Managing Unhealthy Alcohol Use in Clinical Practice: Best Practices

BU Chobanian & Avedisian School of Medicine

1

Diagnosis and Treatment Retention Podcast
Episode One: Screening

NOTE: Please be sure to download the provider and patient handouts that accompany this activity, at the website.

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Ilana Hardesty: Welcome to *Managing Unhealthy Alcohol Use in Clinical Practice*, Boston University's new podcast discussing best practices in the diagnosis and treatment of alcohol use disorder. I'm Ilana Hardesty, your moderator. This series consists of three episodes. If at any point you want more information on receiving credit for this course, please visit the website that is linked in the podcast description. There are also resources that accompany this series. All of them can be found at that website.

In this first episode, I'll be speaking with Dr. Daniel Alford, a primary care physician and an addiction medicine specialist at Boston Medical Center and on the faculty at Boston University; and with Alexandra Hines, a social worker who provides training, technical assistance and coaching in Screening, Brief Intervention, and Referral to Treatment and motivational interviewing to individuals and organizations across the state of Massachusetts. We'll discuss how to screen for unhealthy alcohol use and how to discuss the results with your patients.

Let's begin with a case scenario. Sandra Green, a 32-year-old woman, presents to establish primary care after moving to be closer to her mother. She lives with her husband and five-year-old son and works remotely as a software engineer.

Dr. Daniel Alford: Hi, Ms. Green. Nice to meet you.
Sandra: Nice to meet you, too.
Dr. Alford: So, let's start with any issues that you'd like to discuss during this first visit.
Sandra: Um, I don't really have any issues. I just wanted to establish primary here.
Dr. Alford: Okay. Any past medical history, or do you take any medications?
Sandra: Well, I have been told that my blood pressure is sometimes high, so I limit the salt in my food and I try to exercise five days a week. I'm not taking any medication though, because my husband and I are trying to have a second child.

Dr. Alford: Oh, okay. That sounds great. And it's great that you're taking care of yourself. Any family history of medical problems?
Sandra: My father was an alcoholic and he died of liver disease. My mother – she has high blood pressure – I think she takes medicine for high cholesterol. Otherwise, she's super healthy.
Dr. Alford: Okay. And do you smoke?
Sandra: No.
Dr. Alford: Do you drink alcohol?
Sandra: I only drink wine. I'd say I'm more of a social drinker.
Dr. Alford: Any drug use?
Sandra: No, never.

[Music]

Ilana Hardesty: Let's turn to you first, Alex. Is there any reason to worry about alcohol use in this patient who drinks wine socially?

Alexandra Heinz: The term social drinking is a term that's used quite commonly, including by health care providers, and it's very ambiguous. It might mean a lot of different things to a lot of different people. So, it's really useful to gently explore that more in order to have a clearer sense of how to effectively partner with a patient around their health and their decisions related to alcohol.

Ilana Hardesty: How does her family history of an alcohol use disorder play into your thinking about her alcohol risk?

Alexandra Heinz: There's a lot of factors that can influence someone's potential for developing risk related to alcohol and their potential for developing a more serious problem like an alcohol use disorder. Those factors might include what they're drinking – so the dose, the potency, the frequency – the age of onset; how they experience the effects of alcohol; their overall health status; of course, genetics and family history, as you mentioned; their motivation and mindset for drinking; the environment in which they use: lots of different stuff that we might think about. So, I think in primary care settings, it's really important and helpful to screen for alcohol use among all of our patients; to do that universally. We know that alcohol use is really common among adults in the US, and many people have experienced some risks related to their use or may experience risk down the line. Screening universally helps to reduce stigma and bias that can be introduced when we only do targeted screening. And it really gives us the

opportunity to identify potential risks early on, so we can strengthen our conversations and support patients in making the best decisions for them.

