accustomed to seeing and recognizing the more severe alcohol use disorders, which are Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses, alcohol abuse and dependence. In these disorders, consumption is heavy and consequences severe.
Dependence is often referred to more colloquially as alcoholism.
Harmful drinking is a term from the International Classification of Diseases whose definition is similar to alcohol abuse from the DSM, meaning that there have been recurrent consequences of drinking without meeting criteria for dependence.
Problem drinking means a consequences or problem has occurred due to drinking.
Risky drinking refers to amounts that risk adverse consequences, but in the absence of consequences thus far.
Unhealthy alcohol use is a term that encompasses all the categories just described, and included within the red dashed border.
Lower risk drinking refers to more moderate amounts (less than risky amounts), also with no consequences (except perhaps some cardiovascular benefits for some).
In its 1990 report, the IOM recommended identifying drinkers in the red dashed border, particularly those who had not yet progressed to abuse or dependence, in the hopes of decreasing drinking and consequences when it was easier to do so and before significant morbidity or mortality occurred. Risky drinking is much more common than dependence:
almost one-third of drinkers in the US drink risky amounts and nearly one in four of these individuals have alcohol dependence.
About 1 in 12, or 17 million adults in the US suffer from alcohol abuse or dependence (more than have hypertension, asthma, or arthritis). Yet only about 10% receive treatment.
Finally, alcohol is a leading cause of preventable medical conditions, disability, and deaths, (approximately 85,000/year), second only to tobacco and physical inactivity.

Slide 8



Why screen for alcohol-related risks and problems?
First, most patients with alcohol abuse or dependence are not detected by physicians. But the patients are being seen by physicians—79% of adults in the US saw a health professional in the past year, and half of physician visits are with primary care physicians.
In addition, physicians are less likely to detect unhealthy alcohol use when screening tools are not used universally, and in patients whom are not expected to have unhealthy alcohol use such as in women (in whom the prevalence is in fact lower than men), whites, and persons of higher socioeconomic status.
Laboratory testing is not sufficiently sensitive or specific (although, for example, certainly a high gammaglutamyl transferase and MCV and aspartate aminotransferase without other explanation strongly suggest alcohol as the etiology); standardized questions are better.
Finally, brief, valid screening tests are available, and brief intervention by physicians is effective, and recommended in practice guidelines issued by the US Preventive Services Task Force, a group that requires high level evidence before endorsing any recommended practices.
How should one ask about alcohol use and consequences when screening?

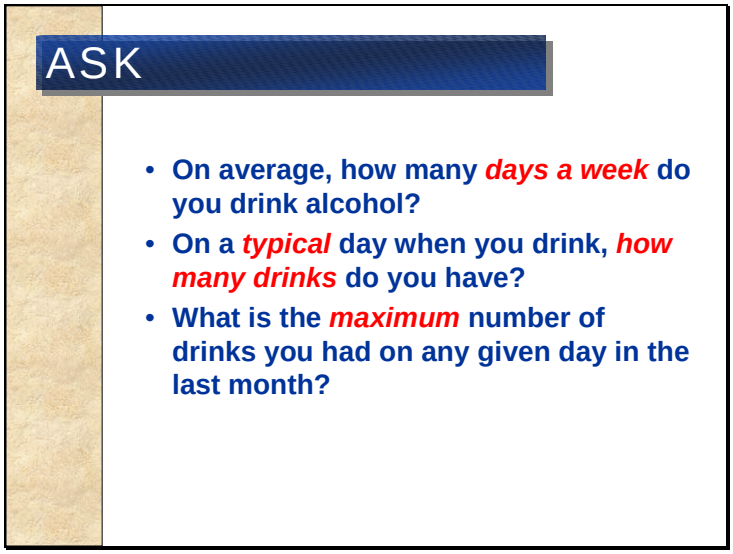
Slide 9



There is more than one way to screen for unhealthy alcohol use. The NIAAA recommends a single item screening test for people who drink alcoholic beverages at least sometimes. The question is: "How many times in the past year have you had 5 or more drinks in a day *(for men)* or 4 or more drinks in a day *(for women)*?" The screening test is positive if the answer is one or more times. One "standard drink" is equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits. It is also a good idea to define alcohol as beer, wine or liquor.

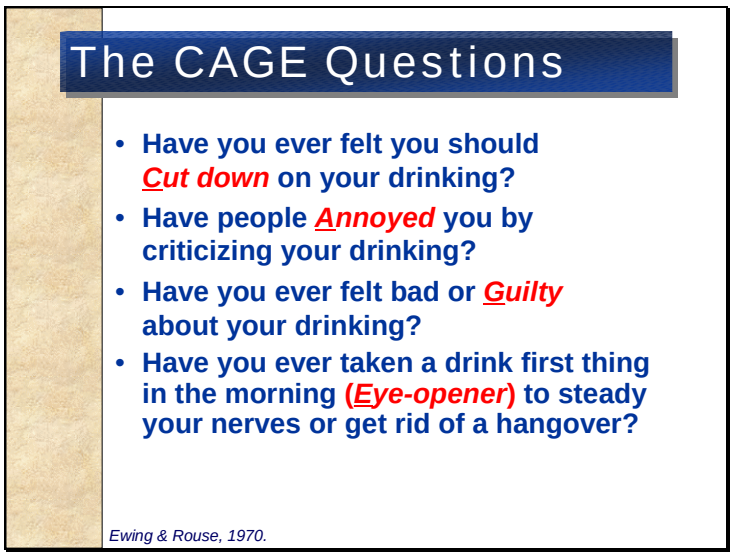
Other screening tests can be used. For example, the 10-item Alcohol Use Disorders Identification Test, is useful as a written self-report instrument, provided at http://www.niaaa.nih.gov/publications/Practitioner/guide.pdf "Helping patients who drink too much. A Clinician's Guide." Another alternative is to directly ask about risky drinking amounts, with or without the familiar CAGE questionnaire.

Slide 10



These 3 simple questions will allow you to categorize a patient's alcohol consumption as risky or not.
First, consider an opener like: "Do you ever drink any beer, wine, liquor or other drink containing alcohol?" and/or "What do you usually like to drink?" Then Ask: On average, how many *days a week* do you drink alcohol?
On a *typical* day when you drink, *how many drinks* do you have? What is the *maximum* number of drinks you had on any given day in the last month?

Slide 11

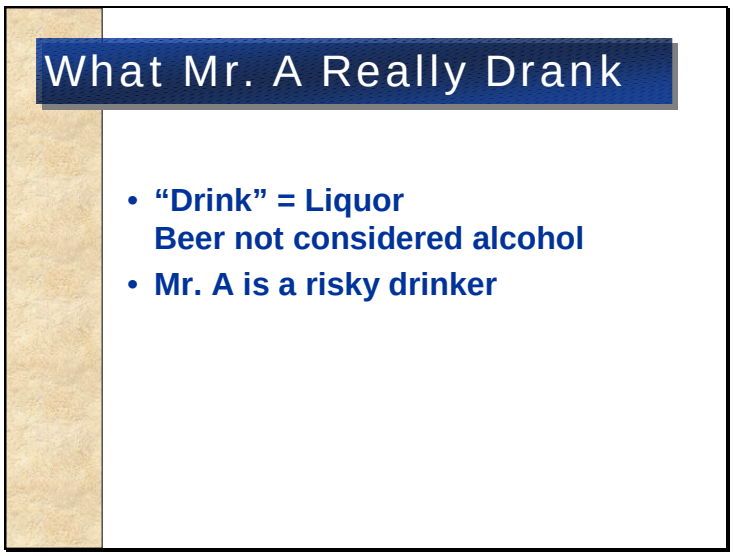


Some physicians like to Ask everyone the CAGE questions listed here. These can be part of a standard approach, or can be asked only when patients report drinking risky amounts. Asking everyone will identify more patients with past problems or patients with current heavy drinking who did not understand the prior questions or accurately report their drinking amounts. When asked, the CAGE questions should be asked verbatim as part of the routine medical history.

The CAGE questions are:
Have you ever felt you should *Cut down* on your drinking?
Have people *Annoyed* you by criticizing your drinking?
Have you ever felt bad or *Guilty* about your drinking?
Have you ever taken a drink first thing in the morning (*Eye-opener*) to steady your nerves or get rid of a hangover?

The CAGE questionnaire alone, using 1 affirmative response as a positive test, is about 80-90% sensitive and specific for an alcohol use disorder. Using 2 as a cutoff is less sensitive.

Slide 12



So let's get back to thinking about Mr. A. How much was he really drinking?
For him the word "drink" meant liquor. He didn't consider beer to be alcohol. In addition, his beer was a pint (16 ounces, more than a standard drink). So in fact Mr. A was drinking three 16 ounce beers and three shots at a time, exceeding per occasion risky drinking limits.
The physician asked the right questions but a more efficacious communication approach might have yielded more accurate answers, leading to a correct diagnosis and to appropriate intervention.

Slide 13

The acronym RESPECT summarizes an approach that can help Assure cross-cultural efficacy, obtain accurate information, and ensure your patient accurately understands you. Since all physician-patient encounters are essentially cross-cultural, there is a risk of misinterpretation and misunderstanding. Differences in "culture" can range from social class, income, sex, race, and age, to simply different life experiences because of health professional and physician training or other reasons. Patients and physicians almost always differ on some life experience (even if only by exposure to medical training). Attention to this fact can help assure efficacy of screening and avoid gathering inaccurate information leading to inefficiency and misdiagnosis.

Physicians and patients need to arrive at the same understanding (shared meaning) of the problem. Issues include:

Demonstration of Respect (e.g. eye contact, listening attentively, and being nonjudgmental).

Understanding the patient's explanatory model. This is the model or rationale that patients use to explain their condition, illness or behaviors. It is derived from the patient's view of the world and may reflect values, beliefs or "common knowledge" among family and peers. In this case, the patient has a well formulated rationale for his use of alcohol. The physician needs to understand this rationale to fully understand the extent of the patient's drinking (e.g. clarify meaning of "drink").

Being aware of the patient's sociocultural context as viewed and explained by the patient to avoid stereotyping assumptions can help avoid misunderstanding.

Awareness of the ever present Power differential. Why should we remain aware of this explicitly? To have a low threshold to check in with the patient about the information they are reporting, and in order to accomplish the rest of the things listed on this slide. How can the power differential be minimized? Some ways are to use good eye contact, to sit at the patient's level rather than above or facing away from the patient or sitting behind a barrier, and to avoid the use of medical jargon.

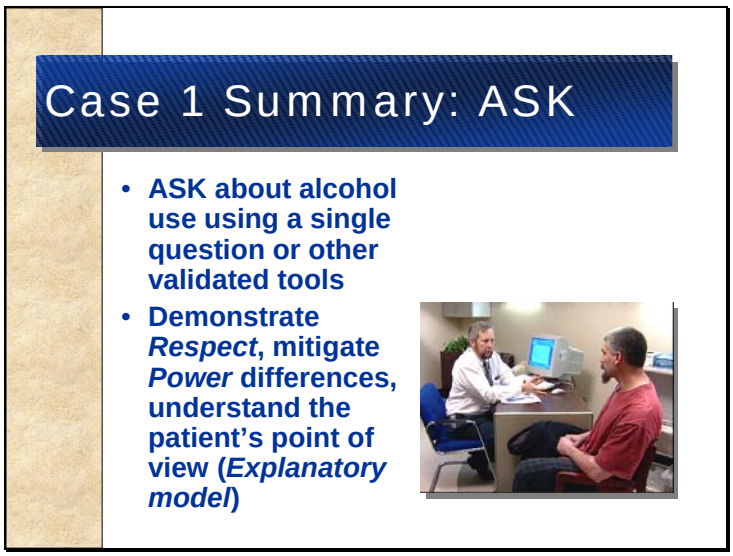
Express empathy by making sure the patient feels heard and understood (repeating what the patient has said while making eye contact can help achieve this goal). Empathy is a powerful and proven intervention that helps physicians address drinking problems with their patients.

Eliciting concerns from the patient can help direct the conversation, share the power, and ensure that the patient feels heard.

And finally, establishing a trusting and therapeutic alliance is essential to having patients report their practices and thoughts, and to having the physician's advice be heard and followed.

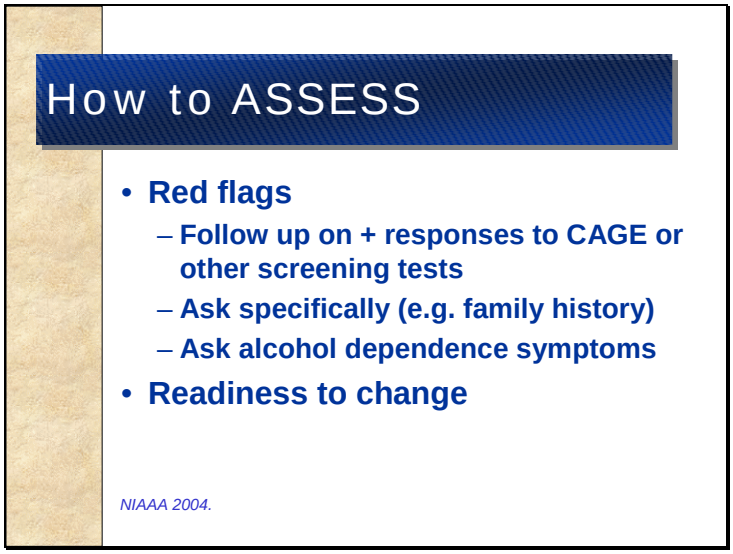
BUMC Diversity Curriculum Task Force 2001, based on the work of Kleinman et al., 1978, Carillo et al., 1999.

Slide 14



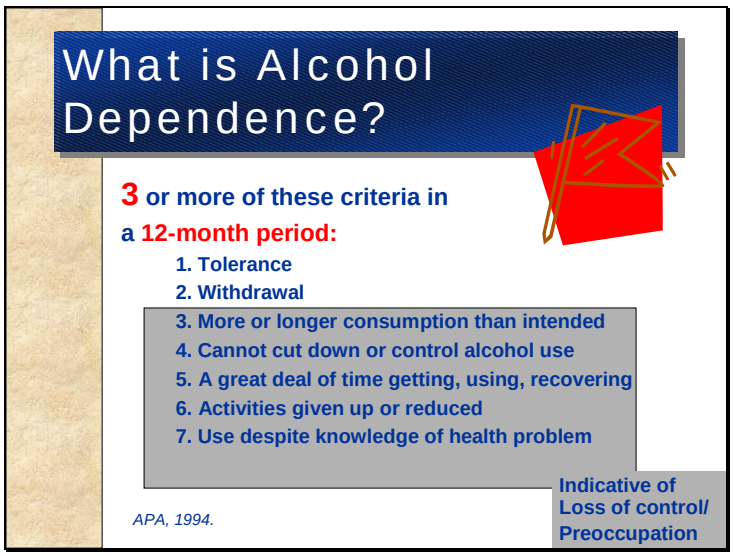
In summary, physicians should screen for unhealthy alcohol use, as recommended by the US Preventive Services Task Force 2004 Guidelines and the National Institute on Alcohol Abuse and Alcoholism, by asking a single validated question about consumption or by using other validated tools such as quantity and frequency and CAGE questions or the AUDIT. While asking, demonstrating respect, mitigating power differences, and understanding the patient's point of view will lead to more accurate information gathering and facilitate the next steps in the process, Assessment and Advice.

Slide 15



How should one Assess efficiently? Look for Red Flags and then Assess readiness to change. Red flags are drinking risks or consequences of drinking that help determine the best course of action. To look for them, ask follow-up questions to any affirmative response to CAGE or other screening tests (e.g. what happened when you tried to cut down? What did you feel guilty about?), ask about specific red flags, like a family history of alcoholism, and query patients regarding alcohol dependence symptoms.

Slide 16



What are the symptoms of alcohol dependence one should ask about? The key features of alcohol dependence are tolerance, withdrawal, and signs and symptoms in the gray box indicative of loss of control or preoccupation with alcohol. To meet the Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM IV) criteria for dependence, the patient must have 3 or more of these 7 criteria in a 12 month period:

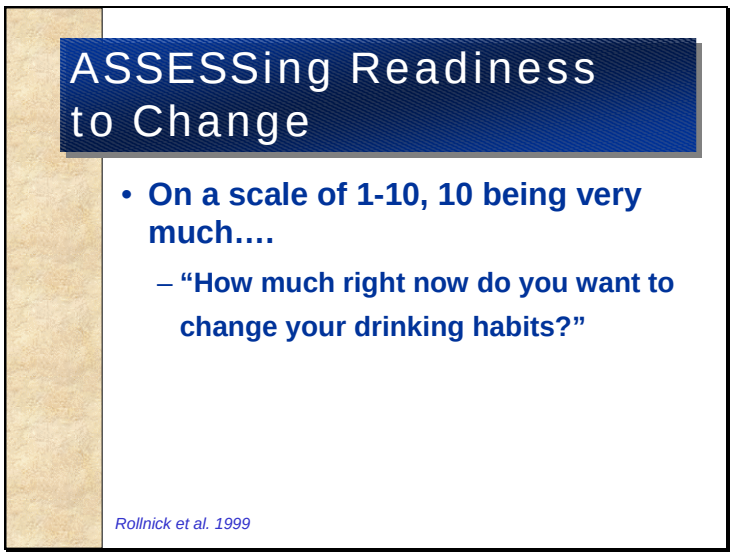
1. Tolerance:

Defined as increased amounts to achieve effect, or
Diminished effect from same amount.

2. Withdrawal:

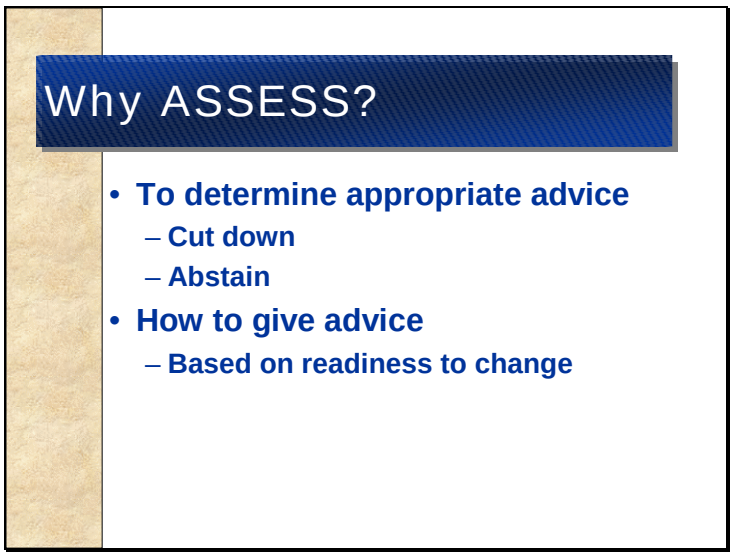
Defined as 2 or more withdrawal symptoms after cessation or reduction in alcohol use, including sweating or rapid pulse, tremor, anxiety, nausea or vomiting, hallucinations, psychomotor agitation, and seizures.
Or
More or longer consumption than intended, inability to cut down or control alcohol use, spending a great deal of time getting, using, or recovering from the effects of alcohol, giving up activities or reducing them as a result of drinking, and use despite knowledge of health problem.

Slide 17



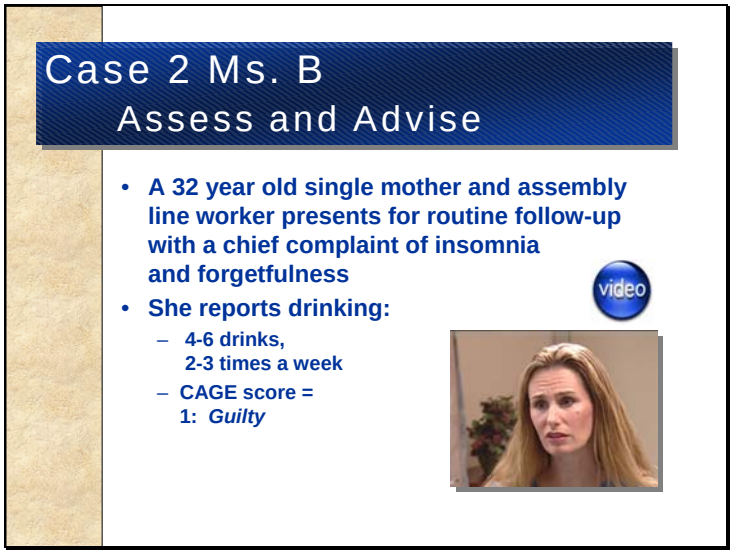
To Assess and discuss readiness to change, a simple question is:
"On a scale of 1-10, where 10 is being very ready, how much right now do you want to change your drinking habits?"
If the patient answers 10, there is little need to address motivation, except perhaps to confirm it later and anticipate changes in motivation. If the patient answers 2, ask "why didn't you answer 0?" to prompt the patient to tell you why they do want to change. Also ask "What would it take to get you to a 5?" to have the patient outline some strategies for change that will be acceptable.
Also, consider exploring components of readiness to change by asking "How important is it for you right now to change your drinking habits?" and "If you decide to change your drinking habits, how confident are you that you would succeed?" and discussing those answers in the same way. These questions help provide areas for focus of further discussions (e.g. One does not need to emphasize the health consequences of heavy drinking if the patient already thinks it is important to quit but they just don't think they can do it).

Slide 18



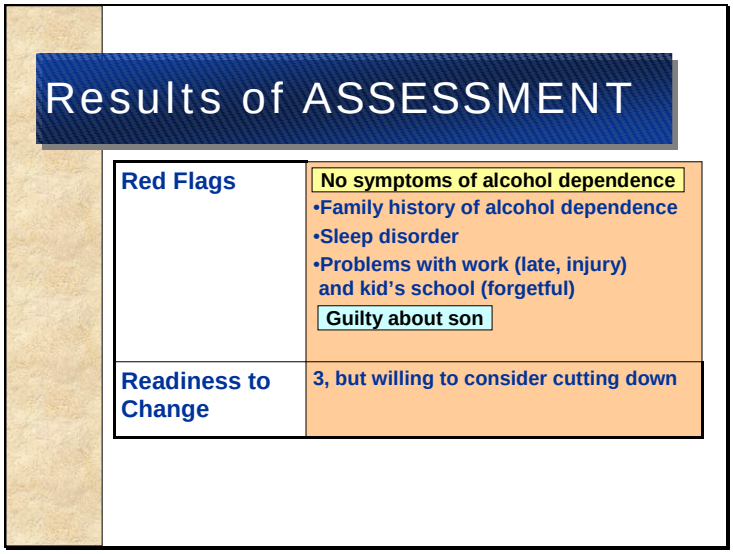
Why do an Assessment? Because it helps determine the appropriate advice, including whether to cut down or abstain, and because it helps determine how to give Advice consistent with how ready the patient is to change their drinking.

Slide 19



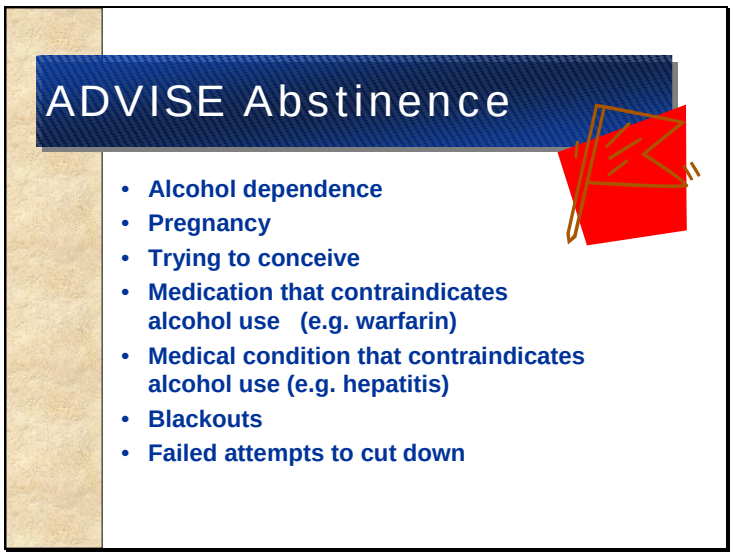
Case 2 will focus on what follows screening: how you Assess for alcohol related problems and how you then give appropriate Advice.
Ms. B is a 32 year old single mother and assembly line worker who presents for routine follow-up with a chief complaint of insomnia and forgetfulness. She reports drinking 4-6 drinks, 2-3 times per week, putting her use of alcohol at least at the "high risk" level. Remember that the risky limits for women are more than 3 drinks on an occasion and more than 7 drinks per week.
In this case, the patient has already given 1 positive response from the 4 CAGE screening questions: she admits to feeling guilty about her drinking.
Lets find out more about her alcohol use.

Slide 20



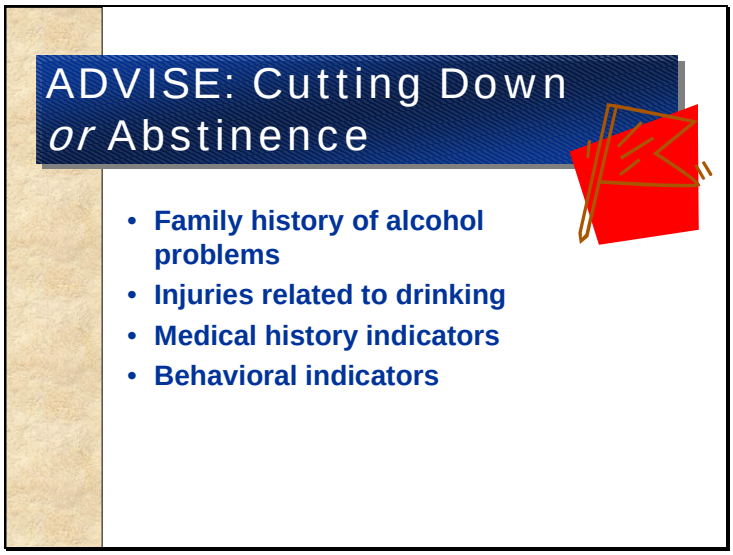
As we just saw, the physician performed an Assessment of this woman's alcohol use.
What specific things did the physician do (well) to Assess the patient? She followed up on CAGE questionnaire responses. She also focused on complaints complaints of concern to the patient (sleep and memory issues) and alcohol consequences related to them. And she asked about Red Flags, like withdrawal symptoms, and Assessed readiness.
What could the physician have done differently? It might have helped the patient recognize consequences of her drinking if the physician had emphasized and repeated the patient's own reported consequences like being late and injured due to drinking.
So, an Assessment includes looking for Red Flags for unhealthy alcohol use and assessing readiness to change alcohol use behaviors
Assessing for Red Flags includes asking about symptoms of alcohol dependence, a family history of alcohol dependence, history of injuries related to alcohol use, medical problems such as hypertension, depression, insomnia, social problems such as problems at work, at school or at home, pregnancy or trying to conceive, medications and medical conditions that may make concurrent alcohol use dangerous, history of blackouts or repeated failed attempt at cutting down.
Assessing readiness to change can be done in a variety of ways including using 0 to 10 point scales to have patients state their readiness in a quantitative way.
In this case, the patient had no symptoms of alcohol dependence but had red flags including a family history of alcohol dependence, insomnia, problems at work and with family responsibilities, and she rated her readiness to change as a 3 on a scale of 0 to 10.
Based on clinical judgment, this patient would benefit from either cutting down or abstinence. For example — if there has been a pattern of repeat alcohol-related consequences such as injuries related to drinking (including motor vehicle crashes, driving while intoxicated), medical history indicators (including hypertension, anxiety, depression, sleep disorders) or behavior indicators (including problems at work, school or home) cutting down may be inadequate. However, if there is a family history but no personal consequences, and a history of safe drinking – cutting down may be adequate.

