Brief interventions for problem drinking among hospital patients

Emmen, M.J.

Citation for published version (APA):
The Motivational Drinker’s Check-Up:

a brief intervention for early stage problem drinkers

Maria J Emmen¹, Gerard M Schippers¹, Gijs Bleijenberg², Hub Wollersheim³

¹Amsterdam Institute for Addiction Research, Amsterdam, the Netherlands
²Expert Centre for Chronic Fatigue and ³Centre for Quality of Care Research
University Medical Centre St Radboud, Nijmegen, the Netherlands

ABSTRACT

Brief interventions can reduce alcohol consumption and problems for early-stage problem drinkers. Brief motivational interventions are a subcategory of brief alcohol interventions, which aim mainly to increase the awareness of alcohol problems and enhance the motivation to change. The Motivational Drinker’s Check-Up is an example of a brief motivational intervention, which consists of an assessment session followed by a feedback session. The assessment tests are selected to detect early manifestations of alcohol-related impairment. Shortly after the assessment, the drinker returns for the second session, which consists of personalized feedback of the assessment results. The preferred style for the feedback session is motivational interviewing, a directive, client-centred style which elicits behaviour change by helping the client to explore and resolve ambivalence, and applies stage specific strategies according to the stages of change model. This chapter presents the Dutch Motivational Drinker’s Check-Up (DVA), an adaptation of Miller’s original Drinker’s Check-Up (DCU), which is shorter, more compact and follows a manual. The components of the Dutch Motivational Drinker’s Check-Up (DVA) are described and illustrated by a case example. The chapter also presents evidence for the effectiveness of the Motivational Drinker’s Check-Up and discusses implementation issues. It is concluded that the Motivational Drinker’s Check-Up is a feasible and effective early intervention for problem drinkers that can be applied in a variety of health-care facilities.
INTRODUCTION

Across a diversity of cultural settings, clinical research teams have demonstrated that relatively brief interventions can have significant beneficial effects in reducing alcohol consumption and problems. They involve less time than the usual intensive treatment and can be delivered by professionals other than specialists in substance abuse. Brief interventions can be used both to impact drinking behaviour directly and facilitate referral to more intensive treatments. Most brief interventions aim for moderate or harm-free drinking rather than total abstinence. Target groups for brief intervention are hazardous drinkers who drink in excess of guidelines for safe drinking, problem drinkers with low or moderate dependence, and high-dependence problem drinkers who are not reached by conventional treatment services. From the literature, Moyer et al.\(^1\) and Miller and Wilbourne\(^2\) concluded that brief interventions for alcohol problems are significantly more effective than no treatment, and are often as effective as more extensive treatments. According to Heather, brief interventions are not a type of treatment, but a category of interventions that are restricted to one to four or more sessions of assessment, advice, and optional counselling with educational components, often supported by self-help manuals or other forms of bibliotherapy.\(^3\) Interventions of more than one session include a follow-up, which is aimed at repeating the advice given during the feedback session and monitoring the progress that was made subsequently. One-session interventions are referred to as minimal interventions. The advice may be based on feedback on an individual’s risk status, and may include setting a goal for moderate drinking or to accept referral for additional help. Most brief interventions emphasize the personal responsibilities of the drinkers, aim at enhancing their self-efficacy, and stress the importance of the counsellor’s empathy.\(^4\) A subcategory of brief interventions, called brief motivational interventions, aim mainly to increase the awareness of alcohol problems and enhance the motivation to change. An example is the Motivational Drinker’s Check-Up, originated by Miller and colleagues as the DCU.\(^5,6\) This chapter describes this intervention and discusses its effectiveness. It presents a manual-guided version developed in the Netherlands: the Dutch Motivational Drinker’s Check-Up.\(^7\)

BRIEF MOTIVATIONAL INTERVENTIONS FOR PEOPLE WITH ALCOHOL PROBLEMS

Miller and Rollnick suggested that the primary impact of brief interventions is on motivation for change and that once such motivation has been impacted, individuals may proceed to change their behaviour with minimal assistance.\(^8\) The often observed evidence in favour of brief treatment over no treatment suggests that brief interventions instigate natural change processes that otherwise would not occur or would be delayed in onset. Miller and Rollnick further suggested that brief interventions contain the critical conditions needed to instigate change in a substantial proportion of the cases seen. The emphasis on the motivational character of brief interventions fits into the transtheoretical perspective proposed by Prochaska and DiClemente.\(^9,10\) They described the process of changing addictive behaviours as moving from early stages of change (precontemplation and
contemplation), through the determination and action stages, where the actual behaviour change takes place, and finally into the maintenance stage, or possibly relapse. According to the stage model, there are active agents in interventions for addictive behaviours: motivational enhancement, self-control empowerment, and relapse prevention. Motivational interventions focus mainly on the first element: enhancing the motivation to change. Because not all people need active assistance in self-controlled behaviour change and the prevention of relapse, motivational enhancement will itself, for some people, function as an effective intervention. Brief motivational interventions can be carried out in different communication styles. Confrontational and directive styles have been used, as described in Walters’ review.\(^8\) Miller and Rollnick, however, recommend a motivational style called motivational interviewing.\(^8,12\) Motivational interviewing is a client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence. The style is distinguished from other approaches by being empathic, non-confrontational, and applying stage-specific strategies. It appraises motivation not as a stable, trait-like characteristic of a client but as the result of an interaction between the drinker and those around him or her. This means that there are things a therapist can do to increase motivation for change. Miller and Rollnick described four broad clinical principles underlying motivational interviewing: expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy.\(^8\)

