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BRIEF MOTIVATIONAL ENHANCEMENT INTERVENTION TO IMPROVE SOCIAL HEALTH

MET Training Manual

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I. Overview of the Manual

This intervention manual is designed for use by health care providers trained in both intimate partner violence (IPV) interventions (safety assessment and safety planning) and motivational enhancement therapy (MET).The techniques in this manual are designed to encourage patients to reduce unhealthy alcohol consumption and address relationship conflict. The manual provides an outline of the necessary skills to effectively perform a brief intervention with patients in a medical setting who have been identified as IPV-involved problem drinkers. Though originally developed for use with female patients, the manual has been recently modified to be gender-neutral, as well as for use with victims of violence, perpetrators, or both.

The following sections provide background information of the MET intervention, as well as describe its critical components. An easy to follow, step-by-step approach to performing the intervention is also included. While the manual gives the reader a critical overview of the intervention, participation in a training course, followed by successful completing of practice cases is recommended before beginning practice with patients.

The provider's job will be to confirm patient willingness and consent, to administer the proposed brief intervention in a private setting in one session lasting about 20 minutes, and to work with the patient to identify a safe, individualized follow-up plan and collect adequate contact information for a 10 minute "booster" session to be delivered by phone or in person approximately 10 days following the medical visit.

The provider begins the intervention by asking permission from the patient to review the results of the "Social Health Interview" and discuss two of the concerns addressed in the interview: relationship conflict and alcohol use. Ask the patient to choose a topic to begin the conversation (the relationship conflict or the alcohol use) and follow the MET intervention given in this manual for that topic. If the patient is receptive, explore the connection between IPV and heavy drinking, and address whichever topic (IPV or heavy drinking) that was not selected for discussion at first. If the patient desires it, conclude with the development of an action plan and a safety plan - generated collaboratively with the participant - to address both the heavy drinking and IPV behaviors. It is important that the plan focus on only behaviors that the patient can control – it should be made clear throughout the intervention that survivors of IPV cannot control the actions of their partners (Burke et al., 2010). The agreed upon plan (if one is created) will be the start of the 10 minute "booster" session to be delivered by the provider approximately 10 days after the medical visit. If the patient is not ready or willing to move to an "action plan," that is fine – the booster will then be framed as a check-in to see how he or she is doing 10 days later. Review the individualized safe contact plan, and develop individualized contingency plans for ending a call (with code words), contacting the police on their behalf, and for re-establishing contact in the event the call needs to be ended or rescheduled.

The provider's primary role in the intervention and booster is to use the principals of motivational interviewing to help build and support each patient's self-efficacy for change and self-protection. Ask the patient's permission before discussing available community-based IPV and the local alcohol treatment referrals (for themselves and/or their partner). If the patient is interested, offer to put him or her in direct contact with community based referrals (either the 24-hour IPV hotline, or the local alcohol treatment program and/or Alcoholics Anonymous).

II. Background Information

Introduction

Unhealthy alcohol use (Saitz, 2005) is a major preventable public health problem resulting in over 100,000 deaths each year (McGinnis & Foege, 1993) and costing society over 185 billion dollars annually (Harwood, 2000). The effects of unhealthy alcohol use have far reaching implications not only for the individual drinker, but also for the family, workplace, community, and the health care system.

Prevalence

Unhealthy alcohol consumption has been associated with increased morbidity and mortality along with significant economic costs. Alcohol use is estimated to be the cause of 100,000 deaths annually and a $100 billion in cost (U.S. Department of Health and Human Services, 1993). There is a high prevalence of alcohol related problems in primary care and Emergency Department (ED) patients (Cherpitel, 1993; Whiteman, Hoffman, & Goldfrank, 2000; Bernstein et al., 1996). Alcohol has been shown to be a major contributing factor in up to 50% of major and 22% of minor trauma cases (Rivara, Jurkovich, & Gurney, 1993; Degutis, 1998). Prevalence rates in primary care range from 2% to 29% depending on which conditions are defined (Fiellin et al., 2000).Therefore, there is a critical need for effective and practical interventions aimed at reducing the deleterious effects of drinking that can be administered by health care providers and health care social workers.

Spectrum of Alcohol Use/Terminology

Patients presenting to health care settings, represent the entire spectrum of unhealthy alcohol use, as described in empirically-based guidelines from the National Institute of Alcohol Abuse and Alcoholism (NIAAA) illustrated in Figure 1 (NIAAA, 1995). While Intimate Partner Violence (IPV) is common across the entire range of unhealthy drinking, it is most closely associated with heavy episodic drinking. Distinctions are important, as Motivational Enhancement Therapy (MET) has been shown to be most effective with hazardous and heavy drinking, where a motivated patient can be expected to cut down to safe levels without encountering physical withdrawal symptoms. However, in the health care setting, it is important for providers to be able to assess the level of drinking and address the full range of drinking problems.

- **Hazardous drinking**: alcohol consumption that puts a patient at risk for injury and illness because s/he drinks in excess of low-risk guidelines, which are less than 14 drinks/week for a man (less than 7 standard drinks per week for a woman) and less that 5 drinks on any occasion for men (less than 4 on any occasion for a woman). (NIAAA, 2005)

- **Heavy episodic drinking**, defined as drinking 4 or more alcoholic drinks on any occasion for women and 5 or more for men (NIAAA, 2005), is the pattern of drinking most associated with IPV victimization and perpetration (Lipsky et al., 2005). Ideally the goal of an MET intervention with a heavy episodic drinker is to support the patient in taking action to cut down alcohol consumption to safe levels.

- **Alcohol dependence:** is implied by an elevated AUDIT score on question 4 (impaired control over drinking - can't stop once you start), question 5 (increased salience of drinking - failed to do what was expected of you because of drinking), and question 6 (morning drinking - needed a first drink in the morning to get going). Elevated scores on items 4 through 6 imply the presence or emergence of alcohol dependence, as does an overall AUDIT score over 19 (Babor et al., 1992; 2001). The goals for alcohol dependent patients are ideally focused on engaging in treatment and community-based support such as Alcoholic Anonymous to achieve abstinence, as opposed to cutting down to safe levels. However, a diagnosis of alcohol dependence can only be made by an experienced clinician "if three or more of the following have been experienced or exhibited at some time in the previous twelve months: 1. a physiological withdrawal state; 2. alcohol use with the intention of relieving withdrawal symptoms and with awareness that this strategy is effective; 3. an impaired capacity to control the onset, termination or level of use; 4. a narrowing of the personal repertoire of patterns of use, e.g., a tendency to drink in the same way on weekdays and weekends, regardless of the social constraints; 5.

progressive neglect of alternative pleasures or interests in favor of alcohol use; 6. persistence of use despite clear evidence of harmful consequences; 7. evidence of tolerance; and 8. a strong desire or sense of compulsion to take alcohol" (Babor et al., 1992, pp.11-12).

