ALCOHOL AND OLDER ADULTS

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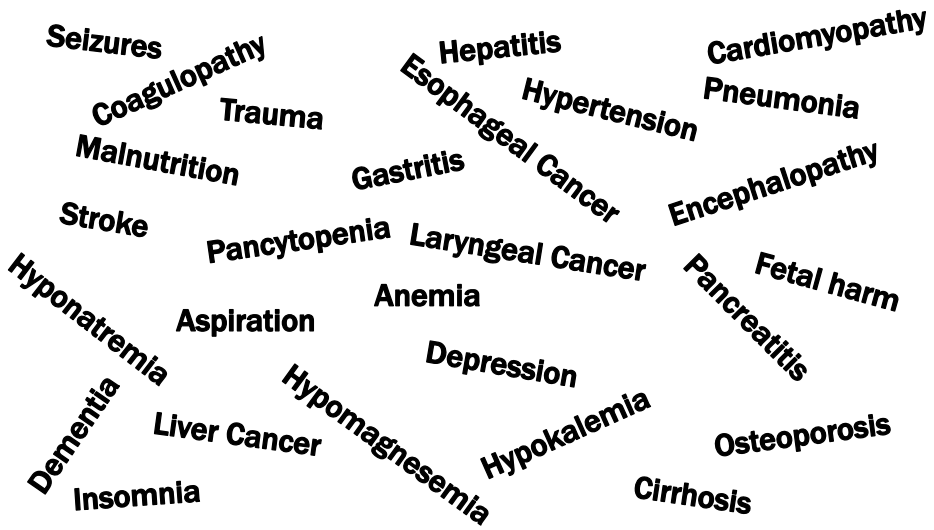
May 19, 2015

Thanks to:
Rick Saitz
Jared Klein
Jocelyn James

ALCOHOL AND OLDER ADULTS

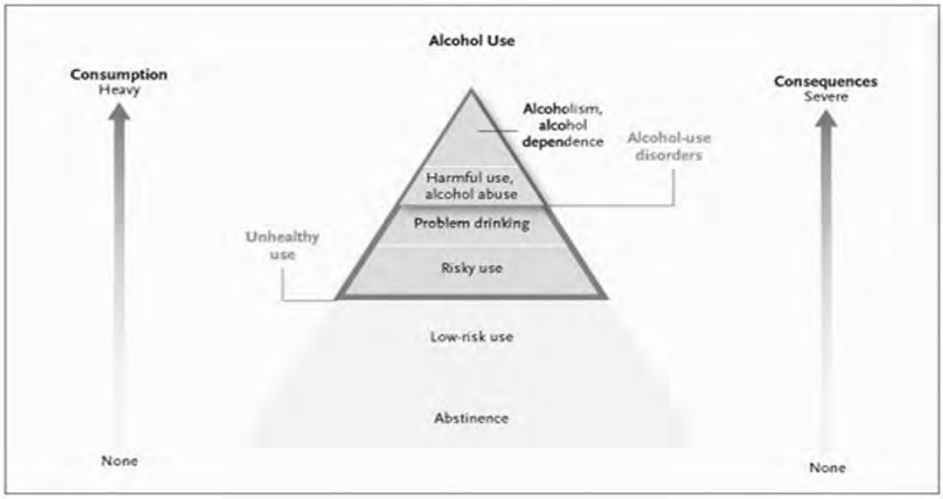
- Presentation in older adults
- Screening, assessment, and diagnosis
- Brief intervention
- Alcohol pharmacotherapy
- Motivational enhancement

ALCOHOL



ALCOHOL AND OLDER ADULTS

- Drinking tends to decrease with aging, but…
- Baby boomer generation has higher rates of substance use
- Effects of alcohol are enhanced with aging
  - Liver metabolism slower
  - Higher BAC and more impairment per drink
- Social interference more difficult to see when retired
- Risk factors associated with alcohol use:
  - Male, white, illness, chronic pain, polypharmacy
  - Depression, irritability, poor coping, sleep problems
  - Affluence, bereavement, unexpected retirement, isolation
- Prior substance use disorder is a risk, but 1/3 of alcohol use disorders develop late in life
- Problems commonly go unrecognized



Saitz R. New Engl J Med 2005;352:596.

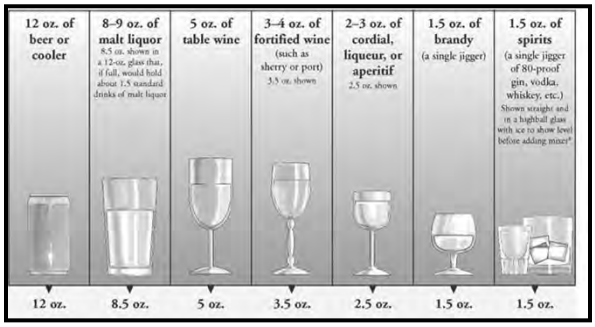
Injury and Alcohol

	Population attributable fraction (%)
Alcohol dependence	4.0
Non-dependent use	**6.6**

Spurling & Vinson. Ann Fam Med 2005;3:47-52. Case crossover study. 2517 acute injuries, 3 EDs in MO. 10.6% Would not have occurred without alcohol consumption.

Risky Amounts

- Men
  - >14 drinks per week, >4 per occasion
- Women, ≥65
  - >7 drinks per week, >3 per occasion



NIAAA, USDA

Drugs: Any?

