Early Intervention Strategies for High-Risk Alcohol Use:

Montana Primary Care Association | AUD Webinar Series, Part 2 of 4

Tuesday, September 8, 2026 | 12:00-1:00 pm MDT

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406 Recovery | Montana nonprofit
Host: Montana Primary Care Association

Series: 9/1 screening & diagnosis / 9/8 early intervention / 9/22 outpatient detox & treatment / 9/29 pregnant/postpartum

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Disclosures

Employment

-406 Recovery (Montana nonprofit) - CEO and co-founder.

-Consultant w/ Community Medical Services and MPCA

Off-label / products

None expected. This session does not cover pharmacotherapy, compounding, or product promotion. Educational, not promotional.

Public role: 406recovery.care/our-team/robert-g-sise/ | No One Point Care affiliation on this activity. | FDA/FTC: no medication efficacy claims in this session.

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Learning objectives

By the end of this session, participants can:

1

Match the response to the screen, diagnostic assessment, and safety picture

2

Conduct a focused brief intervention using motivational interviewing skills

3

Offer harm-reduction and psychosocial options that fit the patient's goals and risk

CLINICAL BOUNDARY

Recognize when withdrawal risk or acute safety concerns require medical/psychiatric evaluation take place before counseling about drinking goals.

3

Where early intervention fits

Early intervention follows screening and assessment. It is one part of a larger clinical response.

Positive screen

Risky or heavy drinking identified

→

Assessment

Pattern, consequences, AUD symptoms, medical and psychiatric context

→

Safety triage

Withdrawal risk, intoxication, suicidality, medical instability

→

Care match

Brief intervention, treatment engagement, or withdrawal management

CORE IDEA

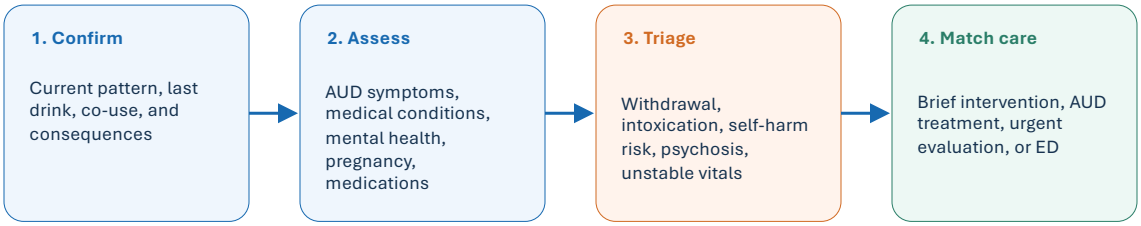
A positive screen is a prompt to understand the patient's alcohol use and safety needs. It does not by itself diagnose AUD or determine level of care.

Source: NIAAA Core Resource; ASAM

4

Clinical response after a positive alcohol screen

Use this sequence to determine whether an early intervention can begin today.



PROCEED WITH BRIEF INTERVENTION

Patient is medically stable, not in acute withdrawal or intoxication, and can participate in a collaborative conversation about alcohol use.

PAUSE AND PRIORITIZE MEDICAL CARE

Concern for severe withdrawal, acute intoxication, seizure, delirium, unstable illness, suicidality, or inability to ensure safe monitoring.

406 RECOVERY | EARLY INTERVENTION STRATEGIES

Source: NIAAA Core Resource; ASAM

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01

Brief intervention

A focused conversation that links risk, patient priorities, and a next step.

EARLY INTERVENTION STRATEGIES FOR HIGH-RISK ALCOHOL USE

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When brief intervention is appropriate

- Heavy drinking without acute withdrawal or medical instability
- Alcohol use worsening sleep, mood, blood pressure, pain, or another condition
- A positive screen with uncertain AUD severity
- Mild AUD when the patient can engage in primary-care or behavioral follow-up
- A patient who declines specialty care but is willing to discuss reducing risk

PRACTICAL SCOPE

A brief intervention usually lasts 5 to 15 minutes. A short, empathic conversation today can open the door to more care later.

Source: NIAAA Core Resource

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When brief intervention needs more support

Brief intervention can begin the conversation, but it rarely stands alone for moderate or severe AUD.

Moderate or severe AUD

Offer medication, behavioral treatment, and continuing care

Repeated alcohol-related harm

Escalate care after injuries, legal consequences, or medical complications

Co-occurring complexity

Integrate mental health, trauma, pain, and other substance-use care

CLINICAL LANGUAGE

“I’m concerned that alcohol is affecting your health. I can help you take a first step today, and I also want to connect you with care that gives you more support.”

Source: NIAAA Core Resource

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Withdrawal management takes priority

Do not frame a reduction or abstinence goal as a routine counseling task when the patient may need monitored withdrawal management.