The Relationship between Problem Drinking and Intimate Partner Violence (IPV)

Intimate partner violence (IPV) is a major source of morbidity and mortality in the United States. The health consequences of IPV include disproportionately high rates of injury, chronic pain, anxiety, depression, somatic concerns, and substance abuse (Campbell, 2002). Extensive literature has documented the high rates of co-morbidity between IPV and problem drinking, and each of these concerns is identified as a significant risk factor for the other (Easton, Swan, & Sinha, 2000; Goldberg, 1995). There is disagreement among experts regarding whether problem drinking is a covariant of IPV, a cause of IPV, or a response to victimization (Fals-Stewart & Kennedy, 2005); in many cases, these two risks may be bi-directional (Bennett & O'Brien, 2007).

IPV victimization and perpetration have both been linked with problem drinking; the 1995-1996 National Violence Against Women Survey found that 33.6 percent of abusive partners and 6.9 percent of victims were using alcohol at the time of a violent incident (Thompson & Kingree, 2006). Heavier levels of drinking are associated with a greater likelihood of both victimization and perpetration of IPV (Lipsky et al., 2005). Intimate partner assaults are more likely to be severe when alcohol is involved than when it is not (Leonard, 2001; Fals-Stewart & Kennedy, 2005). Binge drinkers are three times more likely to have perpetrated IPV than nondrinkers (Kantor & Straus; 1987). Twenty-six percent of aggravated simple assaults and 37% of rapes and sexual assaults are perpetrated by drinking offenders (Greenfeld, 1998). Ninety-two percent of IPV perpetrators used alcohol or drugs on the day of the assault, and 72 percent had prior arrests for substance abuse (Brookoff et al., 1997). Among prisoners convicted of killing an intimate partner, 45 percent reported alcohol consumption prior to the event (Leonard, 2001).

Due to the intensity and complexity of the relationship between problem drinking and IPV, it is likely that for patients with both risk factors, one can not be adequately addressed without the other (Bennett & O'Brien, 2007).

Evidence that the Brief Intervention Works

There is compelling evidence in the literature that screening and brief intervention for alcohol problems is effective in reducing alcohol consumption and associated negative consequences (D'Onofrio et al., 2005). An evidence-based review on brief interventions identified 39 published studies, including 30 randomized controlled trials and 9 cohort studies (D'Onofrio & Degutis, 2002). A positive effect was demonstrated in 32 of these studies. Multiple studies have demonstrated the efficacy of brief interventions in a variety of settings, including general populations, primary care, emergency departments and in-patient trauma care units. Walters et al. (2009) show that combining feedback about a patient's ranking compared to national norms and about healthy levels of alcohol consumption using a motivational interviewing style can be particularly effective for reducing heavy drinking. When feedback is included with motivational interviewing, it is called Motivational Enhancement Therapy (MET). This intervention includes both the motivational interviewing style and feedback interventions, in an attempt to maximize the benefit from our brief motivational enhancement intervention.

In a Primary Care Setting:

Primary care providers are well positioned to recognize and intervene in alcohol-related problems; therefore the National Institute on Alcohol Abuse and Alcoholism encourages primary care providers to identify unhealthy alcohol use (U.S. Department of Health and Human Service, 1995). Validated instruments exist for screening in primary care, and primary care providers are trained in behavior change counseling, initiating referrals and coordinating care with sub-specialty providers, monitoring response to therapy, and promoting relapse prevention. Targeted skills in primary care include comprehensive bio-psychosocial assessments, development of therapeutic relationships, nonjudgmental interactions, empathy-based communication, the ability to treat co-morbid conditions, and working within the context of the family (Samet, Rollnick, & Barnes, 1996; Friedmann, Saitz, & Samet, 1998). Brief, office-based interventions do appear to reduce consumption and increase uptake of substance abuse treatment (Bien, Miller, & Tonigan, 1993).

A recent meta-analysis by Rubak et al. (2005) describes how motivational interviewing is effective in supporting behavior change and is superior to standard of care in approximately 80% of the studies meeting inclusion criteria. Of note, no harm or adverse events have been reported from studies using motivational interviewing. The analysis demonstrated the significant effects of motivational interviewing for effect estimates of blood alcohol concentration (combined effect size=72.92, p-value = 0.0001, 95% C.I. 46.80 to 99.04) and standard ethanol content (combined effect size=14.64, p-value = 0.0001, 95% C.I. 13.73 to 15.55). In particular, the magnitude of the decrease of blood alcohol concentration and standard ethanol content is of clinical relevance and implies that motivational interviewing can and should be used.

Noknoy et al. (2010) conducted an RCT exploring the effect of MET on hazardous drinking in a primary care setting. MET was selected as a brief intervention for use with hazardous alcohol drinkers who were not dependent. The study design assessed the impact of a three-session, 15-min MET counseling schedule for use in primary care settings. Self-reported drinks per drinking day, frequency of daily and weekly hazardous drinking and of binge drinking sessions were reduced in the intervention group more than the control group ($P < 0.05$ in 9/10 outcomes assessed) at 3 and 6 months.

A controlled clinical trial (Project GOAL--Guiding Older Adult Lifestyles) tested the efficacy of brief physician advice in reducing the alcohol use and use of health care services of older adult problem drinkers. The older adults who received the physician intervention demonstrated a significant reduction in 7-day alcohol use, episodes of binge drinking, and frequency of excessive drinking ($P <.005$) compared with the control group at 3, 6, and 12 months after the intervention. There was a 34% reduction in 7-day alcohol use, 74% reduction in mean number of binge-drinking episodes, and 62% reduction in the percentage of older adults drinking more than 21 drinks per week in the intervention group compared with the control group (Fleming et al., 1999).

In an Emergency Department Setting:
Longabaugh (Institute of Medicine, 1990) and colleagues published a clinical trial with injured, harmful/hazardous drinkers in the ED. Patients were randomized to standard care, brief intervention, brief intervention followed by a booster, or a comprehensive intervention subsequent to the ED visit. Patients receiving the brief intervention with a booster - but not those receiving the brief intervention alone - reduced alcohol-related negative consequences and injuries more than did those in the standard care group. All three groups reduced their days of heavy drinking. This study demonstrates that a booster session may be helpful; however this study was limited to injured patients. However, 31% of patients actually assigned to return to the booster session in person did not return. It is possible that a booster session by telephone may be a better solution in ED populations. Their follow-up rate of 83% by phone would support this. However, translation to the real world setting is difficult as the intervention was lengthy, up to an hour, and performed by trained non-ED staff social workers. The demonstration of decreased drinking behavior in all three arms of this study raises the concern that lengthy research assessments, focused on alcohol-related behavior, may serve as an intervention or impact subject reporting. Of note, the generalizability of these findings are unclear because the number of patients who were eligible for the study but not randomized was not reported.

Gentilello and colleagues (2005) studied a subset of hospitalized trauma patients who screened and/or tested positively for the full spectrum alcohol problems (i.e., at-risk drinking to alcohol dependence). He reported a decrease in alcohol consumption in the intervention group who received a brief intervention compared to control group ($p<.03$), which was most apparent in patients with mild to moderate problems ($p<.01$). In a three-year follow-up period, there was a 47% reduction in injuries requiring ED visit, and a 48% reduction in injuries requiring hospital admission. Among the methodological challenges in interpreting the results of this study is the spectrum of alcohol problems with which patients presented. The inclusion of alcohol dependent patients makes it difficult to compare this population with a heterogeneous ED population who experience only harmful and hazardous drinking. The generalizability of this study is somewhat limited by the fact that a single, doctorate level psychologist performed all of the interventions. Finally, follow-up rates were low: approximately 50% at 12 months.