**The Drinker’s Check-Up**

Miller’s Drinker’s Check-Up (DCU) was derived from a health promotion model for early identification of emerging alcohol-related problems.\(^5,6\) It consists of two hours of assessment that yields several dozen objective indicators of alcohol-related problems, followed by a one-hour feedback session. Miller and co-workers presented the DCU as a check-up for drinkers who wanted to find out whether their drinking was causing them any harm. The DCU was free of charge and not part of any treatment program. It was intended for drinkers in general rather than alcoholics and did not result in labelling or diagnosis. The check-up provides clear, objective, personal feedback with which the drinker may do as he or she pleases.

For the assessment part of the DCU, specific tests were selected for their ability to detect some of the earlier manifestations of alcohol-related impairment. The assessment consisted of:

1. The Brief Drinkers Profile, a structural clinical interview to assess drinking pattern, drinking-related life problems and family history, symptoms of pathological drinking, and levels of alcohol dependence.\(^13\)
2. The Alcohol Use Inventory, a self-report inventory that helps to identify distinct patterns of behaviour, attitudes and symptoms associated with the use and abuse of alcohol.\(^14\)
3. Collateral interviews to confirm clients’ self-reports.\(^15\)
4. A serum-chemistry battery of tests that detect alcohol’s impact on bodily systems.
5. A battery of eight neuropsychological tests sensitive to alcohol’s chronic effects on the brain.\(^16\)

The content of the assessment package is not fixed, however. Other valid measures of alcohol use and its consequences can be included. The instruments are administered in a straightforward, objective, and friendly manner, carefully following the instructions in the test manuals. No interpretation of results is given at the time of the assessment.
Following the assessment, all tests are scored; the serum sample is assayed; and a summary evaluation is prepared. The drinker’s scores on all dimensions are displayed within normative ranges to inform the drinker about his or her position relative to the general population, or to a population of alcohol-impaired individuals.

Within a week of the assessment, the drinker returns for a personalized feedback session. A personal profile of the results measured during the assessment is presented orally, and the client is given a written explanation of the results to take home. A personalized blood alcohol concentration table is also provided. The information is presented as objective data, but the focus is on the client’s own concerns and reactions rather than the counsellor’s interpretations. At the conclusion of the feedback, the drinker’s overall reactions to the information are determined.

The content of the last part of the DCU’s feedback session depends on where the client is in the process of change. Precontemplating clients are not yet considering the possibility of change. They need the information and feedback to raise awareness of the problem and the importance of change. Drinkers enter the contemplation stage when they become aware that there is a problem. This stage is characterized by ambivalence: the contemplator both considers change and rejects it. Often people in this stage are responsive to the DCU. For such clients, personal feedback from the check-up should be emphasized but also information and advice should be offered about the possibilities and desirability of behaviour change with or without help. If the client is in the action or determination stage, he or she is considered to be motivated to change and will take action or return to contemplation. The counsellor’s task with clients in this stage is to help them find a change strategy that is acceptable, appropriate, and effective. Information and advice about the possibility and desirability of professional help are given.

Applications of the DCU
According to its developers, the DCU can be applied in a variety of settings and for several different purposes. Firstly, it can be used as part of routine health-screening procedures in hospitals and medical practices. Secondly, the DCU provides a comprehensive range of information appropriate for use in matching patients with optimal treatment approaches and is also applicable as an assessment procedure for clients, such as drunk driving offenders, who are mandated to receive treatment. Further, the DCU can be advertised to the general public as a method for discovering whether or not one’s drinking is having detrimental effects. Finally, the DCU provides a wealth of individual patient data that can be useful in outcome assessments.