Slide 21



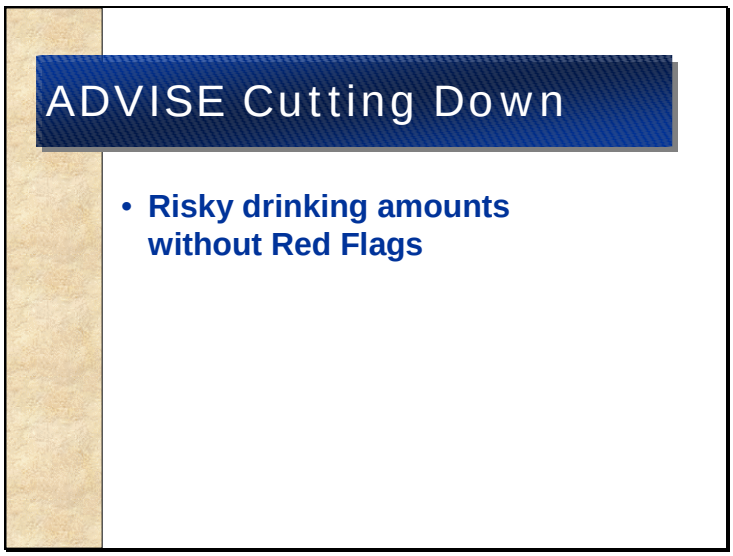
When your patient has any of the following: alcohol dependence, pregnancy or trying to conceive, medications and/or medical conditions that contraindicate alcohol use, history of black outs or failed attempts at cutting down then your Advice should be abstinence. Remember to be clear with the patient about your clinical Advice. The patient may not agree with your Assessment and Advice but that doesn't mean that you should compromise your clinical judgment and change your Advice. We will discuss strategies to help motivate your patient to alcohol-related behavior change later in this presentation.

Slide 22



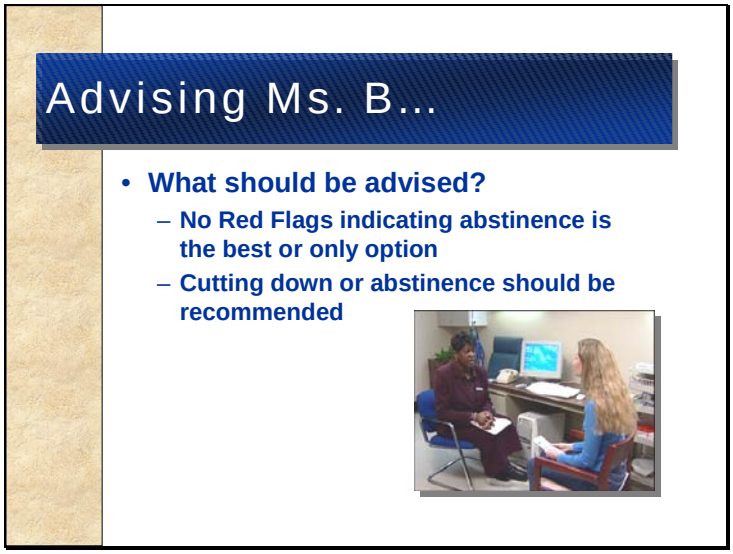
You may Advise cutting down or abstinence if the patient has a family history of unhealthy alcohol use or if there have been injuries related to drinking or medical or behavior indicators suggesting that drinking is harmful.

Slide 23



If your Assessment found no Red Flags but your patient is drinking risky amounts it would be appropriate to advise them to cut down.
Now thinking back to the case (number 2), what is the appropriate advice to give Ms B? Cut down, abstain, or either cut down or abstain?
What parts of her history influence your decision?

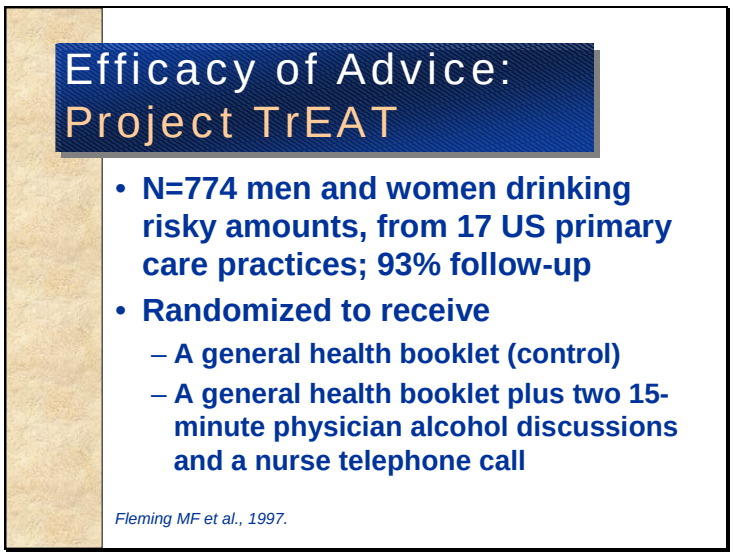
Slide 24



Since there were no red flags indicating abstinence was the only option, either cutting down or abstinence should be recommended.

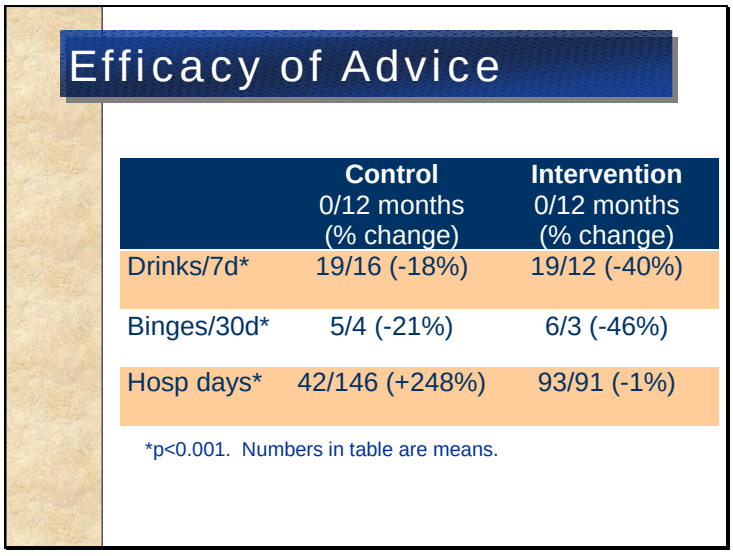
So, does giving brief Advice actually work? Let's take a look at a representative study from the literature.

Slide 25



This study, called Project Treat (the Trial of Early Alcohol Treatment), was conducted in outpatient medical settings. It was a randomized controlled trial in 17 private practices, with 64 physicians and 774 men drinking more than 14 drinks per week and women drinking more than 11 drinks per week. 93% of subjects completed follow-up at 12 months. The control group got a health booklet. The intervention group got the same health booklet, but also received two 10-15 minute physician discussions about alcohol and a follow-up nurse phone call.

Slide 26



So what was the efficacy of the Advice? Both groups decreased their drinking, but the intervention group that received advice cut their weekly and binge drinking by around 40%, about twice as much as the control group. Hospital utilization stayed the same in the intervention group but increased in the control group.

There have been dozens other studies of brief advice in many settings with similar results. Some of these show decreases in gamma-glutamyl transferase (GGT), alcohol-related medical conditions, and one found a decrease in mortality
(D'Onofrio & Degutis, 2002; Emmen et al., 2004; Wilk et al., 1997; Beich et al., 2003; Whitlock et al., 2004; Ballesteros et al., 2004; Poikolainen, 1999; Bien et al., 1993; Fleming & Manwell, 1999; Fleming et al., 2002; Kristenson et al., 2002).

Slide 27

Efficacy and Cost of Advice
TrEAT Long-term Follow-up

At 4 years…	Control	Intervention
Hospital Days (p<0.05)	663	420
ED Visits (p<0.08)	376	302
Risky Drinking* (p<0.001)	35%	23%

Cost of intervention: $166 per patient
(includes patient costs)
Net benefit: $546 in medical costs,
$7780 if societal costs included (mainly motor vehicle)

**36 months. >20 drinks (men), >13 drinks (women) per week*
Fleming MF et al., 2002.

Do changes persist long-term? In Project Treat, after 4 years, Fleming and colleagues found that the number of hospital days, emergency department visits and risky drinking behaviors all remained lower in the intervention group compared to controls. Moreover even though the cost for the brief intervention was only $166 per patient, the net benefit was medical cost savings of $546 and societal cost savings of $7780 per patient. Therefore this brief advice resulted in healthier patients who drank less at lower cost.

Lets now return to case 2 and see what advice was given and how it was done. Pay attention to what the physician did well and what she might have done differently.

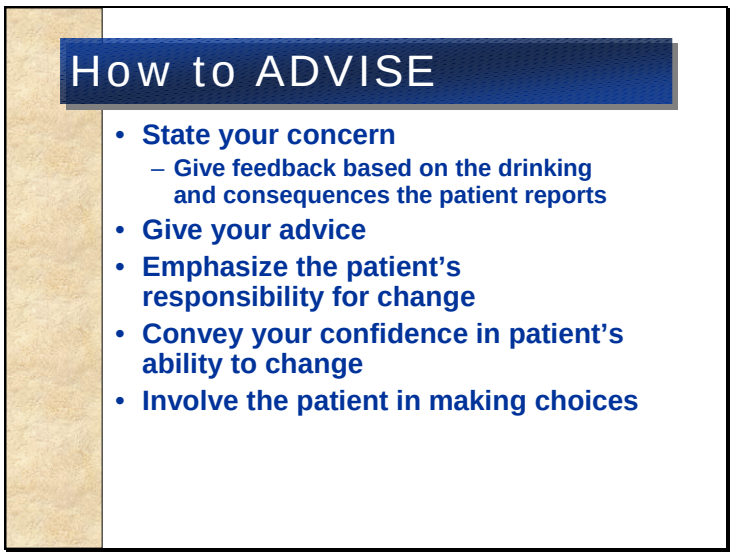
Slide 28

Case 2 Ms. B
Advise and Assist

video

After the video ask:
What did the physician do well? What could she have been done differently? What is the best way to give Advice? The physician gave specific recommendations to cut down and provided the patient with specific drinking limits. She also gave a specific recommendation regarding follow-up emphasizing that the problem was important enough to check up on. The physician could have acknowledged difficulties the patient might have, and done more to negotiate an acceptable plan by asking whether the patient was ready to hear advice, and by asking what she might be ready to do. At one point, the patient says she doesn't want to keep having problems—the physician could have emphasized this for the patient by repeating her own words.

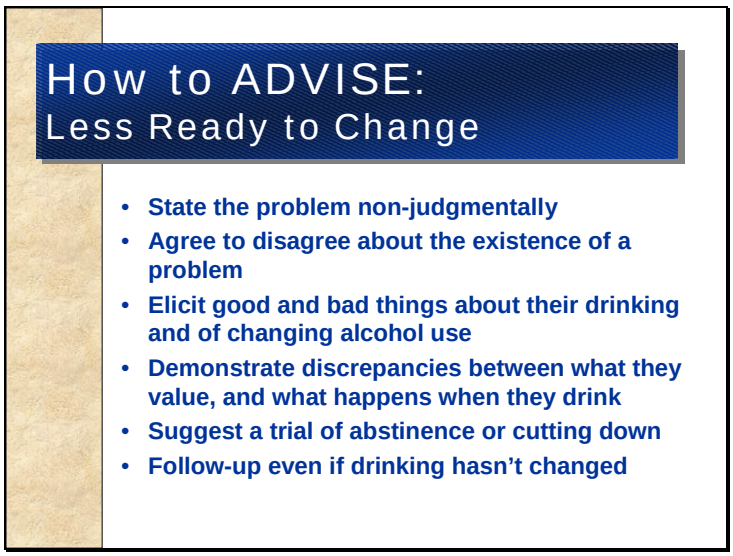
Slide 29



Your goal is to serve as a catalyst in your patient's behavior change.
When giving your patient Advice - to cut down and/or abstain - you should:
State your concern about their alcohol use. Demonstrate empathy, and avoid confrontation. Be specific by giving feedback based on your assessment of their drinking and alcohol-related consequences.
Give your Advice clearly, and ask how the patient feels about the plan: "As your physician I recommend that you (for example) stop drinking (or stop driving after drinking, etc). How does that sound to you?"
Emphasize the patient's responsibility for change: "What you ultimately do about your drinking is up to you." Perceived control is an element of motivation for behavior change.
Convey your confidence in the patient's ability to change. Enhance the patients sense of self-efficacy: for example, "You have had periods of sobriety in the past, there is no reason to think you can't do it again," or "Even though you haven't decided to stop drinking, you've come back to discuss your drinking on several occasions. That tells me you're determined."
Involve the patient in making choices from options: "This is what has worked for others. What do you think might work for you?"

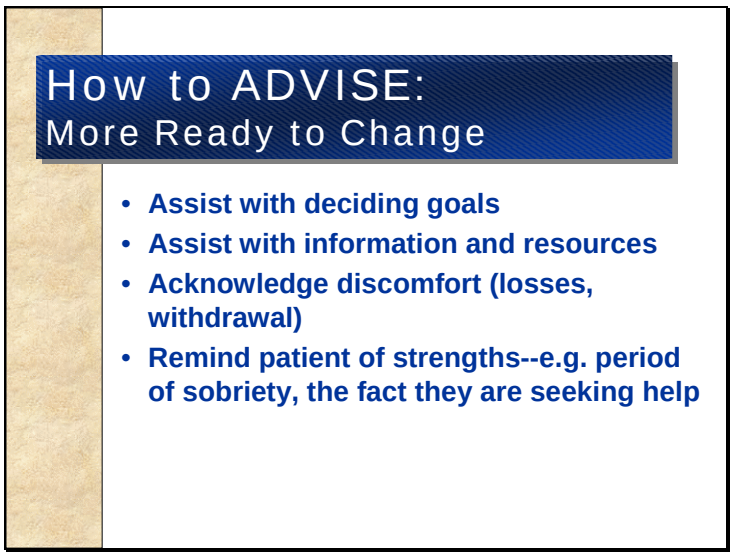
We will now discuss how you can tailor your approach depending on whether your patient is less ready or more ready to change his or her drinking.

Slide 30



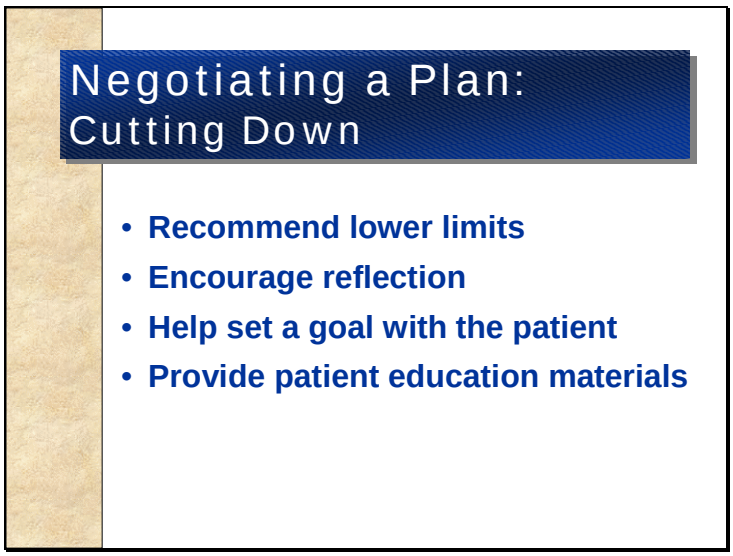
If you find that the patient is less ready to change:
You should state the problem with drinking behavior non-judgmentally, for example, "The amount of alcohol you drink is causing you problems with your health (specify, if possible how, e.g. increased liver enzymes, hypertension, insomnia, etc)." And, be empathic "It must be hard to want to be healthy but to continue to do something (like drink alcohol) that is hurting your health."
Agree to disagree about the existence of a problem: for example, "I think your alcohol use is causing you medical problems but you don't agree. Let's just recognize that we don't agree about that. But would you consider cutting down anyway to see if your heartburn gets better?"
Elicit good and bad things about their drinking: for example, "What do you like about drinking?" "What don't you like about drinking?"
Elicit good and bad things about changing alcohol use: for example, "What would be a good thing about cutting down (stopping) your alcohol use?" "What would be a bad thing about cutting down (stopping) your alcohol use?"
Develop and demonstrate discrepancies between what they value and what happens when they drink: for example, "You've told me how much you enjoy drinking alcohol and yet you say that you hate waking up feeling sick." "You've told me how much your family means to you and yet you say they are upset with your drinking."
Suggest a trial of abstinence or cutting down: for example, "You said that you could stop drinking anytime, that it is not a problem for you; so lets see if you can not drink for the next 4 weeks just as a trial. I'd like you to come back in 4 weeks and tell me how it went."
Follow-up even if drinking hasn't changed: for example, "I want you to see me in 4 weeks even if you are still drinking." "My sense is that this may be more difficult than you think. Don't get discouraged. There are other ways I can help you."

Slide 31



When your patient is more ready to change you should:
Clarify the patient's own goals and strategies for change or assist them in deciding on their goals.
Offer patients a menu of options and assist them with information and resources.
Explore the patient's expectations regarding their course of action acknowledging that it may be difficult and that it may be uncomfortable physically and emotionally. Examples are losses of friends they used to drink with; Physical consequences of quitting include symptomatic withdrawal.
Finally, continue to support their self-efficacy reminding them of their strengths, like a period of sobriety, or the fact that they are seeking help, or good compliance with follow up appointments, etc.

Slide 32



Negotiation is an interactive exchange between the physician and patient resulting in a mutually agreeable plan. In this process, it is important to be clear about your recommendations, to elicit the patient's perspectives, and to be open to compromise. Negotiation may not yield the plan that you believe is best for the patient, but it does allow for a plan that the patient is most likely to follow. Participating in the development of the plan helps shape a plan that is more likely to happen and can lead to health benefits.

Advice should include recommending lower drinking limits. Review lower risk cutoffs for the patient, keeping in mind gender, age, medications, health conditions, etc.
Encourage reflection. For example, Ask patients to weigh what they like about drinking versus their health and life goals and reasons for cutting down. "What do you think you will do?"
Help set a goal with the patient such as a trial of abstinence.
And provide patient education materials.

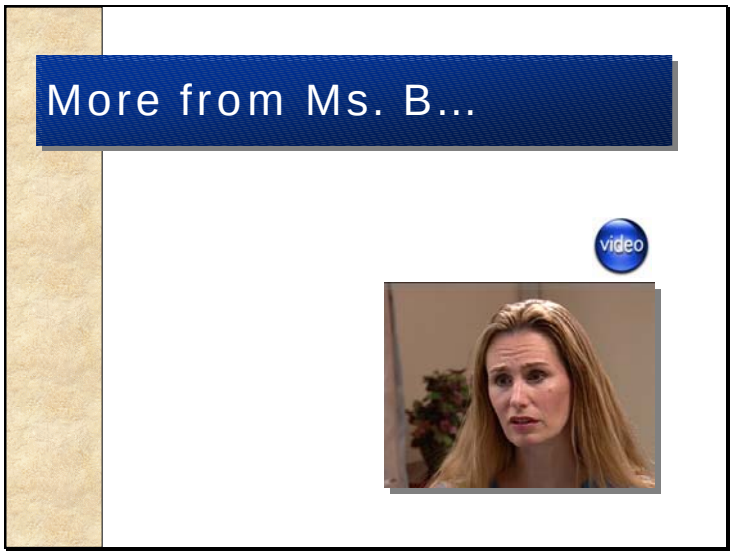
Slide 33

Follow-up is key to adherence to the plan. It provides the patient with the expectation they will be monitored. It will allow you to monitor adherence, and to adjust the plan to better suit the patient and situation over time.

Recommend a specific follow-up interval.
In follow-up, review drinking goals and progress (e.g. drinking, liver enzymes like GGT if elevated at baseline), reassess readiness, reinforce any positive changes, acknowledge change is difficult, revisit advice, and follow-up again.

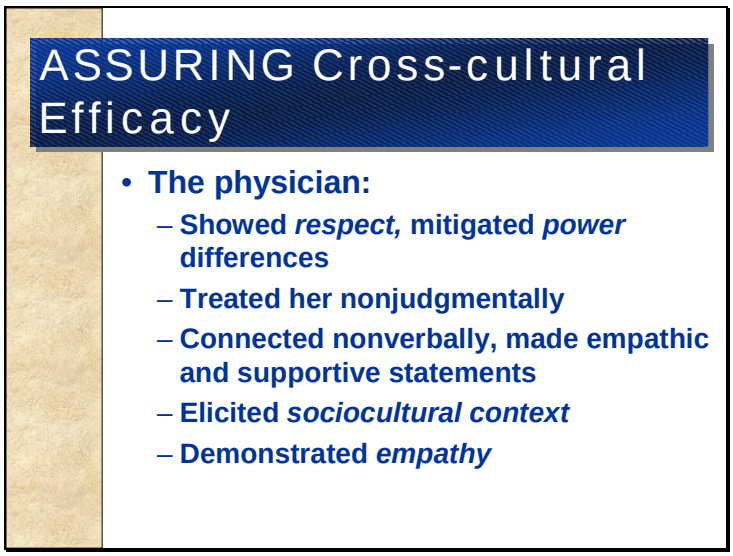
Let's now hear what Ms. B thought of the advice that was given to her.

Slide 34



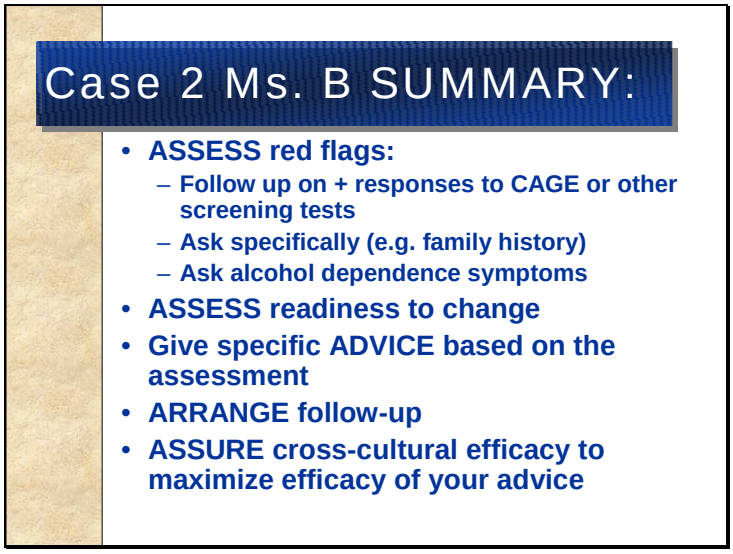
[After the video]
How did the physician communicate in a culturally efficacious way?

Slide 35



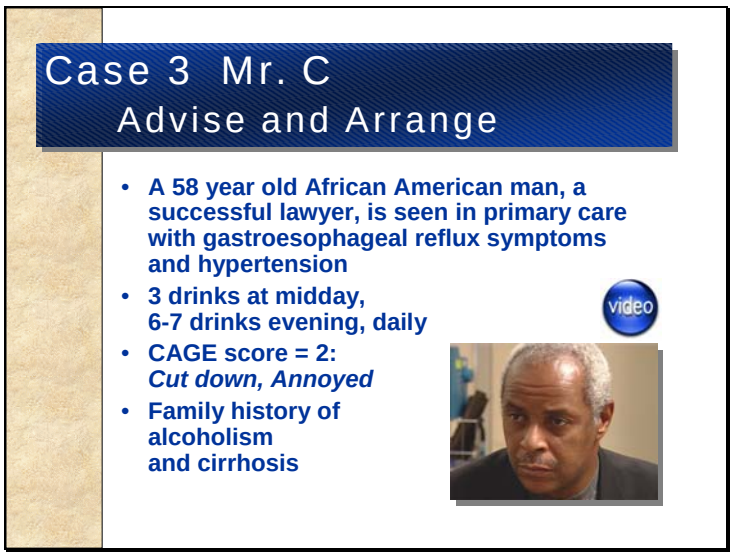
The physician:
Showed *respect*, mitigated *power* differences
Treated her nonjudgmentally
Connected nonverbally (by leaning forward, making eye contact, sitting at the same level), made empathic/supportive statements (e.g. "that must be hard")
Related to the patient on a personal level (*respect*)
Elicited *sociocultural context* (drinks with friends)
Demonstrated *empathy* showing she understood the patient's situation

Slide 36



So, in summary:
Assess for red flags, following-up on positive responses to the CAGE questionnaire or other screening tests and by asking specifically about red flags, including alcohol dependence symptoms and readiness to change to understand severity and determine advice.
Give specific Advice based on the assessment, involving the patient in choices.
Arrange follow-up regardless of drinking.
Assure cross-cultural efficacy by addressing *trust*, *respect* and *sociocultural context* to maximize the efficacy of your advice.