- Prior withdrawal seizure, delirium tremens, or hallucinations
- Current confusion, agitation, autonomic instability, or severe tremor
- Serious medical illness, pregnancy, concurrent sedative use, or unstable housing
- Suicidality, psychosis, or inability to arrange safe monitoring

USE THE BRIEF CONVERSATION DIFFERENTLY

Validate the patient's wish to change, explain the safety concern, and help arrange the appropriate evaluation. Avoid giving a generic taper or "just stop" instruction without assessment.

Source: ASAM Alcohol Withdrawal Guideline

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Evidence for brief behavioral counseling

For adults who screen positive for unhealthy alcohol use, screening followed by brief behavioral counseling has a moderate net benefit in primary care.

WHAT EFFECTIVE INTERVENTIONS SHARE

They offer personalized feedback, connect alcohol use with health and goals, support autonomy, and include follow-up when possible.

WHAT THEY DO NOT REQUIRE

A single script, a confrontational stance, or an immediate commitment to abstinence from every patient.

Evidence and delivery vary by setting. A clinician can use a concise, patient-centered approach without waiting for a perfect workflow.

Source: USPSTF; NIAAA Core Resource

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A practical brief intervention

Ask permission

"Would it be okay to talk about your alcohol use?"

→

Give feedback

Link the pattern to risk and the patient's own health context.

→

Elicit meaning

Ask what the patient likes, dislikes, and wants to change.

→

Agree on a plan

Set one realistic next step and arrange follow-up.

The goal is a useful next conversation, not a perfect intervention in one visit.

Source: NIAAA Core Resource

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Opening the conversation

Start with transparency and permission. This lowers defensiveness and signals respect.

TRANSITION

"Your answers suggest alcohol may be affecting your health. Would it be okay if we spent a few minutes talking about that?"

NORMALIZE

"I ask everyone because alcohol can affect sleep, mood, blood pressure, medications, and safety."

Avoid labels and assumptions. Ask what the patient already knows about the connection between alcohol and the concern that brought them in.

Source: NIAAA Core Resource; SAMHSA TIP 35

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Personalized feedback

Effective feedback is specific, factual, and connected to the patient's priorities.

Pattern

"You described 5 or 6 drinks most evenings."

Health link

"That pattern can worsen sleep and anxiety."

Patient value

"You told me being present at work matters to you."

Then ask: "What do you make of that?"

Source: NIAAA Core Resource

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Eliciting the patient's perspective

- "What do you enjoy about drinking?"
- "What has become less workable about it?"
- "How does drinking fit with the kind of parent, partner, or employee you want to be?"
- "If you changed one thing about your drinking, what would be different?"

> **CLINICAL STANCE**
>
> Curiosity beats persuasion. The patient's own reasons for change carry more weight than a clinician's argument.

Source: SAMHSA TIP 35

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The readiness ruler

Use a 0 to 10 scale to explore readiness, confidence, or importance.

- Explore readiness to change: "On a scale of 0-10, how ready are you to make a change in your alcohol/drug use?"
- If readiness is greater than 2: "Why that number and not a _____ (lower one)?" *"What would help move you one point higher?"*
  If 0-2: "How would your alcohol/drug use have to impact your life for you to think about changing?

406 RECOVERY | EARLY INTERVENTION STRATEGIES

Source: SAMHSA TIP 35

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A patient-centered change plan

Goal

No heavy-drinking days, a reduced weekly total, or abstinence

Trigger

A predictable situation, feeling, time, or social setting

Alternative

A specific action the patient can try when the trigger occurs

Follow-up

A date to review what happened without judgment

MAKE IT CONCRETE

"For the next week, I will bring one alcohol-free beverage to the evening routine and stop before driving. I will track the nights I drink."

406 RECOVERY | EARLY INTERVENTION STRATEGIES

Source: NIAAA Core Resource

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Follow-up turns advice into care

A useful follow-up asks what happened, what helped, and what needs to change in the plan.

- Recheck alcohol use, consequences, withdrawal symptoms, and medication interactions
- Notice partial progress and reinforce the patient's effort
- Review setbacks as data: what led up to the drinking episode?
- Increase support when risk persists or AUD symptoms emerge

> **HELPFUL CLOSE**
> "I'd like to check in soon, whether the plan went well or not. We can learn from either outcome."

Source: NIAAA Core Resource

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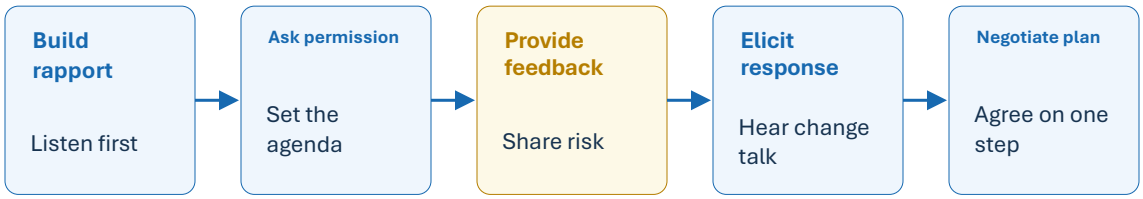
Brief negotiated interview

A brief negotiated interview gives the conversation a reliable structure.