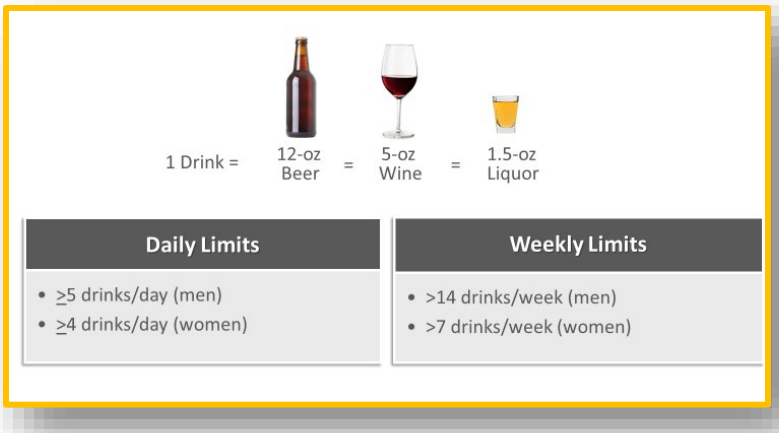
Ilana Hardesty: We'll come back to screening in a bit. But I do have a question for you, Dr. Alford. Isn't some amount of alcohol good for you? I thought a couple of glasses of wine protected the heart.

Dr. Alford: Over the past three decades, researchers, the alcohol industry, media have all stated that moderate alcohol use – mainly red wine; the flavonoids – prolongs life by reducing the risk of cardiovascular disease. However, there are no randomized controlled trials that have confirmed any health benefits of drinking alcohol. Unfortunately, these recommendations are based on lower-quality evidence from observational studies that are population based, and there are lots of confounding factors, such as: moderate alcohol use is associated with favorable lifestyle, higher socioeconomic status and other behavioral factors that may in fact be cardioprotective. So it's not the alcohol that's cardioprotective, but it's the lifestyles that often go along with it. Based on the 2022 World Federation report, alcohol consumption at all levels is associated with increase of fatal hypertensive heart disease, cardiomyopathy, heart failure, atrial arrhythmias, strokes, and even fatal aortic aneurysm.

Ilana Hardesty: That really is important information. What are some other problems to worry about?

Dr. Alford: Alcohol is responsible for over 95,000 deaths per year. That's over 260 deaths per day. It's the third leading cause of preventable death behind tobacco and obesity. And it's a carcinogen for multiple cancers, including breast, liver, colon, rectum, mouth, throat, and esophagus. It's also a teratogen and can cause fetal alcohol spectrum disorders, because we know that alcohol readily crosses the placenta, crosses the blood-brain barrier, and that prenatal alcohol exposure can impair brain development throughout all stages of gestation. And it results in a range of fetal abnormalities that are physical, behavioral, and learning, which unfortunately are permanent. So, it turns out that in the US, FASD, or fetal alcohol spectrum disorders, are the most common preventable developmental disabilities in birth defects.

Ilana Hardesty: We'll be talking a great deal more in the next couple of episodes about alcohol use disorder. But how is risky use defined? Dr. Alford?



Dr. Alford: So risky amounts are really based on quantity and frequency of drinking, and there are daily amounts and weekly amounts that we need to be aware of. So, for men, the daily amounts would be five or more drinks in a day is considered risky, and greater than 14 drinks on average per week is considered risky. For women, greater than four drinks per day and greater than seven drinks on average per week is considered risky. Why do women have lower amounts that are considered risky? It has to do with how alcohol is metabolized by women and also their body composition. So again: five or more drinks in a day or greater than 14 per week for men; four or more drinks in a day or greater than seven on average per week for women.

Ilana Hardesty: It does seem, though, that there are some cultural differences around what is an acceptable amount of alcohol use. Alex, can you comment on that?

Alexandra Heinz: Yeah, I think culture can certainly factor into how we approach screening and assessment and also how people might use alcohol. Different cultures engage in alcohol use in different ways. I also think that the way that we conceptualize standard drinks is little known. You know, it's not something that's common knowledge among our population. And so, it can be really helpful to have some guidelines to go by when we're talking with patients so that we're able to better counsel them on what might be considered a lower risk level of drinking and what might put somebody into a higher risk category.