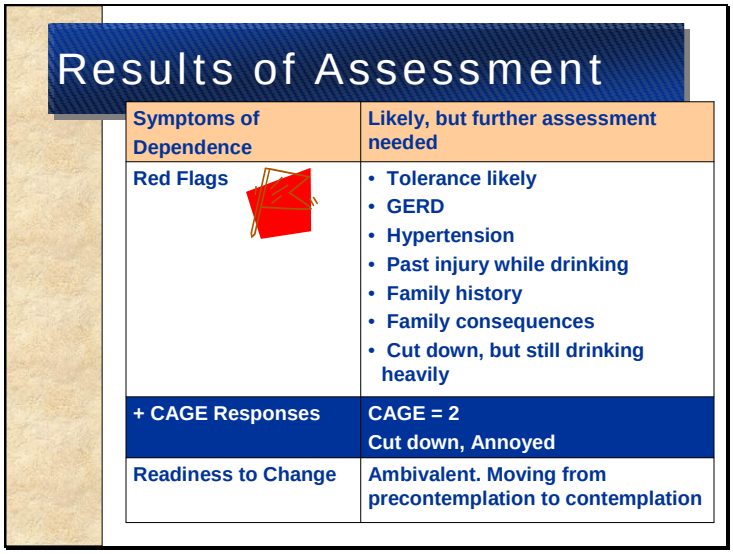
Slide 37



Case 3 is Mr. C, a 58 year old African American man, a successful lawyer, who is seen in the primary care setting with gastroesophageal reflux symptoms and hypertension. He reports drinking 3 drinks a day at midday during lunch, and 6-7 drinks every evening. He reports affirmative responses to two of the CAGE questions, having tried to cut down and having been annoyed by people criticizing his drinking. He also has a family history of alcoholism and cirrhosis.

When watching the video, consider the following:
Does Mr. C have consequences of alcohol use?
What are the red flags that indicate problems or higher risk of consequences of alcohol use?
Does he have alcohol dependence?
How ready is he to change his drinking?

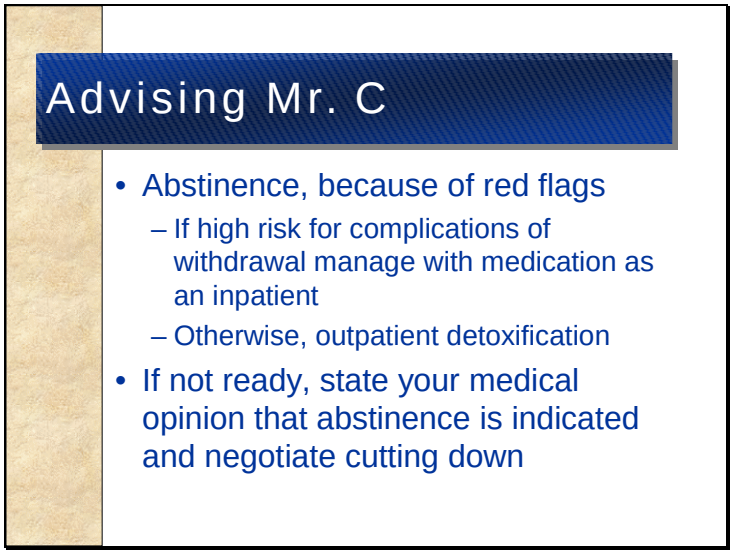
Slide 38



What were the results of the Assessment?
Did he have symptoms of alcohol dependence? He likely did have alcohol dependence but further assessment is needed to determine if he would meet criteria for the disorder.

What red flags indicate Mr. C is at risk for alcohol use consequences, and what consequences did he already have?
His consumption amounts suggest tolerance.
He has reflux symptoms and hypertension, both of which can be caused or exacerbated by regular heavy drinking.
In addition, he reports past injury while drinking, a consequence of heavy drinking on an occasion.
Family history and other family consequences place him at risk for consequences of drinking.
Finally, he has tried to cut down, but is still drinking heavy amounts, and he has been annoyed by others criticizing his drinking, 2 affirmative CAGE responses.
How ready is he to change his drinking? He appears somewhat ambivalent, perhaps moving from precontemplation to contemplation.

Slide 39



What should be Advised for Mr. C?

The best advice for Mr. C would lead to improved health. In this case, abstinence would be advisable because of the red flags indicating dependence including attempts to cut down that have not eliminated the alcohol consequences.

Because advice is only fully heard by those ready, willing and able to listen, asking permission to give advice is one effective strategy (e.g. “May I give you some advice about your drinking?”). Another effective approach is to clarify that in your medical opinion abstinence works best for most people with alcohol use similar to the patient’s use.

The next issue that arises when advising abstinence is the need to manage the detoxification. Patients with high risk for medical complications of withdrawal require inpatient management and/or medication, benzodiazepines, to prevent seizures and delirium. Patients at high risk are those with seizures, past delirium tremens, acute medical, surgical or psychiatric illness, or other drug use (particularly benzodiazepines or barbiturates or other sedatives). Outpatient detoxification (with or without medication) can be done if the patient has a place to stay, someone to assist with their care, and the patient agrees to close contact with you or your clinical staff.

If the patient is not ready to abstain, simply state your medical opinion that abstinence is indicated but negotiate other options (e.g. what do you feel might work best for you for your drinking).

Slide 40

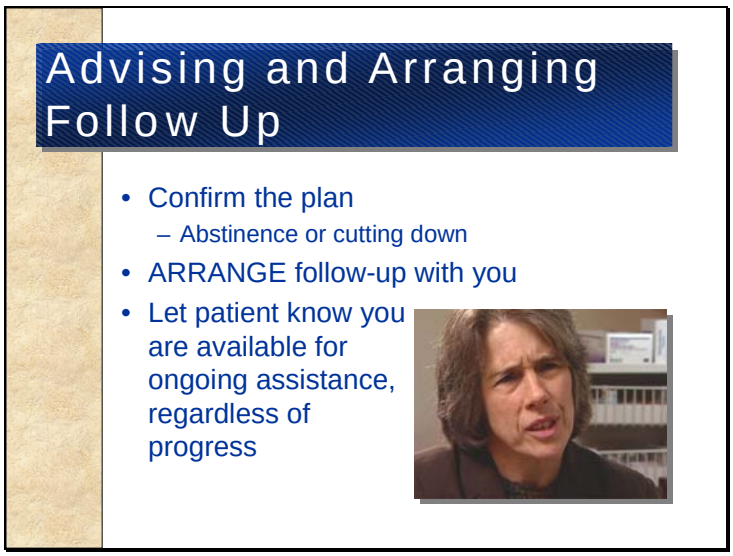
Patients who are ready to receive additional help, or those who do not succeed with cutting down or abstaining, should be offered referral for additional assistance. Discuss referral as you would for a more traditional medical issue (e.g., I would like to refer you to a specialist, she has helped my patients before; I'd like to get another opinion to confirm the diagnosis, etc.).

In order to refer one must know local resources and involve patients in the referral decisions. **Explain** to patients what might happen when they complete the referral and explore the patient's thoughts about the referral (e.g. you will meet with a counselor regularly; you will be admitted to a residential facility; they may offer you medications). Involve patients in decision making. **Consider** scheduling a referral appointment while the patient is in your office because this increases the likelihood it will be completed. **In addition** to addressing the alcohol problem, address medical and psychiatric comorbidity as needed, which will also facilitate alcohol treatment. **Communicate** with referral providers with the patient's permission and signed releases as appropriate, to increase the likelihood that specialty treatment will be optimal (much as a medical specialist will provide optimal treatment when the question and information from the referring physician are clear and communicated). Practically, in most settings in the US, referral options include contact with a substance abuse case manager from a patient's health plan, direct referral to providers regardless of insurance for patients who choose to pay for their care, public addiction services for the uninsured, Employee assistance programs, 1-800-662-HELP or http://findtreatment.samhsa.gov to locate local programs. Primary care physicians can certainly manage these problems if they have expertise and resources to do detoxification, counseling, and pharmacotherapy for alcohol dependence.

Referral to AA is also appropriate for most patients with alcohol dependence. To do so, demonstrate you know about AA. To learn more, attend a meeting so you can speak from personal experience. Provide lists of locally available meetings and meeting types (e.g. beginner, open, closed, non-smoking, female). Information is available in pamphlets, by phone to the local central service office and at www.aa.org. Encourage the patient to go to their first meeting with someone, have them try several different meetings, and follow-up on attendance as you would follow-up on other referrals (e.g. did you go to AA? How many meetings a week are you attending? Do you have a sponsor?). Finally, if the patient has these specific concerns, reassure that belief in God is not required (only a desire to quit drinking is), and reassure that AA neither condones nor prohibits medication use.

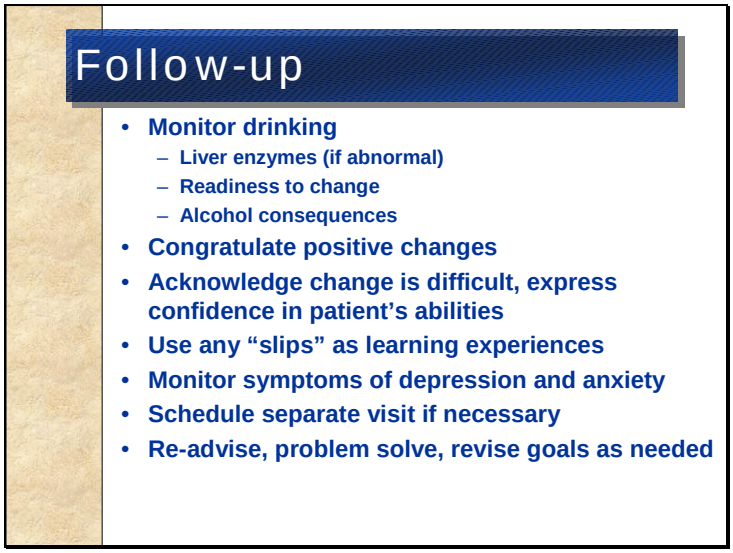
Finally, **pharmacotherapy** should be considered for all patients because no treatment alone has perfect effectiveness. Disulfiram, particularly when given under the supervision of another person at home, naltrexone, and acamprosate have efficacy in the treatment of alcohol dependence. They should be started after abstinence (though naltrexone could be started sooner), and in the context of psychosocial counseling.

Slide 41



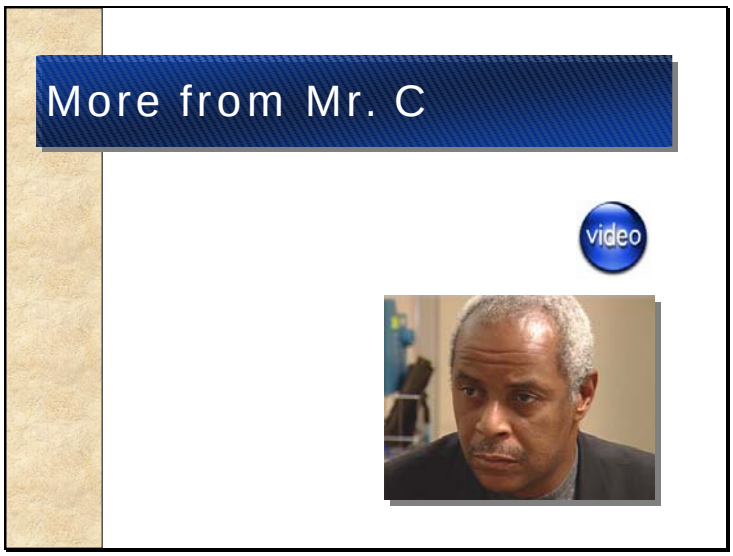
Once the course of action is negotiated, confirm the plan (to abstain or cut down) and then Arrange follow-up with you to check progress. Let the patient know you are available for ongoing assistance regardless of progress.

Slide 42



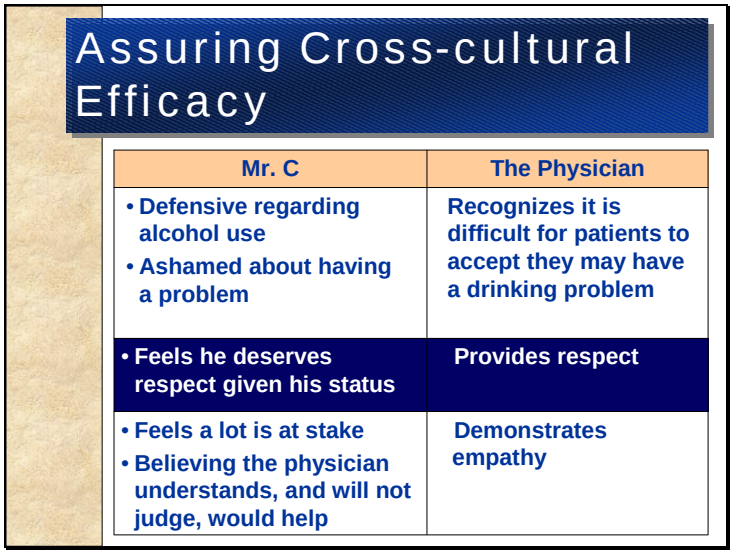
What should be done in follow-up? Monitor by asking about alcohol use, re-check liver enzymes if abnormal at baseline, reassess readiness to change and reasons for ambivalence, and check for any new or ongoing alcohol consequences. Emphasize and congratulate any positive changes to reinforce them. Acknowledge that change is difficult, and express confidence in the patient's ability to cut down, abstain, and perhaps most importantly, to maintain any positive changes made. If the patient reports a slip, using alcohol during a period of attempted abstinence, use it as a learning experience— "what led you to have a drink?" "Is there anything you think you could do differently next time you get the urge to drink?" Normalize the slip: "Having a slip is something that you want to avoid, but it is normal. It doesn't mean that you have failed, you just have to think of new ways to keep trying." Monitor for symptoms of depression and anxiety and recognize them and treat them as necessary. These can be related to withdrawal and/or to underlying diseases being unmasked. Consider scheduling a separate visit to focus on follow-up for drinking. Negotiate the next plan of action, re-advise, that is give your best advice again, solve problems such as difficulties when in situations where friends are drinking, and revise the drinking goals as needed. NOTE: Forms which can assist with patient follow-up are available (*NIAAA 2005*).

Slide 43



Let's hear what Mr. C thinks about his drinking and the advice he received.

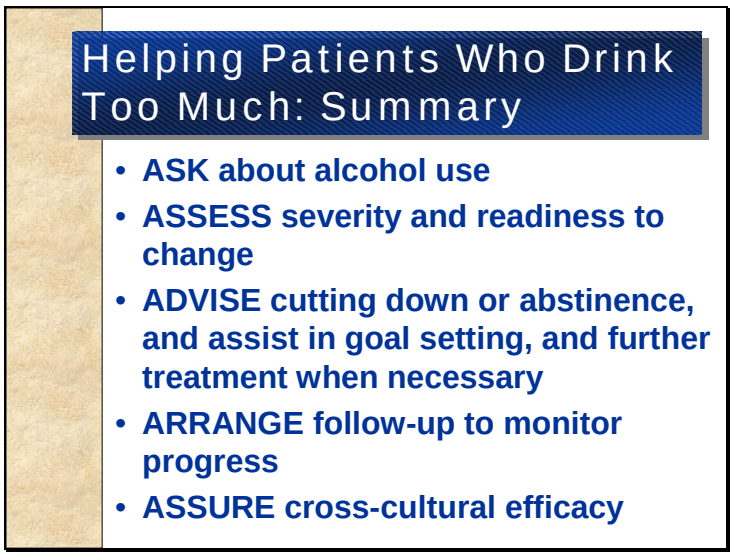
Slide 44



How did the physician and patient connect in this case? What strategies helped assure cross-cultural efficacy?

When the patient was defensive about his alcohol use, and was ashamed at the suggestion that he had a problem, the physician recognized that it is difficult for patients to accept that they may have a problem. She demonstrated respect for the patient. And, she demonstrated empathy, recognizing that much is at stake for the patient. The patient therefore believed that the physician understood, would not unfairly judge him, and would in fact help him.

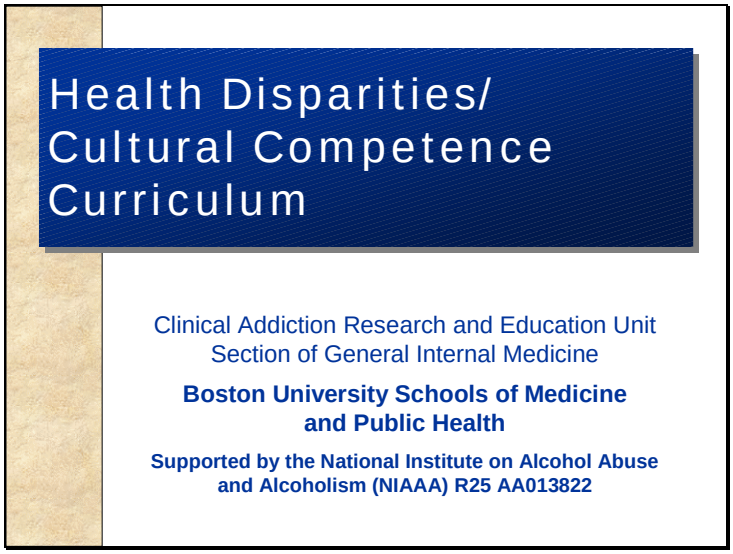
Slide 45



In summary, a patient-centered, cross culturally efficacious evidence-based approach can be used to efficiently address unhealthy alcohol use in generalist healthcare settings. In such an approach:
Ask about alcohol use using validated screening approaches that can identify the spectrum of problems from risky drinking to dependence such as the CAGE questionnaire, quantity and frequency questions, or the AUDIT.
Assess the severity of identified problems by following up on positive screening responses, looking for red flags, and asking about coexisting conditions that place people at higher risk for problems or that may suggest a need for abstinence.
Advise cutting down or abstaining, negotiate treatment options, and assist in goal setting, and further treatment when necessary, including referral, pharmacotherapy and AA.
Arrange follow-up to monitor progress.
All of this should be done with attention to cross-cultural efficacy, arguably a feature of any doctor patient encounter. One way to do this is to demonstrate respect, attend to the patient's explanatory model by understanding how the patient makes sense of the world and their health/health behaviors, be aware of the patient's sociocultural context (avoiding stereotyping), mitigate power and status differences, express empathy, make sure the patient feels heard and understood, elicit the patient's concerns about drinking, and by doing all of these, establish a trusting and effective therapeutic alliance.

Related Curriculum: Health Disparities/Cultural Competence Curriculum

Slide 1

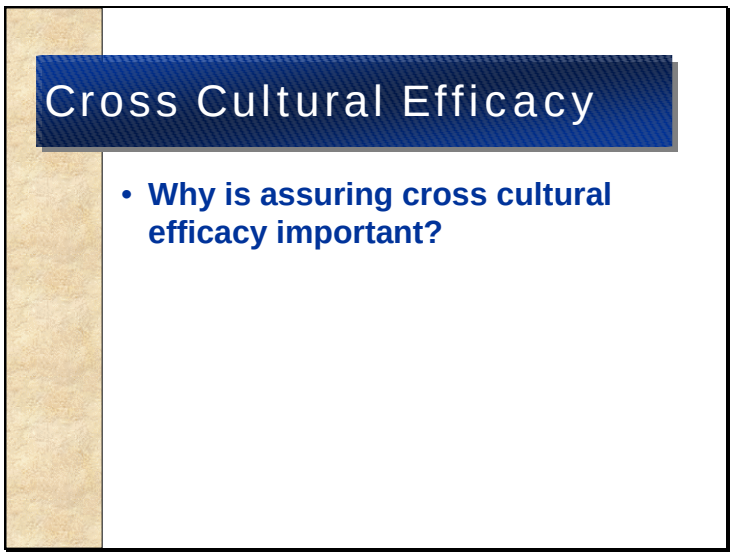


Helping Patients Who Drink Too Much. This web-based curriculum for primary care physicians was developed at the Boston University Schools of Medicine and Public Health with support from the National Institute on Alcohol Abuse and Alcoholism.

Slide 2

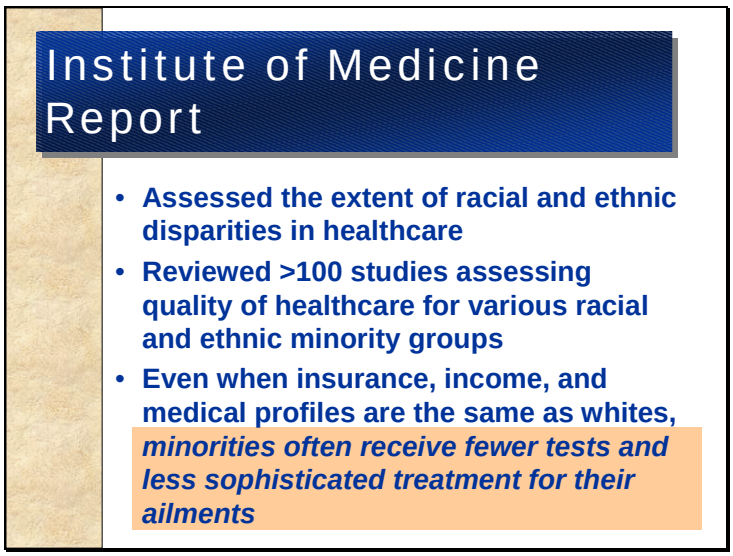
The objectives for this presentation are outlined above. Why is it important to attempt to assure cross-cultural efficacy? Often we, as clinicians don't give much thought to our cross-cultural efficacy until something seems to have gone wrong ie. a patient's non-adherence to a regimen we have prescribed, a patient's complaint that we have treated them somehow differently than others. Assuring cross-cultural efficacy is an important part of the provision of quality heath care with the goal of excellent health care outcomes. Why is assuring cross cultural efficacy important? (As noted in the next slide, the facilitator might want to pose this question to the group being addressed and elicit their responses.) The following definitions are included for clarification of terms that may come up in discussion: Ethnic identity: an individual's identification with ancestry producing a sense of belonging and historic continuity. Cultural identity: may include but is much more than race, ethnicity, religious orientation. Cultural identity refers to ways in which and individual relates philosophically to values, symbols, and common histories that identify him or her as a member of a discernable group. Cultural identities may form around age, physical ability, political affiliation or [common and shared] circumstances. The concept of "privilege" must be emphasized. For members of a majority/dominant group, this cultural identity is presumed, often "invisible," and accepted as normative. It is positively reinforced. Members of minority/subdominant group on the other hand are considered "different" and may be subjected to ridicule, minimization, marginalization or other negative portrayals. NIDA research supports that infusing cultural responsiveness into all treatment programs can make these interventions more effective. (adapted from the New England technology transfer center website-reference-www.samsha.gov/PRESS/99/99070nr.htm)

Slide 3



The facilitator might want to pose the question to the group being addressed…. "Is Cross Cultural Efficacy important ?" Why or why not?
There could be a range of responses from your audience depending on a number of factors ie. Participant's cultural identity and experience, experience of cultural congruence or incongruence in their work place (and whether this is a positive or negative experience).
As you teach this material, you might feel a certain level of discomfort yourself. You, yourself might be much more comfortable staying strictly within the boundaries of accepted medical culture ie. Present the data as an expert, with a dazzling power point presentation, followed by a 10 minute question and answer period…very much in a position of power and control! Our format allows for a multimedia and varied format for teaching. Your participant's responses might be much more unpredictable. We encourage you as a facilitator to model the ability to explore your own biases as you explore the material presented.
Aren't all people the same? Don't we all have common problems and issues? Shouldn't those who come to our country accept our customs and ways? If a patient doesn't understand you, isn't it his or her responsibility to adapt? We just don't have time to cater to the special needs of all of our patients.
These opinions are not uncommon in medical and other settings. It's helpful to explore where powerful, negative responses come from. Recognizing one's own cultural construct as but one of many, helps us to see "difference" as "difference" as opposed to "right" vs "wrong" .Addressing the less obvious aspects of cultural difference to better serve our patients will improve patient satisfaction and improve our own effectiveness.

Slide 4

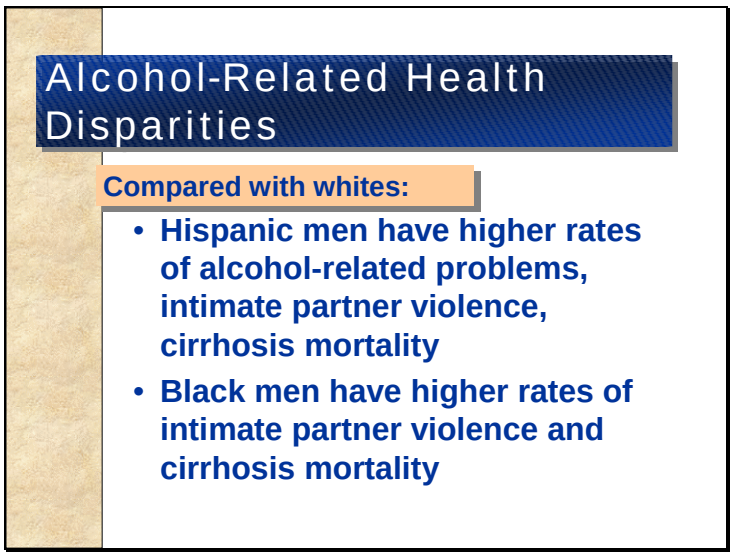


We are also concerned about assuring cross cultural efficacy of care because of the mounting evidence of racial and ethnic disparities in Health Care.

The NIH defines Health Disparities as differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the U.S. (NIH,2000)

In 1999, Congress requested that the Institute of Medicine assess the extent of racial and ethnic disparities in healthcare. The characteristics of their rigorous research design are as follows:
Followed patients prospectively
Controlled for access factors such as insurance status, patient income, other access-related factors; age, gender, co-morbid diseases, where care received (private vs. public), disease severity
Looked for potential sources of disparities
Confronting Racial and Ethnic Disparities in Healthcare, Institute of Medicine, Smedly BD, Stith AY, Nelson AR, March 2002.

