8

Brief Counseling Interventions

LEARNING OBJECTIVES

Upon completion of reading this chapter and participating in the guided exercises, the learner will be able to

- understand the need for brief interventions in the addictions counseling field;
- distinguish between multiple brief intervention approaches and identify clinical settings they are utilized in; and
- begin practicing skills of brief intervention models under supervision of an advanced counselor.

In Chapter 6 we discussed the assessment process for addictions, and in Chapter 7 we discussed the diagnostic process and recent changes to the standard diagnostic manual emphasizing the spectrum of addiction disorders. This current chapter examines the growing field of brief counseling interventions, which may be used at different points along the addiction spectrum. Historically, these have been found to occur between assessment and diagnosis following a short screening tool. We are encouraged that these interventions have been found to be applicable for individuals along the full range of the spectrum, not only the diagnostic portion of the arc.

In this chapter, we will begin with discussing the history of brief interventions, and discuss the need for this type of approach for working with clients. Specific models such as the FRAMES model (Miller & Sanchez, 1993), the Brief Negotiated Interview (D'Onofrio, Pantalon, Degutis, Fiellin, & O'Connor, 2005), and a client-centered subjective model developed by Dr. Laura Veach will be introduced. The use of this approach in a variety of settings (e.g., medical settings, school settings, and judicial settings) will be discussed, and a case study will demonstrate the utility of brief interventions.

History of Brief Interventions

The first empirical investigation examining the utility of brief intervention for addiction has been credited to Griffith Edwards and his colleagues for a study conducted in 1977. The study team enrolled 100 males addicted to alcohol and randomized the participants into a traditional treatment group or a single-session treatment group, following a 3-hour assessment session (Edwards et al., 1977). They completed follow-up interviews with 94% of the participants, and discovered that there were no significant differences in outcomes between the two groups, suggesting that brief one-session treatment was just as meaningful as the longer intensive treatment common of the time. In further support for the findings of the original Edwards et al. study, the participants were followed up with 12 years later, and again, there was no difference found in outcomes between the two treatments (Heather, 2004). The foundation for providing brief interventions was laid.

Since the Edwards et al. (1977) study there have been numerous studies examining the use of brief interventions for risky use of alcohol and other drugs. In fact, conducting a Google Scholar search for the words "brief interventions" provided over 2.2 million hits of scholarly works (e.g., books, peer-reviewed articles). Wilk, Jensen, and Havighurst (1997) conducted the first meta-analysis of brief interventions among heavy alcohol drinkers, marking this heavy use by binge activity but not dependence. The meta-analysis included studies conducted in both health care settings (e.g., primary care, emergency departments) and substance abuse treatment centers. After identifying 12 studies that fit inclusion criteria, the authors found that heavy drinkers who received an intervention were more than 2 times as likely to moderate their drinking, as compared with those individuals who did not receive the intervention.

Since the Edwards et al. study, brief interventions have expanded into numerous settings, including health care, university, school settings, and mental health service providers.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has provided millions of dollars in funding to examine the benefits of brief interventions, and more specifically the program titled Screening, Brief Intervention and Referral to Treatment (SBIRT). Within SBIRT, brief interventions are a core component, providing care to individuals identified as at risk via the initial screening—in danger of developing addiction, or suffering other negative consequences from alcohol and/or drug use (e.g., death, injury, sexually transmitted diseases).

Box 8.1: SBIRT

"Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use." (Substance Abuse and Mental Health Services Administration, n.d., para. 1).

A 10-year review of SBIRT-funded research was conducted by SAMHSA in 2012, with results suggesting the model, and specifically brief interventions, to be highly effective at reducing risk for individuals. From over 425 settings, the research conducted intakes with approximately 1.5 million individuals, and completed 6-month follow-ups with 21,035 people. Of these follow-ups, the rate of abstinence increased to 41.1% at follow-up from 16.1% who identified abstinence at intake. In addition to substance-related outcomes, rates of employment, and stable housing increased at follow-up, and there was a decrease in criminal justice activity for the participants. Mental health outcomes indicated decreases in depression rates (47.3% at intake vs. 37.3% at follow-up), anxiety (46.7% at intake vs. 40.5% at follow-up), reported hallucinations (8.3% at intake vs. 5.6% at follow-up), and in reported suicide attempts (4.5% vs. 1.5%). In addition, risky behaviors, such as unprotected sex with an HIV-infected partner or unprotected sex with an intravenous (IV) drug user, were also found to decrease at follow-up. Overall, the research supporting the SBIRT model, and specifically brief interventions, has a wide breadth of positive outcomes any professional counselor would be excited to see in his or her client population.

Need and Evolution of the Brief Intervention Model

The need for brief intervention models has risen out of the recognition of the power of early interventions as well as the need to identify the treatment gap in our country. The Early Intervention Foundation defines early intervention as "taking action as soon as possible to tackle problems for children and families before they become more difficult to reverse" (n.d., para. 1). The problem that becomes difficult to reverse, as it is relevant to our discussion, is that of addiction. The treatment gap refers to the identified need for addiction treatment among members of our society, but a lack of individuals receiving treatment. For instance, in 2014, there were 22.5 million Americans aged 12 or older who were recognized as needing treatment for a substance use disorder, either alcohol or illicit drugs (SAMHSA, 2015). Of these 22.5 million people, only 4.1 million received some form of treatment, and only 2.6 million received treatment at a specialty addiction treatment facility (SAMHSA, 2015). This means that over 70% of individuals needing treatment for a substance use disorder did not receive treatment during 2014. The individuals that make up the 70% represent the essence of the treatment gap phenomenon.