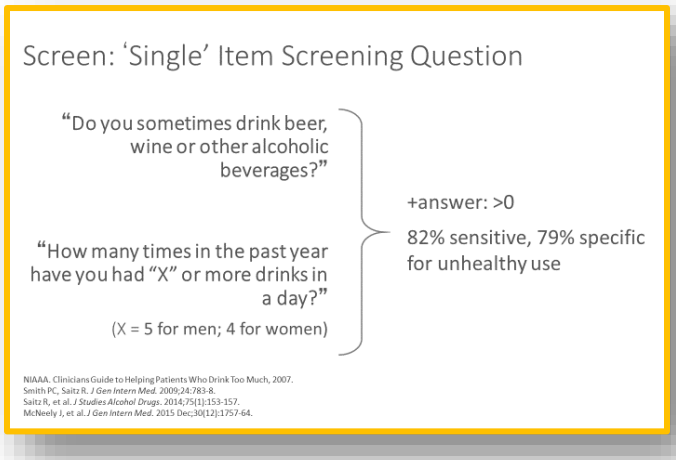
Ilana Hardesty: I can imagine that clinicians might worry that patients will be offended if we ask too many questions about their alcohol use.

Alexandra Heinz: You know, I think that it's important to convey curiosity and compassion when we're approaching these conversations with our patients. And a lot of times what I like to do is introduce the conversation in a way to help people to feel more comfortable. And so, I might talk about, you know, "as you think about exploring your health goals, we want to make sure that we cover several areas that can be relevant to your health and wellbeing, and we want to offer you holistic support here. One of the topics we ask all of our patients about is their alcohol use. It's just one question and we ask without judgment. Is it okay if I ask you that question?" And so, I might do a small introduction like that in order to make it more likely that

a patient feels comfortable to engage in that discussion. And then I think also by asking permission, we're really conveying this sense of partnership between ourselves and our patient. And it gives them the opportunity to choose to engage in that discussion and probably more likely that they'll be comfortable being forthcoming with their responses.

Ilana Hardesty: I understand that patients who drink a lot will tend to underreport their actual use. Dr. Alford, how would you recommend getting a reliable alcohol use history?

Dr. Alford: If you're going to ask a question, you want to ask a question that's going to give you reliable information. And the good news is there are validated screening questions that are short and easily implementable in primary care settings. And the one that I use is called the single item screening question. The single item screening question is actually two questions. And the first question is, "Do you sometimes drink beer, wine or other alcoholic beverages?" And as you can imagine, in our country, drinking is normative. So, most people are going to say yes. In fact, if someone says no to this normative behavior, I would ask, why not? Because maybe they're in recovery and you didn't know that; maybe they have a family history and you didn't know that. Or maybe it's against their religion or they don't like the taste or for whatever reason, they're not drinking, that's fine. So more than half of your patients will say, "Yes, I do sometimes drink." And now you want to know, do they drink risky amounts? So the validated question is, "How many times in the past year have you had five or more drinks in a day (for men)/four or more drinks in a day (for women)." Anything other than never is considered positive or unhealthy alcohol use. And that's really a binge drinking question. And there are other screening questions as well. There's a three-question screener called the AUDIT-C, or the Alcohol Use Disorder Identification Test-Consumption items. Those questions are little harder to memorize and they need to be scored. So, it's a little hard to have that in the back of your mind. But the single-item screening question is easy to memorize.



Ilana Hardesty: So those questions would get at defining what Sandra, in our case, means by social drinking?

Dr. Alford: That's right.

Ilana Hardesty: If Sandra has risky drinking, what's the best way to counsel her about alcohol use?

Alexandra Heinz: My approach here is to use a particular model that we call the Brief Negotiated Interview, and I think it's really helpful, especially in primary care settings, because it can be delivered in a manner that's fairly short and at the same time, it's pulling from strategies that are evidence-based and well known in motivational interviewing that have demonstrated a lot of utility in helping patients arrive at behavior change if they want to, if they decide to.