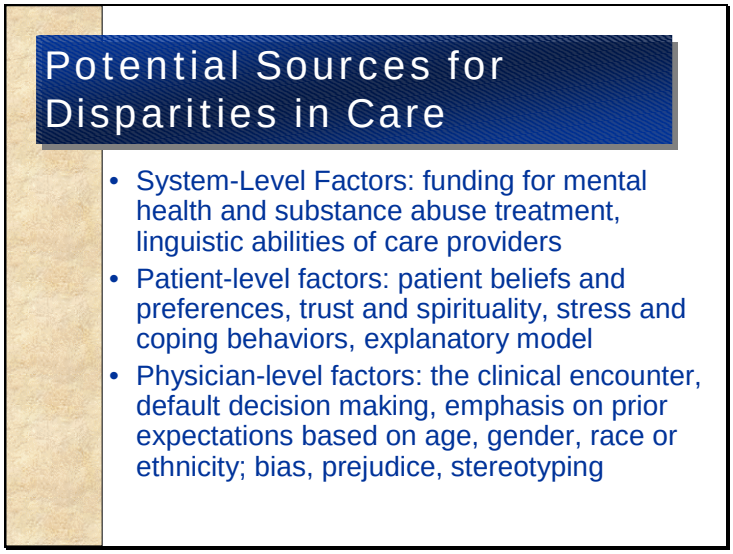
Slide 5



Data quantifying difference due to race are collected from a variety of sources. Epidemiological Findings are currently being reviewed. For example, we note an important trend indicating a reduction in the proportion to drinkers who drink five or more drinks per occasion among whites but not among blacks and Hispanics. Between 1984 and 1995, the prevalence of this drinking pattern decreased from 20 to 12 % among white men but remained stable among black (15 %) and Hispanic men (17-18%) (Caetano and Clark, 1998). There are other national surveys that report levels of drinking where the differences among ethnic groups are not as dramatic. Some variances may be due to the way heavy drinking is defined.

Alcohol-Related Health Disparities and Treatment-Related Epidemiological Findings Among Whites, Blacks, and Hispanics in the United States,Caetano,R, Alcohol Clin Exp Res, Vol 21, No 8, 2003: pp 1337-1339.

Slide 6



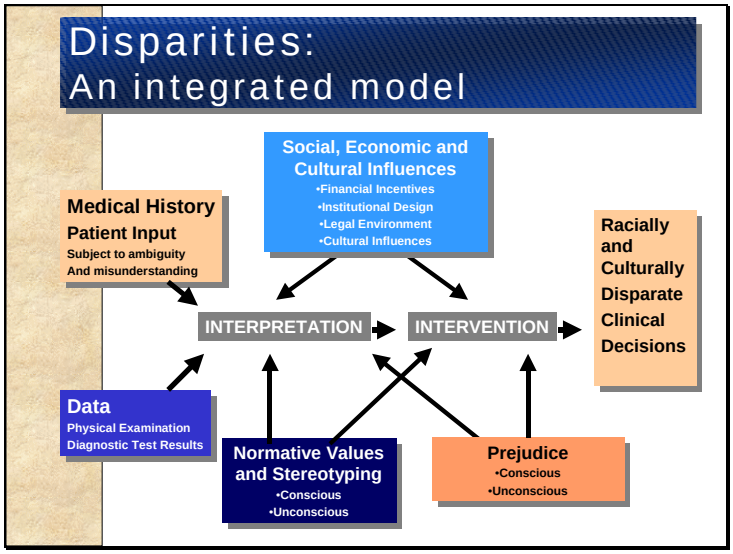
The medical community is just beginning to quantify disparities in care and attempt to identify the causes for such disparities in care.
The facilitator might encourage the participants to generate their own list of potential sources for disparities and then review and categorize their answers as system, patient, or physician/clinician level factors.

You might want to use an illustrative example such as: the non-English speaking patient with alcohol dependence that you would like to refer to a treatment program-Does the program conduct counseling groups in his/her native language?, Does the patient's insurance cover the length of stay that you would deem necessary?, Would the patient perhaps prefer a spiritually based program? , Do you as the provider have a personal opinion about the type of program the patient attends that might influence your recommendation? , How optimistic or pessimistic are you about the patient's prospects for recovery, and why?
What subtle factors may affect the selective ordering of medical tests and treatment?

In our module we have chosen the area of focus for attention the patient / clinician encounter.

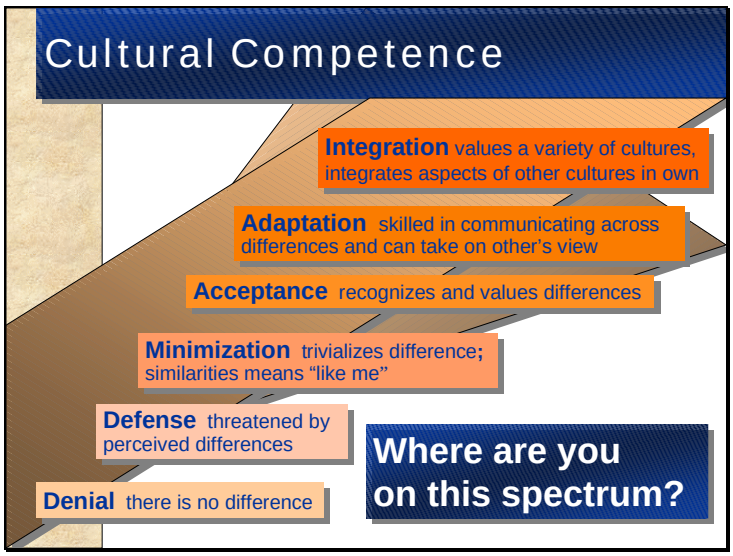
Long, J, Update on the Health Disparities Literature, Ann Intern Med, Vol.141(10), November 16, 2004.805-812
Corbie-Smith,G, Distrust, Race, and Research, Arch Intern Med, Vol.162(21). Nov. 25, 2002.2458-2463

Slide 7



This slide presents one representation of the complex interface that is present within the patient/clinician encounter. The clinician elicits and is presented with data during the visit which needs accurate interpretation that will lead to an appropriate intervention. We all learn the accepted means of collecting information from patients via the standard history and physical exam…but ambiguities can arise. Here in the United States we view each other through the lens of race. Whether conscious or unconscious the history of race relations is in the background of our encounters. Words used as a patient describes their medical history might not be interpreted equally by the clinician and provider and there may be powerful emotion and meaning behind history that the clinician can miss or the patient might fail to share. Both patient and clinician are subject to the influences of their respective social, economic and cultural influences. The facilitator might want to brainstorm with their audiences some of these factors ie, the 20 minute visit, the need for a patient to miss appointments due to child care responsibilities, incentives for physicians to meet performance standards that don't necessarily reward clinicians for patient education and prevention, how we respond to the patient who is very demonstrative about their pain vs. the stoic. We tend to like people who are most like us…so how does that effect your interaction with a diverse patient population. Stereotyping and prejudice are factors that influence both the clinician and the patient. Influences that affect clinician behavior are often subconscious. Objective data collected via the medical history, physical exam and lab tests are subject to interpretation by clinicians before interventions are selected. Ultimately, the subtle effects of factors influencing clinician decision-making might result in disparities in care. Adapted From: Assessing potential sources of racial and ethnic disparities in care: Patient-and system-level factors. Smedley BD, Stith AY, Nelson AR (eds). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington: National Academies Press, 2003, p. 127.

Slide 8



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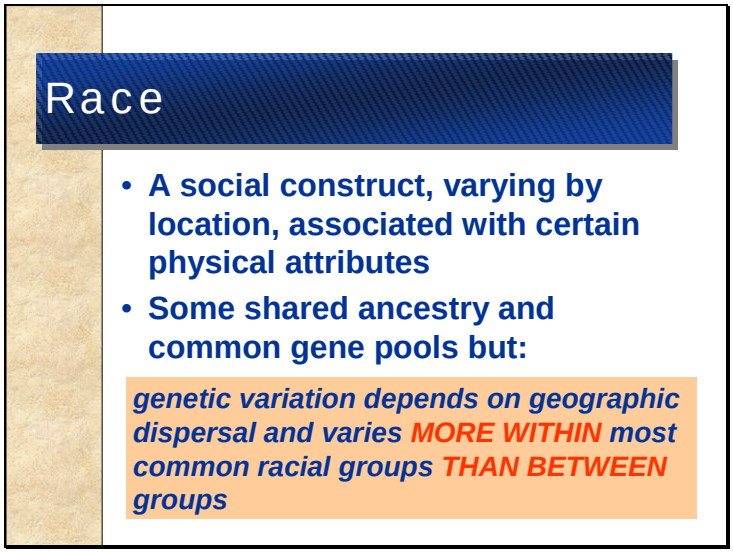
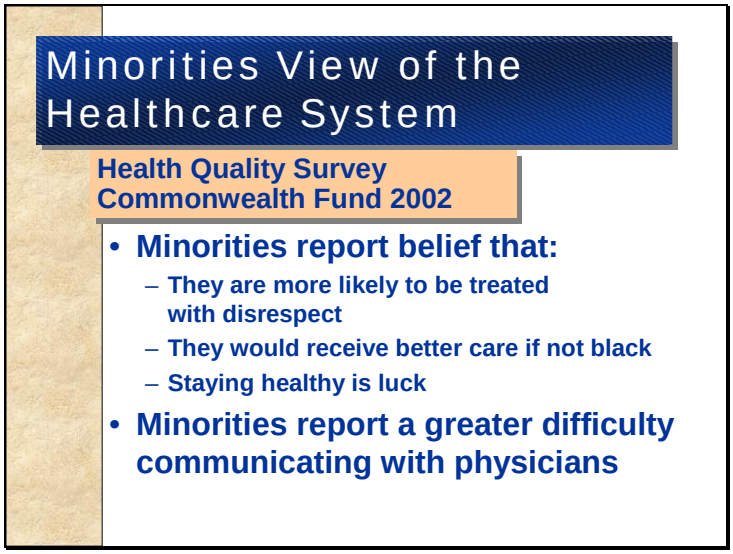


Race…often hard to talk about. Why? Brainstorm with your group to break the ice. Examples: we fear being politically incorrect, we wouldn't want to hurt anyone's feelings, we are angry, we've been hurt in the past. Why is it important to get past these limitations?...because we have so much we can learn from each other, because if we in the medical community can't talk about race (where the power differential may be less marked) then how could we possibly touch this area with our patients?

Often clinicians comment that they do not see race when they look at their patients. This response relates well to the concept of "white privilege". "Culture" and "race" are different constructs. The concept of "race" is socially constructed. Most often the societal application of racial difference is manifested as a difference in power or oppression. There is also a power differential between patient and clinician. A participatory style of interaction helps to share the power.

Particularly in the U.S., race is a social designation based on the shared experience of being seen and treated as black. If the group you are facilitating is ethnically diverse you might elicit meaningful insights from those who have immigrated from other countries and now experience the American society defining them as black.

Slide 10

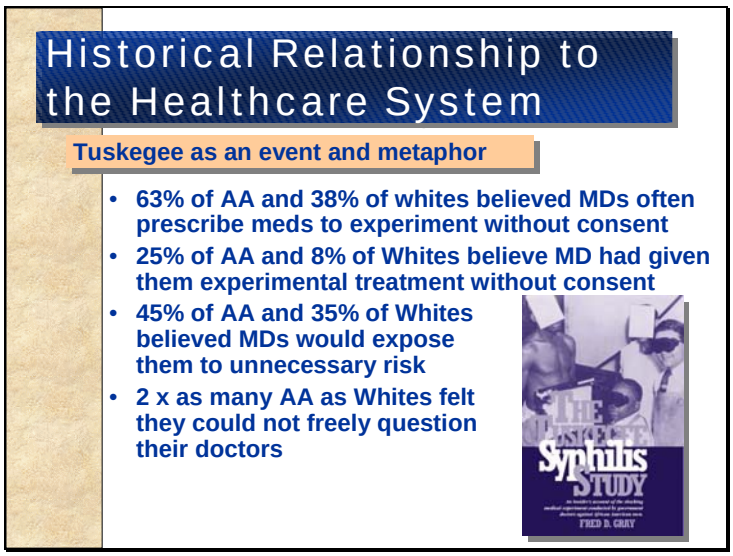


Although clinicians may report that race does not seem to be a factor in the clinical encounter, have your group take a look at the results from the Commonwealth Fund Survey. This survey explored the beliefs of minorities regarding the Healthcare System.

Some members of your audience might feel that these results are some how not valid or that the fault lies with the patient. On what might some of these patient impressions be based? Examples: past personal experience, past family experience, experiences of lack of personal or collective power.

Betancourt et al. Healthcare Quality Survey. Commonwealth Fund 2002

Slide 11

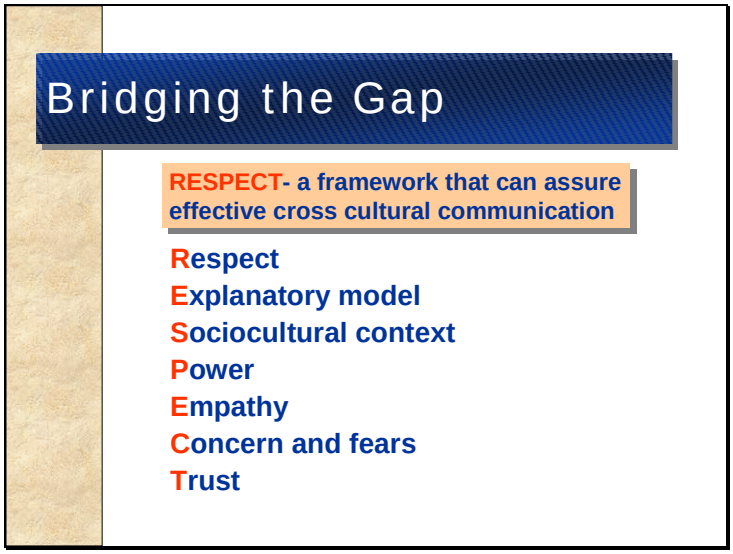


Background:
The Tuskegee Syphilis Study was conducted by the United States Public Health Service from the 1930's until 1972. More than 400 black men with syphilis participated and 200 men without syphilis served as controls. The men were recruited without informed consent and, in fact, were misinformed that some of the procedures done in the interest of research (e.g., spinal taps) were actually "special free treatment". By 1936 it was clear that more infected men than controls had developed complications and in 1946 a study reported the death rate among those with syphilis was twice as high as in the controls. In the 1940's penicillin was found to be effective in the treatment of syphilis. The men were neither informed nor treated. The study continued until 1972 when the first accounts of the study appeared in the national press.

The above slide reviews the results of a survey done by Dr. Corbie-Smith, et al in 2002. She provides a compelling link between a group's collective historical experience and personal belief.

Corbie-Smith. G, Thomas SB, St George DM. Distrust, race and research. Archives of Internal Medicine ,2002; 162: 2458-2463

Slide 12

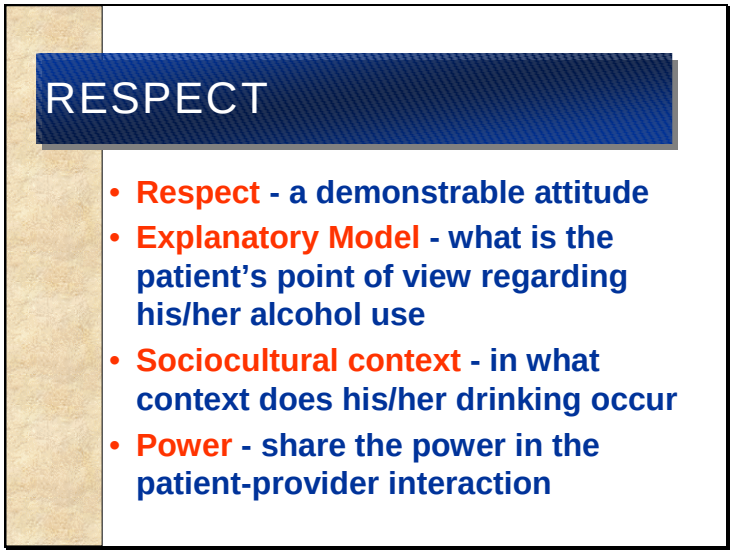


So how can we, as clinicians, bridge the potential cross-cultural gap?

In 2001, the Diversity Curriculum Task Force of the Boston University Medical Center and Boston University Residency Training Program in Internal Medicine developed the RESPECT model based on the work of Betancourt, Carrillo and Green.
Each element of the RESPECT model is outline on the following slides.
The importance of the power differential within the medical encounter is included. One should remain mindful of the experience of race, history and oppression as it affects the cultural identity of both providers and patients.

Bigby,J, Beyond Culture: Strategies for Caring for Patients from Diverse Racial and Ethnic, and Cultural Groups, Cross-Cultural Medicine, Bigby, J (ed),American College of Physicians-American Society of Internal Medicine,2003,p.20.

Slide 13



Respect-May be most important when the power differential is greatest within the patient-provider encounter. Those with drinking problems are often ashamed of their drinking and the consequences of their behaviors. Establishing a non-judgmental environment is particularly important.

Explanatory model-based on the Kleinman model. What is the patient's point of view? One of the most frustrating components of addiction to alcohol for providers is the element of denial. When a patient is in denial or precontemplative one might engage the patient in a discussion of the pros and cons of drinking from his/her perspective. In response one might take the opportunity to offer patient education regarding the disease of addiction and offer the medical perspective on the risks of heavy drinking. Encourage the patient to think about their drinking and suggest more dialogue at a subsequent visit.
Do you view your drinking as problematic? Why or why not?
If viewed as problematic, What do you think caused your problem?
Why do you think it started when it did?
What does your alcohol use do for you?
How severe is your problem with alcohol?
What kind of treatment do you think you need?
What are the most important results you expect from treatment?
What are the problems your illness has caused for you?
What do you fear most about your sickness?

Sociocultural context- recognize how drinking influences or is influenced by class, race, education, ethnicity, family and gender roles (among others).

Power-A participatory style of interaction shares power within the medical encounter. When discussing a particular intervention, ask the patient if this is something he/she would be willing to try.

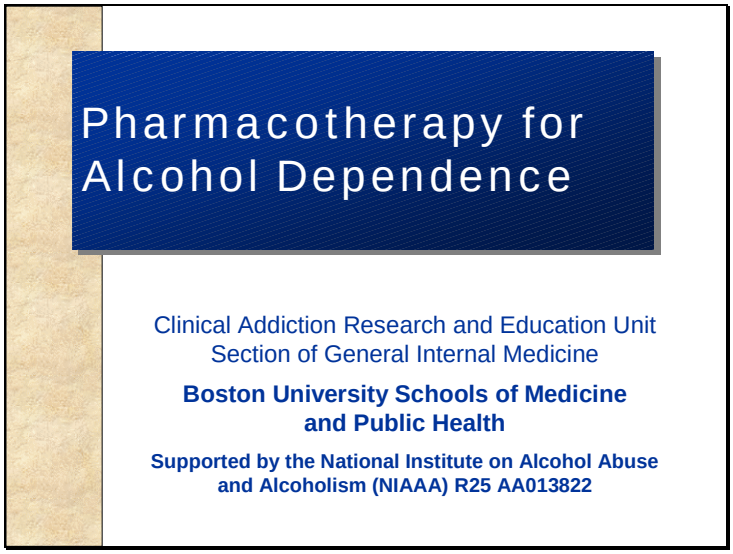
Slide 14

Empathy-Play back to the patient what you heard them say with attention to the patient's concern so the patient feels understood.
Concerns and Fears. Often a patient who is abusing alcohol has hidden fears about his/her drinking but is afraid to acknowledge these because of worry regarding the provider's ill judgment of them. The provider may want to give examples that express your experience and understanding. ie " I know some mothers drink alone and are worried about this. They might fear mentioning this because they are afraid they will be judged a bad mother". "Some people have family members who are alcoholic and they are afraid this could happen to them". "Are any of these concerns you might have?"

Therapeutic Alliance/Trust- Providers will enhance adherence and compliance with treatments and health promotion if they negotiate these with a patient who feels valued and understood

Related Curriculum: Pharmacotherapy for Alcohol Dependence

Slide 1

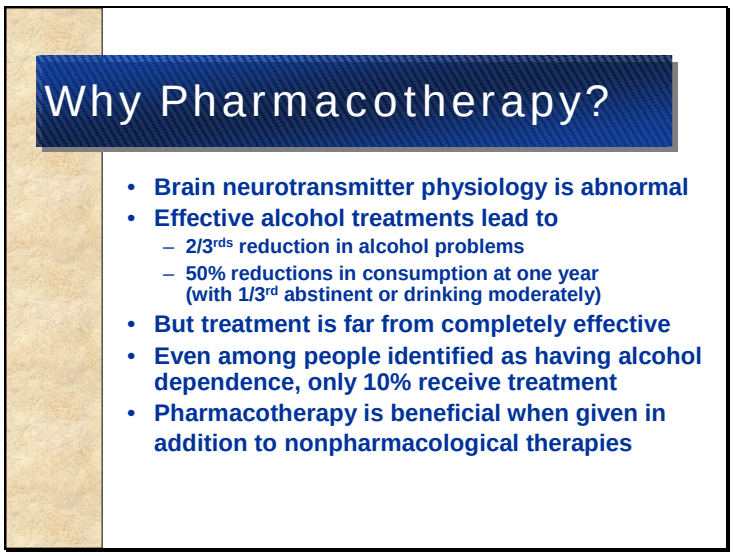


Helping Patients Who Drink Too Much. This web-based curriculum for primary care physicians was developed at the Boston University Schools of Medicine and Public Health with support from the National Institute on Alcohol Abuse and Alcoholism.

Slide 2

The goal of this presentation is to understand the role of pharmacotherapy in the treatment of alcohol use disorders. By the end of this presentation, you should be able to identify appropriate candidates for pharmacotherapy for alcohol dependence, describe and compare the efficacy of available medications, be able to prescribe pharmacotherapy and monitor for desired and adverse effects, be aware of the importance of providing or referring patients for psychosocial therapy when using pharmacotherapy, describe pharmacotherapy options for alcohol use disorders in patients with comorbid psychiatric disorders, and to be aware of pharmacotherapies under study but not yet ready for routine clinical use.

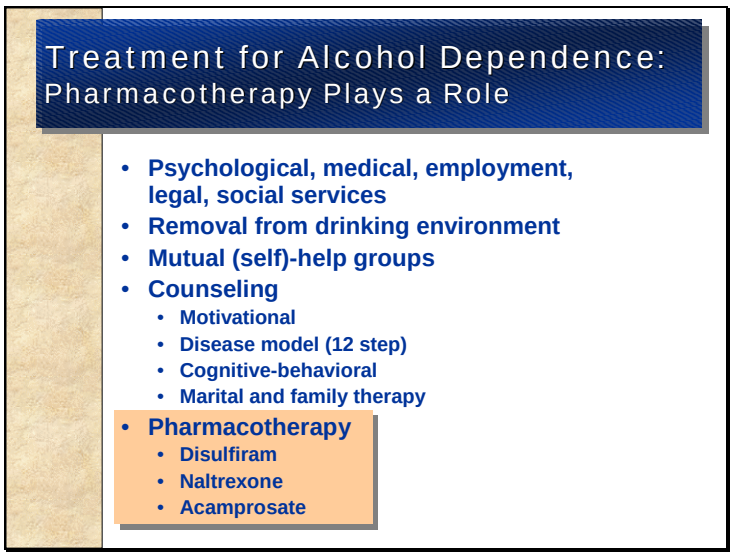
Slide 3



Why should we consider pharmacotherapy as a treatment for alcohol dependence? First of all, brain neurotransmitter physiology is not normal in people with alcohol dependence, and these neurotransmitter systems can be affected favorably by pharmacological interventions. Second, although alcohol treatments like counseling and/or medications are effective, leading to 2/3rds reductions in alcohol problems and 50% reductions in consumption and a third abstinent or drinking moderately, treatment is far from completely effective. All known effective treatments should be made available, including medications. Yet even among people identified as having alcohol dependence, only 10% receive any treatment. Finally, pharmacotherapy is known to be beneficial when given in addition to nonpharmacological therapies. Pharmacotherapy can help reduce drinking, reduce relapse to heavy drinking, and maintain abstinence.

(4th bullet) McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The quality of health care delivered to adults in the United States. *New England Journal of Medicine* 2003;348(26):2635-2645.
(For 2nd bullet) Miller WR, Walters ST, Bennett ME. How effective is alcoholism treatment in the United States? *J Stud Alcohol* 2001;62:211-220.

Slide 4



What treatments are effective for alcohol dependence? Because alcoholism can affect all aspects of health, all patients should receive access to psychological, medical, employment, legal, and social services as needed. Some patients will benefit from removal from an environment in which drinking is encouraged or facilitated. Mutual or self-help groups such as Alcoholics Anonymous and others are an effective adjunct to health professional delivered treatments and can help patients develop and re-establish sober social networks. Specific types of counseling that have been described in detail in manuals for counselors, and proven effective in clinical trials include motivational enhancement therapy, disease model counseling or 12-step facilitation, cognitive behavioral therapy, and marital and family therapy. Pharmacotherapy with disulfiram, naltrexone or acamprosate also have proven efficacy in clinical trials.

Slide 5

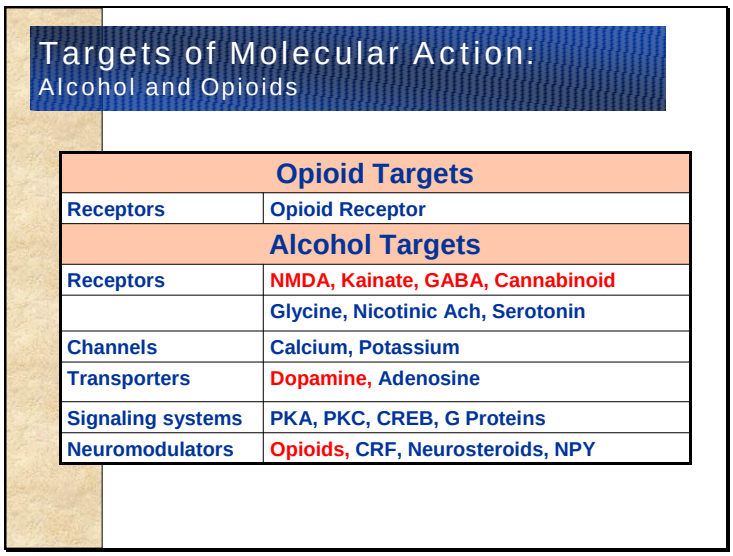
For whom is pharmacotherapy appropriate? For all people with alcohol dependence who are currently drinking, or who are experiencing craving or who are at-risk for return to drinking or heavy drinking. Considerations include, in addition to patient acceptance, any specific medication medication contraindications, patient willingness to engage in psychosocial support/therapy, your relationship with the patient and their willingness to follow-up, and a setting for clinical care delivery in which it is feasible to prescribe and monitor the medication.