The Health Care Visit is an Opportunity for Intervention

Although few healthcare providers screen for IPV, 15-35% of women visiting an ED and 12-23% of women in Family Medicine settings reported having been physically abused or threatened by their partner within the last year (Hamberger et al., 1992; Elliott & Johnson, 1995; Richardson et al.,2002; Bradley et al., 2002; Dearwater et al., 1998; Abbott et al., 1995). Oriel et al.(1998) reported that 13.5% of male primary care patients in Family Medicine settings reported perpetrating minor violence (throwing, pushing, or slapping) over the past 12 months; 4.2% reported at least one episode of perpetrating severe violence (kicking, beating, threatening to use or using a knife or gun). Two studies reported 42-63% of perpetrators had sought care in a healthcare setting within the previous six months of the study (Gerlock, 1999; Coben & Friedman, 2002). Coben et al. (2002) reported that a large proportion of male perpetrators had been seen by healthcare professionals close to the time they were arrested, with 42% of sample of men in treatment for IPV perpetration having sought medical care within the past six months for issues related to injury (36%), illness (30%), and "check-ups" (21%). Even among patients who seek medical treatment for conditions that do not stem from IPV, there is a high prevalence of recent IPV involvement. The health care setting therefore has the potential to play two critical roles in the understanding and prevention of IPV and alcohol-associated IPV in particular: (1) identifying persons in abusive relationships and persons with problem drinking (2) initiating preventative interventions. The health care visit offers a potential "teachable moment". This may be particularly true if the IPV or alcohol use is associated with an event prompting the visit (D'Onofrio et al., 1998).

Why MET for IPV?

Patients involved in an MET intervention are active collaborators and decision-makers whose views and experiences are given precedence and guide the outcome of the intervention (Burke et al., 2010; Martino et al., 2006). Evidence suggests that motivational interventions can be successful in reducing adverse drinking behaviors in problem drinkers, and we anticipate this therapeutic modality also has the potential to be successful in sensitively and effectively addressing the critical issues faced by many IPV-involved patients.

The principles of trauma-informed practice guide interventions with IPV survivors, and recent work has recognized strong parallels and compatibility between trauma-informed practice and motivational interventions. Both trauma-informed practice and motivational interventions focus on strengths and capabilities, self-efficacy, collaboration, empowerment, and respect for personal choice and autonomy (Burke et al., 2010). Critical to both MET and trauma-informed practice is the need for the practitioner to listen actively and suspend judgment in order to explore and understand the client's point of view. Understanding these foundational principles can help the trauma-informed MET practitioner avoid the replication of coercive, intimidating, and controlling tactics often used by abusive partners (Ganley, 1996). We believe that an MET intervention can support healing and feelings of self-efficacy in survivors of IPV.

The same MET principles that evoke positive outcomes in IPV victims are pertinent to IPV perpetrators. Active confrontation of batterers has been relatively standard in the treatment of IPV perpetration by practitioners in this country; though recent findings support the non-confrontational nature of MET, especially in terms of client retention and the completion of treatment (Scott et al. 2011). Treatment grounded in stages of change, as is MET, has also been evidenced to decrease recidivism and partner's reports of physical assault posttreatment. MET seems to overcome the fairly low motivation to change often indicated in partner-violent individuals, that may begin simply with an individual's increased responsibility assumption for abusive behaviors (Murphy & Ting, 2010). Positive developments then contribute to increased feelings of self-efficacy for the perpetrator and measurable behavioral change.

III. Overview of the Motivational Enhancement Therapy Brief Intervention for IPV and Alcohol

The Motivational Enhancement Therapy (MET) intervention is a short, 20-30 minute health promotion session that incorporates brief feedback and guidance with motivational enhancement techniques to assist patients in changing their drinking patterns (D'Onofrio, Bernstein, & Rollnick, 1996) and increasing their safety. The techniques employed in the MET intervention are those of motivational interviewing (MI). What differentiates the MET intervention from pure motivational interviewing is the addition of a feedback component by the provider. As with MI, the goal of an MET intervention is to elicit the client's self-identified reasons for change (not the practitioner's) and help the client resolve ambivalence. The MET intervention is patient-centered, and the patient's own motivation and readiness to change are the heart of the intervention. Eliciting this motivation is accomplished largely through the use of **reflective listening** and **open-ended questioning techniques,** assisting the patient as he or she builds an argument for change.

Patients participating in the MET intervention are encouraged to identify any linkages between their drinking habits and their involvement in partner violence. For many patients, the product of the MET intervention will be an agreement to reduce either alcohol use or its ability to cause harm (medical problems or trauma), to identify and agree to implement effective coping strategies for situations that are high-risk for IPV, and potentially to connect with informal or community-based supports via provider referral. The practitioner and patient come to this agreement through a process of planning described in the following sections. If the patient expresses an unwillingness or inability to consider change, the provider's primary role is to encourage the patient to explore any existing ambivalence and support of the patient's autonomy and personal agency, even if s/he makes a decision not to change. In MET, the spirit of preserving and supporting the patient autonomy and personal choice are paramount (see MET-consistent practices).

IV: Overview of Skills for Delivering MET Interventions

MET-Consistent Practices (Adapted from Martino et al., 2006)

1. Maintain Motivational Interviewing Spirit
2. Ask Open-Ended Questions
3. Affirm Strengths and Change Efforts
4. Make Reflective Statements
5. Recognize and Support Motivation to Change
6. Support a harm reduction approach to change

MET-Inconsistent Practices (Adapted from Martino et al., 2006)

1. Offer Unsolicited Advice, Direction-Giving, or Feedback
2. Emphasize Abstinence
3. Directly Confront Patient
4. Highlight Patient Powerlessness and Loss of Control
5. Assert Authority or Expertness
6. Ask Closed-Ended Questions

V: MET-Consistent Practices (Adapted from Martino et al., 2006)**1. Maintain Motivational Interviewing Style or Spirit**

Key elements:

- Use a supportive, warm, non-judgmental, and collaborative approach
- Aim to elicit the patient's motivation to change
- Strike a careful balance between following the patient's lead/agenda, but also maintaining focus on the target behavior.
- Honor the patient's experiences and point of view
- Support the patient's autonomy

A practitioner who maintains the spirit of MET employs an empathic, supportive, collaborative, non-judgmental approach and handles resistance skillfully instead of head-on. The practitioner consistently aims to elicit the patient's motivation for change. The therapeutic style is one of calm and caring concern and an appreciation for the experiences and opinions of the patient. The practitioner conveys empathic sensitivity through words and tone of voice, and demonstrates genuine concern and an awareness of the patient's experiences. The practitioner avoids advising or directing the patient in an unsolicited fashion. Decision-making is shared. As the practitioner listens very carefully to the patient, the practitioner uses the patient's reactions to what the practitioner has said as a guide for proceeding with the session. The practitioner avoids arguments and sidesteps conflicted discussions or shifts focus to another topic where eliciting the patient's motivation for change may be more productive. The practitioner follows the patient's lead when structuring the discussion, instead of implementing the practitioner's agenda. New

perspectives are invited but not imposed. In brief, the practitioner captures the patient-centered way of being with a patient when conducting MET.