LOW RISK ALCOHOL USE

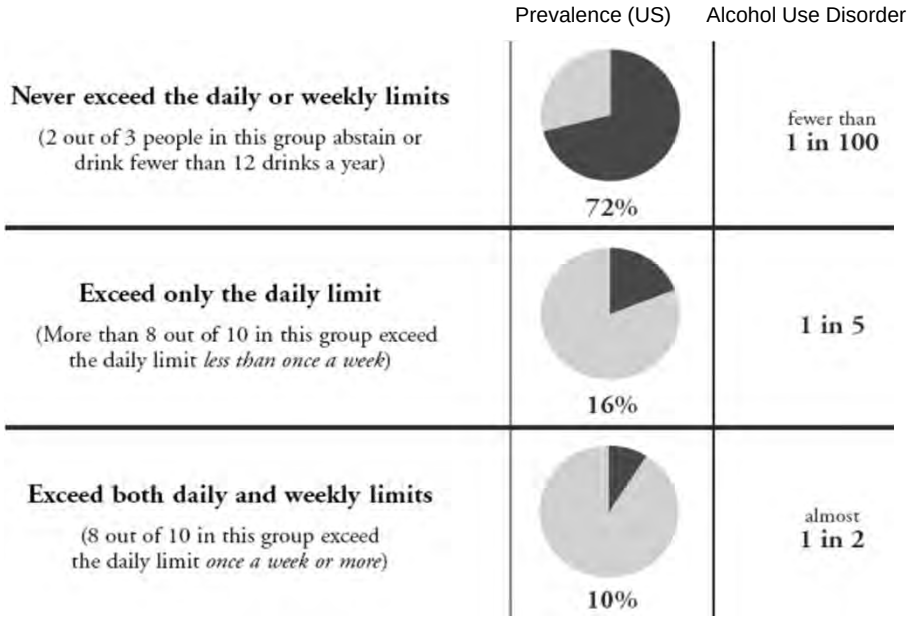
- Moderate alcohol use associated with health benefits, but…
- Based on observational studies with serious problems
  - No RCTs
  - Consumption poorly characterized over time
  - Low consumption associated with many markers of good health
  - Sick quitters
- Evidence of benefit is insufficient to recommend alcohol for prevention

Single Item Screening

- **"Do you sometimes drink beer wine or other alcoholic beverages?"**
- **"How many times in the past year have you had 5 (4 for women) or more drinks in a day?"**
  - **Positive screen: >0**
  - **82% sensitive, 79% specific for unhealthy use**
    - **8 or more consistent with dependence**

NIAAA. Clinicians Guide to Helping Patients Who Drink Too Much, 2007.

Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. J Gen Intern Med 2009 24:783-8 and erratum. DOI: 1007/s11606-009-0928-6 .



NIAAA, NESARC. 2% exceed weekly only; 1 in 13 have disorder

CAGE

Cut back? Annoyed? Guilty? Eye-opener?

For current…	Sensitivity	Specificity
Unhealthy alcohol use (≥2)	53-69	70-97
Alcohol Use Disorder (≥2)	77	79
Alcohol Use Disorder (≥1)	89	81

Maisto & Saitz Am J Addict 2003;12:S12-25.

CAGE & CONSUMPTION

- All patients
  - Do you drink alcohol, including beer, wine or distilled spirits?
  - CAGE
- Current drinkers
  - On average, how many ***days per 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 ***occasion*** during the last month?

NIAAA. Physicians Guide to Helping Patients With Alcohol Problems, 1995.
Friedmann PD et al. J Stud Alc 2001;62:234-8.

Alcohol Use Disorders Identification Test Consumption items (AUDIT-C)

AUDIT-C

Question #1: How often did you have a drink containing alcohol in the past year?	
• Never	(0 points)
• Monthly or less	(1 point)
• Two to four times a month	(2 points)
• Two to three times per week	(3 points)
• Four or more times a week	(4 points)
Question #2: How many drinks did you have on a typical day when you were drinking in the past year?	
• 1 or 2	(0 points)
• 3 or 4	(1 point)
• 5 or 6	(2 points)
• 7 to 9	(3 points)
• 10 or more	(4 points)
Question #3: How often did you have six or more drinks on one occasion in the past year?	
• Never	(0 points)
• Less than monthly	(1 point)
• Monthly	(2 points)
• Weekly	(3 points)
• Daily or almost daily	(4 points)

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Replace six with four for women, in item 3

- Requires scoring
- ≥3 women, >4 men
  - 73-86% sensitivity
  - 89-91% specificity
- ≥7 to 10 suggests dependence
- Can be part of severity assessment

Saitz R. Screening for unhealthy use of alcohol and other drugs. UpToDate April 2012.

SCREENING IN OLDER ADULTS

- Older adults less likely to be screened
  - Stigma
  - Multiple other problems to address
  - Alcohol symptoms overlap with other medical issues
  - Older adults may not recognize problems related to alcohol
- Comorbidity-Alcohol Risk Evaluation Tool (CARET)
  - Quantity and frequency
  - Presence of comorbid diseases
  - High risk behaviors (e.g. driving)
  - Concomitant use of medications that interact with alcohol
- Michigan Alcohol Screening Test – Geriatric (MAST-G)
- ASSIST for multiple substances

POSITIVE SCREENING TEST: WHAT NEXT?