The structure supports the relationship. It should not sound like a checklist.

Source: adapted from BNI / NIAAA Core Resource

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Brief intervention: "Dave”

Source: adapted from SBIRT Oregon, https://www.sbirtoregon.org/

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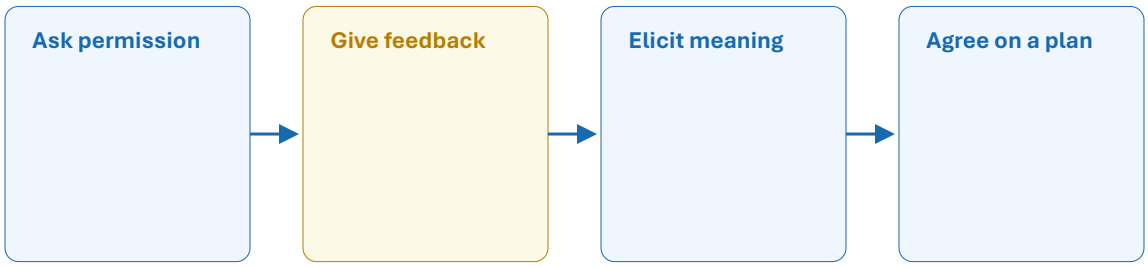
How did this PCP do?



Did it achieve the goal: facilitating the next useful conversation?

Source: NIAAA Core Resource

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How did this PCP do?

Ask permission

"is it okay if we go over this screening form that you filled out today on your alcohol use?

"So is it okay if we talk a little bit more about your alcohol use?"

Give feedback

"Looks like you use alcohol two to three days a week...you typically have five or six drink...we define binge drinking as having more than four drinks on one occasion... cause things like heart disease, different kinds of cancer liver problems... depression and anxiety are more likely to happen."

Elicit meaning

"what do you like about drinking alcohol?...what about your drinking do you not like... is there anything that worries you...so on one hand... but on the other hand... so weighing those things... hypothetically ?

Agree on a plan

"When we come back for the 3 month f/u appointment for your ADHD.. Check in about your alcohol use too, if that's OK.."

Did it achieve the goal: facilitating the next useful conversation?

Source: NIAAA Core Resource

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02

Motivational interviewing skills

A collaborative style for working with ambivalence about alcohol use.

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Motivational interviewing spirit: PACE

MI works with ambivalence rather than trying to defeat it.

PARTNERSHIP

The patient brings lived experience. The clinician brings clinical knowledge and support.

ACCEPTANCE

Respect autonomy, affirm strengths, and avoid shame or confrontation.

COMPASSION

Keep the patient's welfare as the goal of the conversation, not the clinician's agenda.

EVOCATION

Draw out the patient's own reasons for change instead of supplying them yourself.

WHY COMPASSION IS ON THE LIST

Compassion is what separates MI from skilled persuasion. The same OARS techniques, aimed at the clinician's agenda rather than the patient's welfare, are not MI.

406 RECOVERY | MOTIVATIONAL INTERVIEWING SKILLS Source: Miller & Rollnick, Motivational Interviewing, 3rd ed.; SAMHSA TIP 35 1

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Core communication skills: OARS

Four skills carry the conversation. The fourth is not a longer reflection.

Open questions	"What concerns you most about your drinking?"
Affirmations	"You have been trying to protect your family."
Reflections	"Part of you wants relief, and part wants things to change."
Summaries	"So far: sleep is the biggest cost, you've cut back on your own before, and weeknights are hardest. Did I get that right?"

REFLECTION VS SUMMARY

A reflection hands back one thing. A summary collects several threads and checks that you got them right.

406 RECOVERY | MOTIVATIONAL INTERVIEWING SKILLS Source: Miller & Rollnick, Motivational Interviewing, 3rd ed.; SAMHSA TIP 35 2

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Recognizing change talk: DARN-C

Five kinds of patient language signal movement toward change.

Desire

"I want to feel better in the mornings."

Ability

"I think I could skip drinking on work nights."

Reason

"My partner is tired of the arguments."

Need

"I can't keep going like this."

Commitment

"I will try three alcohol-free nights."

RESPOND WITH A REFLECTION

"You are seeing that your drinking and your relationships are not lining up the way you want."

Source: Miller & Rollnick, Motivational Interviewing, 3rd ed.; SAMHSA TIP 35

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Responding to sustain talk

PATIENT

"Drinking is the only way I can unwind."

AVOID

"That is not true. You need to stop."

TRY

"Unwinding matters to you. What else has helped, even a little, when alcohol was not available?"

Do not argue with ambivalence. Reflect the concern, ask a curious question, and keep the door open.