The DCU formed an important element in Motivational Enhancement Therapy (MET), one of the three treatment modalities evaluated in Project MATCH. The four-session intervention did not guide clients through recovery, but employed motivational strategies to mobilize their own change resources. The first session of MET was organized as the DCU feedback session, presenting clients with selected data collected in the Project MATCH research assessment battery. MET is more extensive than the DCU, with three more counselling sessions, and with a significant other usually being involved. MET used a manual for all sessions, and included a Personal Feedback Report, a written statement with feedback data.
Marlatt and colleagues have recently developed BASICS, a motivational module for problem drinking college students.\textsuperscript{20,21} This is an individualized, manual-guided assessment and feedback intervention delivered in two 50-minute sessions, with referral to substance abuse treatment for those requiring services beyond the two sessions. Several studies have demonstrated the effectiveness and efficacy of BASICS with high-risk college students.\textsuperscript{21-24}

**THE DUTCH MOTIVATIONAL DRINKER’S CHECK-UP**

Modelled after the DCU, the Dutch Motivational Drinker’s Check-Up (DVA; Doorlichting, Voorlichting Alcoholgebruik) was developed by Schippers, Brokken, and Otten in 1994.\textsuperscript{7} The DVA differs from the DCU in that the DVA is shorter, more compact, and fully manual-guided. The manual is detailed, and includes three DVA instructional videotapes. The first tape gives instruction on motivational interviewing; the second one gives an overview of the DVA; and the third gives instruction on the DVA feedback procedure. No blood tests are included, as in the original DCU, because psychologists in the Netherlands are not allowed to interpret medical tests. The neurological tests are more selective and finer-tuned than in the original DCU. Feedback is given in the form of bar graphs, comparing the subtest results with each other. Data for the feedback are presented in a Personal Feedback Report. After the DVA face-to-face contacts, the counsellor sends a personal letter to the client, summarizing the results, including the data that had been fed back to the client, the conclusions drawn, and the advice given.

**Protocol of the DVA**

The different elements of the DVA are illustrated here with a case example. For each element, short descriptions of the *assessment phase* and *feedback phase* are presented consecutively.

**Case study: Peter**

Peter is a 50-year-old man. The internist advised him to reduce his alcohol consumption after a consultation for pain in his upper abdomen. He had never sought help for alcohol problems before and was in the early contemplation stage. Because on the hospital ward a counsellor was available who could deliver the intervention, the internist recommended that Peter participate.

The counsellor began with a short introduction:

"I would like to follow a procedure to look at the role that alcohol plays in your life. We will meet two times. The first time we will discuss your drinking behaviour. There are some questionnaires for you to complete, and I would also like to test your skill at certain tasks. During our second appointment, we will discuss the results of the earlier meeting, and you will receive a written report of the results. It is up to you to decide what, if anything, you want to do with the feedback that you are given. Is the procedure clear to you? Do you have any questions? Do you want to take part?"
**Demographic information (Interview)**
The procedure starts with the counsellor’s recording a few of the person’s demographic characteristics, such as gender, age, education, weight, and names of medications taken.

**Alcohol use (Interview)**

*Assessment.* Alcohol use is assessed by several questions concerning the person’s current and past drinking behaviour. The timeline follow-back (TLFB) technique is used to assess quantity, frequency, and location of drinking. Detailed information is first collected about drinking during the prior week. A typical drinking week is also analyzed to establish a representative quantity and frequency of alcohol use. Further questions are asked about highest alcohol consumption ever, periods of excessive drinking in the past, and contacts with treatment services.

*Feedback.* The counsellor discusses with the client the number of standard drinks per week that the person consumes and his or her estimated blood-alcohol levels (BALs). A table is used to illustrate the meaning of BALs. If the client does not experience the effects that normally occur at particular BALs, the phenomenon of tolerance to alcohol can be discussed.

C: You remember that during the assessment part of the DVA we went through a typical week of drinking for you. After the assessment, I added up how much you usually drink in a week. It came out to about 50 standard drinks a week. One “drink” is a standard size glass of beer or wine, or about a 33 millilitre serving of spirits. What do you think about that?
P: It seems like a lot. I never really added it up before, but I don’t think of myself as a heavy drinker.
C: You are surprised.
P: Yes, I didn’t think it would be that much.
C: We also estimated your blood alcohol levels based on your drinking patterns. The estimate is that you reach .25 g/ml. In the table you can see that at this level people usually feel that they are intoxicated.
P: But I don’t ever feel that drunk. How is that possible?
C: It’s common for heavy drinkers not to feel their alcohol like other people do. This is called tolerance. You can have a fairly high blood alcohol level, enough to affect your driving and even to do damage to your internal organs, without feeling intoxicated.
C: Now let’s look at the blood-alcohol level you reach when you drink the heaviest. Your level gets as high as .30 g/ml.

**Family history (Interview)**

*Assessment.* To get an impression of whether the person has a family history of alcohol problems, he or she is asked to describe the father’s, mother’s, and partner’s drinking, by placing each of them into a drinking category. By sorting cards, the client assigns each person to one of the following categories: abstainer, light drinker, moderate drinker, heavy drinker, problem drinker, or alcoholic. To assess genetic risk factors, the client is also asked about alcohol problems in other biological relatives.
Feedback. When none of the family members is described as having had alcohol problems, it can be explained that it is unlikely that the drinking problem is genetically determined. This usually means that heavy drinking patterns did not occur early in life but were acquired later. When there is evidence for alcohol problems in the family, the implications that this might have for the person’s own drinking in the future are discussed.