- Assess for moderate-severe disorder
  - CAGE
  - Have a conversation:
    - "Tell me about your drinking."
    - "Have you had any problems related to your alcohol use?"
    - "Have you ever had treatment for alcohol use?" (confirms diagnosis)
    - Usually DSM-5 criteria emerge, but may need to review them specifically

Goal: Differentiate patients with risky use from those with moderate-severe disorders

ALCOHOL USE DISORDER: DSM-5

- Moderate-severe AUD ≈ alcohol abuse/dependence (DSM-IV)

ALCOHOL USE DISORDER
Larger amounts than intended
Persistent desire to cut down or quit
Significant time spent taking, obtaining
Craving or urge to use
Failure to fulfill obligations
Continued use despite negative interpersonal consequences
Reduced social, recreational activities
Use in physically hazardous situations
Use despite knowledge of harms
Tolerance (excludes rx medication)
Withdrawal (excludes rx medication)
* Recurrent legal problems deleted

SEVERITY
No SUD: 0-1
Mild: 2-3
Moderate: 4-5
Severe: >5

Key principles:
- Negative consequences
- Cravings
- Tolerance
- Withdrawal

DSM-5 IN OLDER ADULTS

DSM-5 Criteria	Considerations in Older Adults
Substance taken in larger amounts or over a longer period than intended	Cognitive impairment may prevent self-monitoring
Persistent desire to cut down or quit	Same
Great deal of time spent*	Consequences can occur with small amounts
Craving or strong desire to use	Craving may not be apparent with entrenched habits
Use results in failure to fulfill obligations at work, school, or at home	Ordinary role obligations may not exist or may differ from younger adults
Use in spite of social or interpersonal problems cased by substances*	May not realize problems are due to substances

* Endorsed less frequently by older adults
Bold: best criteria to discriminate AUD in older adults
Kuerbis A. Clin Geriatr Med 30 (2014) 629-54, Kuerdis A. Subst Use Misuse 2013;48(4):309-22

DSM-5 IN OLDER ADULTS

DSM-5 Criteria	Considerations in Older Adults
Social, occupational, recreational activities given up due to use	Older adults may engage in fewer activities, so harder to detect
Use in physically hazardous situations*	May not identify use as hazardous, especially with small amounts
Use in spite of physical or psychological problems caused by use	May not realize problems are caused by substances
Tolerance: needing more for the same effect, or less effect with same amount *	Due to aging, tolerance is lower rather than increased
Withdrawal with cessation	Withdrawal may be more subtle and protracted

* Endorsed less frequently by older adults
Bold: best criteria to discriminate AUD in older adults
Kuerbis A. Clin Geriatr Med 30 (2014) 629-54, Kuerdis A. Subst Use Misuse 2013;48(4):309-22

Assessment: Dependence or Not Patient self-assessment

http://rethinkingdrinking.niaaa.nih.gov

Symptoms and signs of disorder or risk

- Abscess
- Burns, injuries
- Heartburn
- Gastrointestinal upset
- AM cough or HA
- Anxiety, stress
- Insomnia
- Concentration
- Memory
- Tachycardia
- Hypertension
- Skin track marks
- Nasal congestion, perforation
- Tremor
- Pupil dilation or constriction
- Menstrual irregularity
- Ecchymosis/purpura
- Palmar erythema
- Scars from trauma
- Gynecomastia
- Hepatomegaly
- Spiders
- Uric acid, glucose
- MCV, AST, HDL, GGT
- Medical history
  - Cellulitis, phlebitis
  - STD/HIV
  - Endocarditis
  - Blackouts
  - Depression
  - Hypertension
  - Trauma
  - Chronic abdominal pain
  - Liver disease
  - Sexual dysfunction
  - Sleep disorders
- Use in high risk situations?
- Medical condition
- Medications
- How often maximum?
- Personal or family history?
- Pregnancy
- Interpersonal or work problems
  - Family
  - Work/school
  - Accidents/injuries

BRIEF INTERVENTION FOR UNHEALTHY ALCOHOL USE IN PRIMARY CARE

- Not for moderate or severe AUD)
- Strong evidence base (>50 RCTs, 24 systematic reviews)
  - Reduces proportion of problem drinkers by 25%
  - Reduces consumption by ~40 g (2-3 drinks/week)
  - Effect may persist for years
  - goal is short (5-10 min), empathetic, repeated
- Elements of brief intervention
  - Clear feedback: "You are drinking more than is safe for your health"
  - Clear recommendation: "no more than 2 (or 1) drink per day"
  - Assess readiness: "Are you willing to cut back?"
    - If no, assess pros and cons, support, follow up
    - If yes, make a plan and follow up

Alcohol & Alcoholism, 2014; 49(1).
Cochrane Review, 2007; CD004148.

Brief Intervention Duration and Frequency

Brief and very brief

Author(s)	N	Difference	Comment
Richmond et al. (VB)	378	-	Nonrandom
WHO (VB)	1559	+ B & VB	NS for women
Anderson & Scott	154	+	Men
Nilssen	338	+	
Senft et al.	516	Borderline	
Maisto et al.	301	-	Outside clinic
Scott & Anderson	72	-	Women

Negative study
Positive study

Example intervention (Fleming)
health booklet +
2 10-15" physician discussions
And follow-up nurse phone call

Whitlock et al. Ann Intern Med 2004; 140:557-68.