Potential roadblocks:

- Insisting on the practitioner's agenda
- Failing to actively listen to the patient
- Lack of empathy or sensitivity to the patient's experiences and reasons for pursuing change or maintaining the status quo

2. Ask Open-Ended Questions

Key elements:

- Encourage information-sharing and conversation
- Give the patient a range of options for discussing their experiences

Open-ended questions are questions that encourage the sharing of meaningful information, and cannot be answered with a single word (such as "yes" or "no"). Open-ended questions can help the practitioner elicit the patient's perception of their problems, motivation, change efforts, and plans. Open-ended questions do not pull for terse answers or very specific pieces of information, but rather invite dialogue. They give the patient a wide range of options for discussing their life circumstances, including their relationship conflict and substance use patterns.

Open-ended questions often begin with the following interrogatives: "What," "How," "In what" or lead off with the request, "Tell me…" or "Describe…"

Examples of open-ended questions:

- *"When you are drinking, tell me about the circumstances."*
- *"What does a typical drinking occasion look like for you?*
- *"What are your drinking habits like?"*
- *"Tell me about your relationship.*
- *"What concerns you about your drinking/relationship?"*

Potential roadblocks: Examples of closed-ended questions:

- *"How many drinks do you have every day?"*
- *"Did you drink yesterday?"*
- *"Do you and your partner drink together?"*
- *"Did you and your partner get in any fights last week?"*

3. Affirm Strengths and Change Efforts

Key elements:

- Affirmations communicate confidence in the patient's abilities and foster hope for success
- Practitioners can affirm by:, acknowledgment of personal qualities that might promote change, recognizing efforts toward change

- Affirmations are an important part of MET, provided they are presented sincerely. They verbally reinforce the patient's strengths, abilities, or efforts to change their behavior. Affirmations communicate to the patient that the practitioner has confidence in their ability to achieve their goals. The practitioner may affirm

the patient using many different approaches: a) using compliments or praise, b) acknowledging the patient's personal qualities, competencies or abilities that might promote change, c) recognizing effort or small steps taken by the patient to change. Sometimes, the practitioner might use a positive reframe to affirm the patient (e.g., noting how multiple treatment episodes and numerous relapses are evidence of the patient's persistence in trying to deal with their substance use problems and not giving up). By complimenting, positively reinforcing, and validating the patient, the practitioner fosters the belief in the patient that there is hope for successful recovery and that the patient can change his/her own substance use behaviors. Multiple "failures" can reframed as persistence or commitment to change

Some tips for providing affirmations:

- Focus on specific behaviors
- Avoid using the phrase "I think" or "I believe"
- Focus on descriptions, not evaluations
- Attend to non-problem areas rather than problem areas

4. Make Reflective Statements

Key elements:

- Reflective listening should constitute a large portion of an MET intervention
- Reflective listening communicates efforts to understand and encourages elaboration

Reflective listening is the heart of MET. A ratio of approximately two reflective statements for each question asked of patients is suggested. Reflective statements made by the practitioner restate the patient's comments using language that accurately clarifies and captures the meaning of the patient's communications and conveys to the patient the practitioner's effort to understand the patient's point of view. The practitioner uses this technique to encourage the patient to explore or elaborate on a topic.

Types of reflective listening

- **Simple reflection:** Stays very close to what the patient has said; communicates interest and stabilizes the patient.
- **Complex reflection:** Goes well beyond what the person has said and may not use the same words; often cognitively reframes the material, infers greater meaning, and may include affect.
- **Amplified reflection:** Pushes on an absolute statement by the patient; may back the patient away from their absolute position.
- **Double-sided reflection:** Acknowledges both sides of ambivalence.
- **Reflective summary:** Combines several pieces of patient information in a summary with the goal of inviting more exploration of material, to highlight ambivalence, or to make a transition to another topic.

Examples of reflective listeningPatient says: *"My relationship has been stressing me out lately. I keep trying things other than drinking to help myself feel better, but nothing seems to work except having a couple of drinks."*

Simple reflection: "*You keep looking for ways to cope besides drinking."*
Complex reflection: *"You seem frustrated by the lack of payoff for your hard work."*
Amplified reflection: *"Drinking is the only possible way to cope."*
Double-sided reflection: *"Drinking helps in the short term, and part of you recognizes that it may not be a great long-term strategy."*
Reflective summary: *"Let me see if I understand what you've said so far…"*

**A note about reflective listening: Depending on the tone of the provider, a reflection can sound like a question. Avoid inflection in the voice which suggests a question is being asked. Patients will usually provide additional information and clarification if necessary.*

5. Foster a Collaborative Atmosphere

Key elements:

- Therapy is a joint effort in which decisions are made together
- The patient's autonomy and personal choice are paramount
- The practitioner emphasizes realistic and viable choices

A collaborative atmosphere is fostered when the practitioner seeks guidance from the patient or acts as though therapy were a joint effort as opposed to one in which the practitioner consistently is in control. The practitioner emphasizes the (greater) importance of the patient's perspective and decisions about if and how to change. Any explicit practitioner statements that verbalize respect for the patient's autonomy and personal choice are examples of fostering collaboration during the session. The practitioner makes direct and clear references to the patient's capacity to draw their own conclusions or to make personal choices about how to proceed with a plan for change. In a collaborative atmosphere, the practitioner emphasizes viable personal choices rather than choices that are unrealistic for the patient.

Potential roadblocks

- Practitioner emphasis on options that are not realistic or desirable to the patient
- Practitioner assertion of authority or confrontation of patient
- Practitioner assumption that s/he can create change for the patient, rather than the patient building upon their own motivation for change

6. Recognize and Support Motivation to Change ("Change Talk")

Key elements:

- Recognize the lack of desire/ability to change as a viable option
- Ask questions about current importance of change, readiness to change, or confidence to change, as a way to strengthen commitment
- Develop discrepancies between the patient's current behavior and his/her beliefs and values
- Acknowledge that ambivalence is a normal part of the change process
- Explore ambivalence and reasons for both changing and staying the same
- Manage and redirect "sustain talk" with active listening and reflection

Supporting motivation to change involves practitioners' attempts to elicit patient self-motivational statements or "change talk," which are present in any discussion about change and are critical to MET. This is often accomplished through questions or comments designed to promote greater awareness of/concern about a problem, recognition of the advantages of change, increased intent/optimism to change, or elaboration on a topic related to change. The practitioner might ask the patient about whether other people view the patient's behavior as concerning or problematic and how these concerns of others impact the patient's motivation for change. Focusing on the importance of relationships with friends or family members who are concerned about the unhealthy behavior(s) (IPV, heavy drinking, drug use, etc.) can reinforce a patient's desire to change. The practitioner also might initiate a more formal discussion of the level of motivation by helping the patient develop a rating of current importance, confidence, readiness or commitment to change and explore how any of these dimensions might be strengthened.