C: You told me your father had some drinking problems.
P: Yes, he was a real alcoholic, which was terrible for my mom. After he lost his job, he would spend long hours in the pub every day. And sometimes I am afraid I will become like him.
C: How does your drinking seem like your father's?
P: Lately, there have been some times when I was late getting to work, because I was drinking too much the night before. And sometimes I can't concentrate on my work very well.

Drinking styles in the social environment (Interview)

Assessment. The drinker categories are used in two other ways. First, a drinking style is assigned to the person. Second, the categories are used to determine the client's perception of the drinking style that important other people assign to him. Making use of the same Q-sort, clients also choose a drinker category for themselves, and are asked which category the partner, a best friend, and most people who know them would choose.

Feedback. Clients' own perception of their drinking is compared with the imagined perceptions of other people. If there is a discrepancy between the two sets of perceptions, clients might be concealing their drinking from other people, and the meaning of hiding one's drinking can be discussed.

C: You think that your best friend would describe you as drinking less than you actually do. P: Yes, that's right. I would call myself a heavy drinker, but I think my best friend would say that I am a moderate drinker.
C: So your best friend doesn't know how much you drink?
P: No, he knows I like to drink beer, but most of the time he is not there when I am drinking.

Structured diagnostic interview for alcohol dependence (DSM-IV)

Assessment. With this semi-structured diagnostic interview, the diagnosis of alcohol abuse and alcohol dependence according to the DSM-IV criteria, can be established. Alcohol abuse is described as a destructive pattern of alcohol use, leading to significant social, occupational, or medical impairment. Important criteria for the diagnosis of alcohol dependence are: alcohol tolerance (the need for increased amounts of alcohol to achieve intoxication or diminished effects with continued use of the same amount of alcohol), alcohol withdrawal symptoms (such as sweating, rapid pulse, increased hand tremor, and insomnia), and loss of control over or preoccupation with drinking.

Feedback. Feedback about having or not having a diagnosis of alcohol abuse or dependence can easily be experienced as a demotivating form of labelling. In some cases, however, it can have a
motivating effect. In cases where the client is seriously wondering whether or not he or she is an alcoholic or in cases where such a diagnosis has been made, an open discussion with concrete answers given non-judgmentally can be reassuring.

**Alcohol-related problems and consequences (Q-Sort)**

Assessment. Information is gathered about current life problems by having the client sort 18 cards depicting a variety of these problems. The clients select those cards with life problems that pertain to them, and rank these cards in terms of their importance. The influence of alcohol use on the selected and ranked life problems is identified. For each alcohol-related life problem, the client is asked if drinking alcohol preceded or followed the life problem, or both.

Feedback. In the feedback session, current life problems and their possible relationship to drinking alcohol are discussed. For each of the problems, whether alcohol-related or not, the client is asked about any prior sources of help, professional or otherwise. The counsellor then assesses whether the help was adequate. For unresolved mental health problems in particular, clients are advised to visit a professional counsellor.

C: You mentioned different problems that are occurring in your life. The problem that concerns you most is your physical health, especially the problems with your stomach.

P: Yes, I'm really worried about my stomach. Sometimes the pain is unbearable.

C: You also told me a week ago that the stomach problems are related to your drinking. Can you tell me more about it?

P: Sometimes when my stomach is hurting so badly, I take a drink to relieve the pain.

C: Does it give you relief?

P: Yes, at first but after a while the pain comes back even worse than before.

C: So the drink can relieve the pain in the short-term, but in the long-term it makes the problem worse?

P: Yes, I'm afraid that's right.

C: What conclusion would you draw from this?

P: Drinking seems to be bad for my stomach.

**Neuropsychological tests**

Assessment. Feedback of impairment in neuropsychological functioning that is possibly or probably related to excessive alcohol use can provide a potent motivational boost, because such information is new to the person and not available from his or her ordinary daily experiences. In the DCU Miller, Sovereign and Krege used the Wechsler Adult Intelligence Scale (WAIS) and subtests of the Halstad-Reitan to assess neuropsychological functioning. The selection of these tests was based on a review of the literature on neuropsychological impairment and brain damage in alcohol-dependent patients as assessed by different psychological tests. Miller and Saucedo sought to find combinations of tests of neuropsychological functioning that would reflect excessive alcohol use. They wanted to compile a test battery comprising pairs of subtests, one of which was alcohol-sensitive and the other alcohol-insensitive. Alcohol-sensitive subtests were defined as those on
which people with alcohol dependence score lower than comparable non-alcohol-dependent people. Alcohol-insensitive subtests were those unaffected by alcohol use.