Brief multi-contact

Author(s)	N	Difference	Comment
Maisto et al.	301	-	Decrease but NS
Curry et al.	307	+	Good quality
Fleming et al.	774	+	Good quality
Fleming et al.	158	+	Good quality; Elderly
Nilssen	338	+	
Ockene	530	+	Good quality
Wallace	909	+	Good quality

DETAILS OF BI LITERATURE

- Key concept: "identified by screening"
- Best evidence: no AUD, unhealthy use, primary care
- Evidence of efficacy for outcomes beyond consumption is limited
  - Little evidence for linkage to specialty care
  - ED and hospital literature is mixed
- Older adults respond as well or better

MANAGEMENT OF MODERATE-SEVERE AUD

- Detoxification is not treatment
- Brief Intervention
- Treatment
  - Counseling
  - Pharmacotherapy
- Self and mutual help

ALCOHOL WITHDRAWAL TRIAGE

- Outpatient
  - Last drink >36 hrs: symptoms unlikely to develop
  - No other risk factors, responsible other
  - Can use anticonvulsants (gabapentin, carbamazepine)
- Consider inpatient
  - Past seizure, drug use, anxiety disorder, multiple detoxifications, alcohol >150 (risks more severe symptoms)
- Inpatient
  - Older age (>60), concurrent acute illness, seizure, moderate to severe symptoms (risks DTs), DTs

MAINTENANCE AND RELAPSE

- Anticipate difficult situations (triggers)
- Emphasize prior successes and use relapse as a learning experience, cope w/craving
- Help patient develop a plan to manage early relapses
- Facilitate involvement in treatment
  - 12-step groups
  - Counseling
  - Pharmacotherapy
  - Comorbid psychiatric disorders

Friedmann PD, Saitz R, Samet JH. JAMA 1998;279(15):1227-31.

AUD TREATMENT IN OLDER ADULTS

- Poor literature base
- As or more effective than in younger adults, but
  - Low utilization
  - Stigma, isolation, inability to pay, transportation
- Programs tailored to older adults may be better
  - Not typically available
- Traditional addiction treatment has limitations
  - Group setting, confrontation
- Best data in older adults supports brief interventions, Supportive Therapy Models (STM), Cognitive Behavioral Therapy (CBT), and medication

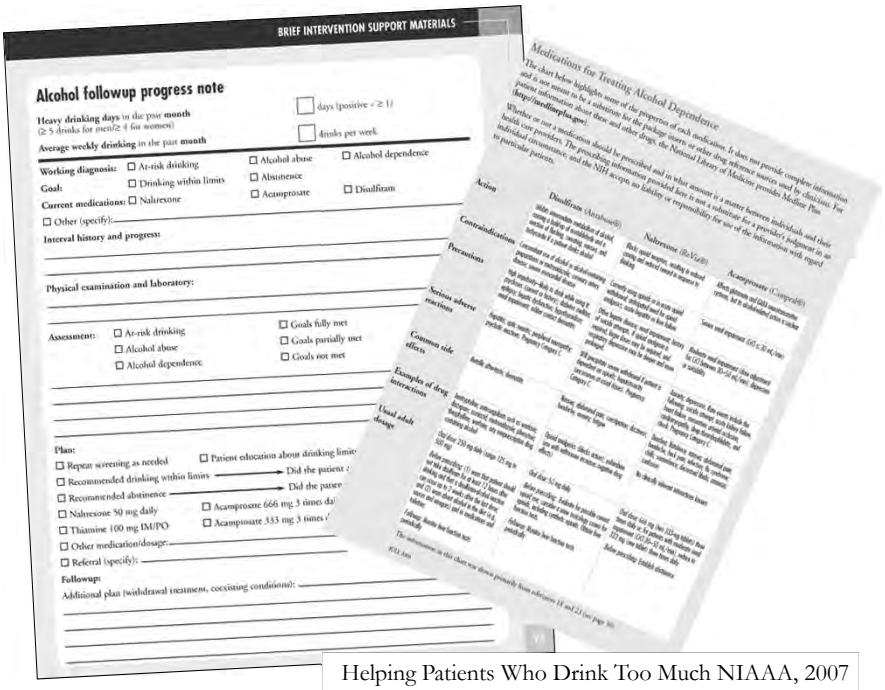
PATIENT SELECTION FOR PHARMACOTHERAPY

- All people with moderate-severe AUD who are:
  - currently drinking
  - experiencing craving or at risk for return to drinking
- Considerations
  - Specific medication contraindications
  - Psychosocial support/therapy and follow-up
    - Primary care med mgt (O'Malley; Anton*) as effective as specialized behavioral therapy**
  - Prescriber, access to monitoring (e.g. visits, liver enzymes)

*O' Malley SS et al. *Arch Int Med* 2003;163:1695-1704.
*Anton RF et al. *JAMA* 2006 May 3;295:2003-17.
**Latt NC, et al. *Med J Australia* 2002;176:530-534.

Medication-Assisted Treatment

Counseling-Assisted Pharmacotherapy



Helping Patients Who Drink Too Much NIAAA, 2007

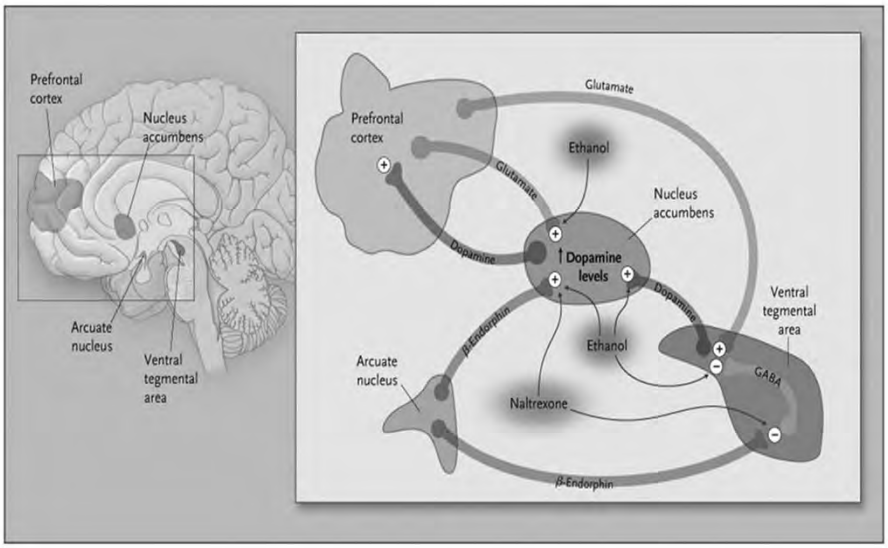
FDA Approved Medications

- Disulfiram (Antabuse)
- Acamprosate (Campral)
- Naltrexone (Revia-PO, Vivitrol-IM)