Brief interventions assist with early intervention efforts, and these initiatives help address the growing treatment gap by meeting people where they are, which is often not in the treatment facilities as shown by the statistics above. These individuals are often easily identified through other avenues, such as the two to be discussed further in this chapter, the medical setting and the university setting. Additional settings such as the criminal justice field and employment settings will be examined in further detail in Chapter 11. It is important to keep in mind that any setting in which a professional counselor finds himself or herself working would be a good setting for brief intervention implementation, given appropriate approval through administrative routes.

Definition of Brief Intervention

There are many different definitions for what constitutes a brief intervention (BI). Many models emphasize the adherence to principles of motivational interviewing (MI) developed initially by Miller in 1983, and refined by Miller and Rollnick in 1991. MI is a client-centered counseling style in which the client is encouraged to consider how they may overcome their ambivalence about change (Miller & Rollnick, 2002). What we feel crucially important to emphasize about the MI approach is that at the heart of the model is adherence to Rogers's (1957) core conditions of counseling. According to Miller and Rollnick (2002), "It is love, and profound respect that are the music in motivational interviewing, without which the words are empty" (p. 13).

Box 8.2: Motivational Interviewing and Empathy

"It is love, and profound respect that are the music in motivational interviewing, without which the words are empty" (Miller & Rollnick, 2002, p. 13).

MI is not something you do *to* a client, but something you use to *engage with* a client, a small difference in words but a vast distinction in actions. MI is included in the National Registry for Evidence-based Programs and Practices (NREPP), and is cited in over 27 other interventions included in the registry. Not only can MI form the basis for a singular session (i.e., brief intervention), but it may also be used as part of an ongoing relationship with clients.

Our definition of a BI follows: a BI capitalizes on a teachable moment in which an individual has been identified as being at risk for personal, medical, employment, and/or familial problems related to his or her substance use and is provided the opportunity for an individualized discussion about reducing his or her risk. The following section provides reviews of three models of brief interventions. It is important to note that in addition to brief intervention, some literature cites brief treatment. The primary difference between brief intervention and brief treatment involves treatment requiring more time, however there is no specific difference agreed upon in the literature.

FRAMES

In 1993, Miller and Sanchez developed the FRAMES model, which was identified after reviewing interventions and identifying the most effective components. FRAMES is an acronym for feedback, responsibility, advice, menu, empathy, and self-efficacy. Feedback involves the provider discussing the individual's personal risk factor or impairment level due to alcohol consumption levels. The second element is that of responsibility; that it is the individual's personal responsibility for change, building that individual's sense of personal control in relation to making a change. Advice involves

an explicit message to the individual, either written or verbal, that a change is necessary. The menu component involves making available a variety of suggested change activities the individual may consider, while remembering that the responsibility is up to the individual to decide what would be most appropriate for him or her. Empathy is a crucial element included within the FRAMES model; an attitude of warmth, reflective and understanding, is key to establish empathy within the brief intervention. Lastly within the FRAMES model is the enhancement of individual self-efficacy, building the notion that change is possible. The FRAMES model as proposed by Miller and Sanchez offers a blueprint of six elements that have been found to produce change following brief interventions.

The FRAMES model is used in the evidence-based programs Drinker's Check-Up and College Drinker's Check-Up (SAMHSA, 2014d, 2014c). The programs are computer-based intervention programs with the main aims of reducing users' alcohol use and consequences from use. Both programs have been reviewed by NREPP and are included in the registry.

Brief Negotiated Interview (BNI)

The BNI was developed by D'Onofrio et al. in 2005, and was targeted for use by personnel in emergency departments. The BNI has four critical components: "(1) Raise the subject of alcohol consumption, (2) provide feedback on the patient's drinking levels and effects, (3) enhance motivation to reduce drinking, and (4) negotiate and advise a plan of action" (D'Onofrio et al., 2005, p. 3). The overarching goals of the BNI are to reduce an individual's alcohol use and also reduce his or her instances of driving under the influence. In 2013, the BNI was reviewed and included in NREPP.

Client-Centered Subjective Model

Dr. Laura Veach developed this alternative model in 2006, choosing to avoid focusing on an individual's consumption rates and patterns, and instead focusing on the client's reported reasons for alcohol use. Adherence to this model includes avoiding discussion of the numbers associated with an individual's drinking and even avoiding the discussion of safe drinking limits suggested by NIAAA, common practices in both of the above-referenced models. Instead, the counselor elicits the client's subjective experience of drinking by using reflective listening techniques. The focus of this intervention is on the reasons behind one's alcohol use, and consideration of alternative ways of achieving the desired outcomes reported by the client. This intervention was tested in a Robert Wood Johnson randomized clinical trial with hospitalized trauma patients. Patients were randomized to one of two intervention arms, the traditional quantity–frequency type of discussion, or the innovative client-centered subjective counseling model. The results of the *Teachable Moment* study (O'Brien, Reboussin, Veach, & Miller, 2012) indicated that there were no differences between the treatment arms at follow-up, providing an initial evidence base for this alternative intervention model.

The three above-referenced brief intervention models are a small representation of what exists in the literature. Overall, all brief intervention models emphasize respect for the individuals we are interacting with. It is crucially important for all individuals involved with this type of work to do a thorough self-inventory of biases as these will emerge and interfere with client care if not identified and challenged.