For the DVA, an updated selection of such tests was made using data from Dutch patients. Existing test results were reviewed from a total of 359 patients with a primary diagnosis of alcohol dependence. The information included demographic characteristics, drinking history, and scores from a variety of tests for which normative scores on non-alcoholic populations were also available. The tests included the WAIS (Dutch version), Trail Making Test (subtest of the Halstad Reitan; Dutch version), and the Stroop Color-Word Test (which tests concentration and attention; Dutch version). Three pairs of subtests were identified as appropriate for use in the DVA, because alcoholics perform differently on these subtests from non-alcoholics, i.e., on one subtest from each set alcoholics matched for age and gender perform the same as non-alcoholic normative samples, whereas on the other subtest alcoholics perform markedly lower than normative groups. The groups of subtests administered to the clients were the Similarities (alcohol-insensitive) and Digit Symbol (alcohol-sensitive) portions of the WAIS; Part A (alcohol-insensitive) and Part B (alcohol-sensitive) of the Trail Making Test; and the colour-congruent (alcohol-insensitive) and colour-incongruent (alcohol-sensitive) cards from the Stroop Color-Word Test. Scores on these subtests range from 0 to 10, corresponding to the 0 to 100 percentiles.

Feedback. The client is told that his or her drinking could influence the scores on the tests administered. Damaging effects of alcohol may be seen in the person’s cognitive abilities, and can be measured by psychological tests. Clients are shown bar graphs representing their scores on the alcohol insensitive and alcohol sensitive tests. It is explained that the scores are presented in relationship to scores of people of the same age and gender from the general population, and that a score “5” means average performance. A low score on any one of the tests does not necessarily give cause for concern, because there can be many reasons for a particular individual’s low score. However, if there is a clear pattern of low scores (i.e., most or all of the alcohol sensitive scores are lower than the non-sensitive ones), it is emphasized that the low scores probably result from the person’s drinking. On the other hand, in cases where there is no evidence for alcohol-related impairment, the client is reassured accordingly. In any case, the counsellor emphasizes that the tests are not a full neuropsychological assessment. Further, the counsellor explains that impairment, when found, might very well be reversible. If the client were to quit drinking, for example, the neuropsychological functioning would likely improve. However, the longer and the greater the quantity of drinking has been, the greater the chance of cognitive impairment, and the slower the improvement will be.

C: Here you can see that your scores on the alcohol sensitive tests are lower than on the alcohol insensitive tests. That could mean that alcohol has affected your brain and especially your mental ability and concentration.

P: You mean that drinking alcohol has already destroyed some part of my brain?

C: Well, it seems that there is some impairment, indeed. We cannot say for sure from these few tests that it was caused by alcohol, but the possibility cannot be ruled out either.
Knowledge about alcohol (Questionnaire)

Assessment. A knowledge-about-alcohol test is administered that was developed in the Netherlands. The 17-item true-false questionnaire measures clients’ knowledge about alcohol and its effects. Examples of items are: Alcohol increases the body’s temperature. Drinking coffee decreases the effects of alcohol on the body. Regularly drinking alcohol causes brain damage. Clients choose from three answers: “true”, “false”, or “don’t know”. The questionnaire ends with an open-ended question about the legal blood-alcohol level for driving.

Feedback. The client is informed about the number of correct answers. Items that were answered incorrectly are discussed, and the correct answers explained. The client is then given a take-away information booklet with all the questions, correct answers, and an explanation for each of them. Although no normative scores are available for this test, experience shows that most clients know the correct answer to 12 or more of the items.

Drinking and craving situations (Questionnaire)

Assessment. Clients are administered the Dutch Drinking Habit Scale (SVD; Schaal Voor Drinkgewoonten). Walburg and Van Emst modelled this test after the Inventory of Drinking Situations (IDS). For six kinds of situations, clients rate on a five-point Likert scale how much craving they experience and how often they drink while experiencing unpleasant emotions, while feeling embarrassed, while experiencing unpleasant physical sensations, in high-risk and non-high-risk drinking situations, and during social interactions.

Feedback. The counsellor first discusses the situations in which the client does and does not usually drink, and then characterizes the situations in which the client often drinks.

C: I would like to give you some feedback on your drinking habits. You don’t drink in all situations. In some situations, such as being in a pub, with friends, or at parties, you usually drink, but when you feel guilty, depressed, or alone you almost never drink. Correct?

P: Yes.

C: When you are with friends you often drink, but is that always the case?

P: Most of the time it is, but not always. One of my friends has a liver disease. When I am with him, I don’t drink. I know he likes alcohol very much, but is not allowed to drink anymore, and I don’t want him to see me drinking.

C: Can you give examples of other situations in which you are with friends and you don’t drink?

P: Yes, when I have a football game the next day. I know that I play really awful if I drank the day before.

C: So you can also have a good time with friends without drinking alcohol?

Further the counsellor compares the client’s degree of craving in the different situations with the frequency of drinking in them. Habitual drinking without craving or craving without drinking can be pointed out.
C: In situations where people can feel embarrassed about something, you seem to crave a drink, but you don’t actually drink.

P: Yes, that’s true. For example, when I feel guilty about not being nice to my wife. I really want a drink, but I know if I drink I will feel even more guilty. I would do better to do something nice for my wife.

C: So when you crave a drink, you can resist it.

Finally, the counsellor asks the client how he or she would interpret the results.