NON-FDA Approved Medications

- Topiramate (Topamax) – high level of evidence
- Varenicline – single positive study
- Ondansetron – for early onset alcohol use disorder
- Gabapentin (with Naltrexone) – also effective for withdrawal
- Baclofen – small studies, mixed results
- **www.clinicaltrials.gov**

Neurochemical Circuits Involved in Alcohol Dependence and Craving



The NEW ENGLAND JOURNAL of MEDICINE

Anton R. N Engl J Med 2008;359:715-721

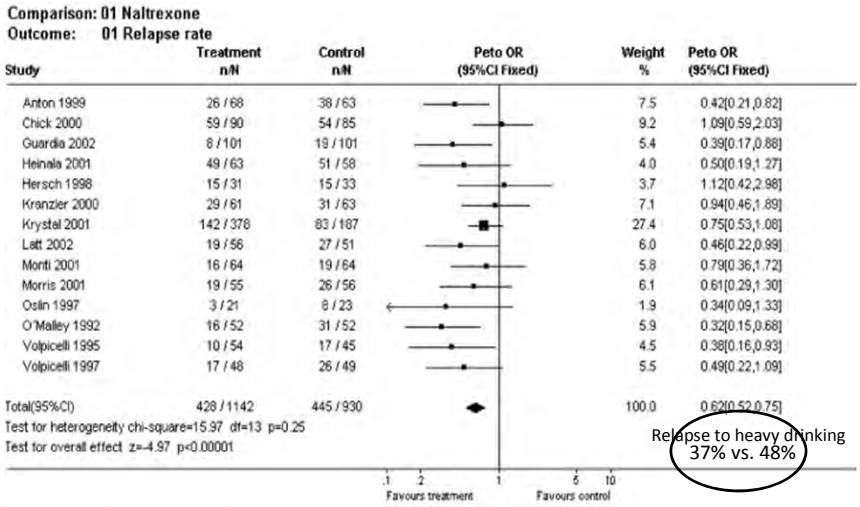
PHARMACOTHERAPY FOR ALCOHOL

- Most trials start with abstinent patients with mod-severe AUD
  - Disulfiram and acamprosate are best started after detox
  - Naltrexone can be started in patients still drinking
- Goals: abstinence vs reduction in heavy drinking
  - Heavy drinking: ≥5 drinks/day for men, ≥4 drinks/day for women
  - Reduction in heavy drinking is most closely associated with negative life consequences (impaired driving, medical problems, interpersonal problems)
- Duration of treatment
  - Most trials 2-6 months
  - Experts recommend pharmacotherapy for 6 months or longer with an additional 6 months of follow up

Naltrexone (ReVia PO, Vivitrol IM)

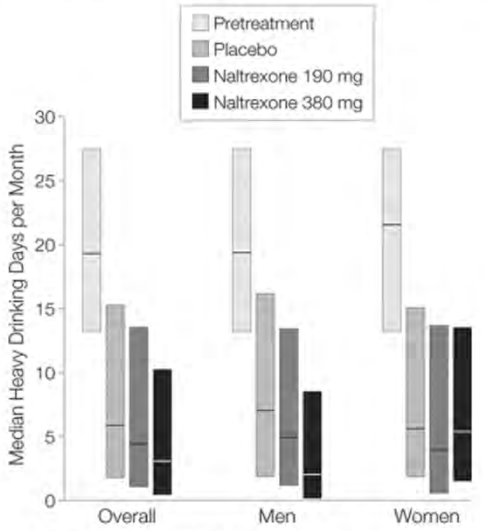
- 50 mg PO daily OR 380 mg IM monthly
- Safe in active drinkers – moderates heavy use
- Contraindicated with opioids; caution in acute hepatitis, liver failure.
- Reduces heavy drinking to 83% of that of placebo
- Side effects: nausea > headache, dizziness, which subside or improve with continued use. Can lower to 25 mg PO.
- IM formulation = $$$ ($500-1000/month). Injection site reactions can occur.

Efficacy of Naltrexone



Bouza C et al. Addiction 2004;99:811

Median Heavy Drinking Days per Month for Each Treatment Group Overall and by Sex



Garbutt, J. C. et al. JAMA 2005;293:1617-1625.