"Change talk" reflects desires, ability, reasons, or needs to change. Below are examples of each:

Desire: *"I wish things were different." "This is not the life I want/the person I want to be."*
Ability: *"I know what I have to do – I just need to do it."*
Reasons: *"I don't want my kids to have to see the fighting." "If I drank less, I might feel better."*
Needs: *"I can't keep living like this." "Something has to change."*

Eliciting "change talk":
The practitioner can elicit "change talk" by:

- Encouraging the patient to verbalize desire, ability, reasons and need to change
- Reflecting commitment language if it occurs
- Arranging the conversation to increase the likelihood of the patient offering reasons for change
- Asking directly for change talk:
    - *"In what ways does this concern you?"*
    - *"How would you like things to be different?"*
- Asking for elaboration:
    - *"You said things were better then. Tell me about a time when you and he/she got along better. Specifically, what was happening?"*
    - *"What does it look like when you get angry? Tell me about a time like that."*
    - *"Can you describe to me the ways in which your life has been affected by your relationship?"*
- Exploring goals:
    - *"How would you like things to turn out?"*
    - *"What things would you like to be different?"*

Exploring pros, cons, and ambivalence involves facilitating a discussion of specific consequences of the patient's drinking and relationship conflict. This may include the positive and/or negative results of the patient's past, present, or future behaviors. An important stylistic component accompanying these techniques should be the practitioner's verbalizing an appreciation for ambivalence as a normal part of the change process. The practitioner should ideally discuss ambivalence in detail or explicitly facilitate a costs/benefits analysis with patient input concerning change versus remaining the same.

"Sustain talk"
Sustain talk is a part of ambivalence, and often a sign that the practitioner needs to change course. It is talk in favor of the status quo, or keeping things the way they are.

Managing "sustain talk"

- Sustain talk can be addressed with: simple reflections, reflection with amplification, coming alongside the patient, and open-ended questions. Some examples:
    - *Patient: "I am not an abuser and I hate when people say that!"*
      Provider: "It sounds like you don't want to be labeled."
    - *Patient: "My relationship isn't that bad. Other people have it worse."*
      Provider: "So you're completely satisfied with the way things are."

If a patient resists any previously-suggested approaches to addressing IPV/drinking:

- *"You may be right. That works for many people, but not everyone. Maybe we need to try a different way to approach this. What makes sense to you?"*
- *"What would your life be like in a year (five years) if things stayed the way they are?"*
- *"What would make this a problem for you?"*

7. Engage in "Change Planning" Discussion

<u>Key elements:</u>

- The crux of MET-centered therapy lies in fostering "change talk"
- The practitioner plays a crucial role in helping the patient develop an action plan for proposed change – primarily through highlighting specific, practical, and feasible steps of a potential plan
- The plan must be patient-initiated and driven by self-identified goals

- Collaboration within this change planning process is paramount

Engagement in change planning discussion involves the practitioner and the patient collaboratively developing a change plan on behalf of the patient. This process should include an initial discussion of the patient's readiness to prepare a change plan in addition to a discussion on the patient's self-identified goals that support the proposed change plan. A change planning discussion or intervention typically involves a discussion that includes many of the following areas: (1) the desired changes, (2) reasons for wanting to make these changes, (3) steps to make the changes, (4) people available to support the change plan, (5) impediments or obstacles to change and how to address them, and (6) methods of determining whether the plan has worked. An effective practitioner will guide the patient through a thorough discussion of change planning, with high emphasis on specific details. It is important that the practitioner allows sufficient time to explore all aspects of the change plan and elicits information from patient by utilizing open-ended questions and reflections. If a patient presents with ambivalence, the practitioner should attempt to resolve it towards the direction of change and resist pushing a potentially unprepared patient into a change plan.

Potential Roadblocks:

- Lack of individualization of a change plan
- Inadequate time to discuss an action plan
- Pushing patient forward without adequately exploring details and potential insecurities
- Focusing on a plan that does not match the patient's desires and goals

8. Facilitate Patient-Centered Problem Discussion and Feedback

Key elements:

- Practitioner seeks to explore in-depth the patient's concerns and provide personalized feedback that is:
    - objective
    - patient-centered
    - non-judgmental
    - curious
    - solicited by patient (or after permission is granted by the patient)

Patient-centered problem discussion and feedback involves explicit attempts by the practitioner to inquire or guide a discussion about relationship conflict and drinking, as well as the many related problems in living that are associated with those issues. The practitioner facilitates the development of a full understanding of the nature of the patient's difficulties. This process may involve the review of assessment results obtained during prior assessments. The method is less important than is the task of learning about the patient's problems and providing requested feedback to the patient about their problems in an objective, patient-centered manner. The practitioner guides this discussion and provides feedback using a non-judgmental, curious, collaborative patient-centered style. When providing feedback, the practitioner should seek out the patient's permission, if not directly solicited. Additionally, practitioner should utilize open-ended questions, reflections, and affirmations while providing feedback to create a supportive and relaxed environment in which the patient will be able to accept feedback.

Potential Roadblocks:

- Providing generic feedback without adequate thought or preparation
- Lecturing
- Drawing conclusions without sufficient evidence
- Practitioner acting as the "expert"

Example of asking permission to provide feedback:

"You have given me an excellent description of some of your concerns. I would like to put this information together with some of the other information you provided when you began this study so we will both have a complete view of what might be helpful for you. Would that be alright with you?"

VI: MET-Inconsistent Practices (Adapted from Martino et al., 2006)

1. Offering Unsolicited Advice, Direction-Giving,

This practice involves the practitioner providing unsolicited advice, direction-giving, or feedback about a specific situation rather than drawing out the patient's intentions or plans. In other words, the practitioner unilaterally offers specific suggestions, advice, direction, or feedback to the patient, when the patient has not asked for it. Practitioners that use this inconsistent practice typically adopt a prescriptive style of telling the patient how to be successful in their proposed recovery or change instead of maintaining a more collaborative, patient-centered tone. The message is one of "I'm telling you what to do."

2. Emphasizing Abstinence/Termination of the Relationship

This practice refers to the extent to which the practitioner explicitly discusses the rationale for absolute abstinence/relationship termination and was unequivocal in his/her recommendation of these as the only acceptable goals for the intervention. In this process of emphasizing abstinence/termination, the practitioner also typically articulates the disadvantages or dangers of having alternative goals of reducing drinking or reducing/modifying contact with their partner. These instances involve the practitioner seeking to impose his/her judgment about the goals of the intervention and emphasizes that these outcomes are considered the necessary standards for judging any improvement. Emphasizing that any goal of "harm reduction" or "controlled use" is not acceptable and unrealistic for patient would also be inconsistent with MET.

3. Directly Confronting Patient

Confrontation is defined as any practitioner statement or series of statements that involve telling the patient what they have not acknowledged or needs to know and accept. The message of the practitioner's communication is clear: "I know better than you, and I am telling you what you haven't realized." The practitioner's statement is a call to the patient to see their situation in more "realistic" terms. Often, the practitioner's confrontations will be blunt or, at times, dramatic, although it does not need to occur in a flamboyant manner. It may also occur in a lecturing style designed to impart information to the patient. Most times direct confrontation is motivated by his/her concern over the destructiveness of the patient's current behavioral pattern. It can also center around the patient's lack of progress on their established change plan. Most times, confrontation involves the patient feeling "labeled" or thought of as "ignorant" in the eyes of the practitioner, which is counter-therapeutic.