C: We discussed situations in which you usually drink and those in which you don’t drink. You often drink during holidays or when you are in a pub or with friends. You also told me that being with friends does not always mean drinking alcohol. Although your craving is high in situations where you feel embarrassed about something, you don’t drink in these situations. What does this information mean to you?

P: Maybe I don’t need alcohol as much as I thought. I can resist the urge to drink when I feel embarrassed. I also enjoy spending time with friends without drinking.

**Self-evaluation questionnaire**

*Assessment.* The Self-Evaluation Questionnaire is a Dutch modification of Appel and Miller’s Self-Evaluation of Drinking Questionnaire. Clients complete the self-evaluation by answering 14 questions on a five-point scale about perceived consequences of drinking on different life areas. Each consequence is illustrated with a short text elaborating the topic.

*Feedback.* Clients’ answers on the Self-Evaluation Questionnaire are represented in a decisional balance sheet. Systematically evaluating the positive and negative effects of alcohol on all life areas can help the client clarify the relative effects of drinking in the different areas.

C: Your answers about perceived consequences of drinking are shown in this balance sheet. This side of the sheet represents the benefits of drinking, and that side the disadvantages. Here you can see that alcohol seems to benefit your mood and social life. On the other side, you can see that alcohol has negative consequences for your physical health and mental functioning.

P: Yes, that’s the problem. I am used to drinking with my wife and friends and to have a good time, but I know that drinking is not good for my body.

C: For you, drinking means having a good time, but you are also concerned about your health.

The last question on the Self-Evaluation Questionnaire concerns the client’s motivation to reduce the drinking. The person’s answer to this question is used to discuss the pros and cons of reducing or stopping. If clients are not interested in cutting down, they are asked about their reluctance. If they do want to cut down, they are asked the reasons for wanting to.

C: On the question about the importance of reducing your drinking, you answered that it is very important for you to cut down. Can you say more about this?
P: I think that I have to change my drinking, especially for my health. I know that drinking alcohol is bad for my stomach. The doctor said so. Besides, I know now that drinking might have already destroyed some of my brain cells. I don't like that at all.

C: To take care of your stomach and brain, you would like to reduce your drinking. Are there other reasons for reducing it?

P: Yes, I am also afraid of becoming like my father who was a real alcoholic.

Conclusions, information about options for support, and advice
After discussing the assessment results, the last part of the feedback session is devoted to conclusions, giving information about support, and advice. Strict rules for this part of the intervention are not followed, because the content will depend on the information from the assessment and the client's reactions to it. Nevertheless, it is important to follow the order conclusions, information on options for support, and advice. The counsellor gives no information and advice before the client has drawn conclusions from the results of the DVA. Advice to change is not provided until information about options for support is given, if this is necessary. In this way, the client is maximally motivated to self-interpret the results presented, to consider the desirability of change, and to present self-committing statements for future change.

Conclusions
Generally, a good way to prompt clients to draw their conclusions from the results is to ask their overall reactions to the whole procedure.

C: We've covered a lot of ground. I wonder what you think about all these results?

At this point, the counsellor asks the clients what the results mean to them, if it changed their way of thinking about drinking, if they think change is important, if they would like to change something, and if so, what, and over what period of time. If clients are resistant to change or still wonder if change is necessary, their doubts will be reflected back to them. To draw a conclusion from the results does not necessarily mean making a decision to change. The counsellor summarizes clients’ conclusions to confirm that they were understood.

Information about options for support
Whether or not information about options for support is provided depends on what clients need and want. Accordingly, the counsellor should be familiar with all available and appropriate professional and non-professional treatment resources and self-help programs. The counsellor should describe the available options in a way that is understandable to clients. The counsellor needs to be able to evaluate whether clients’ unwillingness to accept help is due to their lack of knowledge about treatment possibilities, practical barriers like cost or transportation issues, or simply resistance to accept help. Furthermore, the counsellor should be prepared to answer questions about controlled drinking.
P: Maybe drinking is not so good for my health. I am damaging my stomach and brain and I want to stop that.

C: What would you like to do to stop damaging your stomach and brain?

P: I don’t know. I would like to cut down my drinking, but I am afraid I cannot do that by myself. Do you know how I could do that?

C: I can tell you about different kinds of help, but I cannot decide what you need. You have to decide that for yourself. May I give you some information about different kinds of help?

Advice

If the client is unable to draw a conclusion from the DVA results or is still precontemplating changing his or her drinking, the counsellor does not give advice about change. Rather, the client is encouraged to take the time to consider the DVA results and later to draw a conclusion from them. However, often clients want advice about the need to change their drinking and how they can accomplish it. Counsellors offer the best advice they can, based on the information from the DVA. They can advise about drinking limits, changing drinking with or without treatment, and about the kinds of treatment. Of course, the advice should be consistent with the client’s needs, preference, treatment experiences, and readiness to accept help. If a client is ready to change his or her drinking commitment to a plan for change is elicited.