Slide 6

Of patients treated for alcoholism, only 3 to 13 percent receive a prescription for naltrexone. Why do so few patients receive medications for alcohol dependence? There are many reasons, which include but are not limited to the following. The alcohol dependence treatment system is not set up for long-term prescribing. Treatment is often delivered in short episodes of care, and prescribers may not be available or accessible. Patients and clinicians may lack awareness of pharmacotherapy options. Although there are many efficacy studies of medications for alcoholism, effects are modest, and few studies assess effectiveness in the complex clinical practice setting. The failure to provide any alcohol dependence treatment is sometimes attributed to lack of clinician time, and for medications specifically, patient reluctance to take medications for this disorder, either because of concerns that they may be addictive or other reasons. Although AA materials explicitly state the acceptability of prescribed medications in general, the message to individuals is sometimes that the 12-step philosophy proscribes their use. Finally, medication price and insurance coverage may limit their use.
Lack of awareness
Lack of evidence of efficacy in practice
Side effects
Lack of time for patient management
Patients' reluctance to take medications
Medication addiction concerns
Alcoholics Anonymous (AA) philosophy
Price/insurance coverage

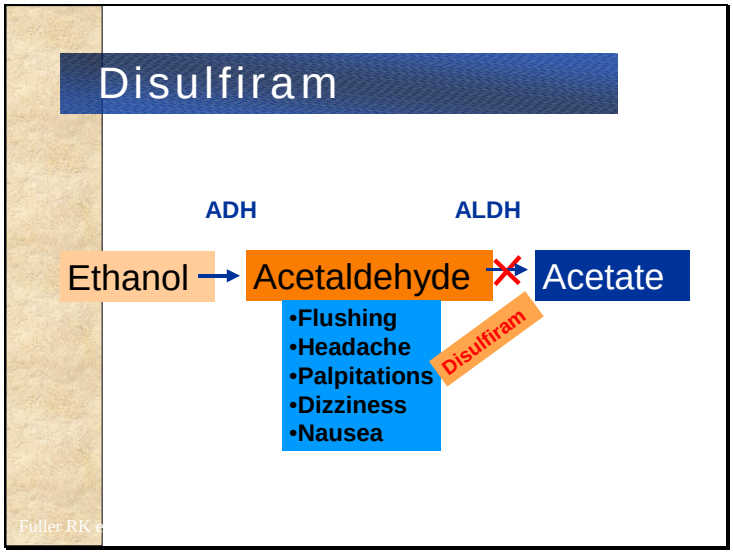
Ting-Kai Li. National Institute on Alcohol Abuse and Alcoholism. Department of Health and Human Services. National Institutes of Health. Fiscal Year 2006 President's Budget Request for the National Institute on Alcohol Abuse and Alcoholism. Accessed at http://www.niaaa.nih.gov/AboutNIAAA/AdvisoryCouncil/DirectorsReports/Statement3_05.htm December 16, 2005; Mark TL, Kranzler HR, Poole VH, Hagen CA, McLeod C, Crosse S. Barriers to use of medication in alcoholism. *American Journal on Addictions*. 2003;12:281-94; Thomas CP, Wallack SS, Lee S, McCarty D, Swift R. Research to Practice: adoption of naltrexone in alcoholism treatment. *American Journal on Addictions*. 2003;24:1-11; Mark TL, Kranzler HR, Song X, Bransberger P, Poole VH, Crosse S. Physician's opinions about medications to treat alcoholism. *Addiction.* 2003;98:617-626.

Slide 7



While pharmacotherapy has been successful for other addictions, that success may have been more predictable for drugs that have one receptor target, such as opiates. Alcohol, unlike many other psychoactive drugs, affects a large number of receptors and molecular targets. Those in red have been targets of alcohol dependence pharmacotherapies. In addition to receptors and neurotransmitters, pharmacotherapies can target enzymatic pathways.

Slide 8



An old standby for alcoholism treatment since the 1940s has been disulfiram, an inhibitor of aldehyde dehydrogenase, ALDH, that results in increased levels of acetaldehyde and an unpleasant reaction after consumption of ethanol. In one of the largest studies of this medication, disulfiram was no better than placebo in achieving abstinence. But it is not clear that a placebo controlled trial is the best way to test a drug whose efficacy depends on the patient knowing that they may experience a very unpleasant reaction. Of note, in post hoc analyses, the drug was more effective in those who were adherent to it.

(Fuller RK et al. JAMA 256:1449, 1986)

Slide 9

Monitored Disulfiram: Randomized studies

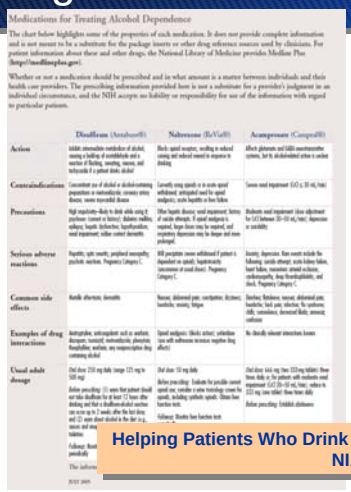
Author, Yr	Follow-up	Disulfiram	Abstinence
Gerrein, 1973	85%, 39%	Monitored Unmonitored	40% 7%
Azrin, 1976	90%	Monitored Unmonitored	90-98% 55%
Azrin, 1982	100%	Monitored Unmonitored	73%* 47*
Liebson, 1978	78%	Monitored Unmonitored	98% 79%

Length of follow-up was as follows: Gerrein 1973: 8 weeks; Azrin 1976: 2 years, Azrin 1982: 6 months; Liebson 1978: 6 months. * Thirty-day abstinence at 6 months

In controlled studies, 4 trials have shown significantly improved abstinence rates when disulfiram is taken under direct monitoring by a concerned other.

Slide 10

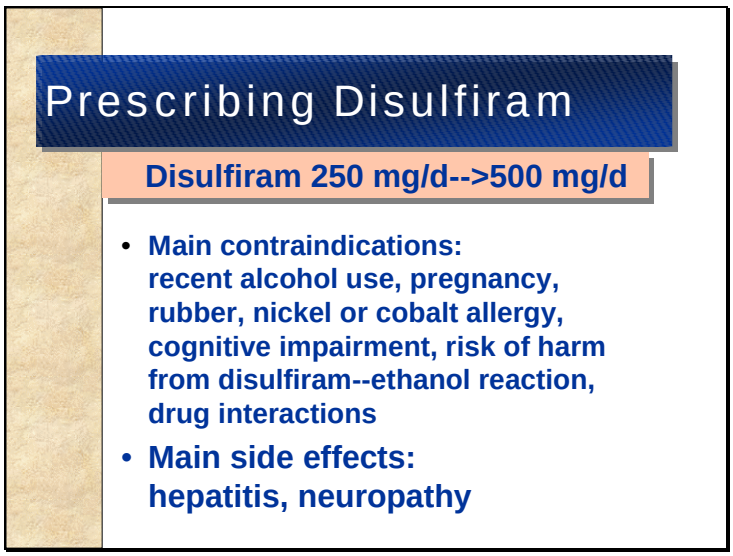
Prescribing


Medications for Treating Alcohol Dependence

Helping Patients Who Drink Too Much
NIAAA, 2005

Pharmacotherapies for alcohol dependence are no more difficult to prescribe than antidepressants. However, a decade since the approval of naltrexone and more than 50-60 years since the availability of disulfiram, pharmacotherapy has not been used extensively for alcoholism. What are the main prescribing issues? See the handout for details on prescribing all three FDA-approved medications for alcohol dependence.

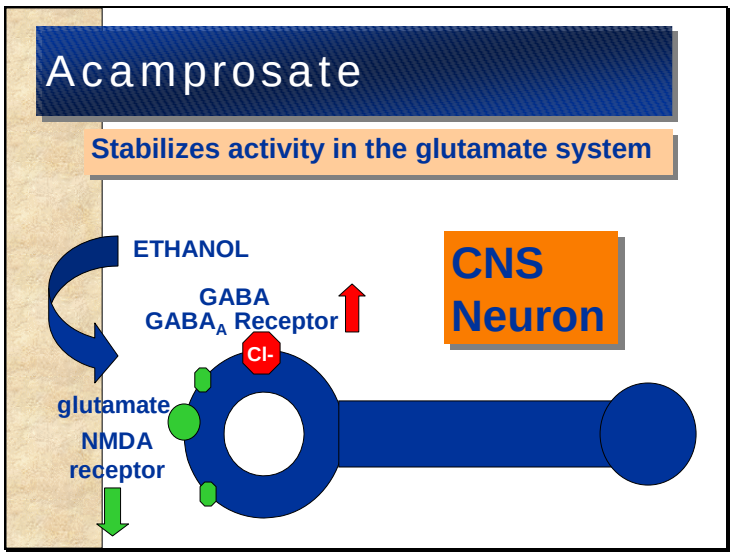
Slide 11



Of all of the approved, efficacious medications, disulfiram may be the most difficult to use since it is an aversive therapy that works best when its administration is monitored.

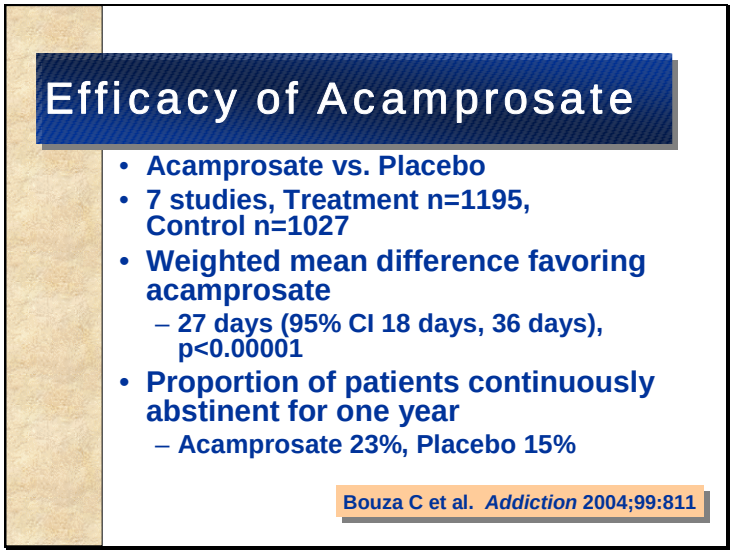
Disulfiram should be started at 250 mg a day, up to a dose of 500 mg. The drug can be used daily or just prior to risky situations, and it lasts 4-7, and up to 14 days. Tell the monitor and the patient they are to take the medication as prescribed. The monitor should observe the patient as he or she takes the pill and call you if the patient is non-adherent.
The main contraindications are recent alcohol use, pregnancy, rubber, nickel cobalt allergy, cognitive impairment (since awareness of the risk of the reaction is essential), and as a relative contraindication, conditions that would increase the risk of harm from the disulfiram ethanol reaction, for example, coronary artery disease, esophageal varices. Disulfiram also has numerous drug interactions, including warfarin and anticonvulsants. The main side effect is an idiosyncratic sometimes fulminant hepatitis, and neuropathy seen at higher doses. Regular monitoring of liver enzymes is advised, as is a clear recommendation to avoid alcohol even in over-the-counter medications.

Slide 12



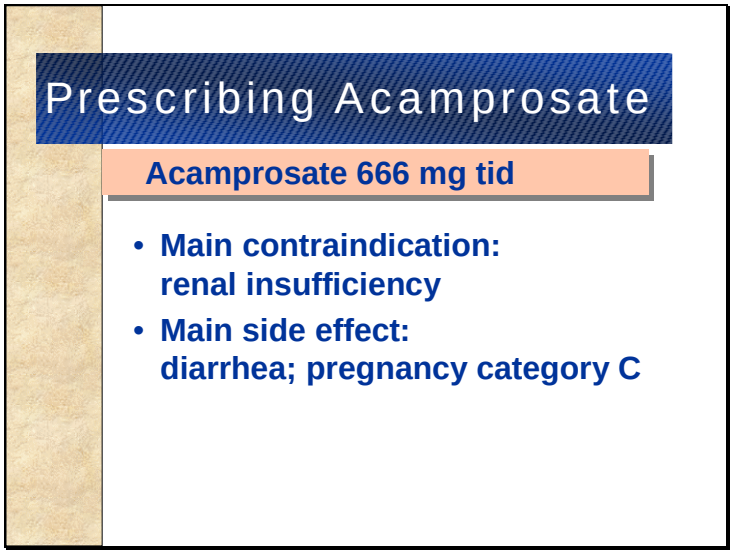
Acamprosate is another FDA approved pharmacotherapy for alcohol dependence. The exact relevant mechanism of action is unclear. The drug is a gamma-amino-butyric acid, or GABA analogue, and it has also been suggested that it modulates action in the NMDA (N-methyl-D-aspartate) glutamate system. Alcohol is an agonist at inhibitory GABA receptors, and an inhibitor of excitatory glutamatergic receptors. It may work by reducing symptoms of protracted abstinence such as insomnia, anxiety and restlessness.

Slide 13



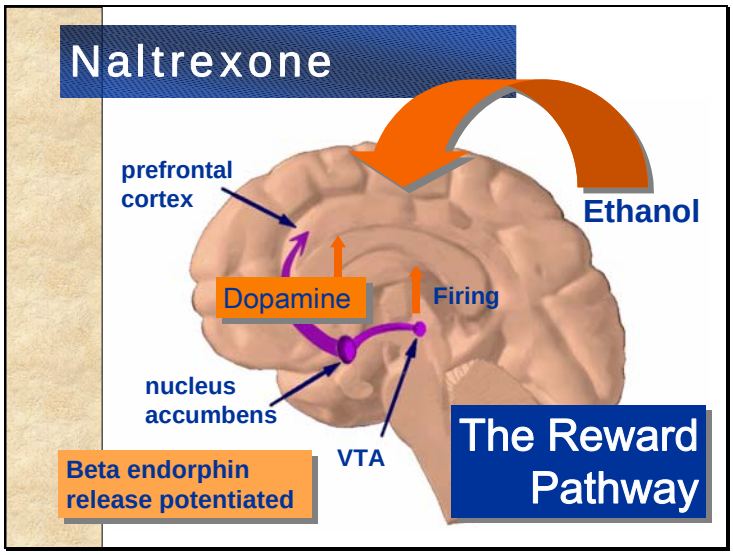
This meta-analysis summarizes randomized placebo controlled trials comparing acamprosate with placebo in people with alcohol dependence. Subjects were abstinent for 5-30 days when they started treatment. The meta-analysis summarized results of 7 trials in over 2000 subjects. Acamprosate increased the cumulative duration of abstinence by 27 days. It also was associated with an increase in the proportion of patients with continuously abstinent for a year from 15 to 23%.

Slide 14



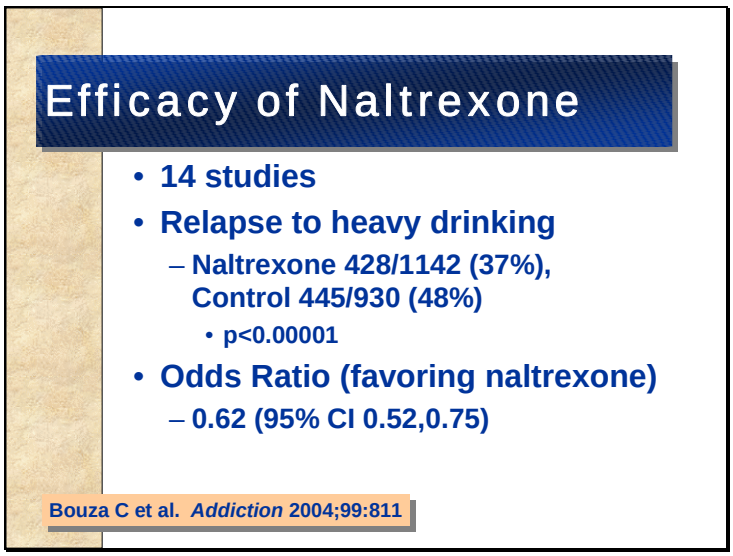
Acamprosate is dosed three times a day, 666 mg. The main issue with Acamprosate is that it is contraindicated in renal insufficiency (Cr CL <30 ml/min, half dose for 30-50 ml/min) and its main side effect is diarrhea. Acamprosate and all other alcohol dependence pharmacotherapies are pregnancy category C, meaning that there are no controlled studies in pregnant women, and that they should be prescribed during pregnancy only if clearly needed and the benefits are likely to outweigh the risks.

Slide 15



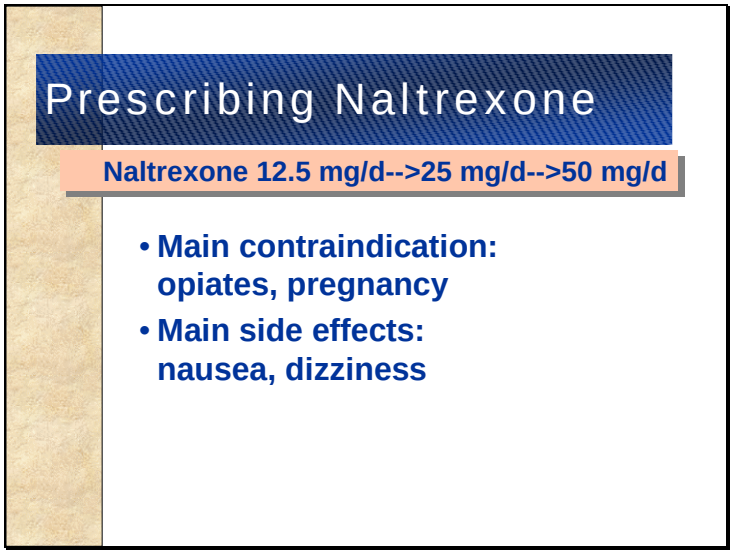
Despite the myriad actions of alcohol in the central nervous system, all drugs of abuse including alcohol work by affecting the same reward pathway, that connects the ventral tegmental area or VTA to the nucleus accumbens, where dopamine is released, and the prefrontal cortex. Other neurotransmitters are also involved, including endogenous opioids released as a result of dopamine surges.

Slide 16



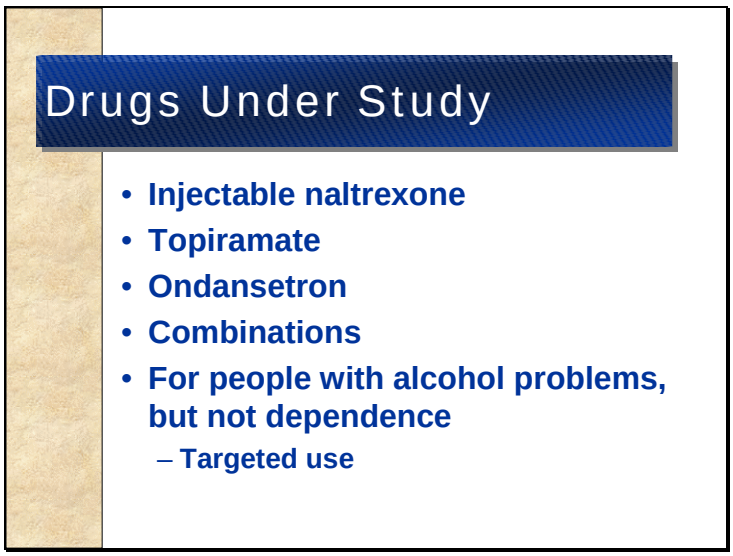
Naltrexone blocks opioid receptors, including receptors for endogenous opioids. Since these receptors are in part responsible for feelings of pleasure during drinking, naltrexone blocking these receptors makes drinking less pleasurable. For this reason, rather than abstinence, the clinical trials of this drug have focused on relapse or return to heavy drinking rather than total abstinence. This meta-analysis included 14 clinical trials, in which relapse was decreased significantly, from 48% to 37%. The odds ratio favored naltrexone, 0.62, suggesting a 38% decrease in heavy drinking. In one study, patients were not abstinent before beginning naltrexone. In another study, the drug was effective in a primary care setting. In a third study, naltrexone was effective for reducing heavy drinking in nondependent heavy drinkers. In a fourth study, the combination of naltrexone and acamprosate was as safe and more effective than either alone.

Slide 17



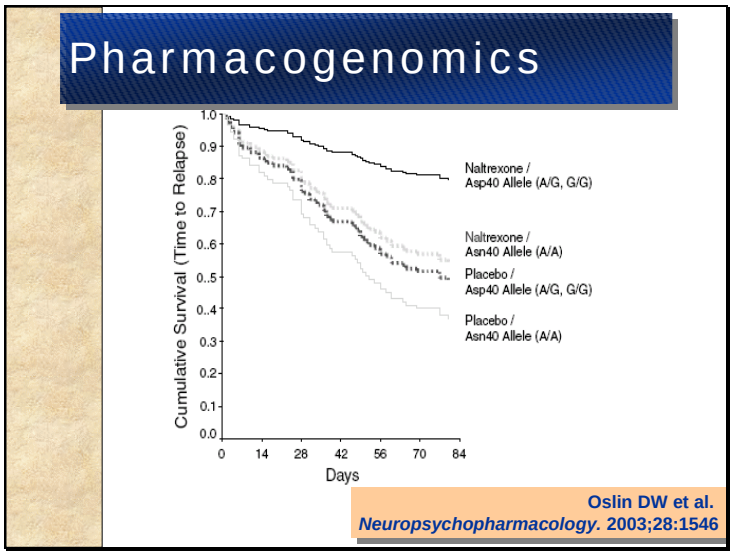
Naltrexone can be started at 12.5 or 25 mg a day and advanced to 50 mg a day. Its main contraindication is opiate dependence or need for opioids. The main side effects are nausea and dizziness, which can be avoided by starting at a low dose and increasing it to the therapeutic dose of 50 mg per day over time as tolerated, usually after a few days. Liver enzymes should be monitored because of hepatitis seen at much higher than the doses recommended for alcoholism (for example, >300 mg a day). The main difficulty with the use of naltrexone is that it can complicate pain management, leading to a need to give very high dose opioids in the event of acute pain, or stopping and restarting therapy perioperatively.

Slide 18



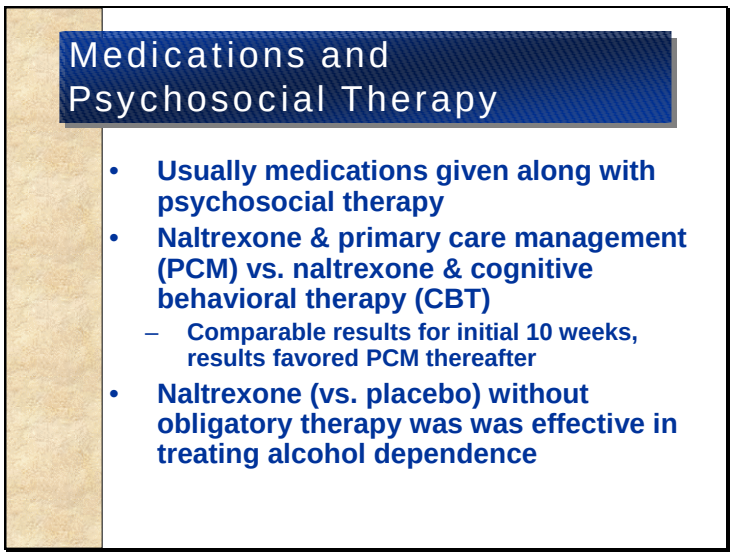
Other medications have been studied and initial studies have shown efficacy for injectable naltrexone, topiramate, and ondansetron, at least for some patients. Combinations of effective medications are also being studied to see if they will be more effective than a single drug alone. Another related use of medications with efficacy for alcohol dependence is treatment of patients with alcohol problems but not dependence. In that circumstance use has been targeted, taking the medication just before exposure to situations in which people are predictably at risk for heavy drinking.

Slide 19



Given the modest effects demonstrated in clinical trials, pharmacotherapies are clearly not cures for alcohol dependence. But it may be possible to better target their use to patients for whom they are more effective. This study examined the association between two specific polymorphisms of the gene encoding the mu-opioid receptor and treatment outcomes in alcohol-dependent patients who were prescribed naltrexone or placebo. In these data combined from 3 randomized trials, time to first relapse in the naltrexone-treated subjects was significantly longer in those with the Asp40 allele coding for the mu-opioid receptor. There were no differences between those assigned to placebo and those without the Asp 40 allele assigned to naltrexone.

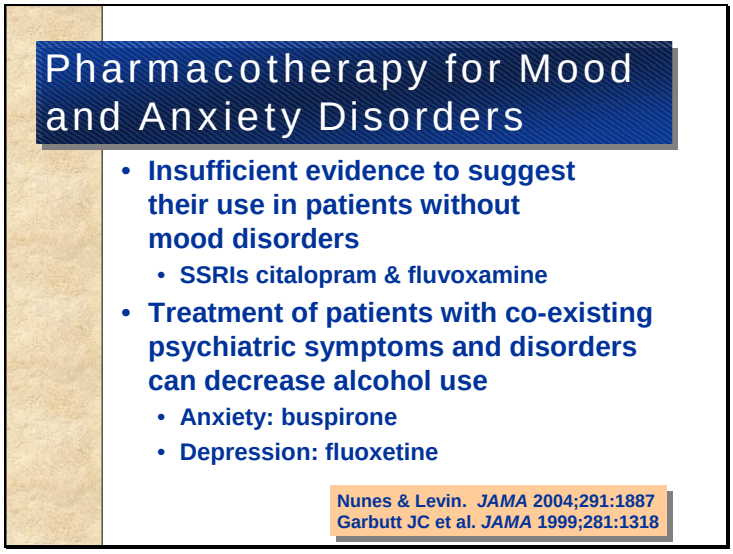
Slide 20



In most studies medications are given along with psychosocial therapy. But questions remain regarding the minimum therapy required. For example, O'Malley and colleagues compared counseling designed to be feasible in primary medical care settings with standard cognitive behavioral therapy in clinical trials of naltrexone. Both types of counseling yielded comparable results during the initial 10 weeks of treatment and results favored primary care management after that. In another clinical trial, naltrexone was efficacious even without psychosocial therapy.