4. Highlighting Patient Powerlessness and Loss of Control

This MET inconsistent practice involves the emphasis of patient powerlessness over their life – substance abuse and/or relationships; the disease conceptualization of addiction or "fatalism" within relationships. These concepts assert that the patient has a chronic, progressive "illness" which, if not arrested, will lead to further loss of control and damage, and eventually lead to insanity or death, much like many other medical diseases/mental illnesses. This discussion will often involve an emphasis on abstinence as the only method of "controlling" or arresting the progression of the addition or "disease." Often, the practitioner will state that if a patient takes even one drink, they inevitably will lose control and have a full-blown relapse. Similarly, statements that imply that if the patient

communicates, even once, with their partner, they will get back together with him/her and the violence will persevere, convey a lack of hope and a lack of trust for patient.

5. Asserting Authority or Expertness

The practitioner who dominates the direction of the counseling session by promoting his or her agenda rather than trying to elicit the patient's goals for the intervention is asserting their authority. Likewise, references to the clinician's own experiences, knowledge and expertise is also asserting practitioner authority and minimizing the expertise of the patient. The practitioner who lectures the patient about what does and does not work or warns that recovery will be impeded and outcome will be poor if the patient follows their own goals rather than the usual guidelines in treatment is MET-inconsistent. Such practices may actually discourage the patient from "writing their own treatment plan."

6. Asking Closed-Ended Questions

These questions typically seek very specific answers or information. Often the patient can answer them with a "yes" or "no" response. The questions leave little room for patient elaboration. Often practitioners use them to "get to the point" or to acquire information the practitioner deems as necessary for the purposes of evaluation and treatment.

VII. Components of the MET Intervention for IPV and Alcohol

The MET procedure consists of 5 steps, borrowed from Miller and Rollnick (2013):

1) Engagement
2) Focusing:
   - Raise the subject and set the agenda
3) Evoking:
   - Explore areas of concern and provide feedback
   - Elicit Change Talk and Enhance Motivation
4) Planning: Develop an action plan (if appropriate) and offer referrals (if desired)
5) Booster

Note: The following scripts are provided as examples of Motivational Enhancement Therapy techniques. If an action plan is developed with the patient, it will vary depending on the patient's readiness to change and severity of IPV and drinking risk.

Step 1: Raise the Subject and Set the Agenda

Goal: to outline the content of the MET session and ask the patient's permission to proceed.

Critical components:

1. Be respectful
2. Obtain permission to engage in the discussion
3. Avoid arguing or being confrontational

Preparation:

- Review Social Health Assessment

Part 1: Establish rapport, explain practitioner's role, provide an outline of the MET

> *"Thank you for completing the Social Health Survey. Now I'd like to talk to you for 10-15 minutes about two of the concerns that we discussed in the interview: the conflict in your relationship and your alcohol use. Is that alright with you?"*
>
> *"Which of these concerns would you like to discuss first/is most concerning to you/is most important to you?"*

Note: This first step sets the climate for a successful MET intervention. Asking permission to discuss the patient's health concerns formally lets the patient know that their wishes and perceptions are central to the treatment.

Step 2: Explore Areas of Concern and Provide Feedback

Goal: to raise the patient's awareness of IPV and risky drinking and begin to listen for "change talk" related to these concerns. Ideally, the patient will be identifying concerns and connections, but the practitioner may provide informational feedback to the patient if it is needed to stimulate change talk.

Possible components:

- Identify patient's primary concerns related to alcohol use and/or IPV
- One issue will usually be more important to the patient.

About alcohol:

- Review the patient's drinking quantities, frequencies, and patterns
- Elicit the patient's perspective about problematic aspects of alcohol use
- Help the patient make connections between drinking and other health outcomes and psychosocial issues
- Help the patient make the connection between their drinking and their medical visit (medical problem or injury if applicable)
- Compare the patient's level of drinking to national norms and provide feedback , if patient permits.

About IPV:

- Elicit the patient's perspective about problematic aspects of relationship conflict
- Review the patient's IPV involvement, patterns, triggers
- Elicit the patient's knowledge of danger potential/health risks of IPV and provide feedback as necessary
- Plan for safety, if indicated

About the connection between alcohol and IPV

- Raise the subject of the connection between alcohol and IPV
- If the patient acknowledges/identifies the connection, encourage them to elaborate or give examples.
- Ask permission to discuss data linking heavy drinking and increased likelihood of severe IPV as indicated by patient situation/interest.

Preparation:

- Review the screening data provided by Social Health Survey and eligibility assessments.

Part 1: Discuss drinking and IPV

Begin with whichever concern the patient identified – drinking or IPV.

"I'm glad you identified that as a concern. Tell me a little more about that."

<u>Suggested strategies if the patient identifies drinking as a concern:</u>

- **Review the patient's drinking patterns**

  "From what I understand you are drinking…Tell me more about that."

- **Elicit the patient's perspective about problematic aspects of alcohol use**

  "What aspects of your drinking are concerning to you?"

- **Elicit the patient's knowledge about safe levels of alcohol use**

  "What do you already know/what have you heard about the medically recommended levels of safe drinking?"

  - **Offer feedback (if necessary):**

    "May I give you some feedback about what is considered a safer level of drinking?"

    "These are what we consider the upper limits of low risk drinking. No more than 14 drinks per week, and no more than 4 at one time. **[Show Gender-specific Guidelines & National Norms, Pictures of Standard Drinks]** *By low risk we mean that you would be less likely to experience illness or injury if you stayed within these guidelines. What do you make of this?"*

- **Help the patient make connections between drinking and other health outcomes and psychosocial issues.**

  "What connection (if any) do you see between your drinking and this visit?"

  "What connection (if any) do you see between your drinking and your overall health?"

- **Initiate a discussion about IPV:**

"I'm curious to know more about the conflict in your relationship. From what I understand, you experience_____ in your relationship. Tell me more about that."

- **Elicit the patient's perspective about problematic aspects of relationship conflict**

  "What aspects of your relationship are concerning to you?"

  "What do you already know about the impact of relationship conflict like yours on a person's health?"

- **Help the patient make connections between alcohol use and IPV**

  "What connection (if any) do you see between the times when you drink and conflicts you have with your partner? What happens?"

  - **Offer feedback (if necessary):**

    "May I give you some information about what we know about the connection between alcohol use and relationship conflict?"

    "We have seen that patients who drink more frequently/heavily often have more serious incidents of relationship conflict than those who don't. People who drink heavily (more than 3 drinks in one day for a woman, more than 4 for a man) are more likely to severely hurt their partners and commit acts of aggression against them. You might be less likely to hurt/be hurt by a partner (feel more aggressive, have more severely impaired judgment, etc.) if you (or your partner) cut down on drinking. What is your reaction to this information?"

Suggested strategies if the patient identifies IPV as a concern:

- **Review the patient's history of relationship conflict. This can be assessed at intake using scales such as the CTS2S, WEB, and Danger Assessment.**

  "From what I understand, you and your partner have experienced…Tell me more about that."

- **Elicit the patient's perspective on relationship conflict**

  "What aspects of your relationship are concerning to you?"