P: You told me about different kinds of help. I am certain that I don’t want to go to a clinic for alcoholics because my problem isn’t that big. But I really don’t know what kind of help will be best for me. What would you advise?

C: It is difficult to say what approach is best for you. But we can talk about the options that appeal to you, and I will try to help you find the approach that is right for you.

Closing the session and follow-up letter

At the end of the feedback session, the counsellor summarizes the most important findings on assessment results, the clients’ conclusions about the need for and willingness to change, and change options. The client is given the opportunity to correct the counsellor’s conclusions. The counsellor indicates that the client will receive a personal letter with the summary and offers the client the Personal Feedback Report with the assessment results. The counsellor closes the feedback session by wishing the client success in reaching the goals selected.

As soon as possible after the last contact, the counsellor sends the personal letter to the client. Points discussed in the letter include the risks and problems that the assessment revealed and the client’s own reaction to the feedback, including self-motivational statements that the client may have made. Additional points to cover include the person’s need for and willingness to change and accept professional or non-professional help, and concrete decisions that were reached about when the change would be made.
Example
In your typical drinking week that we discussed, you drank 50 beers. You usually drink when you are in the pub with your friends or at parties. You experience problems with your health and mental functioning. You have stomach pain and problems concentrating on your work. Both of these problems are related to your alcohol use. Alcohol can relieve the stomach pain for a short time, but the long-term effects of the drinking are to make the pain worse. You also think that your alcohol use affects your ability to concentrate, which is also shown in the results of the neuropsychological tests that you took. You are afraid that you are becoming more and more like your father who had severe alcohol problems and lost his job as a result of them. The pain in your stomach, problems with concentrating, and your fear that you are getting the same alcohol problems as your father are all reasons for you to reduce your drinking. You don’t think you can reduce your drinking by yourself, and you prefer some kind of help. We discussed different treatment possibilities. Because you mostly drink when you are with your friends and at parties, it is important for you to learn to say “no” in these situations when someone offers you drink of alcohol. As we decided, it would be good for you to take a course to learn assertiveness skills.

Administering the DVA
The DVA can be given at the request of a referring professional. In such cases, the referring person is usually informed of the results of the DVA. The information could be limited to the fact that the client was seen on the two occasions. Usually, however, it is desirable also to give information about the conclusions that were drawn. This information could be given verbally, or by sending the referring person a copy of the letter sent to the client. Users of the DVA have had good experiences with referrals from a department of internal medicine at a general hospital, where the physicians regularly refer clients with probable alcohol problems. In this case, the written DVA conclusions are sent to the patient and the medical specialist, and are added to the patient’s medical record.

EFFECTIVENESS OF THE MOTIVATIONAL DRINKER’S CHECK-UP

Empirical evidence for the effectiveness of the DCU
Miller, Sovereign, and Krege first evaluated the DCU in a study of 42 problem drinkers recruited through media advertisements. These problem drinkers were randomized to receive an immediate or delayed DCU. In the immediate DCU group, both alcohol consumption and peak intoxication were significantly reduced from baseline at both the six-weeks and 18-month follow-ups. While the delayed group waited to receive the DCU, they showed no change in their drinking. After receiving it, they too showed a significant reduction in alcohol consumption and peak levels of intoxication. Family members and other collateral informants verified the self-reported changes in both groups. Across both groups, 14% had sought help for their alcohol problems within six weeks after feedback, and 33% had done so within 18 months of having the DCU.

Miller, Benefield, and Tonigan replicated the findings of the first study. They assigned 42 problem drinkers randomly to three groups: immediate DCU with directive confrontational
counselling, immediate DCU with client centred counselling or delayed DCU. Participants receiving the immediate DCU demonstrated significantly less weekly alcohol consumption, lower peak blood-alcohol levels, and fewer drinking days relative to the delayed DCU group at a six-week and 12-month follow-up. Analysis of therapist style indicated that the directive confrontational counselling style evoked significantly more client resistance behaviour like arguing, ignoring and interrupting which in turn predicted poorer drinking outcomes.

Two other studies were conducted in treatment settings. Patients being admitted to a residential substance-abuse program were randomly assigned to receive or not receive a DCU prior to treatment. Therapists in the residential program who were unaware of patients' group assignment perceived patients who had received the DCU to be more motivated and involved during treatment than the patients who had not received it. Moreover, the patients who had received the DCU showed significantly lower alcohol consumption than the other patients three months after discharge.

Bien, Miller and Boroughs, using the same design with severely alcohol-impaired outpatients in a Veteran Affairs Medical Centre, reported similar findings. A three-month follow-up analysis using a composite drinking measure (total consumption, peak blood-alcohol level, and days abstinent) for the prior 30 days showed significantly lower values for the DCU than the control group.