Source: SAMHSA TIP 35

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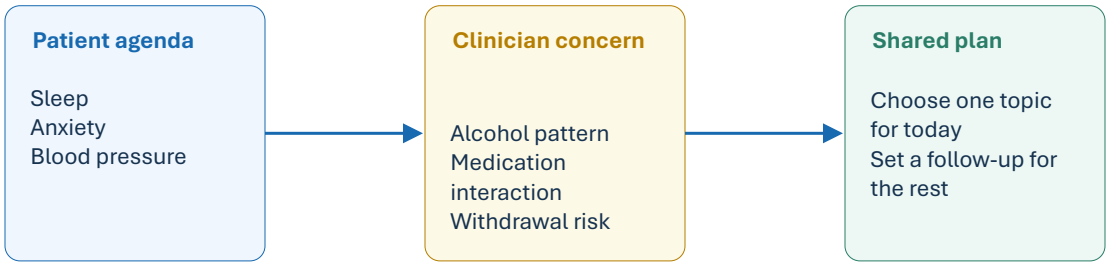
Shared agenda mapping

When alcohol is not the stated reason for the visit, ask permission to place it on the agenda.



EXAMPLE

"We have a few things to cover. Would it be okay to spend five minutes on alcohol because it may be affecting your sleep?"

Source: SAMHSA TIP 35; NIAAA Core Resource

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03

Harm-reduction counseling

A patient-centered approach that reduces alcohol-related risk while keeping treatment engagement open.

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Harm reduction and alcohol care

Harm reduction supports meaningful improvement when a patient is not ready for abstinence or is working toward it in steps.

- Reduce heavy-drinking days and alcohol-related consequences
- Protect safety while supporting the patient's autonomy
- Use goals that can evolve with health status, risk, and patient preference
- Continue to recommend abstinence when it is medically indicated or clearly safer

> **IMPORTANT DISTINCTION**
>
> Harm reduction does not mean minimizing risk. It means discussing risk honestly while offering realistic, patient-centered steps toward safer outcomes.

406 RECOVERY | EARLY INTERVENTION STRATEGIES

Source: NIAAA recovery definitions

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Naltrexone in Harm Reduction

SUBSTANCE ABUSE, 36: 21–33, 2015
Copyright © Taylor and Francis Group, LLC
ISSN: 0889-7077 print / 1547-0164 online
DOI: 10.1080/08897077.2014.904838

Routledge
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Extended-Release Naltrexone and Harm Reduction Counseling for Chronically Homeless People With Alcohol Dependence

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The Harm Reduction Counseling Component

Contemporary Clinical Trials 2014; 38: 221-234.

Safer Drinking Steps

Here are some tips to keep you safer and healthier no matter if/how you choose to change your drinking. These steps may help you reduce the "not-so-good things" about your drinking.

Ways to stay healthier when you drink	Drink water	• **Why?** Reduces hangover effects • **How?** Drink water while you are drinking or alternate between water and alcohol
	Count your drinks	• **Why?** Knowing how much you drink helps you think about how much alcohol you really want or need. It can help you take control of the effects of alcohol. • **How?** Keep your bottlecaps and screwtops in your pocket and count them later. You can keep track of this over time to see what amount works best for you.
	Try to eat	• **Why?** Food eases the pace of alcohol entering the bloodstream so it does less harm. Food gives you important nutrients. • **How?** Try to eat before you start drinking and while you drink. Proteins (meat, cheese, eggs) and carbs (bread, rice) are especially good choices when you drink.
	Take vitamins	• **Why?** Drinking can take away important nutrients from your body. • **How?** If you can, try to take B-vitamins: folate, thiamine, B-12. Your case manager might be able help with this.
Ways to make your drinking safer	Avoid nonbeverage alcohol	• **Why?** Mouthwash, aftershave, cooking wine, vanilla extract, cleaning spray, sterno contain unpredictable amounts of alcohol and other poisonous ingredients. • **How:** If you drink, be sure to drink alcoholic beverages (beer, wine, liquor).
	Drink beer vs malt liquor	• **Why?** You might be getting more alcohol than you thought. A 24 oz. 211 Steel Reserve = nearly 4 12oz regular beers. A 24oz. Joose or Tilt =nearly 6 12oz beers. • **How?** Check the labels and try beer with 4-6% alcohol instead, like Bud or Keystone
	Space your drinks	• **Why?** Keep the buzz going for longer and avoid the not-so-good things. • **How?** Pace yourself; sip your beer, alternate between beer and water.
	Avoid mixing drugs	• **Why?** Drinking and drugging at the same time can stress your heart and liver and can lead to overdose. • **How?** When you drink, try to avoid other drugs.
	Drink in a safe place	• **Why?** People can take advantage of you when you're drinking. Drinking on the streets or in unsafe places can lead to fights, hassels and arrest. • **How?** If you can, avoid drinking heavily with people you don't trust. Try to drink in places where you feel more in control of your surroundings.
Ways to change how much you drink	Less is more	• **Why?** Most things people like about alcohol occur when they are buzzed not drunk. • **How?** Think of some way you can limit your drinking, then pace your drinking to keep the buzz going on less drinks. You might ask your case manager or a friend to help you stick with your limit.
	Chose not to use	• **Why?** Not drinking--even for a few hours--gives your liver, kidneys and pancreas a rest and may help you avoid other problems. • **How?** Try a few hours of not drinking or introducing one nondrinking day a week. To stop altogether, medically supervised detox might help.
	Avoid withdrawal	• **Why?** Alcohol withdrawal--getting the shakes, seizures or DTs--can be serious • **How?** If you want to stop drinking altogether and you get more than a little shaky if you don't drink, medical detox is safest. If you choose to drink, alcohol can relieve withdrawal symptoms. Check with your doctor about anti-seizure meds.