Second bullet: O'Malley SS et al. *Arch Int Med* 2003;163:1695-1704
Third bullet: Latt NC, et al. *Medical Journal of Australia* 2002;176:530-534

Slide 21



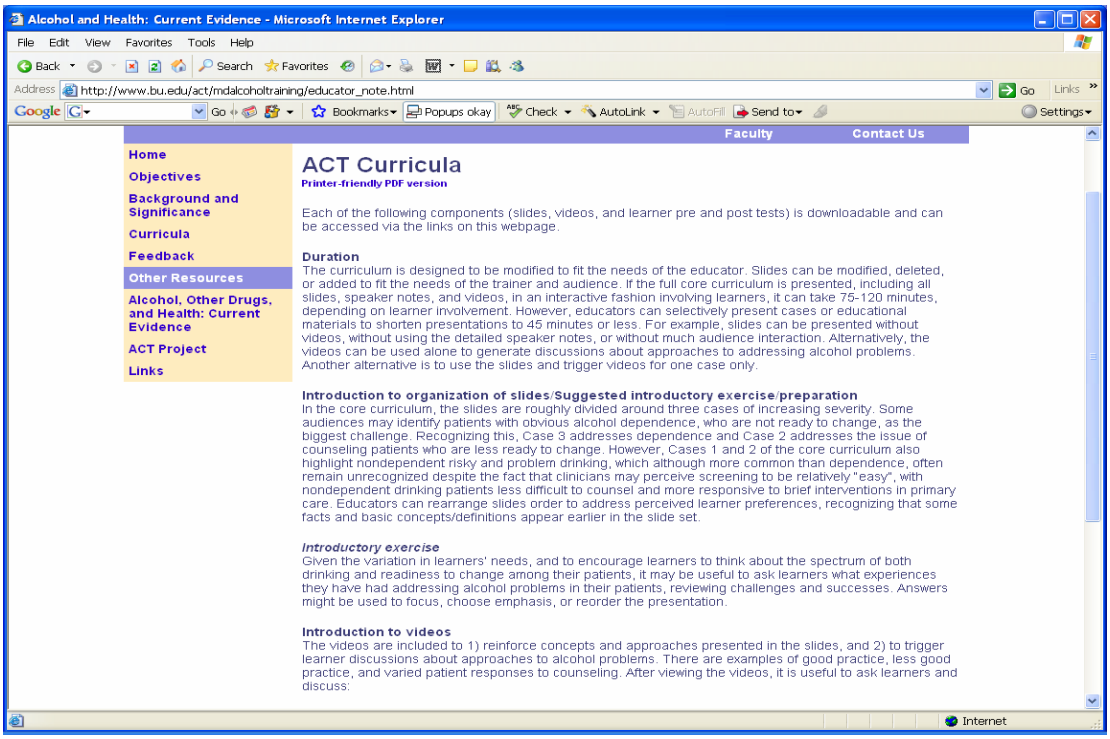
About 50% of people with alcohol dependence have psychiatric comorbidity. Although selective serotonin reuptake inhibitors (SSRIs) have been efficacious for treating alcohol dependence even in patients without depression or anxiety, there is insufficient evidence to suggest their use in patients without these disorders. In people with coexisitng anxiety, buspirone can decrease heavy drinking, and in depression, fluoxetine can decrease heavy drinking. But the most important issue is to not delay treatment for psychiatric comorbidity while awaiting resolution of drinking.

Slide 22

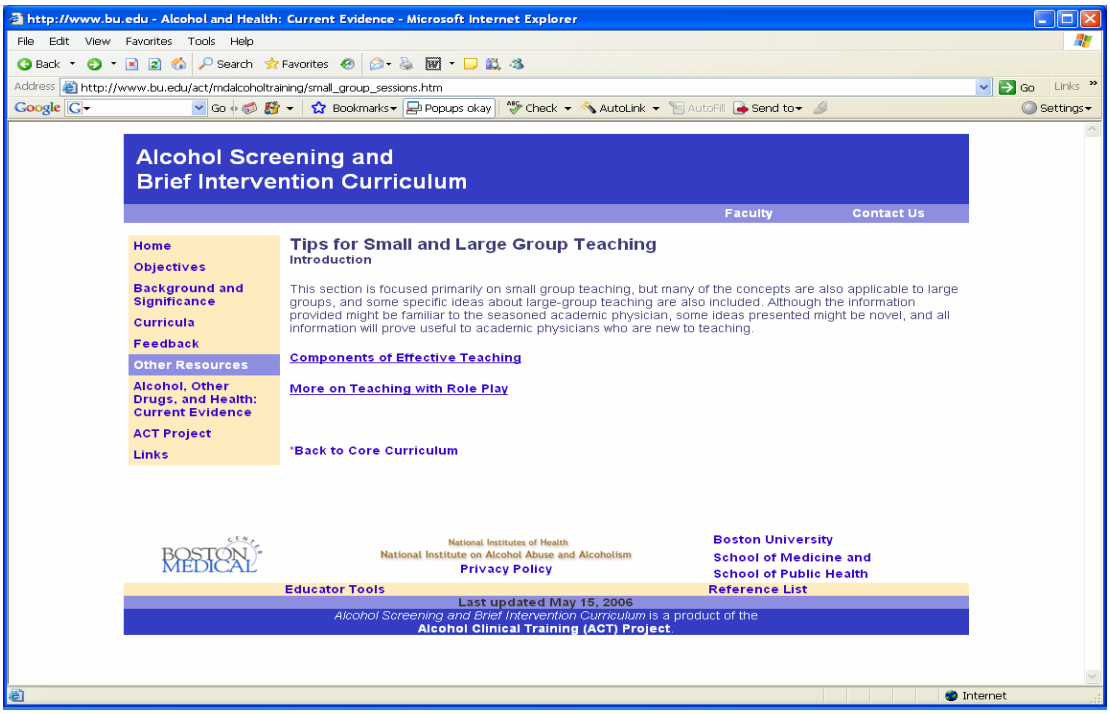
In summary, pharmacotherapy for alcohol dependence has efficacy and should be considered for all patients with alcohol dependence. Pharmacotherapy has proven efficacy when prescribed along with psychosocial counseling. There is no clear single drug of choice for this indication, and combinations of efficacious drugs and new drugs for this indication hold promise.

2. EDUCATIONAL TOOLS

Instructor's Guide to the Curricula



Tips for Small & Large Group Teaching



Guide for Using ACT Curriculum in Small and Large Group Sessions

Introduction

This section is focused primarily on small group teaching, but many of the concepts are also applicable to large groups, and some specific ideas about large-group teaching are also included. Although the information provided might be familiar to the seasoned academic physician, some ideas presented might be novel, and all information will prove useful to academic physicians who are new to teaching.

Components of Effective Teaching

1. Preparation
__ Decide on goals for teaching
__ Familiarize yourself with ACT learning objectives
__ Decide on teaching resources
__ Prepare handouts
__ Arranged for equipment

2. Setting the Stage
__ Introductions
__ Create effective learning climate
__ Set ground rules
__ Review plans, goals, objectives

3. Teaching Methods
__ Provide instruction and opportunities for discussion, problem-solving and practice
__ PowerPoint Presentations
__ Video cases
__ Role play

4. Activity
__ Manage the session
__ Engage all learners

5. Debriefing
__ Ensure learners have understood what has been discussed
__ Clarify confusing points
__ Address clinical application

6. Provide and receive feedback

Components of Effective Teaching: Expanded from Outline

1. Preparation

Adequate preparation is key to effective teaching. Begin the process by considering the size and nature of your group and the purpose of the teaching session.

a. Decide on goals for teaching
Consider reasonable outcomes of teaching. What will be your impact? What do you expect learners to walk away with? Which skills are most important and what content is necessary to support those skills?

Goals for teaching should be achievable. The most common mistake that medical teachers make is attempting to teach too much content in a too short period of time. It is better to teach one thing well than many things poorly. With a short time slot, it is most effective to focus on key knowledge and skills – perhaps one to three main messages. Additional or ancillary learning may be assigned using readings or other resources that learners can access on their own time. Mostly, you want your teaching to be meaningful and profound. This won't happen if you try to cram too much into a limited timeframe.

b. Familiarize yourself with ACT learning objectives
Overall ACT Curricular Goals and Objectives:

- Learners will understand the importance of alcohol screening and intervention.
- To describe and demonstrate a practical approach to screening and brief intervention for alcohol problems in medical settings with attention to cross-cultural efficacy and health disparities.
- Using a patient-centered, evidence-based approach learners will be able to…
    - ASK about alcohol use
    - ASSESS severity and readiness to change
    - ADVISE cutting down or abstinence, and ASSIST in goal setting, and further treatment when necessary
    - ARRANGE follow-up to monitor progress
    - ASSURE cross-cultural efficacy by building trust through respect, eliciting patients concerns and explanatory models, mitigating power differences, and expressing empathy

c. Decide on teaching resources
Depending on the size of your group, time available, teaching environment and resources, different approaches to teaching will be more effective. These approaches may range from straight-forward didactic presentations for a large-group venue, to an interactive small group with role play or standardized patients. In either case, you may use the same resources, but in a different way. For example, PowerPoint slides can be used in either setting and, although role play or standardized patients are more effective in small groups, they may be used for demonstration in large group teaching.

In order to plan your approach, begin by reviewing all of the ACT curriculum materials, and selecting those that are most well suited to your goals, your learners, and the context of your teaching. If you have ample time, consider augmenting your teaching with:
- testimonials from a recovering patient
- demonstration interviews with a recovering, standardized, or role play patient
- interviews with actual patients

d. Prepare handouts
Handouts might include copies of PowerPoint slides, related articles, or summaries of key points in curriculum presentations. Handouts should reiterate your main messages and provide background information for learners.

e. Arrange for equipment
Arrange for computer equipment, Internet access*, LCD projector, and speakers connected to the computer. The curriculum is useable on a PC or Macintosh (OSx10) computer. Be sure to plan for ample time to check the equipment and practice your presentation. Technical glitches can ruin the pace and effectiveness of a teaching session.

The curriculum is available online in several media formats and your technical requirements will vary accordingly. The curriculum needs to be downloaded for group presentation.

The curriculum itself is presented as a series of PowerPoint presentations so you will need Microsoft PowerPoint. Slides are augmented with video cases, so if you are giving the presentation on a computer connected to the Internet you will need Real Player to play the video.

If you want to give the presentation without an Internet connection you must first download the curriculum which is packaged as a .zip file. You then need to extract the files for use. Be sure to keep the files in the folder when copying to another drive or another computer. The video files in this case can be played with Windows Media Player.

If you choose to use any of the accompanying pre-recorded narration with the PowerPoint, download the file identified as “curriculum with narration”. The sound will play automatically as each slide is advanced. A set of speakers with a volume control would best facilitate a live presentation in this format.

2. Setting the Stage
a. Introductions
Introductions are important to small group functioning, and large groups can feel more included if you use introduction techniques. In small groups, every member should introduce him/herself by name. You should record each person’s name and where they are sitting so that you can use names when asking directed questions. This is particularly helpful when the group or an individual learner is not very interactive. You can request other information in the introduction as well if it will enhance small group dynamics or to provide you with additional insight into the learning needs and experiences of the learners. You may choose to ask learners to reveal their greatest challenge with patients who abuse alcohol, or their greatest success. Or, to understand your learners past experience better, you might ask them to tell of any alcohol or cross-cultural training they might

have had in the past. With larger groups introductions are more difficult. If you need to understand the level of training in a large group of learners, you may use polling techniques: “How many of you screen all of your patients regularly for alcohol problems?” or: “Who had training in using the CAGE questions in Medical School?”

b. Create effective learning climate
Learning climate is the tone or atmosphere of the teaching setting including whether it is stimulating and whether learners can comfortably identify and address their limitations. Learning climate can be affected by the instructor and by participants. Issues like creating a safe place to try new skills, setting a coaching rather than an evaluative tone, and encouraging participants to take intellectual risks can be modeled by the instructor and reinforced through positive feedback. Particularly in small group settings, the make-up of the group may also affect learning climate. Every group has its own dynamic depending upon the size and composition of the group. Small groups are heavily influenced by the personality characteristics of their members. In the best groups, members balance each other, assist each other, and participate appropriately and proportionally in the learning activity. If a group is unbalanced, competitive or dominated by certain individuals, the learning process can be negatively influenced, and the instructor must intervene to restore a positive climate.

c. Set ground rules
Ground rules are especially important to small group teaching. Ground rules can be used to enhance learning climate or to intervene if group dynamics interfere with group functioning. Ground rules include things like honesty, confidentiality, focusing on positive feedback before negative, equal opportunity to participate, or allowing the option to pass on participation. Ground rules should grow out of your goals for the session as well as the nature of the group.

d. Review plans, goals, objectives
Or – “Tell them what you are going to tell them.” It is important from the outset that learners be informed of what to expect in the teaching session. This gets everyone on the same page and makes it easier to manage the agenda for the time allowed. Learners should be aware of what they need to do to be successful in the session and how they will be evaluated. They should also understand the purpose of your teaching – why are they learning this material? How is it important to their training?

3. Teaching Methods
a. Provide instruction and opportunities for discussion, problem-solving and practice
Here is where you implement your methods to accomplish your goals. Again, always be careful not to attempt to teach too much in a too short period of time.
When planning your methods consider what learners need to know in order to practice and apply a skill, how they might get the opportunity to practice in your teaching session, and how they might translate their learning into clinical behaviors. In the ACT curriculum, materials are provided to you so that background knowledge can be reviewed (PowerPoint presentations) and skills demonstrated (video case discussions).

b. Using PowerPoint presentations
When using PowerPoint presentations with small groups (rather than larger groups), it is best to avoid excessive formality and to retain the more intimate nature of the small group. If possible, arrange seating in a U-shape, and remain seated during your presentation. This will encourage learner attention and participation throughout your presentation. PowerPoint presentations are an excellent way to convey content in an efficient manner. Visuals reinforce your verbal messages, and models or graphs can be especially useful. When appropriate, you can make your presentation more interactive by asking learners to explain concepts or models included in your slide set.

c. Using video cases
ACT video cases provide opportunity for observation of clinical examples, reflection and discussion. Depending on the group, video cases may trigger immediate relevant discussion, or may trigger irrelevant discussion or silence. Before using video cases, be sure to review them and prepare a series of questions should your group be the quiet type. Be sure to steer the group back on track should the discussion wander off topic (e.g., did you notice the beard on that guy??). If discussion is on-topic, be aware of the key points that you want to reinforce and use Socratic method to draw these points from the learners. You can do this informally or collect the points on a board or flip chart as discussion progresses.

d. Using role play (*or skills practice sessions*)
To allow an opportunity for practice you may use role play techniques using 2 learners or a learner and a standardized patient. Role play is a common method used to teach clinical communication and counseling skills. It is important to first establish a safe setting, by establishing certain ground rules like:

- Anyone playing the clinician in the role play is the first to critique his/her performance.
- Start with positive feedback, “What went well?”
- Model positive feedback yourself
- Provide corrective feedback like a coach, “next time try….” Or “you could improve your performance by…”

When using role play, assign both clinician and patient roles. Be careful with the patient role though. If you are teaching residents or practicing physicians and they devise the patient role themselves, they may portray the most difficult patient. Be sure to provide guidance to the “patient” about where they are willing to listen, respond, and compromise.

4. Activity
a. Manage the session
The greatest benefits of small group approaches to teaching are its potential for active learning, discussion, and the development of meaningful interpersonal relationships. The small group becomes not only the venue for teaching, but also a resource for teaching. Effective facilitation skills allow the instructor to manage and direct the resources of the small group to maximize teaching potential.

Managing the session is the manner in which teaching interaction is focused and paced as influenced by the instructor's leadership style. A **directive** style is instructor-centered, with the instructor calling the shots, informing and directing the learners. This style requires the greatest effort by the instructor, and may be most effective in larger group settings. The **democratic** style engages students in making decisions by rule of the majority. This requires frequent polling and runs the risk of neglecting minority views. The **non-directive** style relies on the skills and self-efficacy of learners to take responsibility for leadership of group activities. This approach may be most effective in working groups. For most teaching activities, the instructor will adapt leadership style to be consistent with the learning activity. For example, a directive style would be appropriate for didactic presentations, a democratic style for situations where there are different options for learning, and a non-directive style for certain discussions.

b. Engage all learners

Engaging learners is an art form. The basis for engagement includes learner expectations, and interest in the content, but it is also highly influenced by the relationship between instructor and learner. Artful ways to encourage engagement include the use of facilitation skills.

Facilitation skills for teaching are similar to those used in physician-patient interactions. As in the clinical setting, eye contact, non verbals, knowing your learner's name, open-ended questioning, and vocal cues like "uh-huh" and "tell me more" can help learners contribute to small group discussion. And, always be aware of the quiet learner – the one who may need an overt invitation to participate. Students who are shy about participation without an invitation appreciate instructors who 1) notice that they have not contributed; and 2) specifically invite their contribution.

Nonverbals and silence can be effective management tools not only to curb discussion when needed, but also to foster it:

- To foster discussion, pose an open-ended question and remain silent
- To encourage discussion from a quiet group member, look at him/her, or provide a verbal invitation to speak
- To close discussion look away, check the clock or interrupt if necessary. To stop a rambling learner use touch if possible

Focusing and expanding discussion can be accomplished using standard Socratic methods. To open discussion, pose a clinical case or open question. To expand discussion, add more open questions or different cases. Use "what if" scenarios to change the case or steer it in a more interesting or controversial direction. To focus discussion, use gradually more specific and focused questions.

Finally, be sure to avoid the common pitfalls:

__ When you ask a question don't answer it yourself or try to reformulate it, count to 10 silently before speaking again

__ When you have something you *could* say (which is most of the time), count to 10 again

__ Look around the group both when you are speaking and when a learner is speaking. That way learner will quickly recognize that they are addressing the group rather than just you. It will allow you to pick up cues from those who want to speak but are inhibited

5. Debriefing

a. Ensure learners have understood what has been discussed

Near the end of a teaching session, be sure to set aside time to summarize the main teaching points and to connect teaching to clinical practice. You may set goals for the learners, such as, "Try this with one patient tomorrow, and let me know how it turns out." If there is additional reading or assignments that learners must complete, this is the time to review these items. It is also important to emphasize how the learner will be held accountable for learning. You can also ask learners to state what was the most important lesson they learned from the session.

b. Clarify confusing points

Take the time to ensure that all learners are clear about the content, how the content will be applied to clinical practice, and what learners are expected to do next. To elicit potential confusion, verbally quiz the students at the end of the session to ensure that they are clear.

c. Address clinical application

You can ask learners to state in which settings they could envision themselves using the material learned from the session. You can ask the whole to discuss potential barriers and facilitators to using the new knowledge or skills in their clinical practice.

6. Provide and receive feedback

It is good to get into the habit of requesting feedback at the end of every teaching session. This will provide you with important information about the effectiveness of your teaching, and will also model your ability to hear and accept both positive and negative feedback on performance.

Providing feedback to learners about their performance should be an on-going process throughout the teaching session as well as during clinical supervision. Effective feedback is intended to reinforce the positive aspects of performance, and provide information and coaching on performance in need of improvement. In order to provide effective feedback, performance must be directly observed, and both successes and challenges noted.

Whenever providing feedback to a learner, start with learner self-evaluation. When you give a learner the opportunity to self-evaluate, he or she will often identify many salient problem areas, and will sometimes be even more critical than expected. Allowing learners to self-evaluate serves several purposes:

1. Reduces shame as learners can save face by recognizing performance problems first.
2. Provides you with insight into which problems learners are aware of, and which problems elude the learner's awareness.
3. Provides you with an opportunity to correct misperceptions.
4. Develops learner's self assessment skills and contributes to lifelong learning.
5. Makes your job easier as the most obvious shortcomings in performance are already on the table.

Some principles of effective feedback include:

1. Feedback should be expected. Be sure to set expectations for learners so there are no surprises.
2. Provide feedback immediately after performance if possible. If not, the sooner the better.
3. Be concise, focused, and objective.

4. Make your feedback specific to the performance you have observed. Include specific suggestions for improvement.
5. Highlight the positives to improve the likelihood that these behaviors will be repeated.
6. For problem areas, provide helpful advice, resources and suggestions to improve performance.
7. Remain future-oriented: “The next time you do this try X. You will find that it is a more effective approach.”

To enhance the learners receptivity for feedback, use the “sandwich” technique, starting with praise for something done well, followed by suggestions for improvement, and ending with positive reinforcement.

Teaching with Role Play

1. Prepare learners
    __ State goals and objectives
    __ Set ground rules
    __ Offer to demonstrate role play/skills
    __ Assign patient and provider roles
    __ Assign observer roles
    __ Set time limit (5 minutes or less)

2. Run the role play
    __ Arrange chairs
    __ Review communication goals
    __ Start the role play
    __ STOP if necessary; discuss and restart
    __ **At 5 minutes** STOP the role play for debriefing

3. Debriefing
    __ Ask for physician assessment of the interaction
        - What went well?
        - What would you have liked to have done differently?
    __ Ask for patient assessment of the interaction
        - What went well?
        - What would you have liked to have seen done differently?
        - How did you feel about the interaction?
    __ Ask for observer assessment of the interaction
        - What went well?
        - What might you have done differently?
    __ Lead a general discussion
    __ List learning points, open questions
    __ Agree on how to proceed

Teaching with Role Play (*or Skills Practice Sessions*): Expanded from Outline
When using role play for teaching, use the following guidelines:

1. Prepare the learners:
a. Explain the goals and objectives of the role play exercise.

b. Set ground rules. The exercise should be a safe and supportive one. Observing learners should consider what helpful feedback they can provide at the end of the role play. Role play participants should have the opportunity to call time out if they want to stop and break role. Frame the exercise as an opportunity to experiment and try new techniques; performance is not expected to be perfect. Role plays should be **brief - less than five minutes each** to allow for processing and feedback.

c. If this is a new skill, offer to demonstrate the interaction yourself prior to learners first attempts. This gives them an opportunity to observe the skills as they are operationalized by faculty. It also models the role play technique, self-reflection, and elicitation and acceptance of feedback by faculty.

d. Assign roles including the physician and patient, and observational roles. It is often easier to get the learners to volunteer for a role if you ask for volunteers for the patient role first. Learners observing the role play can be given specific skills, interactions or responses to look for and provide feedback on. This focuses their observation role and helps address all important aspects of skills for feedback.

e. Set time limits for the role play. Generally speaking, role plays should not exceed 5 minutes. Longer role plays are too much to review and process. If you are teaching a complicated skill that requires more time, break the role play into several component pieces and deal with each piece separately.

2. Run the Role Play:

a. Arrange chairs for role play participants.

b. Review the communication goals of the 5 minute (or less) segment of role play you are covering. Ensure that both physician and patient are clear about their roles.

c. Start the role play. (Note: You can jump in and stop the role play at any time if the physician seems to be floundering, not sure where to go, or is experiencing anxiety. The physician in the role play may also call time out. At that point, ask the physician to talk about what he or she has accomplished so far, and what next steps he or she would like to take. Once this is clarified, continue. If necessary, model some skills yourself, ask the patient to take a different track, or ask for a volunteer from the group to carry on.)

d. Stop the role play at 5 minutes or less for debriefing.

3. Debriefing Guidelines:

a. General principles - 1) Focus on successes; 2) Comments should be confined to behaviors not personality traits or other characteristics of the participants; 3) Feedback should be positive or corrective never negative; 4) Always ask the learner in the physician role to comment first; 5) Hold your comments for last after patient and observers have completed their feedback; 6) Facilitate and manage patient and observer feedback to ensure that feedback is helpful, not punitive.

b. “Physician” self-assessment questions include: 1) What went well? 2) What would you have liked to have done differently? (Note: You can restart the role play to try out options if important alternative approaches come up or if the physician player requests.)

c. “Patient” debriefing questions include: 1) What went well? 2) What would you have like to seen done differently? 3) How did you feel about the interaction? (Note: Be sure to keep the patient centered. Highly critical patients can be harmful to the physician and will not improve skills. In such a situation, ask the patient about specific techniques that would have been helpful. Consider reversing patient and physician roles as a strategy.)

d. Observer debriefing questions include: 1) What went well? (First focus on successes.) 2) What might you have done differently? (You can try some of these suggestions in an additional role play.)

e. Lead a general discussion of all participants.

f. List learning points, open questions and agree on how to proceed with this or other role plays.

4. Continuation options:

a. Allow replay; Change physicians; Switch roles and restart; Continue with scenario/next step/next visit; Change conditions/character; Change roles.

Alcohol Clinical Training (ACT) Pre-Session Survey

1. **Are you:**

   Male. 1

   Female.....2

2. **Are you Hispanic or Latino?**

   No.....0

   Yes 1

3. **Do you primarily consider yourself:**

   (circle one)

   American Indian or Alaska Native 1

   Asian 2

   Black or African American..... 3

   Native Hawaiian or other Pacific Islander 4

   White 5

   Other (specify)_____ 6

4. **What is your year of birth**? ____ ____ ____ ____

5. **Were you born in the U.S?**

   No.....0

   Yes 1

6. **Were *BOTH* of your parents born in the U.S?**

   No.....0

   Yes 1

7. Is English your first language?

No.....0

Yes 1

8. How many languages *other than English* do you speak fluently? ____ ____

9. What year did you complete your residency or clinical training? ____ ____ ____ ____

10. To which type of practice do you belong?

Academic Hospital.....1

Non-academic Hospital.....2

Large Group Practice 3

Small Group Practice 4

Solo Practice 5

For the next 2 questions, a standard drink refers to a 12 oz beer, a 5 oz glass of wine, or one 1.5 oz shot or mixed drink.

How many standard drinks are considered low risk drinking amounts for a healthy 45 year-old man?

11. NO MORE THAN ____ ____ drinks per week (on average)

12. NO MORE THAN ____ ____ drinks per drinking occasion

How many standard drinks are considered low risk drinking amounts for a healthy, non-pregnant 35 year-old woman?

13. NO MORE THAN ____ ____ drinks per week (on average)

14. NO MORE THAN ____ ____ drinks per drinking occasion

Please identify what the 4-letters in the CAGE acronym stand for (key words only):

15. C = _____

16. A = _____

17. G = _____

18. E = _____

You have just finished assessing your patient for alcohol use, and have determined that he has had to drink increasingly more over the past year to achieve the same effect. He describes having 'the shakes' in the morning, and has blacked out on more than one occasion. He recognizes that his drinking is a problem, and has tried without success to cut down over the past few months.