- **Elicit the patient's current knowledge about the health impact of IPV**

  "In your experience, what do you already know about the impact of relationship stress on your health?"

- **Help the patient make connections between IPV and other health outcomes and psychosocial issues.**

  "What connection (if any) do you see between your relationship conflicts and this medical visit?"
  "What connection (if any) do you see between your relationship conflicts and your overall health?"

  - **Offer feedback (if necessary):**

"We know that people in relationships with this kind of conflict often experience depression, anxiety, headaches, stomachaches, etc. We also know injury rates are high. What do you make of this?"

- **Help patient make connections between IPV and alcohol use**

"What connection (if any) do you see between the times when you have conflicts with your partner and the times when you drink? What happens?"

  - **Offer feedback (if necessary):**

"May I give you some information about what we know in the field about connections between relationship conflict and heavy drinking?"

"We have seen that patients who drink more frequently/heavily often have more serious incidents of relationship conflict than those who don't. People who drink heavily are more likely to become aggressive and hurt their partner, or be hurt by them. You might be less likely to hurt/be hurt by a partner (feel more aggressive, have more severely impaired judgment, etc.) if you cut down your drinking. What is your reaction to this?"

Suggested strategies if the patient seems unconcerned about both the IPV and the drinking:

It is important that the patient's agenda is honored during the MET intervention. Begin the discussion with an attitude of curiosity, and the patient will generally offer additional information. Below are strategies to initiate a discussion about IPV and alcohol with a patient who does not seem concerned about either. Note that a critical component of the intervention is listening to and respecting a patient's reasons to maintain the status quo.

- **Typical day:**

"I know some information about your life, based on what you've already told me. Still, I don't know what a typical day in your life would be like, and that seems pretty important. So I was hoping you could fill me in about your daily routine, starting with waking up in the morning. What is your day like?"

"Thank you for sharing that. So on days when you are drinking/experiencing conflict with your partner, how are those days different?"

OR

"How does drinking fit in to your day?"

- **Normalize the behavior:**

For patients who hesitate to discuss their concerns, it is especially important that they do not feel judged. Embed an inquiry about the patient's IPV/drinking into a series of questions that have a natural flow so they feel less intrusive.

"Couples handle disagreements and fights in a variety of ways. Some talk it through, walk away, or yell. Some break things or get physical. There is a whole range of responses couples use. When you two get angry, how do you fight?"

"On days when people drink, some have one drink, some have 24. What is your drinking like?"

Part 2: Check in with the patient about the information discussed and ensure your understanding with a summary

"What do you think about what we've just discussed?"

"From what I've heard you say, you are concerned about….What have I missed?"

Step 3: Enhance Motivation

Goal: to elicit change talk that moves toward action by exploring reasons to change and potential challenges.

Critical components:

1. Assess importance of change
2. Assess confidence to change
3. Develop discrepancy
4. Discuss reasons for change, possible challenges, and ambivalence
5. Use reflective listening
6. Use open-ended questions

Preparation:

- "Importance of Change Ruler" and "Confidence to Change Ruler" (Appendix G)

Part 1: Assess importance of change

- **Ask patient to self-identify importance of changing drinking behaviors/relationship conflict, on a scale of 1-10 (Importance of Change Ruler)**

  "Given everything we have been talking about, on a scale from 1-10, where 1 means 'not at all important' and 10 means 'very important,' how important is it to you that you change any aspect of your drinking/your relationship?"

Part 2: Assess confidence in ability to change

- **Ask patient to self-identify confidence in ability to change drinking behaviors/relationship conflict, on a scale of 1-10 (Confidence Ruler)**

  "On a scale from 1-10, where 1 means 'not at all confident' and 10 means 'very confident,' how confident are you in your ability to change any aspect of your drinking/relationship conflict?"

Part 3: Develop discrepancy

If patient says…

- **2 or higher, ask:**

  "*What made you choose that number and not a lower one?"*

- **1 or unwilling, say:**

"You mentioned that you don't see your drinking/the conflict in your relationship as a big problem for you. Has anyone else in your life mentioned that it is a concern for them?"

OR

"In what ways has drinking/relationship conflict been a problem for you? (work, health, other relationships, etc.) Have you ever done anything related to drinking that you wish you hadn't?"

OR

"What would make drinking/your relationship a problem for you?"

Part 4: Discuss reasons for change, possible challenges, and areas of ambivalence

- **Use open-ended questions and reflective listening to elicit "change talk." Some examples of probes:**

"So on the one hand, you like _____ about drinking. On the other hand, you're concerned that_____."

"The conflict in your relationship doesn't really worry you. On the other hand, you are concerned about the impact of your anger on your child."

"You've tried to change, but it's been difficult. What made you persist in your past efforts?"

"What has worked for you in the past?"

"I'm not sure you're saying you'd like to change, but if you are, it sounds like you would need…"

Note: Patients are often ambivalent about change. Developing discrepancies between the patient's present behavior and their own expressed concerns may tip the scales towards readiness to change. Reflective listening is a way in which to check what the patient meant by a statement. Intonation should turn down at the end of the remark to encourage patient response.

Step 4: Develop an Action Plan (if appropriate) and Offer Referrals

Goal: to assist the patient in identifying and committing to specific action steps that will address IPV and risky drinking ifs/he desires to do so. Note that the option of not changing must also be respected.

Critical components:

1. Negotiate a plan on how to cut back and/or reduce harm (if desired by the patient)
2. Discuss risky situations for IPV and ways to cope with them (safety planning) (if desired by the patient)
3. Summarize goals
4. Give referrals
5. Plan for booster session

Preparation:

- Patient Social Health Resource Guide

Part 1: Elicit the patient's ideas about possible "action steps" and secure a commitment if applicable

"What do you think you will do?"

"What might be a good first step?"

"It must be uncomfortable now, learning that your (drinking, relationship conflict) is_____. What is your next step?"

"What could you do? What are your options?"

"It sounds like it would be tough for you if things stayed as they are now. What are you going to do?

"Which option might suit you best?"

"What are your most important reasons to change?"

Strategies for eliciting specific commitments to a goal:

"That can mean different things to different people. What does it mean to you?"

"What strategies have you explored that might help you do this?"

"What ideas do you have about ways that you can do this?"

"I have some ideas about what might be helpful, but first let me hear what you've already considered."
Note: If the patient has already initiated change or is in the action phase, see Appendix B for useful tips.

Part 2: Identify risky situations and coping strategies

"You mentioned that you and your partner sometimes get into conflicts. In what situations is someone most likely to get hurt?"

Part 3A: Safety plan (with victims only)

"We've talked about some of the conflicts that you experience with your partner, and I'd like to talk about some ways you can help yourself stay safe before you leave. Is that okay with you?" **If yes, proceed to safety plan (see Appendix D). Ask the patient to fill out safety plan form (if desired), and provide safety tips sheet.**

"What can you do to avoid severe conflict when those risky situations happen?"

"What ideas do you have about ways you can keep yourself safe in your relationship? What have you already done?"

"What are your thoughts about ways you can drink safely?"

Part 3B: Safety plan (perpetrators)

"We've talked about some of the conflicts that you experience with your partner, and I'd like to talk about some ways you can help yourself and your partner stay safe before you leave. Is that okay with you?" **If yes, proceed to safety plan (see Appendix D). Ask the patient to fill out safety plan form (if desired), and provide safety tips sheet.**

"What can you do to avoid severe conflict when those risky situations happen?"