Evidence-Based Practices in Clinical Settings

The treatment gap in our society indicates that approximately 70% of individuals needing addiction-related treatment are not receiving such care (SAMHSA, 2015). Although these individuals are not receiving specialized addiction treatment, it is also unlikely that they are living in isolation, completely off the grid. Two settings in which we are likely to interact with these individuals are medical settings and university settings. As mentioned earlier, other common areas for interaction will be explored in Chapter 11.

Medical Settings

Alcohol in particular takes a devastating toll on our nation's health care system. Williams et al. (2010) determined that approximately 25% of all patients admitted to general hospitals have alcohol use disorders, or were injured due to risky drinking. This corresponds to an earlier estimate that 24% to 31% of emergency department patients are there due to alcohol misuse (D'Onofrio & Degutis, 2004/2005). Further estimates suggest that approximately 15% to 20% of patients within primary care have alcohol use disorders (McQuade, Levy, Yanek, Davis, & Liepman, 2000). And the most significant population, by prevalence rate, is the trauma population, with upward of 50% of patients being hospitalized as a result of injuries incurred as a result of the patient's or another individual's alcohol consumption (American College of Surgeons [ACS] Committee on Trauma, 2003).

Primary Care

Primary care specialists are the generalists of the medical field. Most of us typically use primary care physicians as an entry point into the medical community, whether as a last stop due to cold and flu symptoms, or in order to facilitate a referral with another medical specialist (e.g., oncologist, podiatrist, ob-gyn). Primary care has been identified as an opportune setting for implementation of SBIRT services (Moyer, 2013). Structured literature reviews and meta-analyses support the implementation of these practices in primary care (Williams et al., 2011). Reduction in illicit drug use, reduction in alcohol use, and also reduced days of alcohol intoxication are some of the positive outcomes associated with providing such services in primary care (Gryczynski et al., 2011). SAMHSA has recognized the importance of providing such services in primary care settings and has developed a medical residency training program specializing in SBIRT

(Agerwala & McCance-Katz, 2012). There has been some difficulty in implementation due to lack of substance use disorder knowledge, lack of time issues, and other logistic issues (Agerwala & McCance-Katz, 2012). The positive outcomes associated with providing these services in primary care, along with the trouble of some medical practitioners to fully engage with the model, provide strong support for professional counselors to be involved in these activities.

Emergency Medicine

The emergency department setting sees a large number of patients seeking care for substance-related issues each year (D'Onofrio & Degutis, 2010). Patients may be seeking medical care due to an injury incurred while intoxicated, which will be further explored in the trauma care section below, or they may be seeking care for another illness related to substance use (e.g., pancreatitis, withdrawal symptoms). Patients that are risky users of substances may also be seeking care for an illness that primarily is not due to his or her alcohol or drug use; this highlights the opportunity to interact with individuals that are not actively seeking treatment in addiction centers, yet are interacting with our health care system. One of the most well-known full-scale implementation efforts of brief interventions in the emergency department setting is known as Project ASSERT. Project ASSERT was initiated in the mid-1990s, and found large changes in participants' alcohol use, frequency of drinking six or more drinks in one settings, and satisfaction with the program at follow-up (Bernstein, Bernstein, & Levenson, 1997). Project ASSERT has had success with implementation following the initial settings (e.g., D'Onofrio & Degutis, 2010) and is now identified as an evidence-based program listed in the NREPP.

Trauma Care

As indicated above, many patients seek health care for injuries incurred while intoxicated. In fact, according to the American College of Surgeons Committee on Trauma (2006) approximately 50% of all trauma patients have alcohol in their systems at the time of injury. The startling numbers have led Desy, Howard, Perhats, and Li (2010) to declare that alcohol is the "single greatest contributor to injury in the United States" (p. 538). It is not difficult to understand the need for providing brief interventions within the trauma setting, particularly following the research support examined below.

The results of the first randomized control trial of alcohol interventions in a Level I Trauma Center were reported by Gentilello et al. (1999). The purpose of the study was to identify whether providing a brief intervention to trauma patients would limit recurrent traumatic injuries and subsequent visits to the trauma center. The total sample size was 762, with both intervention and control groups (366 and 396 participants, respectively). The researchers reported a 47% reduction in new injuries that would have involved a subsequent visit to the trauma center in the intervention group, and a 48% reduction in inpatient hospital admissions for the intervention group, both results significantly different from the control group. The results also suggested a reduction in

alcohol consumption in both groups. The reported reduction was significantly greater for the intervention group (21.8 standard drink per week reduction) in comparison to the control group (6.7 standard drink per week reduction). Although both groups reduced their alcohol consumption level, the control group's reduction diminished over time, while the intervention group maintained reduction in alcohol consumption at follow-up. The results of the study by Gentilello and his colleagues not only provided significant hope for intervening with the trauma population but also a strong empirical foundation from which other research could be conducted.

In 2006, the American College of Surgeons (ACS) mandated the screening and brief intervention mechanisms be implemented nationwide in order for trauma centers to uphold Level I and Level II accreditation (Gentilello, 2007). According to the ACS Committee on Trauma (2006),

> alcohol is such a significant associated factor and contributor to injury that it is vital that trauma centers have a mechanism to identify patients who are problem drinkers. Such mechanism is essential in Level I and II trauma centers. In addition, Level I centers must have the capability to provide an intervention for patients identified as problem drinkers. (p. 116)

Trauma care represents a unique opportunity for professional counselors to be involved in the immediate aftermath of an alcohol-related injury. Both of the authors of this text have provided care to patients in trauma settings and recognize the powerful moments such injuries provide to helping patients rethink their alcohol and other drug use.