And usually it starts out with building some engagement or rapport, sort of circling back, asking a few follow up questions about the screening questions that they just answered, and also kind of understanding a little bit more about them and how they contextualize drinking within their life. So, you might say something like, you know, "tell me a little bit more about how your use of alcohol fits in." And then I go into exploring the tradeoffs of their use. And so usually I ask some questions around what they particularly like about using alcohol. And then also what are some of the drawbacks or downsides for them. What's helpful about exploring both sides is we're able to work with them to examine their ambivalence about their drinking. And after we've done that examination together, we can offer up what's called a double-sided reflection, where we do a short, structured summary that ends on their potential reasons for making a change. And usually whenever we highlight those reasons back to somebody, they are able to consider them more, kind of take them in and develop nuance in their own understanding of themselves. It can be one of these things that's really helpful in increasing their motivation to consider making a change.

I usually go into an opportunity to offer some feedback or education, and so in this case it might be helpful to discuss what those lower risk drinking guidelines look like and have a conversation

with the patient about, you know, kind of where she's at in terms of planning for her next pregnancy and factoring any risks that we might know about drinking while someone is pregnant or drinking while someone's trying to conceive. And then from there, we can also borrow another tool from motivational interviewing. It's called the Readiness Ruler, where we get to get a gauge on where this person is right now. And we also have an opportunity to evoke more from them: their potential desire, ability, reason or need to make a change. And so, we'll use a number ruler to understand where they're at. And then we usually ask a follow-up question like, "Why are you that number and not a lower number?" And that helps to evoke more reasons, more intrinsic reasons, from them why they might want to make a change. Then our final step: we have an opportunity to explore next steps with them. So, you know, "given our discussion, what do you think you might do or what are your next steps? Where do you want to go with this?"

Ilana Hardesty: So, for a patient who has risky alcohol use, how would you offer advice?

Alexandra Heinz: For a patient who is engaging in drinking that may incur some risk, it may just be working with them to reduce their risk in some ways. And a lot of times patients have really creative ideas about how they might want to work this in. If they're not sure, I can also offer some ideas with permission and partner with them around that. If I have a patient who's engaging a much higher risk alcohol use or who I might have concern that could have an alcohol use disorder, this is an opportunity where I might offer a referral to treatment or other supportive services. And then usually we wrap up the conversation. I would say in the context of a primary care visit, usually this conversation can be as short as 3 minutes and you know, as long as the time that you have. But usually primary care visits, we don't have much time, and so it can be quite quick.

Ilana Hardesty: Now, let's hear Dr. Alford perform a Brief Negotiated Interview with our patient, Sandra, and then we'll hear Alex and Dr. Alford reflect on what they've heard.

Dr. Alford: Ms. Green, you mentioned that you drink wine socially.
Sandra: Yeah, usually one or two glasses of wine. Sometimes on the weekend I'll drink a bit more.
Dr. Alford: So how many times in the past year have you had four or more glasses of wine on one occasion?
Sandra: Um, sometimes when I'm out with friends, like at our book group, we can lose track of time, but not usually.
Dr. Alford: Is it okay if we talk more about your alcohol use?
Sandra: Sure, I guess?