FIGURE 1 Safer drinking strategies handout.

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Naltrexone in Harm Reduction

12-week studying XR-NTX administration and harm reduction counseling for homeless w/ EtOH Use D/O

31 subjects from 2 community-based agencies (including UW-HMC), 24 complied with all study procedures

Measures included self-reported alcohol craving, quantity/frequency, problems, and biomarkers (ethyl glucuronide [EtG], liver transaminases).

XR-NTX and harm reduction counseling were administered monthly over the 3-month treatment course.

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Naltrexone in Harm Reduction

Outcomes = decreases in:

- alcohol craving (33%)
- typical (25%) and peak use (34%)
- frequency (17%)
- medical complications/ED visits (60%)

Corroborated reported changes in use with changes in EtG from the baseline to the 12-week follow-up (Ps < .05)

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Matching goals to risk

Abstinence is the safest goal

- Pregnancy
- Alcohol-interacting medications
- Serious alcohol-related illness
- Unable to maintain non-heavy use

Reduction can be a first step

- No heavy-drinking days
- Lower weekly total
- Decrease alcohol-related harms
- Improve treatment engagement

Keep reassessing

- AUD severity
- Withdrawal history
- Medical and psychiatric risks
- Patient goals

406 RECOVERY | EARLY INTERVENTION STRATEGIES

Source: NIAAA recovery definitions; CDC

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Lowering risk during drinking episodes

- Plan transportation before drinking. Do not drive or ride with an impaired driver.
- Avoid combining alcohol with sedatives, opioids, or other substances that increase overdose and impairment risk.
- Eat, hydrate, and avoid rapid consumption. Track standard drinks rather than relying on container size.
- Set a spending limit and a stop time before the event begins.
- Tell a trusted person the plan and arrange a way to leave if safety changes.

Source: CDC; NIAAA patient resources

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Changing the environment around alcohol

Behavior changes become easier when the patient adjusts the cues, routines, and access around drinking.

HOME

Remove alcohol from the most automatic setting. Stock preferred nonalcoholic alternatives. Change the after-work routine.

SOCIAL SETTINGS

Practice a refusal line. Bring a supportive person. Leave before the situation becomes high risk.

DIGITAL AND FINANCIAL CUES

Mute alcohol marketing. Avoid online ordering. Limit cash or delivery-app access during high-risk times.

Source: NIAAA Core Resource; CDC

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Case 1: high-risk use in primary care

Jordan, 34, reports 5 to 6 drinks most weeknights. He has poor sleep, morning anxiety, and rising blood pressure. He denies morning drinking, prior seizures, hallucinations, or suicidal thoughts.

SCREEN AND ASSESSMENT

AUDIT-C positive. He reports difficulty cutting down but no major role impairment. Last drink was last night. Vitals are stable.

QUESTIONS FOR THE GROUP

What feedback would you offer? What alcohol goal might fit Jordan's priorities? What follow-up would you arrange?

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Case 1: a brief intervention response

OPEN & PROVIDE FEEDBACK

"Would it be okay to talk about how alcohol may be affecting your sleep and blood pressure?"
+
Review AUDIT-C and drinking patterns

ELICIT

"What do you like about drinking in the evening? What do you like less about it?"

PLAN

Jordan chooses three alcohol-free weeknights, no alcohol before driving, and a two-week follow-up with a drinking log.

ESCALATE IF NEEDED

At follow-up, reassess AUD symptoms, blood pressure, withdrawal risk, and interest in medication or specialty behavioral treatment.

A good plan is observable, achievable, and revisited.

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Case 1: high-risk use in primary care

Jordan, 34, reports 5 to 6 drinks most weeknights. He has poor sleep, morning anxiety, and rising blood pressure. He denies morning drinking, prior seizures, hallucinations, or suicidal thoughts.

TEACHING POINT

This is a setting for a brief intervention plus diagnostic assessment, not a reason to wait for a specialty referral before offering help.

04

Psychosocial interventions

Use evidence-based approaches to build skills, support motivation, and strengthen recovery.