School Settings

There may be no other opportune setting to intervene early with adolescents' alcohol and drug use as there is in the school setting. There is a drop-out crisis in our country, with over 1 million students dropping out each year (Balfanz, Bridgeland, Bruce, & Fox, 2012). Although the literature related to school drop-out patterns identifies school engagement, suspensions, and even familial responsibilities as primary drop-out reasons (Doll, Eslami, & Walters, 2013), we are positive substance use and abuse may be an underlying reason for these drop-outs. For example, the reason for lack of school engagement may be due to the fact that an individual is smoking marijuana before coming to school in the morning. Or a reason for suspension might be that the student had substances on the campus. Because of a recognized role substances play in the lives of adolescents and harms associated with use, there have been screening and brief counseling intervention efforts implemented across the country with beneficial outcomes reported.

Mitchell et al. (2012) conducted a study with adolescents aged 14–17 in 13 different school-based clinics in New Mexico. Students were screened using the CRAFFT screening tool (see Chapter 6 for a review) in the health clinic and, if screened positive, were referred to the behavioral health counselor (masters level) on site at the school. Results from the study found significant reduction in drug use and a significant reduction in

days drinking to intoxication. In addition, the researchers found a reduction in reported days drinking alcohol, although this was a non-significant reduction. These results are important to consider the wide impact that providing screening and brief services to students can have, all while being implemented within the school setting. It would behoove all school systems to embrace a mode of brief intervention delivery, to target the most at-risk students, and encourage success not only in their current lives, but also in their futures.

College and University Settings

According to the National Institute for Alcohol Abuse and Alcoholism (NIAAA; 2015), approximately 80% of college students report alcohol use. In addition, approximately 22.3% of full-time college students aged 18–22 reported illicit drug use in 2013 (SAMHSA, 2014a). A surprising number of college students are engaging in risky substance use, which leads to adverse effects such as slipping grades, relational difficulties, and also to severe consequences such as death.

It is no surprise to many that university settings have recognized the value of providing brief interventions for students identified as partaking in risky substance use. The three main routes for an individual to become identified as someone who could benefit from a brief intervention are through university judicial programs, student health centers, and/or mental health counseling centers. We will offer an example of each of the different entrance points through case studies.

Case Study 8.1: Entry Point 1, Judicial Program

Selma is a 19-year-old white woman, attending a local state school. Selma is a sophomore although because of advanced placement credits from high school is taking upper-level courses with juniors and seniors. Most of Selma's friends are older, and many have recently reached the legal drinking age. Selma has maintained great grades throughout her two years at the university and has been active in many different campus organizations. One Friday night, Selma and her friends were having a small get-together in the university apartments. There was a knock on the door, and the campus police officers were responding to a noise complaint from a neighbor. Once the campus police officers saw the alcohol they requested to see all individual's identifications, and Selma of course was identified as being underage. She received a citation and a referral to the judiciary committee of the school. Selma attended her judicial hearing and was mandated to community service hours and was required to attend a meeting with the university's addiction counselor. During their initial meeting, Selma was provided a questionnaire to complete, and her counselor discussed the results of the survey and they discussed Selma's drinking.

Now consider that you were Selma's counselor as you answer the following questions.

1. What are some reasons Selma might want to consider cutting back on her drinking?

2. What are some reasons Selma might have for not wanting to cut back on her drinking?
3. What information would you want to help Selma understand about her drinking?
4. Is there anything else you would want to talk with Selma about?

Case Study 8.2: Entry Point 2, Student Health Center

James is a 22-year-old Asian American male who is coming to the student health center because of cold symptoms. When James arrives at the center he is invited to check in for his appointment using a computer system. James has to enter his personal information and then is asked a series of questions. One of the questions asks James about his alcohol use and his medication use. James enters that he has approximately three beers on the weekends, and also takes Adderall. After James completes the check-in process he is invited into the exam room. Dr. Ortiz enters the exam room and continues to conduct a full evaluation of James, attending to his symptoms of common cold. James is primarily concerned because the cold symptoms have lasted for over a month. Dr. Ortiz discusses appropriate over-the-counter medications James may find relief from, and he also asks about his Adderall use because it is not documented in his chart. James reports that he gets the medication from his roommate; it helps his focus as he is studying for the LSAT for law school, and he assures Dr. Ortiz it is not like he is "popping the pills like crazy, only about a couple a week." Dr. Ortiz is concerned about James's use of non-prescribed medication as well as his combination of alcohol. Dr. Ortiz discusses his concerns with James and provides a referral to the campus addiction counselor who has an office right down the hall from Dr. Ortiz. James must stop by the office to schedule an appointment before leaving.

Now consider that you were James's counselor as you answer the following questions.

1. How would you begin the session with James?
2. What information do you feel you need to know but were not provided with above, and where would you get that information?
3. What do you think James is feeling about having to come see you?
4. What concerns you about James's situation?

Case Study 8.3: Entry Point 3, University Counseling Center

Lily is a 20-year-old biracial woman, in her third year of college. Lily recently transferred to a college closer to home as her father was diagnosed with Alzheimer's. Lily has been attending the university counseling center for three sessions. Lily initially began attending due to issues with her family. Due to her father's illness, Lily has had a lot of responsibility placed on her, and although she is happy to help, she reports feeling angry that she is not able to enjoy college "like all of my other friends." Lily

discusses with her counselor that the only time she is able to be free from the stress of her family is on the weekends when she goes out with her friends. Lily and her friends have a local restaurant they go to and are friends with the bartenders, who will serve them although they are underage. The counselor asks about Lily's alcohol consumption rates and Lily reports drinking upward of seven or eight cocktails and a few shots on most Friday nights.