Dr. Alford: You sound hesitant.
Sandra: Well, I thought drinking a couple of glasses of wine is good for you.
Dr. Alford: Well, that's not actually the case anymore. The research about the benefits of alcohol are no longer considered to be that accurate or true.
Sandra: But I don't drink a lot. How could that be hurting anything?
Dr. Alford: Well, for women who are not pregnant, or not trying to get pregnant, risky alcohol would be considered four or more drinks on an occasion, or more than seven drinks on average per week. The risks that I'm talking about include accidents, trauma, increasing your blood pressure, like yours, in increasing your risk for certain types of cancers, including breast cancer.
Sandra: Okay, so if I drink less than those amounts, I'll be okay?
Dr. Alford: Well, it'll certainly decrease your risk. But since you told me that you're trying to get pregnant, many people don't know that drinking alcohol during pregnancy can cause physical, behavioral, and learning problems with your baby.
Sandra: Okay, but when I was pregnant last time, my doctor told me a drink every once in a while was fine. And I drank wine when I was pregnant and my son is completely fine.
Dr. Alford: Yeah. So I can completely see why this is surprising information given your past experiences. However, some children develop problems when their mothers drink alcohol during pregnancy and others don't. Each pregnancy is different and, unfortunately, we really can't predict which babies will have problems and which won't. What we do know is that alcohol use during your pregnancy can increase the risk of your child having one of these problems; that is, physical, behavioral, and learning problems.
Sandra: Okay. This is really surprising. So what happens if I have just one glass of wine right when I got pregnant?
Dr. Alford: Yeah, good question. We really don't know. But what we do know is that alcohol can be harmful during pregnancy. And so no alcohol use during pregnancy is actually the safest choice. And my goal here really is to share with you information to maximize your chances of having a healthy baby. I really want you to be able to make healthy choices. Now, I'd like to ask you a few more questions about your alcohol use. Is that okay?
Sandra: Yeah.
Dr. Alford: So what is it that you like most about drinking wine?
Sandra: Well, it's a nice way to relax after a long day, and chill out after work while I make dinner.
Dr. Alford: Okay. Anything else?
Sandra: I mean, not really.
Dr. Alford: Is there anything you like less about drinking wine?
Sandra: Not really – except now, I'm pretty worried about drinking if I am pregnant, or that it might cause my blood pressure to be high.

Dr. Alford: Got it. So, to summarize: sounds like you enjoy having a couple of glass of wine to help you relax, and you're concerned now about drinking and how it might impact your blood pressure and might cause problems with your pregnancy. Did I get that right?
Sandra: Yeah.
Dr. Alford: So where does that leave you with your alcohol use?
Sandra: Well, I guess I won't drink for now while I'm trying to get pregnant. I mean, I just don't want to risk anything.
Dr. Alford: Okay, that sounds like a good choice. Now, given what we've been discussing, on a scale of zero to 10, how ready are you to change your alcohol use? Where zero is, you're not ready at all; 10, you're completely ready.
Sandra: Oh, I guess maybe an eight? Probably a nine.
Dr. Alford: So why didn't you choose a lower number? Like a four or five?
Sandra: I don't want to put my baby at risk.
Dr. Alford: Okay. So what types of changes do you think you'll make?
Sandra: I think this will be easy. I don't need to drink wine while I'm trying to get pregnant.
Dr. Alford: So what's your next step?
Sandra: I'll find other ways to relax. Like maybe taking a walk before dinner or listening to music while I'm cooking.
Dr. Alford: That's great. Now, one final thing. If it turns out that it's more difficult to make this change than you think, let me know. Come back and we'll talk about it. And we'll think about other strategies.
Sandra: Okay. Thanks.

[Music]

Alexandra Heinz: So, Dr. Alford, are you open to receiving some feedback about this interaction?

Dr. Alford: Sure.

Alexandra Heinz: I wonder if we could just first start out with exploring what you think you did particularly well in the interaction.

Dr. Alford: Well, I followed the steps of the Brief Negotiated Interview, and it seemed to go pretty smoothly. It did allow her to express her interest in changing based on our discussion. So as opposed to me saying, "Oh, you should stop drinking if you're trying to get pregnant," it was more about her realizing that it might be a good idea to stop drinking before she becomes pregnant. So it came from her as opposed to from me.