Psychosocial intervention toolkit

Match treatment to the patient's needs, access, preferences, and goals. Do not delay care while looking for a perfect modality match.

Motivational enhancement

Build readiness and a self-directed change plan

CBT

Identify triggers and practice coping skills

Mutual support

Build recovery-oriented social connection

Family or couples work

Change relationship patterns that affect alcohol use

Contingency strategies

Reinforce attendance and behavior change

Source: NIAAA Core Resource; Project MATCH

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Motivational enhancement therapy

Motivational enhancement is a brief, structured approach that strengthens a patient's own motivation to change alcohol use.

FEEDBACK

Review assessment results and alcohol-related consequences in a nonjudgmental way.

PERSONAL MEANING

Explore the patient's values, ambivalence, and reasons for considering a change.

CHANGE PLAN

Support a plan selected by the patient and revisit it over time.

Source: NIAAA Core Resource; Project MATCH

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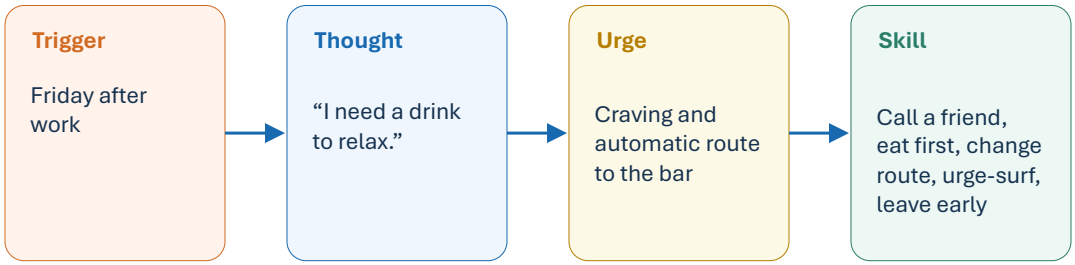
Cognitive-behavioral therapy for alcohol use



CBT helps patients identify the situations and beliefs that support heavy drinking, then rehearse alternatives.

Source: NIAAA Core Resource

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Mutual support and recovery capital

- Offer mutual-support options that match the patient's values and preferences
- Examples include 12-step groups, SMART Recovery, Women for Sobriety, and culturally specific community supports
- Frame participation as an experiment: attend, notice the fit, and decide what is useful
- Strengthen recovery capital: safe housing, relationships, employment, transportation, and meaningful activity

> **CLINICAL MESSAGE**
>
> "You do not have to do this alone. Let's look at what kind of support would feel useful and realistic for you."

Source: NIAAA Core Resource

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Family and social network interventions

Alcohol goals often succeed or fail in a social context. Involve others with patient consent and attention to safety.

SUPPORTIVE INVOLVEMENT

Invite a partner or family member to help with transportation, routines, and nonalcohol activities when the patient wants this.

RELATIONSHIP-FOCUSED CARE

Consider couples or family therapy when conflict, communication, or enabling patterns are central to the alcohol problem.

SAFETY AND CONFIDENTIALITY

Do not presume family involvement is safe or helpful. Assess interpersonal violence, coercion, privacy needs, and patient preference.

Source: NIAAA Core Resource

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Contingency strategies

Contingency strategies use planned reinforcement to support a meaningful behavior target.

Choose a target

Attend treatment
Take medication
Complete alcohol monitoring
Meet a safety goal

Agree on reinforcement

A reward that matters to the patient and fits the setting

Review fairly

Track the target, reinforce success, and reset the plan after missed steps

Source: NIAAA harm-reduction discussion

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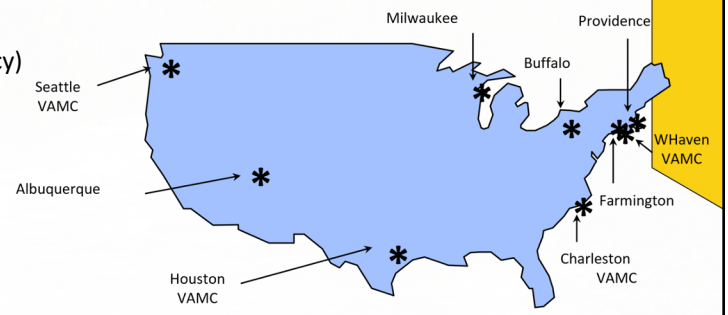
Project MATCH Supported by NIAAA

Project MATCH

Matching Alcoholism Treatment to Client Heterogeneity

Project MATCH was the largest, most expensive AUD treatment trial ever conducted to determine if various types of people with AUD respond differently to different treatment approaches

- **Primary Outcomes**
  - Percent of Days Abstinent (frequency)
  - Drinks per Drinking Day (intensity)
- **Secondary Outcomes**
  - Other measures of drinking
  - Negative consequences of drinking
  - Other substance use
  - Social functioning
  - Psychological functioning



Cutler, R.B., Fishbain, D.A. Are alcoholism treatments effective? The Project MATCH data. *BMC Public Health* **5**, 75 (2005).