Now consider you are Lily's counselor as you answer the following questions.

1. Are you concerned with Lily's alcohol use report? If so, what is concerning?
2. How would you tell Lily you are concerned?
3. It might be helpful to talk to Lily about what she gets out of drinking; how would you broach that with her?
4. What information would you feel Lily needs to know about her alcohol use?

The stories of Selma, James, and Lily are common situations happening daily on college campuses throughout our country. Fortunately, there is support for intervening with students following situations similar to the above-referenced case studies.

Reduction in alcohol consumption and a reduction in alcohol-related consequences following a brief intervention primarily focused on alcohol use are two such positive outcomes of intervening with college students (Martens et al., 2007). The overall positive findings of providing brief interventions have led to the development of evidence-based programs (EBPs) for use with college students. Two of these EBPs will be examined further, and both are listed in the NREPP.

Brief Alcohol Screening and Intervention for College Students (BASICS)

As mentioned above, the BASICS program is included in the NREPP, which speaks to the strength of the research supporting the program. According to SAMHSA (2014b), BASICS has been approved for use among college students, aged 18–25, and research has included appropriate racial and ethnic diversity for wide implementation. The intervention model includes two 1-hour interview sessions, as well as an online assessment survey. Students attend the first session, which is an information gathering session, particularly concerned with identifying alcohol consumption patterns and the student's beliefs about drinking. The student is then provided information about taking the online survey before the next session, and instructed to monitor his or her drinking between the sessions. During the second session, the student receives personalized feedback about his or her drinking and what risks are involved with that drinking. The counselor is also making sure to attend to the rapport with the student, and embraces the core conditions of Carl Rogers's (1957) framework of empathy, unconditional positive regard, and genuineness throughout the sessions.

College Drinker's Check-Up (CDCU)

The CDCU is a computer-based brief motivational interview designed to reduce alcohol use by men and women aged 18–25 who engage in heavy episodic drinking (aka, binge drinking) (SAMHSA, 2014c). The CDCU uses the FRAMES (Miller & Sanchez, 1993) model of brief interventions, and is uniquely tailored to the individual's responses. Participants in clinical trials have been found to have fewer drinks per week, a lower number of drinks in heavy episodic drinking periods, and a lower estimated blood alcohol level during heavy drinking periods as compared with control groups (SAMHSA, 2014c).

Skills in Action

Case Studies

Below you will find two case studies of the use of brief counseling interventions in settings commonly employing professional counselors. The first is an examination of the use of BIs in a school setting, and the second in a medical trauma unit. We are hopeful the two different settings, and cases, will encourage you to consider how and when you will be able to implement these useful interventions in whichever setting you practice in your clinical future.

Case Study 8.4: Tommy, High School Student

Tommy, a 15-year-old high school sophomore, has been referred to the school counselor's office. Tommy's teacher overheard Tommy discussing his previous weekend with some friends in geometry class. Tommy reportedly was talking about how his older brother (a junior in the same high school) was able to get some beers and they had a little party. The school counselor knows Tommy very well, as he is an excellent student, being placed in honors courses since he began at the school two years ago. Tommy has just one older brother, and his mother is a single mother after Tommy's other parent passed away approximately 2 years ago. The school counselor was surprised to receive the referral but eager to talk to Tommy.

School Counselor (SC): What brings you in today, Tommy?

Tommy (T): Mrs. Johnson said I had to come talk to you; didn't she call you?

SC: Yes, she did, but I want to hear from you what brings you in.

T: Ugh, this is so stupid; I don't even need to be here. Just because someone thinks they overheard something, it is no one's business here what I do outside of school!

SC: You're frustrated and in your opinion this is being blown out of proportion.

T: Yes! I mean, OK, so my brother and I had some beers this weekend, it is not like we are the only ones in this school to ever drink . . . gosh, if you all even knew what went on!

SC: In comparison with what others are doing, your drinking feels very minor.

T: Yes!

SC: I hear that this is frustrating for you, and I also want to be able to talk to you some more about drinking. Would it be OK if I ask you some questions?

T: I mean, are you just trying to get me in more trouble?

SC: No, what I want to do is help you think about the decisions you are making, and maybe give you more information about alcohol and what risks it has. I want to get a better picture of what your risk might be so I have a better understanding of you. Does that sound OK?

T: Sure, whatever

[SC continues to administer the CRAFFT screening tool (overview in Chapter 6). The screening results are then given to Tommy.]

SC: Tommy, thank you for going through those questions with me. What was that like for you?

Figure 8.1 Tommy's CRAFFT Results

C Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? _____

R Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? __X__

A Do you ever use alcohol or drugs while you are by yourself, alone? _____

F Do you ever forget things you did while using alcohol or drugs? __X__

F Do your family or friends ever tell you that you should cut down on your drinking or drug use? _____

T Have you ever gotten in trouble while you were using alcohol or drugs? _____

Total 2/6

Knight, J. R., Sherritt, L., Shrier, L. A., Harris, S. K., & Chang, G. (2002). Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of Pediatrics & Adolescent Medicine*, *156*(6), 607–614.

T: Umm, fine.

SC: OK, well the results this screening tool help me understand where you are in terms of risk, either none, little, medium, or high risk. Before I tell you the results, where do you think you fall in terms of your risk?

T: Umm, probably like none. I mean I have drank but it is not often, and it's not like I'm getting wasted.