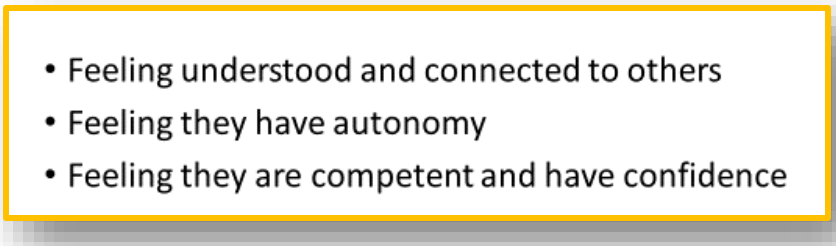
Alexandra Heinz: Yeah. You were really intentional about using some of those evocative, open questions and following those guidelines of the BNI so that you could pull out her own reasons and she could start to think about, you know, how this fits in for her and why she might want to make some changes. And that's going to be a whole lot more motivating for her than us trying to give her what our reasons are. I also noticed that your tone was very engaging throughout the whole discussion. You were open and supportive and very transparent around kind of why you were offering her some guidance or advice at the times that you did that because you wanted to support her goal of having a healthy pregnancy and a healthy baby. I wonder, if you had the opportunity to do it again, what's something that you might tweak or change about your approach?

Dr. Alford: Yeah, that's a good question. I haven't really had an opportunity to think about it. But that's why I'm glad you were observing me. What kinds of changes do you think I could make to improve the interaction?

Alexandra Heinz: Yeah. Yeah. I'd be happy to share some of my thoughts. You know, I think next time you might consider, when you are offering some feedback to the patient, and you specifically talked here about our understanding of the changes in the research about alcohol and how it's evolved beyond thinking that it's actually helped, supportive or provides any benefits. I noticed that as you were delivering that information, the language that you use kind of came in and you said, well, actually, and one of the things that we might consider adjusting on that is thinking about how we can first validate or affirm a patient and then ask permission to offer any additional information. And we want to be really cautious to not have it come off as a confrontation, because sometimes it can make patients defensive. And I just wonder if next time you might just shift your language a tiny bit and say, "yeah, you've read some information in the past that's made you wonder about this, and you had a doctor that told you that it was okay during pregnancy. Is it okay if I fill in the gaps for you in what we know now?" and then when she says yes, she's so much more likely to be open to hearing what you actually have to say and you're probably more likely to get change talk as a result of it. I don't know. What do you think about all that, though?

Dr. Alford: Yeah, and I think that's incredibly helpful. I wish you were watching more of my patient interactions. This patient was fairly agreeable, and I can imagine that some of my patients might pick a zero on the readiness or might not be willing to make any changes. And how would you address that?

Alexandra Heinz: Lately, I've been borrowing a lot of my approaches from something called self-determination theory. And this theory, I think it in some ways underpins a lot of what we do in motivational interviewing and it basically posits that in order for people to want to make changes in their life, they need to feel understood and connected to others. They need to feel like they have autonomy and they need to feel a sense of competence or confidence in making their change. And so when I think about counseling patients who may be more ambivalent about their behavior change, I really think about how I can use my skills to underline those three things. If I'm ever offering my own ideas or advice I'll usually say something like, "At the end of the day, this is your choice and you get to decide what's best for you." And that often brings defenses down really quickly because people just want to feel heard and they also want to feel like they're in control of their own lives. And then finally, in terms of confidence, I really search for a strength that this patient is demonstrating. And then I try to offer an affirmation that is specific about that strength and congruent to the conversation that we're having. And so those affirmations, I think, go a long way in helping to build the patient's confidence and may make it more likely that they'll want to come back and talk to me next time.



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Ilana Hardesty: Thank you both for a great conversation. And thank you for listening to *Managing Unhealthy Alcohol Use in Clinical Practice*, Boston University's new podcast discussing best practices in the diagnosis and treatment of alcohol use disorder. In this episode, we discussed how to screen for unhealthy alcohol use and how to discuss the results with your patients. Next time I'll be joined by Dr. Alford and by Dr. Alyssa Peterkin. They'll discuss a new patient case, someone with severe alcohol use disorder who is in denial and doesn't think he needs treatment. We'll also hear from Jeanette, a real patient in recovery from alcohol use disorder.

This educational activity is funded by an educational grant from Alkermes. Production by Rococo Punch. Please visit the website linked in the program description for visuals, resources, and other relevant materials. To receive credit, you'll need to listen to all three episodes and then go to the website to complete a post-test and evaluation. I'm Ilana Hardesty. Thanks for listening.