Miller et al. developed MET, with the DCU as an integral part, for Project MATCH, a multi-site clinical trial designed to test a series of a priori hypotheses on how patient-treatment interactions relate to outcome. Clients were recruited from outpatient settings or from aftercare settings and randomized to MET, Cognitive Behavioural Therapy (CBT), or Twelve-Step Facilitation (TSF). All clients achieved significant improvements in drinking outcomes (percent days abstinent and drinks per drinking day) during a one-year post-treatment period, but there was little difference in outcomes across the types of treatment. Four sessions of MET produced similar drinking outcomes to twelve sessions of each of the other treatments. For outpatients, these results were sustained over a three-year follow-up period. Probably in accordance with the accepting nature of MET, clients receiving it who were high in anger had better drinking outcomes at both one-year and three-year follow-ups than those receiving either of the other two treatments.

Empirical evidence for the effectiveness of the DVA
The DVA has been evaluated in several different settings. First, in an outpatient alcohol and drug treatment centre, 35 patients given the standard intake procedure were compared with 20 patients given the DVA at intake. At six-month follow-up, significantly more of the DVA patients accepted and received alcohol treatment, although there was no difference between the two groups in the amount of drinking. The same design was used on a psychiatric ward of a general hospital. Twenty patients with primary or secondary diagnosis of alcohol abuse or dependence who received the DVA were compared with 12 patients with the same diagnosis who received care as usual. Patients receiving the DVA accepted and received alcohol treatment more often than those not receiving it. Again, there was no difference between the two groups in the amount that they drank.
IMPLEMENTING THE MOTIVATIONAL DRINKER’S CHECK-UP

Over the years we have learned that implementing the Motivational Drinker’s Check-Up in general and specialized health care is not an easy task. One of the obstacles is to convey the potential value of the procedure to health-care professionals. One reason for the difficulty is that the procedure does not readily fit into the familiar categories of either a complete diagnostic instrument or a complete treatment technique. Further, questions arise about whether the Motivational Drinker's Check-Up should be used within general health care or specialized addiction treatment. Another obstacle is that applying the Motivational Drinker’s Check-Up requires special skills for which special training is needed. Although the procedure could be appropriate to use as opportunistic intervention in general health care settings, most health-care providers lack the necessary counselling skills to use it properly. Professional supervision is necessary for the non-moralizing attitude that must be assumed. In addiction treatment centres, the providers of care usually do have the counselling skills needed, and it is sometimes difficult to convince them that the intervention is intense enough for their clientele.

In the Netherlands, the Motivational Drinker’s Check-Up has also been more readily accepted in other than health care settings: for example, in Employee Assistance Programs. Because the DVA is both a structured and a brief intervention, it is appropriate for use in the workplace to identify problem drinkers and motivate them to start a change process. In companies, the focus with persons with alcohol problems has been primarily on referral rather than on intervention. The possibility to deal on-site with some employees has advantages. It is easier to motivate employees to participate in the DVA than to refer them for a full treatment. In employee assistance programs, collaboration between the medical officer (who administers the DVA) and an off-site counsellor (who delivers the treatment) works quite well.

THE MOTIVATIONAL DRINKER’S CHECK-UP AND SYSTEMATIC MOTIVATIONAL COUNSELLING

How is the Motivational Drinker’s Check-Up related to Systematic Motivational Counselling? When used with alcohol abusers, the first session of SMC resembles the Motivational Drinker’s Check-Up. In this session, both techniques attempt to establish why drinking alcohol has a high incentive value for the drinker. Going beyond the Motivational Drinker’s Check-Up, however, the SMC assesses which non-chemical incentives in people’s lives might motivate them to bring about affective changes by drinking alcohol. The SMC is a more extensive procedure for assessing and modifying the drinker’s motivational structure than the Motivational Drinker's Check-Up. The SMC is broader in scope and based upon an explicit theoretical model.

In a sense, the SMC begins where the Motivational Drinker’s Check-Up ends. SMC offers a technique to enhance motivation to change among people who have already decided they wanted to change their drinking. It does so by framing the drinking behaviour within the person’s broader motivational structure. In contrast, the Motivational Drinker’s Check-Up is a pragmatic technique
for use during early phases of problem identification, more in the context of opportunistic interventions.

In treatment settings, the Motivational Drinker's Check-Up could also be used after SMC. That is, if a client undergoing SMC discovered that drinking alcohol played an important role in the larger network of his or her goals and motivations, that role could be explored further with the problem-focused Motivational Drinker’s Check-Up.

CONCLUSIONS

The Motivational Drinker’s Check-Up is a structured brief intervention based on constructive-confrontational feedback of personalized information about drinking and drinking-related problems using motivational interviewing. Evidence suggests that it is a feasible and effective early intervention for problem drinkers. Although the number of studies evaluating it is still small, the available results support the effectiveness of the Motivational Drinker's Check-Up. Although progress of the Motivational Drinker’s Check-Up has been slow, the procedure has found its way into a growing number of health-care facilities, where it is seen as an important addition to existing ways of addressing alcohol problems in society. When pleas for reform of the existing system for treating alcohol problems are voiced loudly, ready-made, harm-reduction modules like the Motivational Drinker’s Check-Up are highly welcomed.

REFERENCES