SC: For you, based upon your use history and the amount you are drinking, you feel as though it is not of any risk to you.

T: Right.

SC: I hear you, and based upon these results, you are at some risk, but it is little. That is higher than no risk, however. What do you think about that?

T: Well, isn't that your job? To tell me it is risky?

SC: You're worried that I have ulterior motives with this screen. And maybe you are right, but only because I am worried about you. I have seen the negative side effects of alcohol use, starting out as very little risk and elevating very quickly into high risk, and I worry about that being your pathway.

T: But, you know me; you know that is not what is going to happen to me!

SC: Don't you think everyone thinks that it will never happen to them?

T: Hmm, I guess I didn't think of that, but really, I won't let it.

SC: Well, how about we talk some about your drinking.

T: What about it?

SC: Well, tell me some about what drinking does for you?

T: I don't really know, I mean I haven't thought of that.

SC: That makes sense, but thinking back on it now, what do you think?

T: It is just fun! My brother and I just have so much fun, laughing, doing stupid dances we don't normally do; it's like we are little kids again, just having fun.

SC: Alcohol helps you have fun; lets you cut loose.

T: I guess so; like I said, just cut loose.

SC: That makes sense; a lot of people drink alcohol for that reason. I wonder, when you don't have alcohol, what other ways you cut loose?

T: I guess there are a lot of ways. Just being with my brother, we normally just mess around like goofs anyway, or like with my friends after soccer practice, we just are crazy.

SC: You are able to enjoy the same benefits like being able to cut loose, without having to have alcohol.

T: Yeah, like I said, I don't have a problem.

SC: Right, and that's true right now. In the future though, that could be more difficult for you. The more people use alcohol to cut loose, the more that becomes their go-to way to relax. This all has to do with our brains.

T: What do you mean?

SC: Our brains are still developing well into your mid-20s. That is another whole 10 years, and even after that they have the ability to change, and be altered. But what they are really working on now, is forming neuropathways. These are shortcuts for our brain to remember for the future. If your brain finds that it can cut loose after using alcohol quicker than in other situations, it might wire a pathway that makes that the first choice when you are feeling stressed and need to relax.

T: Whoa, really? That sounds weird.

SC: Yeah! It is exciting because we're learning more about the brain all of the time.

T: Yeah, I mean I would never want to be one of those bums, just drinking all of the time.

SC: Do you know anyone like that in your life?

T: My uncle. I mean, he is able to work and do a good job, but immediately when he walks in the door in the evening, he walks right to the fridge and grabs a beer, and then it's all downhill from there. Every holiday he gets bombed throughout the day.

SC: Although you love your uncle, you can recognize that his drinking is interfering in his ability to be present with you all during important holidays.

T: Yeah, I would never want to be like that. Last year he couldn't even play in our flag football game on Turkey Day because he was too tipsy.

SC: I wonder when your uncle started drinking, and how early he learned to relax by drinking.

T: Probably pretty young; I mean, that was way back when he could just walk in and buy a pack of beer for himself and no one questioned it.

SC: For you, getting beer is more difficult.

T: Yeah, I mean, I haven't even ever bought it, it's been my brother, but it has been difficult for him.

SC: There is a lot to be concerned with, money, getting in trouble . . .

T: Yeah, that'd be the worst; my mom would kill me.

SC: That sounds like another reason your drinking is risky.

T: Umm, I guess so; my mom has been through a lot, and so have we, but I would hate to disappoint her.

SC: You really care about her, and making sure your relationship is solid.

T: Absolutely, she's the only parent I have left.

SC: I'm wondering, after this conversation we've had, do you think your drinking is more risky than you initially thought?

T: Umm, I guess a little, again, not like I have a major problem, but if you mean risk then yeah, I can see that.

SC: Are you willing to make some changes with your drinking?

T: Well, yeah, I hate feeling guilty and lying to my mom whenever I drank the night before. I get this feeling in the pit of my stomach that I just hate.

SC: It sounds like that feeling is almost even enough for you to not drink again.

T: Yeah, it is horrible, but of course I always forget about that when I start drinking.

SC: What is one way you think you could remind yourself about that feeling, to help you not drink?

T: Hmm, umm, I don't know. . . . I've never even talked about it or thought about it before.

SC: This is the first time you're really aware of the power of that feeling.

T: Yeah.

SC: Maybe, just us talking about it might be enough.

T: Hmm . . .

SC: And if it isn't, you can always come back and talk again.

T: OK, wow, I can't believe I just talked to you about this.

SC: You're surprised how much you were able to talk to me.

T: Yeah.

SC: That makes sense, especially since I think you thought you were going to get into trouble first thing. But what I heard from you, Tommy, is that your drinking isn't a huge part of your life, but that it does have some negative effects for you, and also some risk. And I also heard that you are concerned about that, and are willing to make some changes, and cut down on your drinking, or even stop completely. Would you agree?

T: Absolutely, that nails it.

SC: Well, thank you for talking to me; and remember, my door is always open, ok?

T: 'K.

SC: Alright, well here is a pass to get back to class.

Case Study 8.5: Jasmine, Medical Trauma Patient

Jasmine, a 43-year-old African American woman, has been admitted to the local Level I Trauma Center. Jasmine's reason for hospitalization was listed as pedestrian-struck, indicating she had been struck by a motor vehicle. Further investigation into the medical report indicates that Jasmine had reportedly been outside a local restaurant and she was arguing with another individual when she stepped off the curb of the sidewalk right into the street. At the same time, a car was passing by at a high rate of speed and struck Jasmine in the right leg. Jasmine had to be air lifted to the trauma center. Upon being admitted, Jasmine's blood alcohol level (BAL) was taken as well as her urine drug screen. The results of the tests showed Jasmine's BAL was 0.30, and she tested negative on her urine drug screen. Jasmine was taken immediately to surgery for injuries to her leg and also her pelvis. It is four days later that the counselor is able to meet with Jasmine.