JAMA

Acamprosate (aka Campral)

- Precise mechanism unclear
- Dose is 666 mg TID (333 mg TID if GFR <50)
- Reduces return to any drinking to 86% of placebo. Little effect on heavy drinking.
- Different results in Europe, US, perhaps due to different populations (US less severe, shorter abstinence)
- Safe in liver disease. Adjust dose in renal failure.
- Side effects include diarrhea, nervousness, fatigue, which improve with use

Efficacy of Acamprosate
"stabilizes activity in the glutamate system"

Comparison: 03 Acamprosate vs Placebo
Outcome: 02 Cumulative abstinence duration (CAD)

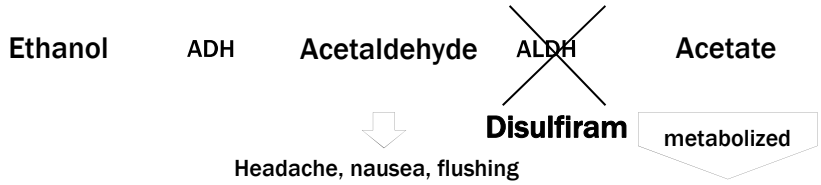
Study	Treatment n	Treatment mean(sd)	Control n	Control mean(sd)	WMD (95%CI Fixed)	Weight %	WMD (95%CI Fixed)
Besson 1998	55	137.00(147.00)	55	75.00(108.00)		3.5	62.00[13.79,110.21]
Geerlings 1997	128	61.00(70.00)	134	43.00(58.00)		33.2	18.00[2.40,33.60]
Gual 2001	141	93.00(75.00)	147	74.00(75.00)		26.9	19.00[1.67,36.33]
Paille 1995	361	210.00(134.00)	177	173.00(137.00)		13.5	37.00[12.54,61.46]
Poldrugo 1997	122	168.00(151.00)	124	120.00(147.00)		5.8	48.00[10.75,85.25]
Tempesta 2000	164	155.00(114.00)	166	127.00(115.00)		13.2	28.00[3.29,52.71]
Whitworth 1996	224	230.00(259.00)	224	183.00(235.00)		3.9	47.00[1.20,92.80]
Complete abst. 1 yr.	23%		vs	15%			
Total(95%CI)	1195		1027			100.0	26.55[17.56,35.54] days/year

Test for heterogeneity chi-square=6.71 df=6 p=0.35
Test for overall effect z=5.79 p<0.00001

-100 -50 0 50 100
Favours placebo Favours acamprosate

Bouza C et al. Addiction 2004;99:811

Disulfiram (Antabuse)



- Contraindicated in recent alcohol use, severe CAD, psychosis, cognitive impairment
- Caution in liver disease and recent drinkers
- Typical dose is 500 mg/day for 1-2 weeks, then 250 mg daily (range 125-500 mg). Active up to 14 days after use.
- Side effects mild: fatigue, headache, hepatitis, neuropathy
- Meta-analysis did not find efficacy compared with placebo

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: Gerrein 1973: 8 weeks; Azrin 1976: 2 years, Azrin 1982: 6 months; Liebson 1978: 6 months.
*Thirty-day abstinence at 6 months.

NON-FDA APPROVED MEDICATIONS

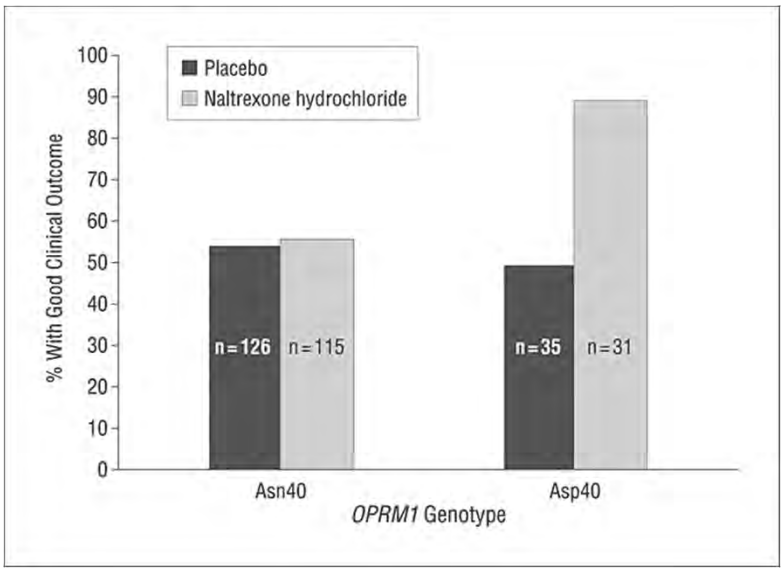
- Topiramate
  - Active at some glutamate, GABA receptors
  - Start at 50mg/day, titrate over two weeks up to max of 150mg bid
  - Effective in multiple RCTs (2 large) in reducing drinking
  - Two trial found no difference compared with naltrexone
  - Look out for cognitive impairment, sedation, kidney stones – higher dropout rates than placebo
- Gabapentin (1800mg per day divided)
  - Moderate evidence (dose-response in recent RCT)
  - Familiar to most physicians
- Baclofen
  - Weak evidence (early studies promising; not replicated)
  - Safe in liver disease
  - May require higher doses (60mg/day)

JAMA. 2007;298(14)
JAMA Intern Med. 2014 Jan;174(1)
Substance Abuse. 2012;33(4)

CHOOSING ALCOHOL MEDICATIONS

- Naltrexone
  - Can be used in active drinkers (unlike others)
  - Predictors of response: +FH, craving
- Acamprosate
  - Safe in liver disease (baclofen too), with opioids
  - Predictors of response: anxiety, severe withdrawal, -FH, late onset, female
- Disulfiram
  - Highly motivated, supervised adherence
- Genetic markers?

Good clinical outcome based on OPRM1 and medication group



Medical management alone (no CBI). Genotype vs. medication interaction p=0.005
Anton, R. F. et al. Arch Gen Psychiatry 2008;65:135-144.