19. The *best* drinking goal for patients like this is:

- ❑ Abstinence only
- ❑ Cutting down only
- ❑ Cutting down or abstaining are equally good goals

20. It is likely that this patient has:

- ❑ Risky drinking without alcohol dependence
- ❑ Alcohol dependence
- ❑ Neither

21. This patient would best be described as being in the following stage of readiness to change his drinking:

- ❑ Precontemplation
- ❑ Contemplation
- ❑ Determination/action

You have screened your patient, a 42 year-old woman, for alcohol use. She reports drinking 3-4 beers about 3 times per week, and answered "no" to all of the CAGE questions. She has a family history of alcoholism. She says that she drinks to help her relax, states that she does not have an alcohol problem, and sees no reason to change.

22. The *best* drinking goal for patients like this is:

- ❑ Abstinence only
- ❑ Cutting down only
- ❑ Cutting down or abstaining are equally good goals

23. It is likely that this patient has:

- ❑ Risky drinking without alcohol dependence
- ❑ Alcohol dependence
- ❑ Neither

24. This patient would best be described as being in the following stage of readiness to change her drinking:

- ❑ Precontemplation
- ❑ Contemplation
- ❑ Determination/action

25. Please rate the following statements according to your current beliefs:

(circle one for each item)

		Disagree	***Somewhat disagree***	***Neither agree nor disagree***	***Somewhat agree***	***Agree***
a.	It takes too much time to address patients' drinking problems	1	2	3	4	5
b.	Understanding a patient's health beliefs is important when addressing alcohol problems	1	2	3	4	5
c.	It is not my responsibility as a physician to address patients' alcohol problems	1	2	3	4	5
d.	Advising a patient about their excessive drinking can improve their health	1	2	3	4	5
e.	Patients who have difficulty understanding me are an unnecessary drain on my clinical time	1	2	3	4	5
f.	I have little patience for patients who refuse to accept that their excessive drinking is bad for them	1	2	3	4	5
g.	Making specific statements to assure patients they have been understood is important when addressing alcohol problems	1	2	3	4	5
h.	I am not interested in patients' explanations and excuses for drinking at unhealthy levels	1	2	3	4	5

26. *In the past 3 months,* I….. *(circle one for each item)*

		Never	*Rarely*	*Sometimes*	*Usually*	*Always*
a.	Asked patients about quantity and frequency of alcohol use	1	2	3	4	5
b.	Screened patients for alcohol problems using the CAGE	1	2	3	4	5
c.	Assessed patients for alcohol consequences after a positive screen	1	2	3	4	5
d.	Assessed patients readiness to change their behavior after a positive screen	1	2	3	4	5
e.	Made specific statements when addressing alcohol problems to assure patients they had been understood	1	2	3	4	5
f.	Elicited the patient's health beliefs when addressing alcohol problems	1	2	3	4	5
g.	Counseled all patients with alcohol problems regarding their alcohol use	1	2	3	4	5
h.	Reflected upon problem drinkers' rationale for drinking	1	2	3	4	5

27. I am confident in my ability to: *(circle one for each item)*

		Not at all Confident →		*Somewhat Confident* →		*Very Confident*
a.	Ask patients about quantity and frequency of alcohol use	1	2	3	4	5
b.	Screen patients for alcohol problems using the CAGE	1	2	3	4	5
c.	Assess patients for alcohol consequences after a positive screen	1	2	3	4	5
d.	Assess patients readiness to change their behavior after a positive screen	1	2	3	4	5
e.	Make specific statements when addressing alcohol problems to assure patients they have been understood	1	2	3	4	5

f.	Elicit the patient's health beliefs when addressing alcohol problems	1	2	3	4	5
g.	Counsel all patients with alcohol problems regarding their alcohol use	1	2	3	4	5
h.	Reflect upon problem drinkers' rationale for drinking	1	2	3	4	5

28. *In the next 3 months,* I intend to: *(circle one for each item)*

		Never	***Rarely***	***Sometimes***	***Usually***	***Always***
a.	Ask patients about quantity and frequency of alcohol use	1	2	3	4	5
b.	Screen patients for alcohol problems using the CAGE	1	2	3	4	5
c.	Assess patients for alcohol consequences after a positive screen	1	2	3	4	5
d.	Assess patients readiness to change their behavior after a positive screen	1	2	3	4	5
e.	Make specific statements when addressing alcohol problems to assure patients they have been understood	1	2	3	4	5
f.	Elicit the patient's health beliefs when addressing alcohol problems	1	2	3	4	5
g.	Counsel all patients with alcohol problems regarding their alcohol use	1	2	3	4	5
h.	Reflect upon problem drinkers' rationale for drinking	1	2	3	4	5

Alcohol Clinical Training (ACT) Post-Session Survey

For the next 2 questions, a standard drink refers to a 12 oz beer, a 5 oz glass of wine, or one 1.5 oz shot or mixed drink.

How many standard drinks are considered low risk drinking amounts for a healthy 45 year-old man?

1. NO MORE THAN ____ ____ drinks per week (on average)

2. NO MORE THAN ____ ____ drinks per drinking occasion

How many standard drinks are considered low risk drinking amounts for a healthy, non-pregnant 35 year-old woman?

3. NO MORE THAN ____ ____ drinks per week (on average)

4. NO MORE THAN ____ ____ drinks per drinking occasion

Please identify what the 4-letters in the CAGE acronym stand for (key words only):

5. **C =** _____

6. **A =** _____

7. **G =** _____

8. **E =** _____

You have just finished assessing your patient for alcohol use, and have determined that he has had to drink increasingly more over the past year to achieve the same effect. He describes having 'the shakes' in the morning, and has blacked out on more than one occasion. He recognizes that his drinking is a problem, and has tried without success to cut down over the past few months.

9. The *best* drinking goal for patients like this is:

- ❑ Abstinence only
- ❑ Cutting down only
- ❑ Cutting down or abstaining are equally good goals

10. It is likely that this patient has:

- ❑ Risky drinking without alcohol dependence
- ❑ Alcohol dependence
- ❑ Neither

11. This patient would best be described as being in the following stage of readiness to change his drinking:

- ❑ Precontemplation
- ❑ Contemplation
- ❑ Determination/action

You have screened your patient, a 42 year-old woman, for alcohol use. She reports drinking 3-4 beers about 3 times per week, and answered "no" to all of the CAGE questions. She has a family history of alcoholism. She says that she drinks to help her relax, states that she does not have an alcohol problem, and sees no reason to change.

12. The *best* drinking goal for patients like this is:

- ❑ Abstinence only
- ❑ Cutting down only
- ❑ Cutting down or abstaining are equally good goals

13. It is likely that this patient has:

- ❑ Risky drinking without alcohol dependence
- ❑ Alcohol dependence
- ❑ Neither

14. This patient would best be described as being in the following stage of readiness to change her drinking:

- ❑ Precontemplation
- ❑ Contemplation
- ❑ Determination/action

15. Please rate the following statements according to your current beliefs:

(circle one for each item)

		Disagree	*Somewhat disagree*	*Neither agree nor disagree*	*Somewhat agree*	*Agree*
a.	It takes too much time to address patients' drinking problems	1	2	3	4	5
b.	Understanding a patient's health beliefs is important when addressing alcohol problems	1	2	3	4	5
c.	It is not my responsibility as a physician to address patients' alcohol problems	1	2	3	4	5
d.	Advising a patient about their excessive drinking can improve their health	1	2	3	4	5
e.	Patients who have difficulty understanding me are an unnecessary drain on my clinical time	1	2	3	4	5
f.	I have little patience for patients who refuse to accept that their excessive drinking is bad for them	1	2	3	4	5
g.	Making specific statements to assure patients they have been understood is important when addressing alcohol problems	1	2	3	4	5
h.	I am not interested in patients' explanations and excuses for drinking at unhealthy levels	1	2	3	4	5

16. I am confident in my ability to: *(circle one for each item)*

		Not at all Confident →		*Somewhat Confident*		→ *Very Confident*
a.	Ask patients about quantity and frequency of alcohol use	1	2	3	4	5
b.	Screen patients for alcohol problems using the CAGE	1	2	3	4	5
c.	Assess patients for alcohol consequences after a positive screen	1	2	3	4	5
d.	Assess patients readiness to change their behavior after a positive screen	1	2	3	4	5
e.	Make specific statements when addressing alcohol problems to assure patients they have been understood	1	2	3	4	5
f.	Elicit the patient's health beliefs when addressing alcohol problems	1	2	3	4	5
g.	Counsel all patients with alcohol problems regarding their alcohol use	1	2	3	4	5
h.	Reflect upon problem drinkers' rationale for drinking	1	2	3	4	5

17. ***In the next 3 months,*** **I intend to:** *(circle one for each item)*

		Never	*Rarely*	*Sometimes*	*Usually*	*Always*
a.	Ask patients about quantity and frequency of alcohol use	1	2	3	4	5
b.	Screen patients for alcohol problems using the CAGE	1	2	3	4	5
c.	Assess patients for alcohol consequences after a positive screen	1	2	3	4	5
d.	Assess patients readiness to change their behavior after a positive screen	1	2	3	4	5
e.	Make specific statements when addressing alcohol problems to assure patients they have been understood	1	2	3	4	5
f.	Elicit the patient's health beliefs when addressing alcohol problems	1	2	3	4	5
g.	Counsel all patients with alcohol problems regarding their alcohol use	1	2	3	4	5
h.	Reflect upon problem drinkers' rationale for drinking	1	2	3	4	5

18. In the next 3 months, how much will you change your practice regarding alcohol problems as a result of this course?

- ❑ Not at all
- ❑ A little
- ❑ Somewhat
- ❑ Very much

3. PUBLICATIONS/PRESENTATIONS

The Alcohol Clinical Training (ACT) Project: A Free Online Alcohol Curriculum for Use by Generalist Clinician Educators

DP Alford, SE Chapman, CE Dubé, N Freedner, RW Schadt, R Saitz

Clinical Addiction Research and Education (CARE) Unit, Section of General Internal Medicine, Boston University Schools of Medicine and Public Health; Brown University

Supported by the National Institute on Alcohol Abuse and Alcoholism, Grant # R25 AA13822

BACKGROUND

- Alcohol problems are rarely identified in medical settings
- Brief counseling interventions are not routinely done
- Existing curricula addressing alcohol and health disparities are not being used
- Fewer than half of internists in practice report receiving recent continuing medical education training about substance abuse

AIM & OBJECTIVES

Aim

- To develop, implement, and actively disseminate a model alcohol clinical training (ACT) curriculum for generalist clinicians that integrates health disparity knowledge and skills

Objectives:

- Develop an evidence-based model curriculum that teaches skills for addressing alcohol problems (including screening, assessment, and brief intervention) in primary care settings with an emphasis on cross-cultural efficacy
- Pilot the curriculum with local target audiences
- Train generalist clinician educators nationwide to disseminate the ACT curriculum
- Make the ACT curriculum freely accessible via the Web to facilitate dissemination

CURRICULUM DEVELOPMENT

- **Team**
  - General internists with expertise in substance abuse and physician education, educators with expertise in curriculum development, teaching methods, and media-based instruction, and a public health-trained project manager
- **Curriculum Development Process**
  - Develop curriculum matrix
  - Write video case vignette scripts
  - Recruit physicians and standardized patient actors
  - Shoot and edit video
  - Develop slides and educator notes
  - Design website
- **Formative research**
  - Design pre- and post-tests
  - Pilot curriculum with residents, faculty physicians, and practicing clinicians
    - Conduct focus groups
    - Collect pre/post evaluative data
  - Revise curriculum based on feedback

CURRICULUM MATRIX

	Case #1	Case #2	Case #3
Alcohol problem severity	At-risk drinking	Problem or Abuse	Dependence
Skills	Ask (screen)	Assess Advise	Advise Arrange
Cross Cultural elements (RESPECT)	**P**ower **R**espect **T**rust	**E**xplanatory Model **S**ociocultural Context	**E**mpathy **C**oncern

CURRICULUM: FINAL PRODUCT

- Curriculum consists of:
  - Educator guide
  - PowerPoint slides with lecture notes and audio narration
  - Three videotaped physician-standardized patient actor interviews
  - Videotaped debriefing comments from the patients
  - Pre- and post-session tests for learners
  - Educator feedback page

VIDEO VIGNETTES

The physician screens his patient for alcohol abuse. Does he get accurate information?

The physician is assessing the severity of the patient's alcohol problem and then giving advice. What does the physician do well or not so well?

The physician assesses her patient's alcohol problems, and conducts a brief intervention. What strategies helped assure cross-cultural efficacy?

PRELIMINARY EVALUATION

Evaluation of Primary Care Physician Training

- Sample from 2 trainings consisting of local medical residents and practicing clinicians in a community-based managed care organization (N=41)
- Following a 2-3 hour ACT course for physician learners:
  - 63% of physicians intended to usually or always use the CAGE to screen, compared with 16% who usually or always used the CAGE in the 3 months prior to the ACT training
  - Knowledge of risky drinking limits increased from 25% correct before the ACT course to 92% correct after the ACT course
  - On a scale from 1 to 5, confidence in screening patients for alcohol problems in a culturally efficacious way increased from 3.7 to 4.5 as a result of the ACT course
  - 100% of participants indicated that their practice regarding alcohol problems would change as a result of the ACT course

Evaluation of Clinician Educator Training

- Sample from 1 regional and 1 national training consisting of alcohol clinical experts and general internists (N=14)
- Following the ACT train-the-trainers course for physician educators…
  - On a 5-point scale from poor to excellent, the overall design and content of the slides and videos was rated as very good or excellent by 99% of course participants
  - 100% indicated that they would use the videos in their teaching; 75% would use the slides as well
  - Physicians indicated that they would use the ACT curriculum in resident (75%) and medical student (50%) conferences, CME courses (38%), inpatient attending rounds (13%), and precepting (13%)

CONCLUSIONS

- Teaching of cross-cultural efficacy can be integrated into the teaching of more general clinical skills
- An Alcohol Clinical Training (ACT) curriculum was designed and developed in an online format for generalist clinician educators
- Primary care physicians who were trained reported positive changes in confidence, and intended to increase screening patients for alcohol use
- Physician educators who were trained rated the curriculum positively, and indicated that they would use it in their teaching

IMPLICATIONS

- Alcohol screening and brief intervention can be taught using a multi-media web-based curriculum
- Such materials may support wider dissemination of appropriate care for patients with unhealthy alcohol use

www.mdalcoholtraining.org

Abstract Citation: Alford D, Chapman SE, Dubé C, Freedner N, Schadt R, Saitz R. The alcohol clinical training project: a free online curriculum for use by generalist clinician educators. SGIM, May 13, 2005, New Orleans, LA (poster). J Gen Intern Med 2005;20(suppl 1):42.

A Web-Based Alcohol Clinical Training Curriculum: Is In-Person Faculty Development Necessary?

DP Alford[1,2], JM Richardson[1,3], SE Chapman[1,2], CE Dubé[5], RW Schadt[4], R Saitz[1,2,3,4]

Clinical Addiction Research and Education (CARE) Unit, Section of General Internal Medicine, Boston Medical Center[1]; Boston University School of Medicine[2]; Youth Alcohol Prevention Center[3], Boston University School of Public Health[4]; Brown University[5]

Supported by the National Institute on Alcohol Abuse and Alcoholism, Grant # R25 AA13822

BACKGROUND

- Alcohol problems are often not identified in medical settings
- Brief counseling interventions are not routinely done
- Existing curricula addressing alcohol screening and brief intervention are not being widely used
- Fewer than half of internists in practice report receiving recent continuing medical education training about substance abuse

OBJECTIVE

- To test whether a free web-based Alcohol Clinical Training (ACT) curriculum would be used by physician educators
- To test whether in-person faculty development would be associated with ACT curriculum use or increased teaching confidence and specific teaching practices

STUDY DESIGN AND METHODS

Study Design

- Controlled educational study of evaluation data collected from workshop attendees (intervention subjects) at an American College of Physicians (ACP) national meeting
- Comparison with workshop applicants who applied after workshop was full (control subjects)

Methods

- Enrolled U.S. physician educators who applied to attend a workshop on the use of the ACT curriculum
- Surveyed both intervention and control subjects at time of application (baseline) and 3 months after workshop (follow-up)

OUTCOMES

- Change from baseline to follow-up, using 5-point Likert Scale, of **teaching confidence** and specific **teaching practices** regarding:
  - Alcohol screening
  - Assessment of readiness to change
  - Counseling about alcohol problems
  - Eliciting patient health beliefs
  - Assuring patients that they are understood
- Curriculum Use - Any use, or use of slides, notes, and/or audio portions for teaching or self-learning

RESULTS

Of 20 intervention and 13 control subjects, 19 (95%) and 10 (77%), respectively, completed follow-up

Physician Characteristics at baseline*

	Intervention Group (N=20)†	Control Group (N=13)
Male (%)	79	62
Mean Age (years)	41	45
Race (%)		
Asian	37	31
Black/African American	11	8
White	37	54
Other	16	8
Hispanic (%)	5	8
Has Substance Abuse Expertise (%)	50	54
Mean # Years Since Residency	10	11
English First Language(%)	58	54

†1 subject missing on all characteristics except gender *No significant differences between groups

Outcomes

Mean Change from Baseline to Follow-up

	Intervention (N=18)†	Control (N=9)†	Between-group P-value
Teaching Confidence∞			
Alcohol screening	+ 1.24**	+ 0.11	**0.006**
Assessment of readiness to change	+ 1.00**	+ 0.11	0.06
Counseling about alcohol problems	+ 1.18**	+ 0.44	0.12
Eliciting patient health beliefs	+ 1.29**	+ 0.67	0.23
Assuring patients that they are understood	+ 1.47**	+ 0.56	0.07
Teaching Practices∞			
Alcohol screening	+ 0.56*	- 0.56	**0.02**
Assessment of readiness to change	+ 0.44	- 0.44	0.09
Counseling about alcohol problems	+ 0.67*	- 0.22	0.08
Eliciting patient health beliefs	+ 0.81**	- 0.33	**0.03**
Assuring patients that they are understood	+ 0.94*	+ 0.11	0.18

*p<.05; **p<.01; ***p<.001; †Baseline data were missing for one subject in each group; ∞Likert scale, where 1=Not at all Confident/Rarely and 5=Very Confident/Always

Curriculum Use at follow-up*

	Intervention Group N=19 %	Control Group N=10 %
Any curriculum use	79	50
Slide Use	58	40
Notes Use	37	20
Audio Use	0	10
Video Use	16	10

*No significant differences between groups

LIMITATIONS

- Small sample size
- Not randomized
- Self-reported outcomes

CONCLUSIONS

- In-person training for physician educators on the use of a web-based Alcohol Clinical Training curriculum is associated with increases in teaching confidence and specific teaching practices.
- Although not significant, a greater proportion of educators who had in-person training used the web-based curriculum
- Even without in-person training, a substantial proportion of subjects reported using the web-based curriculum.

IMPLICATIONS

Though the web serves as an effective dissemination tool, in-person educator training may be required to effect widespread teaching of clinical skills like those involved in alcohol screening and brief intervention.

Abstract Citation: Alford DP, Richardson JM, Chapman SE, Dube CE, Schadt RW, Saitz R. A Web-Based Alcohol Clinical Training (ACT) Curriculum: Is In-Person Faculty Development Necessary? SGIM, April 27, 2006, Los Angeles, CA and Research Society on Alcoholism, June 26, 2006, Baltimore, MD. Alcohol Clin Exp Res 2006;30(6)[supplement]:102A. J Gen Intern Med 2006;21(supplement):7, and AMERSA, November 2, 2006, Washington, DC.

Manuscript Citation: Alford D, Richardson JR, Chapman SE, Dubé C, Schadt R, Saitz R. A Web-Based Alcohol Clinical Training (ACT) Curriculum: Is In-Person Faculty Development Necessary to Affect Teaching? Manuscript Under Review as of July 2007.

4. MARKETING – CURRICULUM POSTCARD

Side 1

www.mdalcoholtraining.org

For generalist clinician educators...

Helping Patients Who Drink Too Much

A free web-based curriculum for screening and brief intervention for unhealthy alcohol use

Supported by the National Institute on Alcohol Abuse and Alcoholism

Side 2

www.mdalcoholtraining.org

This curriculum, which can be adapted to fit the needs of the educator, includes 3 video cases and a slide presentation with educator notes.

Using a patient-centered, evidence-based approach that emphasizes cross-cultural efficacy, learners will be able to:

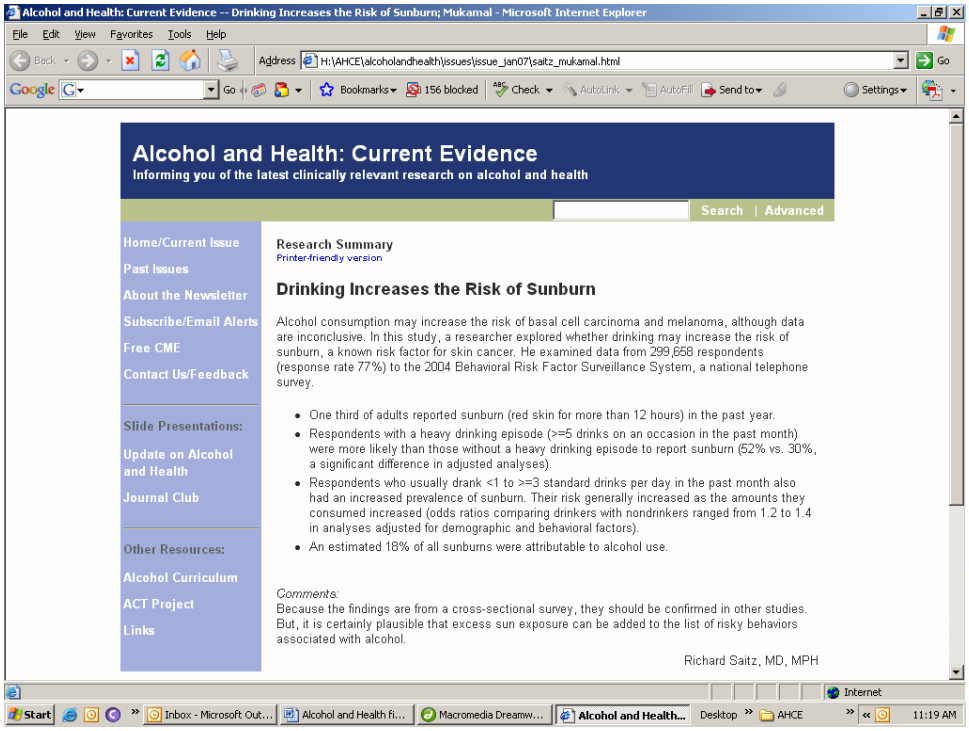
- **ASK** about alcohol use
- **ASSESS** severity and readiness to change
- **ADVISE** cutting down or abstinence, and assist in goal setting and further treatment when necessary

Helping Patients Who Drink Too Much is a product of the Alcohol Clinical Training (ACT) Education Project

www.actproject.org

Appendix C. Newsletter Materials

1. SNAPSHOT PAGES OF WWW.ALCOHOLANDHEALTH.ORG




Alcohol and Health: Current Evidence -- Links - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Address H:\AHCE\alcoholandhealth\links.html
Convert current web page to an Adobe PDF file
Alcohol and Health: Current Evidence
Informing you of the latest clinically relevant research on alcohol and health
Search | Advanced
Home/Current Issue
Past Issues
About the Newsletter
Subscribe/Email Alerts
Free CME
Contact Us/Feedback
Slide Presentations:
Update on Alcohol and Health
Journal Club
Other Resources:
Alcohol Curriculum
ACT Project
Links
Links
Clinician Education
Addiction Technology Transfer Center (ATTC)
Alcohol Education Center (McKnight Brain Institute of the University of Florida)
Alcohol Medical Scholars Program (AMSP)
Center for Alcohol and Addictions Studies (Brown University)
Clinical Addiction Research and Education Program (CARE)
Fetal Alcohol and Drug Unit (University of Washington)
Project Cork
Project Mainstream
Clinical Tools
Clinician's Guide to Helping Patients Who Drink Too Much (from the National Institute on Alcohol Abuse and Alcoholism, NIAAA)
Patient Materials/Resources
Alcoholscreening.org
Drinkerscheckup.com
Patient publications from NIAAA
Substance Abuse Help for Individuals (from the Substance Abuse and Mental Health Services Administration, SAMHSA)
Internet
Start
11:17 AM


Alcohol and Health: Current Evidence -- Journal Club Presentations - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Address H:\AHCE\alcoholandhealth\club.html
Convert current web page to an Adobe PDF file
Alcohol and Health: Current Evidence
Informing you of the latest clinically relevant research on alcohol and health
Search | Advanced
Home/Current Issue
Past Issues
About the Newsletter
Subscribe/Email Alerts
Free CME
Contact Us/Feedback
Slide Presentations:
Update on Alcohol and Health
Journal Club
Other Resources:
Alcohol Curriculum
ACT Project
Links
Journal Club Presentations
These PowerPoint presentations are geared towards anyone who leads a Journal Club session. Each presentation provides a critical appraisal of a study summarized in the newsletter utilizing approaches recommended in the Users' Guides to the Medical Literature.
Presentations by Journal Club Type:
Harm
Therapy
Prognosis
Diagnostic Tests
Qualitative Research
Using Review Articles
Subgroup Analyses
Economic Analysis of Clinical Practice
To learn more about the Users' Guides to the Medical Literature and for other useful information, visit the following links:
Users' Guides to Evidence-Based Practice
JAMA: Users' Guides Interactive
JAMA: Glossary of Methodologic Terms
BMJ: "How to Read a Paper"
Cochrane Library
Internet
Start
11:18 AM

2. JOURNALS REVIEWED

Major Journals Reviewed Regularly:

Addiction
Addictive Behaviors
AIDS
Alcohol
Alcohol and Alcoholism
Alcoholism: Clinical and Experimental Research
American Journal of Drug and Alcohol Abuse
American Journal of Epidemiology
American Journal of Medicine
American Journal of Preventive Medicine
American Journal of Psychiatry
American Journal of Public Health
American Journal on Addictions
Annals of Internal Medicine
Archives of General Psychiatry
Archives of Internal Medicine
British Medical Journal
Drug and Alcohol Dependence
Epidemiology
Journal of Addictive Diseases
Journal of AIDS
Journal of Behavioral Health Services and Research
Journal of General Internal Medicine
Journal of Studies on Alcohol
Journal of Substance Abuse Treatment
Journal of the American Medical Association
Lancet
New England Journal of Medicine
Preventive Medicine
Psychiatric Services
Substance Abuse
Substance Use and Misuse