Counselor approaches client's hospital room, and knocks.

C (Counselor): Good afternoon, Jasmine; is it ok if I come in?

J (Jasmine): Sure, come on in; everyone else just barges in here!

C: Yes, you are probably pretty used to people making your room theirs by now.

J: You have no idea . . .

C: Well, thank you for allowing me to come in. My name is Eli, and I am a counselor here at the trauma center. Have you ever talked with a counselor before?

J: You mean like a guidance counselor? Ha, maybe way back when I was in high school.

C: Yes, well counselors do work in a variety of different places, and I work here. Before we get started I wanted to let you know that what we talk about stays between us, unless I'm concerned for a few different reasons. Those would be if you are contemplating suicide or homicide; if I become aware of any abuse toward children, the elderly, or individuals that are unable to care for themselves; or if I am subpoenaed. I also might have to talk to the medical team if there is something I am concerned with about your medical care. Does this all sound OK to you?

J: Wait, you mean besides those things, you won't go run your mouth to my nurse?

C: That is correct.

J: Hmm, sounds great; everyone is so nosey around here!

C: It sounds like people have really been interested in getting to know you.

J: Yes, but it's not just me, I have learned about all of the drama going on between all of the staff here—some people just like to hear themselves talk!

C: It sounds like you have just fit in perfectly around here; people feel really comfortable talking to you.

J: Yeah, I've always been told I'm a good listener. I guess that's what happens when you have five younger siblings.

C: That sounds like a lot of responsibility.

J: Oh, you have no idea. So, what are you here for?

C: I am here because I go around and talk with all the patients here about their injury. Do you mind telling me about the night you were brought here?

J: Well, from what I remember, because it is all a little fuzzy, I was arguing with my boo, and walked out of the restaurant and boom! Here I am.

C: You remember being out and getting into an argument then waking up here. You mentioned your memory is a little fuzzy.

J: Yeah, I think they gave me a lot of drugs in the helicopter and then I had surgery. Whew!

C: Your body has gone through a lot in the past few days, more than usual. Have you ever been injured before?

J: Not like this! I mean, the worst I have ever been hurt is a broken wrist, and that was back in high school when I played basketball.

C: So this experience sounds like it is completely new to you!

J: And I never want to go through this again.

C: We want to help avoid that too. Another part of what I do with patients here is talk to them about their alcohol use. I know you said your memory was fuzzy that night, and I was wondering if we could talk about your drinking the other night?

J: You got me! Yeah, I had a few glasses of wine, I mean, it wasn't much, but yes, I was drinking.

C: Could I go ahead and ask you some questions about your drinking?

J: Sure, shoot . . .

[The counselor proceeds to conduct the AUDIT screening tool (reviewed in Chapter 6) with Jasmine.]

C: Thanks for going through all of those questions with me, Jasmine. Have you ever been asked any questions like that before?

J: Nope, first time for that.

C: OK, well, let me explain these questions. All of these questions give me a number anywhere from zero, which is someone who doesn't drink alcohol, to a 40, which is someone who would be answering "every day" to most of those questions I asked you. This then is like a scale of risk, from 0–40. Where do you think your score is, considering risk associated with your drinking?

J: Umm, risk? What do you mean?

C: Well, some of those questions asked about risk, about injury, about missing out on responsibilities, or not being able to stop drinking once you started.

J: Hmm . . . umm, I'd say probably like a 9.

C: And what led you to say 9 and not 10.

J: 10 just feels like a bigger deal, and I'm not that bad. But I do see there is some risk when I drink, like we talked about when I wish I could have taken back what I said to my friend after New Year's last year. I really regret that and don't think it would have happened if I wasn't so drunk.

C: For you, you recognize that your drinking does suggest some risk, but that you feel comfortable it has not gotten out of hand.

J: Yes.

C: This tool also has cut-off scores for us to use, and I'm curious what your reaction is if I told you that a score of 4 or more for a woman your age is when we start to become concerned.

J: 4? Is that a joke? I feel like that would be so easy to get!

C: It sounds silly to you that the number is so low.

J: Yes! I mean, come on!

C: Well, that is true that the number is low, and part of that is we have learned that alcohol has a lot more risk than we used to think. But in terms of your number, you weren't too far away from your actual score, which was a 13.

J: Dang, I'm over 10!

C: You are over 10.

J: Are you sure you calculated that right?

C: You're concerned I added the numbers wrong. It sounds like this is hard to believe that your number would be that high.

J: Yes, like I said, I know there is a little risk, but a 13?

C: I wonder what a 13 looks like to you.

J: Well, a 13 is someone who is always getting in arguments with her family, is never going to work, or doesn't even have a job.

C: And that is very different from you.

J: Yes, I always go to work!

C: You are proud of your work ethic.

J: Of course I am.

C: I wonder about the other part of your 13 definition though, the arguments part.

J: Well, OK, that I might be able to see a bit.

C: During the screening, you told me that you regretted getting into a fight with your best friend last New Year's. And earlier you mentioned getting into a fight with your boo right before you ended up on your way here.

J: I know I have a loud mouth, and when I drink it is like my filter is turned off!