The COMBINE Study

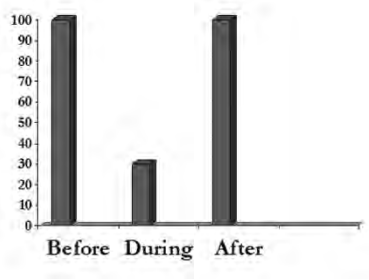
N=1383, 16 week trial	Good Clinical Outcome %
Medical Management and Placebo	58
Medical Management and Placebo and **CBI**	71
Medical Management and **Naltrexone**	74

CBI=Combined Behavioral Intervention
Good Clinical Outcome=Abstinence or drinking moderate amounts without problems.
P<0.025 (interaction p-value 0.02)

Anton RF et al. *JAMA* 2006 May 3;295:2003-17 (NCT00006206)

THE COMBINE STUDY

- One year after treatment ended, the groups did not differ significantly on drinking outcomes
  - Alcohol dependence is an illness that, like other **chronic diseases**, requires ongoing care



Pharmacotherapy

- Efficacious though modest; future promise for individualization
- Naltrexone first line (oral/injectable)
  - Acamprosate tid (renal), disulfiram (monitored)
  - Consider non-FDA approved medications
- Therapy or medical-type counseling
- Medication treatment of anxiety (buspirone) and depression (fluoxetine) can decrease alcohol consumption

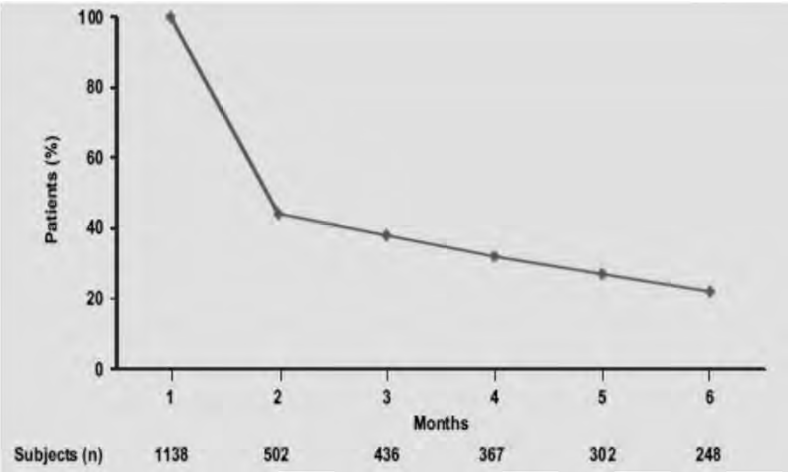
TREATMENT EFFECTIVENESS

- At one year, 2/3rds of patients have a reduction in:
  - alcohol consequences (injury, unemployment)
  - consumption (by 50%)
- 1/3rd are abstinent or drinking moderately without consequences
- Monetary benefits of alcohol and drug treatment to society outweigh costs 4 to 12-fold (depending on drug and treatment type)

Miller WR et al. J Stud Alcohol 2001;62:211-20
Anon. Journal of Studies on Alcohol 1997;58:7-29,
O'Brien CP, McLellan AT. Lancet 1996;347:237-240 and JAMA 2000:284:1689-95.

Receipt of Naltrexone

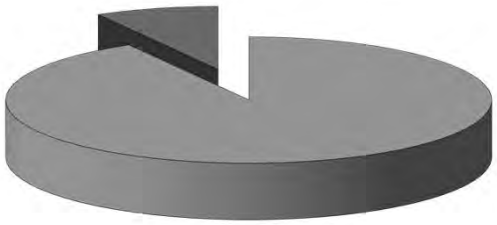
14% got 80% of a 6-mo course



Stephenson JJ et al. (abstract) AAAP 2006.
Medstat MarketScan Commercial Claims data

Alcohol Use Disorder: Treatment Gap

1,600,000 (8%) received treatment



17,900,000 (92%) did not

10.5% of recommended care is received by people with alcohol dependence

Lowest of 25 conditions (54.9% overall)

OAS, CSAT, SAMHSA NSDUH 2006
Green-Hennessey 2002; NSDUH 2009; NAMCS 2008

•National survey and record review, n=6712
McGlynn E et al. N Engl J Med 2003;348:2635-2645

Specialty Treatment

- 2 of 175 programs had a physician director
  - 54% have no physician
  - 34% have a part-time physician
  - 12% have a full-time physician

NSSATS 2002, D'Aunno 2004 & McClellan AT et al. J Subst Abuse Treat 2003

EMERGING MODELS

- Collaborative care for alcohol dependence
  - Modeled on depression/anxiety trials
  - RN intervention/outreach with expert advice
  - Emphasis on medications, lab monitoring
- Harm reduction
  - Monthly naltrexone injections in heavy drinkers
  - Strong outreach/engagement
  - Focus on reducing drinking

Summary: ALCOHOL USE DISORDER

- Screen for unhealthy use with single question
- If positive, assess the severity
- Perform a brief intervention for those with unhealthy alcohol use
  - Unwilling to change? Motivate, follow-up
  - Willing to cut back? Make a plan
- Recommend groups or counseling
- Ok to prescribe for moderate-severe AUD!

MOTIVATIONAL ENHANCEMENT

- Evidence-based style of health behavior change counseling (especially alcohol)
- Change can only come from the patient
- Goal is to enhance motivation and commitment to change
- Practicing these techniques increases the effectiveness of behavior change discussions and is fun!