Journals Reviewed Periodically:

Academic Emergency Medicine
Accident Analysis and Prevention
ACP Journal Club
Acta Psychiatrica Scandinavica
Addiction Biology
Addiction Research and Theory
Adolescent Medicine
AIDS Care
AIDS Research and Human Retroviruses
Alcohol Research and Health
Alcoholism Treatment Quarterly
Ambulatory Pediatrics
American Journal of Health Behavior
American Journal of Obstetrics and Gynecology
American Psychologist
Annals of Behavioral Medicine
Annals of Emergency Medicine
Annals of Epidemiology
International Journal of Epidemiology
International Journal of Fertility and Women's Medicine
International Journal of Gynecology and Obstetrics
International Journal of Psychiatry in Medicine
Journal of Addictions Nursing
Journal of Adolescent Health
Journal of American College Health
Journal of Applied Psychology
Journal of Behavioral Medicine
Journal of Chemical Dependency Treatment
Journal of Child and Adolescent Substance Abuse
Journal of Clinical Epidemiology
Journal of Clinical Psychiatry
Journal of Clinical Psychology
Journal of Clinical Psychopharmacology
Journal of Community Health
Journal of Consulting and Clinical Psychology
Journal of Drug Education

Annals of Neurology
Archives of Disease in Childhood
Archives of Gynecology and Obstetrics
Annals of Family Medicine
Archives of Neurology
Archives of Orthopaedic and Trauma Surgery
Archives of Pediatrics and Adolescent Medicine
Archives of Women's Mental Health
Behavior Genetics
Behavior Modification
Behavior Research and Therapy
Behavioral Medicine
Behavioral Neuroscience
Brain: A Journal of Neurology
British Journal of Clinical Psychology
British Journal of General Practice
British Journal of Health Psychology
British Journal of Psychiatry
British Journal of Psychology
British Journal of Social Psychology
Canadian Journal of Psychiatry
Canadian Medical Association Journal
Clinical Pediatrics
CNS Drugs
CNS Spectrums
Cochrane Database of Systematic Reviews
Cognitive and Behavioral Neurology
Comprehensive Psychiatry
Cortex
Cultural Diversity and Ethnic Minority Psychology
Culture, Medicine, and Psychiatry
Drug and Alcohol Review
Drugs: Education, Prevention, and Policy
Ethnicity and Disease
Ethnicity and Health
European Addiction Research
European Archives of Psychiatry and Clinical Neuroscience
European Psychiatry
Family Medicine
Family Practice
Health Education and Behavior
Journal of Epidemiology and Community Health
Journal of Ethnicity in Substance Abuse
Journal of Family Practice
Journal of General Psychology
Journal of Geriatric Psychiatry and Neurology
Journal of Health and Social Behavior
Journal of Healthcare for the Poor and Underserved
Journal of Nervous and Mental Disease
Journal of Neurology, Neurosurgery, and Psychiatry
Journal of Neuropsychiatry and Clinical Neurosciences
Journal of Pediatrics
Journal of Psychiatry and Neuroscience
Journal of Psychoactive Drugs
Journal of Psychology
Journal of Substance Use
Journal of American Academy of Child/Adolescent Psychiatry
Journal of the American Board of Family Practice
Journal of the National Medical Association
Journal of Trauma
Journal of Women and Aging
Journal of Women's Health
Mayo Clinic Proceedings
Medical Care
Medical Journal of Australia
Mental Health Services Research
Morbidity and Mortality Weekly Report
Milbank Quarterly
Neurology
Obstetrics and Gynecology
Occupational and Environmental Medicine
Occupational Medicine (Oxford)
Occupational Medicine (Philadelphia)
Pediatric Emergency Care
Pediatrics
Pharmacology, Biochemistry, and Behavior
Preventing Chronic Disease
Psychiatric Genetics
Psychiatry
Psychiatry and Clinical Neurosciences
Psychological Bulletin
Psychological Medicine

Health Promotion International
Health Psychology
Health Services Research
HIV Medicine
Injury
Injury Control and Safety Promotion
Injury Prevention
Int'l Journal of Adolescent Medicine and Health
Int'l Journal of Behavioral Medicine
Int'l Journal of Emergency Mental Health
Psychology and Psychotherapy
Psychology of Addictive Behaviors
Psychopharmacology
Psychopharmacology Bulletin
Public Health Reports
Social Psychiatry and Psychiatric Epidemiology
Social Science and Medicine
Substance Abuse Treatment, Prevention, and Policy
Suicide and Life-Threatening Behavior
Women and Health

3. SAMPLE RESEARCH SUMMARY

Alcohol Intake Triggers Recurrent Gout Attacks

Alcohol use may trigger recurrent gout attacks. Researchers tested this hypothesis through a web-based study of people who had a gout attack in the past year. Subjects were recruited online over 10 months and completed online surveys that assessed alcohol use and risk factors for gout attacks.

- Over 1 year of follow-up, 321 gout attacks occurred among 197 subjects.
- In analyses adjusted for diuretic use and purine intake, the likelihood of a gout attack increased as alcohol intake increased within the
    - 24 hours preceding the attack (P <0.02) (e.g., odds ratios comparing drinking with not drinking: 1.4 [95% CI, 0.6–2.4] for 1–2 drinks; 3.1 [95% CI, 1.0–11.0] for $\geq$7 drinks);
    - 48 hours preceding the attack (P <0.005) (e.g., odds ratios 1.1 [95% CI, 0.7–2.0] for 1–2 drinks; 2.5 [95% CI, 1.1–5.9] for $\geq$7 drinks).
- In analyses also adjusted for total alcohol consumption, the risk of an attack was not associated with any specific alcoholic beverage.

Comments:
According to this study, the risk of a recurrent gout attack significantly increases as drinking increases, particularly in people drinking $\geq$7 drinks, in the 24 or 48 hours before the attack. Total consumption appears to affect risk more than intake of a specific beverage. Thus, people with gout should be very careful about consuming alcohol, especially larger amounts, as such consumption could trigger a gout attack.
R. Curtis Ellison, MD

Reference:
Zhang Y, Woods R, Chaisson CE, et al. Alcohol consumption as a trigger of recurrent gout attacks. *Am J Med*. 2006;119(9):800.e13–800.e18.

4. SAMPLE ISSUE

TABLE OF CONTENTS

Alcohol and Health: Current Evidence

NOV-DEC 2006

Alcohol and Health Outcomes

Does Inflammation Influence Alcohol's Cardiovascular Effects?

Light-to-moderate alcohol use can reduce cardiovascular mortality in some populations. To investigate whether this protective effect is influenced by inflammation, researchers assessed alcohol use and inflammatory markers (C-reactive protein and interleukin-6) in 2487 adults, aged 70–79 years, without heart disease at study entry. Over a mean 5.6 years of follow-up, 397 deaths and 383 cardiac events (myocardial infarction, angina, or heart failure) occurred.

- In adjusted analyses, the risks of all-cause mortality and incident cardiac events were lower in light-to-moderate drinkers* than in never or occasional drinkers** (hazard ratios [HRs] 0.7 for all-cause mortality and 0.7 for cardiac events).
- Risks were also reduced in light-to-moderate drinking men with above-median, but not lower, levels of interleukin-6 (HRs 0.5 for all-cause mortality and 0.5 for cardiac events).
- C-reactive protein levels did not affect the association between drinking and risk among men.
- The effect of inflammatory markers was not assessed in women because too few women had an outcome event.

Comments: This interesting research is consistent with prior studies that show reduced all-cause mortality and cardiac events in adults who drink light-to-moderate amounts. Although the study found no relationship between C-reactive protein levels, alcohol use, and outcomes, it did find a lower risk in light-to-moderate drinking men with high (but not low) interleukin-6 levels. To better understand the interaction of inflammation, alcohol, and cardiovascular health, further research on this topic should include different populations, such as people with chronic inflammatory conditions, women, and racial minorities.

Kevin L. Kraemer, MD, MSc

*Drank 1–7 standard drinks per week
**Drank never or <1 drink per week

Reference: Maraldi C, et al. Impact of inflammation on the relationship among alcohol consumption, mortality, and cardiac events: the Health, Aging, and Body Composition Study. *Arch Intern Med.* 2006;166(14):1490–1497.

Long-Term Mortality in People Treated for Alcoholism

Few studies have assessed the long-term mortality of a group of people with alcoholism who received treatment at the same program. Researchers in this study tracked, for over 33 years, state and national death records of 500 people with alcoholism who had been admitted to a comprehensive, community-based alcohol treatment program in San Antonio. Most subjects were white, male, unemployed, and unmarried; they had a mean age of 47 years at enrollment and 61 years at death.

- During follow-up, 449 subjects died. The overall case-fatality rate was 0.057 deaths per person-year.
- Cancer and lung-related death rates were lower than expected in the early years of follow-up and higher than expected in the later years.

(continued on page 2)

Alcohol and Health: Current Evidence is a project of the Boston Medical Center, supported by the National Institute on Alcohol Abuse and Alcoholism, and produced in cooperation with the Boston University Schools of Medicine and Public Health.

Long-Term Mortality (continued from page 1)

- Conversely, death rates of liver disease and "lifestyle-related" causes (accidents, car crashes, homicide, suicide, overdose, and AIDS) were higher than expected in the early years of follow-up and lower than expected in the later years.
- Ethnic and racial differences in mortality included (1) longer survival among whites than blacks and Hispanics, and (2) greater than expected frequency of deaths from liver disease and lifestyle causes in Hispanics than in blacks and whites.

Comments: This long-term follow-up of people with alcoholism admitted to the same treatment program indicates a relatively high mortality rate, early occurrence of liver disease and lifestyle-related deaths, and some differences among ethnic/racial groups. The author acknowledges that findings from this group of urban poor will likely differ from findings in other populations with alcoholism. However, the study illustrates that treatment providers should understand the mortality risks for their patients and incorporate appropriate linkages to medical care and other services.

Kevin L. Kraemer, MD, MSc

Reference: Costello, RM. Long-term mortality from alcoholism: a descriptive analysis. *J Stud Alcohol.* 2006;67(5):694–699.

Moderate Drinking Impairs the Ability to See

Drinking alcohol clearly impairs the ability to drive. To determine whether this impairment is partly due to inattentional blindness—the inability to detect unexpected but visually-salient objects—researchers conducted a randomized study of 46 adults, aged 21–35 years, who were not heavy drinkers.

Subjects received either alcohol or tonic (placebo). Some were accurately told which beverage they received, while others were misinformed. The amounts of alcohol administered were enough to achieve a blood alcohol level of 0.04.

After consuming the beverage, each subject watched a video of teams passing a basketball back and forth. Subjects were asked how many times a particular team passed the ball and whether they noticed the person in a gorilla costume who briefly appeared in the video.

- Only 33% of subjects noticed the "gorilla."
- Subjects who received alcohol were less likely than those who received placebo to notice the gorilla (18% vs. 46%, respectively).
- Telling subjects the content of their beverages did not affect results (30% who were told they received alcohol and 33% who were told they received placebo noticed the gorilla).

Comments: This study suggests that inattentional blindness is more common when people drink than when they abstain. This is particularly concerning given that subjects who received alcohol in this study had a blood alcohol level that was half the legal driving limit in most states. The public should be informed that even low-level drinking before driving is risky.

Rosanne Guerriero, MPH
Richard Saitz MD, MPH

Reference: Clifasefi SL, et al. Blind drunk: the effects of alcohol on inattentional blindness. *Appl Cognit Psychol.* 2006;20(5):697–704.

Alcohol and Cancer Worldwide

Alcohol use can increase the risk of various cancers. Investigators in this study estimated the number of cancer cases and deaths attributable to alcohol drinking worldwide in 2002. They used data on drinking prevalence from the World Health Organization and relative risks of various cancers (oral cavity, pharynx, esophagus, liver, colon, rectum, larynx, and female breast) from recent meta- and pooled analyses.

- Worldwide, 389,100 cases of and 232,900 deaths from cancer were attributable to alcohol. These figures represent 3.6% of all cancer cases (5.2% in men, 1.7% in women) and 3.5% of all cancer deaths (5.1% in men, 1.3% in women), respectively.
- The proportion of alcohol-attributable cancers was particularly high (approximately 9%) among men in Central and Eastern Europe.
- The majority of cancer cases attributable to alcohol in men were of the upper digestive tract (oral cavity, pharynx, and esophagus), while the majority in women were of the breast.

Comments: There are always problems trying to aggregate global data from many sources. A key concern is the lack of information on the health habits and drinking patterns of the individuals who developed cancer. Knowing this information can help provide much more precise estimates of alcohol's effects on cancer than can these global estimates derived from limited data.

R. Curtis Ellison, MD

Reference: Boffetta P, et al. The burden of cancer attributable to alcohol drinking. *Int J Cancer.* 2006;119(4):884–887.

Alcohol-Attributable Mortality and Morbidity in Canada

Researchers in this study aimed to show the impact of alcohol use on chronic diseases in Canada. They linked information from the literature with national statistics on mortality and morbidity, hospitalization data, and results from a national addiction survey.

In Canada in 2002, the following consequences among adults aged 69 and younger were attributable to alcohol consumption:

- A net* of 1631 chronic disease deaths (mostly from cancer or digestive diseases), constituting 2.4% of all deaths for this age group
- 42,996 years of life lost prematurely
- A net of 91,970 hospitalizations, mostly for neuropsychiatric conditions and cardiovascular disease

Moderate drinking (<1.5 drinks per day for women, <3 for men) was associated with 25% of the deaths caused by alcohol and 85% of the deaths prevented by alcohol.

Comments: These data highlight the significant role drinking alcohol, even moderately, plays in chronic disease and death. Far-reaching interventions are needed to reduce the public health burden caused by alcohol in Canada and in other countries.

Richard Saitz, MD, MPH
Rosanne Guerriero, MPH

*The difference between deaths caused and prevented by alcohol

Reference: Rehm J, et al. Estimating chronic disease deaths and hospitalizations due to alcohol use in Canada in 2002: implications for policy and prevention strategies. *Prev Chronic Dis.* 2006;3(4).

Prescription Drug Misuse Is More Common in Drinkers

Few studies have examined the relationship between alcohol consumption and nonmedical use of prescription drugs (NMUPD). To characterize this relationship, researchers analyzed data from 43,093 adults who had participated in a national survey on alcohol and related conditions.

- Of the overall sample, 65% drank and 3% took a prescription drug (opioid, sedative, tranquilizer, or stimulant) for a nonmedical reason in the past year. Approximately 8% had an alcohol use disorder (AUD).
- NMUPD was most common in subjects with past-year alcohol dependence (22%), followed by subjects with alcohol abuse only (8%), a heavy drinking episode* but no AUD (4%), neither a heavy drinking episode nor an AUD (2%), and abstinence (1%).

(continued on page 4)

*>=5 drinks in a single day for men, >=4 drinks for women

Prescription Drug Misuse Is More Common in Drinkers (continued from page 3)

- In adjusted analyses, the odds of NMUPD were significantly greater among drinkers than abstainers (e.g., odds ratios 1.7 for subjects with neither a heavy drinking episode nor an AUD and 18.2 for subjects with alcohol dependence).
- The co-occurrence of AUDs and NMUPD was more prevalent among adults aged 18–24 years (42%) than among older subjects (24%).

Comments: This study showed that drinkers, particularly those with an AUD, were more likely than abstainers to use a prescription drug for a nonmedical purpose. As stated by the authors, these findings underscore the importance of thoroughly assessing prescription drug misuse while treating AUDs, especially among young adults.

R. Curtis Ellison, MD

Reference: McCabe SE, et al. The relationship between past-year drinking behaviors and nonmedical use of prescription drugs: prevalence of co-occurrence in a national sample. *Drug Alcohol Depend.* 2006;84(3):281–288.

Alcohol Outlets Increase Hospitalization for Assault

Violence is a well-described consequence of unhealthy alcohol use. In this study, researchers from California examined whether violent assaults are related to the density of alcohol outlets in certain communities. They linked hospital discharge data on people with interpersonal violence injuries; industry data on the location of liquor stores, restaurants, bars, and pubs; and census data by zip code.

- Rates of hospitalization for assault were highest in densely populated, poor urban areas with a large proportion of minorities and substantial instability (e.g., high unemployment).
- In analyses adjusted for neighborhood characteristics, a greater density of liquor stores was directly related to higher assault rates.
- A greater density of bars was associated with higher assault rates only in unstable, poor urban areas with many minorities and in middle-income rural areas.

Comments: This study of assaults leading to overnight hospitalization, which are more serious and less common than other assaults, is less subject to community reporting bias than are studies based on police reports. The relationship of liquor outlets to community assaults naturally raises questions about the mechanism of action: Does greater availability of alcohol lead to greater consumption and therefore more belligerence? Or, are people who congregate near liquor stores more prone to hostility? Whatever the reason, clinicians have sufficient evidence to advocate for public health initiatives that limit licensure of liquor outlets in vulnerable neighborhoods.

Peter D. Friedmann, MD, MPH

Reference: Gruenewald PJ, et al. Ecological models of alcohol outlets and violent assaults: crime potentials and geospatial analysis. *Addiction.* 2006;101(5):666–677.

Assessments and Interventions

Primary Care Clinicians Lack Comfort and Skills in Discussing Alcohol Use

Often, primary care clinicians inadequately address alcohol use with their patients. To describe alcohol-related discussions in primary care, investigators audiotaped and performed qualitative analysis of outpatient visits involving 14 primary care clinicians (physicians and nurse practitioners) and 29 of their patients. All patients were male veterans who screened positive for unhealthy alcohol use.*

Three themes emerged:

- Patients often disclosed that they consumed large amounts of alcohol and/or experienced negative health consequences from drinking. Clinicians commonly responded by changing the subject, minimizing the significance of their patients' drinking, or pursuing a nonalcohol-related issue.
- Hesitation, stuttering, inappropriate laughter, and ambiguous statements were apparent when clinicians discussed alcohol but not other topics.

(continued on page 5)

*Reported drinking >=14 drinks per week or >=5 drinks per occasion, scored >=1 point on the CAGE questionnaire, or reported ever having a drinking problem

Primary Care Clinicians Lack Comfort and Skills in Discussing Alcohol Use (continued from page 4)

- Advice about drinking was tentative and vague while advice about smoking was more common, decisive, and specific.

Comments: Brief alcohol counseling—an evidence-based practice—has been poorly disseminated into primary care practice. This exploratory study suggests that clinicians' discomfort and limited skills in assessing and advising patients with unhealthy alcohol use are partly to blame. Although training alone is not sufficient to increase alcohol counseling, these findings indicate that educational initiatives to improve primary care clinicians' comfort levels and skills are necessary, nonetheless.

Peter D. Friedmann, MD, MPH

Reference: McCormick KA, et al. How primary care providers talk to patients about alcohol: a qualitative study. *J Gen Intern Med.* 2006:21(9):966–972.

Do Doctors' Drinking Habits Affect Management of Patients' Alcohol Problems?

Two different studies explored whether a physician's approach to his patients' alcohol use is complicated by his own drinking habits. Kaner et al interviewed 29 general practitioners (GPs) in Northern England and found the following:

- Some GPs felt that their own alcohol use provided them insight into their patients' use and helped facilitate discussion with patients.
- Others, however, separated their drinking from their patients' drinking.
- Some GPs recognized and addressed risk only in patients who drank more or differently from them.

Aalto et al surveyed all Finnish primary care physicians (n=3193), 60% of whom completed all survey questions (63% women; mean age 42 years).

- Of these respondents, 15% (7% of women, 27% of men) were heavy drinkers, scoring >=8 on the Alcohol Use Disorders Identification Test (AUDIT).
- Fifty-nine percent offered brief interventions (BIs) —9% regularly and 50% occasionally.
- In analyses controlling for demographic and training characteristics, AUDIT scores did not predict either regular or occasional use of BIs.

Comments: Physician drinking can influence clinical practices around alcohol issues. It does not appear, however, to explain the infrequent use of brief interventions.

Jeffrey Samet, MD, MA, MPH

References: Kaner E, et al. Seeing through the glass darkly? A qualitative exploration of GPs' drinking and their alcohol intervention practices. *Fam Pract.* 2006;23(4):481–487; Aalto M, et al. Do primary care physicians' own AUDIT scores predict their use of brief alcohol intervention? A cross-sectional survey. *Drug Alcohol Depend.* 2006;83(2):169–173.

B Vitamins Are Efficacious for Alcoholic Polyneuropathy

Both the direct toxic effects of alcohol and alcoholism-associated vitamin deficiencies can cause mild to incapacitating sensorimotor polyneuropathy. In a 10-site randomized, placebo-controlled trial, researchers assessed whether B vitamins could benefit 253 patients with alcohol dependence, sensory symptoms, signs of alcoholic neuropathy (as shown on nerve conduction studies), and diminished vibration perception at the big toe (determined by biothesiometry). People with other possible neuropathy etiologies or neuropathy lasting for more than 2 years were excluded.

Subjects were randomized to receive one of the following to be taken orally 3 times a day for 12 weeks: placebo, B vitamins (B_1 250 mg, B_2 10 mg, B_6 250 mg, and B_{12} 0.02 mg), or B vitamins plus folic acid (1 mg). Eighty-one percent of subjects completed the trial.

- Vibration perception at the big toe, the primary study endpoint, improved significantly more in both vitamin groups than in the placebo group (increase of approximately 1–2 points vs. 0.5 points on a scale from 0 to 8).
- Pain, sensory function, and eye-nose coordination with eyes closed also improved more in the vitamin groups.
- The number of adverse events was similar in all groups.

(continued on page 6)

B Vitamins and Alcoholic Polyneuropathy (continued from page 5)

Comments: These findings—B vitamins have efficacy for alcoholic polyneuropathy—are consistent with those reported in other studies. It is difficult, however, to know whether patients will notice improvements with B vitamins or whether these improvements are detectable only via a sensitive research instrument (e.g., biothesiometry). Nonetheless, with favorable safety profiles and low cost, B vitamins are a welcome treatment for people with this often troubling condition.

Richard Saitz, MD, MPH

Reference: Peters TJ, et al. Treatment of alcoholic polyneuropathy with vitamin B complex: a randomized controlled trial. *Alcohol Alcohol.* 2006;41(6):636–642.

Study Does Not Confirm Brief Intervention's Efficacy

Systematic reviews find that screening and brief intervention, at least in primary care settings, can decrease drinking in people with nondependent unhealthy alcohol use. Brief intervention has also shown promise in emergency departments, trauma centers, and other hospital services, where many patients may be receptive to advice.

To assess brief intervention's efficacy in trauma centers, researchers studied 187 adults (out of 4618 screened) who were hospitalized at two Level I Trauma Centers for traumatic vehicular injures and had a blood alcohol concentration (BAC) of >=10 mg/dL. Patients with a BAC <=10 mg/dL, signs of alcohol dependence, or who drank >12 standard drinks a day were excluded.

Subjects, who had an average age of 29 years, were randomized to receive one of the following:

- a 20-minute health interview only (control)
- a health interview and 5 minutes of simple advice
- a health interview, 5 minutes of advice, and two 20-minute brief counseling sessions

Twelve months later (43% loss to follow-up), alcohol consumption and traffic citations significantly decreased. However, there were no significant differences between the 3 groups.

Comments: The improvements seen in these patients after trauma hospitalization were not attributable to brief intervention but may reflect natural history or result from participation in a controlled trial that included alcohol and health assessments. Currently, Level I trauma centers must provide alcohol screening and brief intervention to receive accreditation. Given that resources are limited, how best to deploy this important service will require further study.

Richard Saitz, MD, MPH

Reference: Sommers MS, et al. Effectiveness of brief interventions after alcohol-related vehicular injury: a randomized controlled trial. *J Trauma.* 2006;61(3):523–533.

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5. SUMMARY OF RESULTS FROM SURVEY OF *AHCE* SUBSCRIBERS

Overall satisfaction with the newsletter (scale of 1 to 5):

	1 (not at all)	*2*	*3*	*4*	*5 (extremely)*
With website content (n=173)	0%	0%	18%	46%	35%
With website design (n=165)	0%	1%	24%	44%	32%

Usefulness of newsletter features (scale of 1 to 5):

	1	*2*	*3*	*4*	*5*	*Never use*
Research summaries (n=174)	0%	0%	9%	38%	54%	0%
Physician comments (n=172)	1%	2%	17%	44%	31%	5%
Update on Alcohol and Health (n=169)	0%	3%	21%	27%	31%	17%
Journal Club (n=168)	0%	5%	24%	23%	21%	26%
Continuing Medical Education (n=167)	2%	8%	23%	18%	14%	35%

Usefulness in areas of work (scale of 1 to 5):

	1	*2*	*3*	*4*	*5*	*N/A*
Clinical practice (n=166)	0%	1%	13%	34%	28%	24%
Research (n=165)	1%	0%	13%	30%	38%	18%
Teaching (n=163)	0%	2%	10%	33%	35%	20%

Ever used Update or Journal Club when teaching/presenting:

	n	*%*	
No	96	58%	
Yes	38	23%	(28% of those who teach)
Don't teach or present	31	19%	

Content preferences for future:*

Alcohol's negative effects	135	77%
Interventions	127	72%
Special populations	126	72%
Assessments	103	59%
Alcohol's positive effects	66	38%

Will continue to subscribe if…:	*Would not continue*		*Might continue*		*Would continue*	
Funding from nonprofit organization	6	3%	33	19%	135	78%
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Funding from a restricted pharma grant	91	54%	65	38%	14	8%
Coverage of both alcohol and drugs	5	3%	21	12%	147	85%
Coverage of drugs only	52	30%	56	32%	65	38%

Average no. of research summaries viewed:		
None	20	12%
Few	43	25%
Half	71	41%
Most	39	23%
All	0	0%

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Internet search for alcohol information	58	33%
Group e-mail to professional organization	47	27%
Recommendation from a colleague	24	14%
Presentation at professional meeting	12	7%
A postcard that advertised the newsletter	2	1%
An ad in a journal or newsletter	2	1%

Background		
Other	52	30%
Addictions counselor	30	17%
Physician	21	12%
Administrator	19	11%
Social worker	18	10%
Psychologist	11	6%
Nurse	8	5%
Writer/editor	5	3%
Nurse practitioner	5	3%
Pharmacist	2	1%
Consumer	2	1%
Physician assistant	1	1%

*More than 1 response possible

6. MARKETING – NEWSLETTER POSTCARD

Side 1

Side 2

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