C: That sounds like something you don't like about your drinking.

J: Absolutely not! I would never say half of the stuff I say when I am drinking but it just comes out, and then you can't get those words back.

C: Jasmine, this makes complete sense. Did you know that the first thing alcohol does in our brains is lower our inhibitions. This means that we end up doing things we normally wouldn't do when we are sober. That sounds just like what you are describing.

J: Yes! Ugh, I really hate that.

C: That is something you dislike about your drinking; is there anything else you dislike about drinking alcohol?

J: Well, the hangovers—who likes those?

C: True, normally that is a big disadvantage to drinking. How often do you have a hangover?

J: Well, like a "can't-get-out-of-bed-or-move" one is like only once a month, but I do get headaches pretty regularly.

C: And what happens during those hangovers?

J: I just lay there and think about how I shouldn't have had as much as I did, and how much I hate feeling like that.

C: Regret is a common feeling on those days for you.

J: Yes!

C: Jasmine, I wonder if you have ever thought of cutting down on your drinking?

J: You mean stopping drinking? What would I do with my time?

C: Stopping all together sounds unreasonable for you. What about just cutting back?

J: Oh, umm, well yeah, of course I can do that. I guess I've just never tried to before; I didn't have a reason.

C: And now, you'll have a reason?

J: Well, for one, I don't think I'll be going out much with a broken hip! And I am guessing I'll be on some heavy medicine when I leave and I never drink while taking prescription medicine.

C: That is an important rule for you.

J: Yes, I have heard nightmare stories about people blacking out and not even knowing what happens to them, and I do not want that to be me.

C: You're very clear about that rule.

J: Absolutely!

C: In the coming few weeks it sounds like your drinking is going to change as a result of this accident, but I'm wondering if you see how your drinking contributed to you ending up here.

J: Well, if we just follow the series of events, if I wasn't drinking so much I wouldn't have started that argument, which means I wouldn't have gone outside to get away from him and then boom, no broken hip!

C: Now you recognize that your drinking may have helped get you in here. I only ask because before on that questionnaire, you said you hadn't ever been hurt as a result of your drinking.

J: Hmm, well I guess I didn't think of it like I did now since we've been talking, like about the arguments and stuff.

C: So being able to talk with me helped you see this situation a little differently.

J: Yes, and ugh, if only I could have just kept my mouth shut!

C: And in the future, if you monitor your drinking more carefully you may find your mouth stays shut more easily.

J: True, that is a plus!

C: On a scale from 1 to 10, with 1 representing not committed and 10 representing a full commitment, how committed are you to making a change with your drinking?

J: I'd say probably a 7.

C: Wow, a 7! What made you say 7 and not a 6?

J: I mean I'm not a 10, no way, but I see the need, and can definitely see myself making some changes, and 6 in school would be 60%, which is failing!

C: It is important for you to pass, just like it is important to stick to your no drinking while on medication rule.

J: Yes, exactly.

C: Well, Jasmine, just one last question. You've talked about being committed to making a change, and you are clear about that, but I'm wondering what that change will actually look like for you.

J: Hmm, umm, I guess I just see myself only having one or two glasses of wine, instead of the three or four I usually have.

C: You can envision sticking to one or two glasses. What would make you not stick to that?

J: Well, the bartender always just pours up my glass! That would make this tricky.

C: I wonder if you could talk to the bartender before you begin drinking, and explain your two-glass rule. What would that be like?

J: Yeah, I mean, I know all of the bartenders there! I don't think that'd be a problem at all, and it works out better for them not having to give away free booze.

C: It sounds like all of what we talked about is possible for you, and you are committed to living a healthier life.

J: Yes, I mean, I'm no spring chicken anymore, and I want this to be the last trip to the hospital for a *long* time!

C: Well, Jasmine, thank you for taking the time to talk to me. I hope our paths don't cross like this again.

J: Me too—thank you though! Have a good day.

Experiential Skills Learning Activity

Choose one of the five case studies presented throughout this chapter to practice a brief intervention with a role-play client. Pair up with a classmate and have one role-play the counselor and the other role-play either Selma's, James's, Lily's, Tommy's, or Jasmine's case. After the role-play, discuss with one another the experience. As the counselor, reflect on what you wish you would have said, what you wish you would have known to tell the client, and what you would do differently next time. All of these questions are important for reflection to help you feel more confident in your abilities in the future. As the client, reflect on your overall feeling during the exercise. Did you feel respected and invited to be a part of the process? If not, share with your partner what may have helped you feel that way.

This chapter covered an introduction to brief interventions. We discussed the historical origins of the interventions, and discussed common models of brief interventions.

In addition, we discussed the evidence base of brief interventions in the medical setting as well as university setting and provided case studies for review. Chapter 9 will expand our discussion attending to brief interventions in the legal and employer settings.

RESOURCES FOR FURTHER LEARNING

Books and Book Chapters

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Heather, N. (1995). Brief intervention strategies. In R. K. Hester & W. R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (2nd ed., p. 105–122). Boston, MA: Allyn & Bacon.

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Websites

SAMHSA SBIRT Resources

http://www.integration.samhsa.gov/resource/sbirt-resource-page

Brief Intervention Training Videos, Boston University School of Public Health

http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/

International Network on Brief Interventions for Alcohol & Other Drugs (INEBRIA)

http://inebria.net/

Rethinking Drinking: Alcohol and Your Health, National Institute on Alcohol Abuse and Alcoholism

http://rethinkingdrinking.niaaa.nih.gov

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