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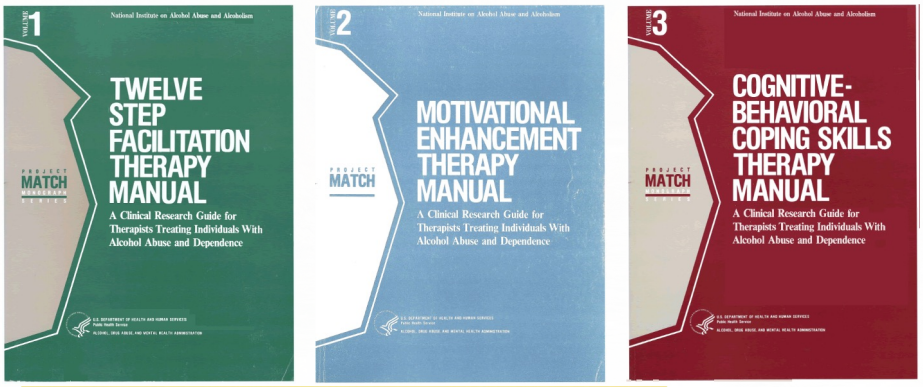
Project MATCH

Matching Alcoholism Treatment to Client Heterogeneity

Therapy Manuals – to evaluate matching clients to distinct, manual-driven, theoretically-based treatments that are widely applicable to a range of settings & providers



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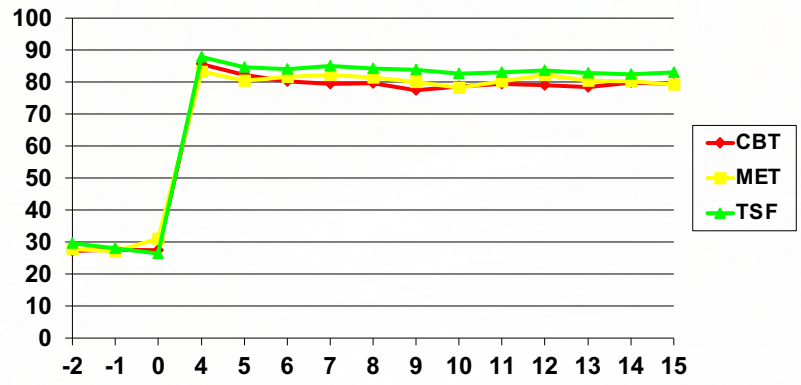
Matching Alcoholism Treatment to Client Heterogeneity

Mean Percent Days Abstinent as a Function of Time (Outpatient)



Project MATCH Research Group, 1997

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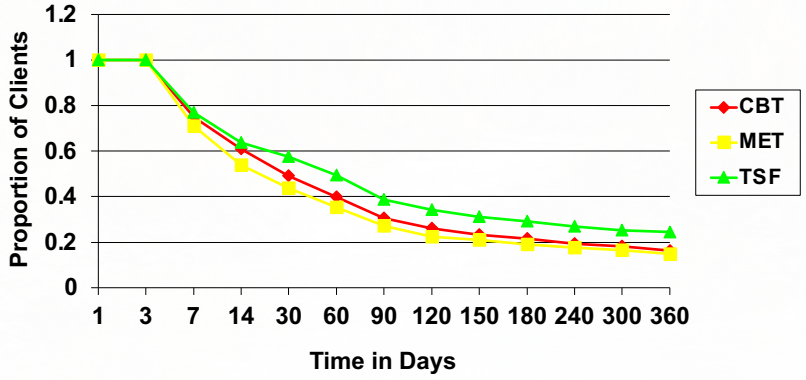
Matching Alcoholism Treatment to Client Heterogeneity

Proportion of Patients Maintaining Total Abstinence as a Function of Time (Outpatient)



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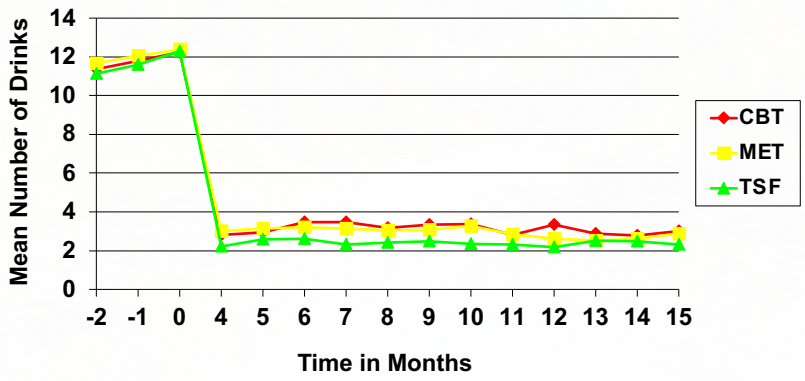
Matching Alcoholism Treatment to Client Heterogeneity