BEHAVIOR CHANGE COUNSELING

- Step 1: Enhancing motivation to change
  - Eliciting self-motivational statements, or "change talk"
  - Tip the decisional balance
- Step 2: Strengthening commitment to change
  - Steps after motivation in place
  - "Closing the deal"

POSSIBLE TIMES TO PRACTICE

- Before you give advice about behavior change (exercise, diet, adherence)
- When a patient agreed to behavior change, but then made no changes
- When a patient expresses resistance to behavior change
- Basically, any time!

ELICITING CHANGE TALK

- "As I hear myself talk, I learn what I believe"
- Includes being open to input about behavior change, acknowledging problems with current behavior, and expressing a desire, need or willingness to change
- Opposite of arguing, which will encourage statements opposing change

RESISTANCE

- Statements opposing behavior change
- Patients who express more resistance are less likely to change
- Clinician style is associated with patient resistance talk
- Motivational techniques seek to minimize resistance talk

ASKING FOR CHANGE TALK

- "Tell me what concerns you about your…?
- Tell me why you think you might need to make a change in your…"
- Follow up with:
  - Open question: "Tell me more about that"
  - Reflection: "So you are worried about…"
  - Probing: "What else?" can probe for other common related problems

THE "IMPORTANCE" SCALE

- "On a scale of 0-10, how important do you think it is to change your…?"
- Follow with "Why is it not less important?"
- Once a concern is stated, encourage further change talk:
  - Open question: "Tell me more about that"
  - Reflection: "So you are worried about…"
  - Probing: "What other concerns do you have?"

REFLECTION

- A key technique worth practicing
- Not just repeating patient statements
- Uses statements rather than questions to clarify patient concerns
- Avoids arguing, correcting, teaching, advising in favor of understanding what is important to the patient
- Take time before developing a plan

MEETING RESISTANCE

- **Never meet resistance head on**
- Assess pros and cons of drinking
- Simple reflection, or with amplification:
  - "So you see no problems at all?"
  - "You can't imagine life without…."
- Double-sided reflection:
  - "On the one hand…, but…."
- Shift focus or topic (but return later)
- Roll with resistance: "You may decide not to change at all. It may be too hard. That is up to you."

BEHAVIOR CHANGE COUNSELING

- Step 1: Enhancing motivation to change
  - Eliciting self-motivational statements
  - "Tell me what concerns you about your…?
  - "Importance" scale
- Step 2: Strengthening commitment to change
  - Steps after motivation in place
  - "Closing the deal"
  - "Confidence" scale

BEHAVIOR CHANGE IS HARD!

- Older adults frequently have multiple chronic conditions
- Many lack confidence, knowledge and skills to manage their conditions
- Summarize pros and cons of behavior change and ask an open ended question, like “so where do we go from here?”

STRENGTHENING COMMITMENT

- Timing of moving toward commitment to action is key
- Too soon and patient not ready
- Too late and determination can be lost
- Time spent enhancing motivation is not wasted
- This transition can be gradual or tentative

SIGNS PATIENT IS READY TO CHANGE

- Stops resisting or raising objections
- Asks fewer questions
- Appears more settled, resolved, unburdened, peaceful
- Makes self-motivational statements
- Patient begins to imagine what it would be like after a change

SIGNS PATIENT IS NOT READY

- Missed appointments
- If coerced by circumstances, have they dealt with that?
- Indecisive, guarded, hesitant, resistant
- Best to explore ambivalence rather than push through

STEPS IN STRENGTHENING COMMITMENT

- Moving toward a plan
  - "Would you consider making a change?"
  - "What are you thinking you might do about this?"
- Elicit the patient's ideas
  - "How do you think you might do that?"
  - "What do you think might help?"
- Reflect, summarize, ask whether you can offer other options

STEPS IN STRENGTHENING COMMITMENT

- Communicate free choice
  - "It's up to you what you do about this"
  - "You can continue as you are or make a change"
- Review consequences of action and inaction
  - Consider hopes and fears
- Information and advice
  - Balance advise-giving with emphasis on choice

THE "CONFIDENCE" SCALE

- "On a scale of 0-10, how confident are you that you could make this change?"
- "Why are you not less confident?" encourages expression of self-efficacy
- "Why are you not more confident?" can identify important barriers to change

ELEMENTS OF A CHANGE PLAN

- Changes I want to make are….
- The most important reasons to change are….
- Steps in changing are…
- Ways others can help are….
- I will know it is working if….
- Some things that could interfere are….

ASKING FOR COMMITMENT

- "Are you ready to commit yourself to doing this?"
- Better to defer a decision if the patient is hesitant or expresses significant ambivalence
- Arrange for follow-up
  - Reviewing progress ("How did it go?")
  - Renewing motivation ("What do you remember as the most important reason to change?")
  - Redoing commitment (reinforce autonomy, self-efficacy)

BEHAVIOR CHANGE COUNSELING

- Commit to practicing!
- Enhancing motivation to change
  - Eliciting self-motivational statements
  - "Tell me what concerns you about your…?
  - The "Importance" scale
- Strengthening commitment to change
  - Steps after motivation in place
  - "Closing the deal"
  - "Confidence" scale

FOR FURTHER STUDY

- Motivational Interviewing in Healthcare by Stephen Rollnick, William Miller and Christopher Butler
- Building Motivational Interviewing Skills by David Rosengren

ALCOHOL AND OLDER ADULTS

- Alcohol problems present differently in older adults
- Screening, assessment, and diagnose determines treatment strategy
- Brief intervention are effective for unhealthy use without AUD
- Alcohol pharmacotherapy effective for AUD
- Practicing motivational techniques can improve patient outcomes and provider satisfaction