Mean Drinks per Drinking Day as a Function of Time (Outpatient)



Project MATCH Research Group, 1997

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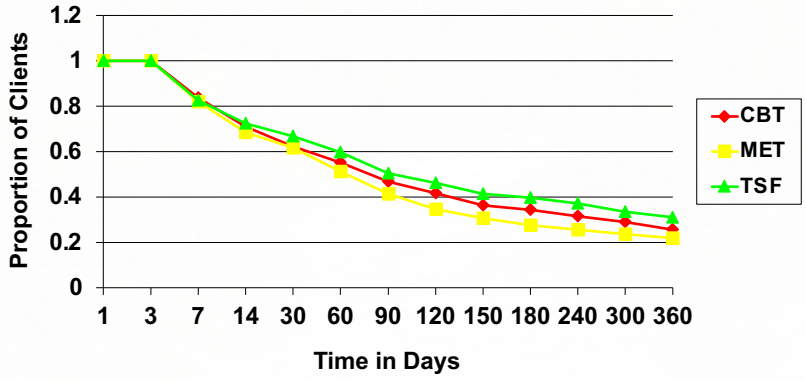
Matching Alcoholism Treatment to Client Heterogeneity

Proportion of Outpatients Avoiding a Heavy Drinking Day as a Function of Time



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Project MATCH - Results

Matching Alcoholism Treatment to Client Heterogeneity

Only 4 of 21 Possible Treatment – Attribute Matches Found

- Alcohol Dependence:
  - In the aftercare group, individuals with high levels of alcohol dependence benefited more from TSF than from CBT, whereas the reverse was true for patients low in dependence
- Psychopathology:
  - In the outpatient group, those without psychopathology were found to benefit more from TSF than from CBT
- Anger:
  - In the outpatient arm of the trial, patients high in anger had more successful outcomes with the MET than with the other two approaches
- Social Network Support for Abstinence:
  - Patients whose social networks offered less support for abstinence had better outcomes in TSF than in MET

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Project MATCH - Results

Matching Alcoholism Treatment to Client Heterogeneity

- Results
  - Treatment attendance was high across all three treatments
  - Excellent overall outcomes, with substantial reductions in frequency and intensity of drinking following treatment
  - **Few differences among treatments**
    - Outcomes similar for MET vs. CBT+TSF
    - Observed main effects generally favored TSF
  - Outcomes are not substantially improved by client-treatment matching

"In sum, Project MATCH's findings challenged the notion that patient-treatment matching is a prerequisite for optimal alcoholism treatment. Other than the 4 relationships, the findings did not show that matches between patient characteristics & treatments produced substantially better outcomes."

Project MATCH Research Group, 1997; NIAAA's 10th Report to Congress

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Teens and young adults

Adapt the approach to development, confidentiality, and safety.

- Any alcohol use is concerning for people under the legal drinking age
- Use youth-validated screening and protect confidentiality within legal and safety limits
- Use developmentally appropriate feedback about driving, school, sports, and relationships
- Involve caregivers when appropriate, safe, and consistent with confidentiality requirements

Source: NIAAA youth guide; SAMHSA

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Case 2:

Rae, 46, wants to stop drinking after a recent argument. She drinks a fifth of liquor daily, last drank six hours ago, and has tremor, tachycardia, nausea, and a prior withdrawal seizure.

Illustrative case; Source: ASAM

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Case 2: when to pause the brief intervention

Rae, 46, wants to stop drinking after a recent argument. She drinks a fifth of liquor daily, last drank six hours ago, and has tremor, tachycardia, nausea, and a prior withdrawal seizure.

DO NOT BEGIN WITH A DRINKING GOAL

Rae's immediate concern is possible complicated alcohol withdrawal. Evaluate urgently and arrange appropriate withdrawal management.

THE BRIEF INTERVENTION STILL MATTERS

Use empathy: "You are taking an important step by asking for help. I am concerned about your safety if you stop without medical support."

After stabilization, return to AUD treatment, harm-reduction goals, and continuing psychosocial care.

Illustrative case; Source: ASAM

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Key takeaways

Early intervention works best when it is timely, collaborative, and matched to risk.

- Use a positive screen to start assessment and safety triage
- Provide brief, patient-centered counseling for high-risk alcohol use when the patient is medically stable
- Offer realistic harm-reduction goals while stating when abstinence is safer
- Connect moderate or severe AUD with medication, behavioral care, mutual support, and continuing follow-up
- Prioritize withdrawal management when clinical red flags are present

Selected sources: NIAAA Healthcare Professional's Core Resource on Alcohol; USPSTF; SAMHSA TIP 35; ASAM Alcohol Withdrawal Management Guideline; CDC alcohol and impaired-driving resources.

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