"What ideas do you have about ways you can keep everyone safe in your relationship? What have you already done?"

"What are your thoughts about ways you can drink safely?"

Part 4: Summarize

"So if I can summarize, I heard you say that you would…(goal) OR *"I remember you said that _____ is important to you. What did I miss?"*

Part 5: Give referrals

"What information do you already have about services/supports that can assist with that?"

"Would you like me to share with you information about services that have helped other people with similar goals/concerns?"

Part 6: Plan for booster session

The goal of this portion of the intervention is to establish an individualized method of contact that will be safe for the patient (See Appendix C for suggested follow up form).

- **Identify phone number and best day and time of day to call.**

  "I'd like to follow up with you in about 10 days to see how you're doing with the goals we just discussed. Can we discuss a way for me to reach you when you are alone and able to talk?"

- **Identify a protocol for safe identification and termination of the conversation if necessary.**

  "Is it safe for me to identify myself as calling from the Social Health Study?"

  "Is there a particular way you'd like me to identify myself that is best for you?"

  "Let's set up a code word or phrase in case I call at a time when you can't talk. For example, you could simply say 'no, I don't want to buy…'" or something like that."

- **Identify code word/phrase for calling the police.**

  "Also, if you feel unsafe and want me to call the police and send them to your home, what can you say to me to let me know to do that?"

- **Closing, goodbye.**

<u>Important information to collect for the booster</u>

- Three telephone numbers at which to reach the patient (identify primary number as well as alternate numbers and an emergency contact)
- The best time of day to reach the patient
- The patient's address (in the event that police need to be sent to their home)
- Code words to ensure safe contact
- Any additional steps that can be taken to help ensure safety

Step 5: Booster Session

Note: The following is a guide to key talking points to be used during the booster session that occurs 7-10 days following the patient's medical visit. In addition to providing a "booster" to the intervention, it is important for the MET provider to make notes regarding any incidents of IPV/drinking, safety, and action steps taken since the medical visit. The MET provider should also assess current motivation (readiness to change) and self-efficacy (confidence).

"Hello, this is _____ from the Social Healthy Study. May I speak with ____?"

"Hi, _____. We met on (date). Is this a safe time to talk?"

Intimate Partner Violence

- Since your medical visit, tell me what your relationship has been like? (Make notes indicating the nature of any conflict- was it physical? Emotional? Did it result in the need for medical care?)
- We had discussed some things you can do to maintain safety in your relationship. when you feel like you might be at risk for harm or harming someone else. What strategies have you tried? How have they worked? What other strategies have you tried?
- What are your questions about the safety plan you established?
- Given everything we've been discussing, if you could choose the best outcome for your relationship with your partner/ex-partner, what would it be?
- Please think about the way you are feeling right now. On a scale of 1-10, where 10 means 'very ready' and 1 means 'not at all ready,' how ready do you feel to take steps to make the changes in your relationship that we've been talking about?
- Using a scale where 10 means 'very confident' and 1 means 'not at all confident,' how confident do you feel about your ability to make changes in your relationship?

Alcohol Use

- I'm wondering what your alcohol use has been like over the past week or so.
- We discussed some things you can do to engage in safer drinking habits. What strategies have you tried? How have those strategies worked out for you? What other strategies have you tried?
- What are your questions about the plan you established?
- What is your next step in terms of your plan to change your alcohol use?
- Using the same scale, where 10 means 'very ready' and 1 means 'not at all ready,' how ready do you feel to take steps to make the changes in your life that we've been talking about related to your drinking?
- Using the same scale, where 10 means 'very confident' and 1 means 'not at all confident,' how confident do you feel about your ability to make changes in your drinking?

Goals

- What has it been like for you trying to work on your goal/s?
- Have particular things been challenging for you?
- How have you dealt with them/how do you plan to deal with them?
- What has kept you motivated to keep working toward your goal?

Resources/ Referrals

- Do you still have the list of referrals I gave you?
- Have you connected with or tried to connect with any referrals we discussed?
- Are there any/any additional supports that you plan to connect with in the near future?

MET Provider Notes

_____
_____
_____

_____

_____
_____

Conclusion/ Evaluation

"As we discussed when we first met, this phone call will conclude the contact that you and I will have. Before you go, I wanted to know if you have any feedback for me about what this experience has been like for you."

- What has been particularly helpful to you?
- What could I have done differently?
- What problems came up during your medical visit or afterwards that are related to your participation in this study?
- Finally, what additional information that you would like from me or what questions do you have?

"Before we conclude our conversation, I would like to make sure that we have accurate contact information for you." (Refer to safe contact form to verify patient's current contact information is correct.)

_____ MET Provider checks here once Safe Contact Form is verified.

Use the space below to record any other qualitative information/ notes below:

Appendix A: EXAMPLE MET DIALOGUES

Example #1: Low Risk Bi-directional IPV and Episodic Binge Drinking (Gender Neutral)

SPEAKER	DIALOGUE
Provider	Thank you so much for completing the Social Health Survey. I'd like to speak with you about your responses to the survey. Is that okay with you?
Patient	That's fine.
Provider	Okay. The survey asks questions about relationship conflict and alcohol use. Which of these topics would you like to address first?
Patient	It doesn't matter.
Provider	Which one is more important to you?
Patient	I guess my relationship. I don't really drink much.
Provider	Okay, you're not too concerned about your alcohol use, but you might like to talk a little bit about your relationship.
Patient	I don't know. It's fine I guess. Just sometimes we yell at each other, and it gets a little out of hand. It's not really a big deal.
Provider	Sometimes things go further than you'd like.
Patient	Yeah. We just aggravate each other, you know?
Provider	You get on each other's nerves. What typically happens when you aggravate each other?
Patient	We just raise our voices, and sometimes we curse each other out. There was once when we started pushing each other…
Provider	That bothers you.
Patient	Yeah, a little. I mean, it didn't hurt much, but our son saw.
Provider	Your son is important to you.
Patient	The most important thing! And I don't want him growing up thinking it's okay for men and women to put their hands on each other when they get mad.
Provider	You want him to see that there's another way.
Patient	Exactly. That's not something kids should see.
Provider	So it seems like you're pretty aware of your son's needs. I wonder what ideas you have about how you can "get along."
Patient	I guess just talking it out.
Provider	That can mean different things to different people. What does 'talking it out' look like to you and your partner?
Patient	I guess just stopping and taking a deep breath – not letting my emotions run away with me. Because the more I yell, the more s/he yells, and then…you know.
Provider	Things get physical.
Patient	Yeah. I just get so mad because it feels like s/he won't listen to me.
Provider	You want to feel like you are being heard.
Patient	Yeah and it's like he just won't hear me.
Provider	Was there a time in the past when you felt like a potential argument turned the other way and went well – when you felt listened to?
Patient	When I talked to her/him calmly and thought about what I wanted to say before I said it. We argued, but it wasn't anything as bad as it's been before.
Provider	So you've sometimes had success in managing conflict.
Patient	I guess so.
Provider	What do you think you might need to continue being successful?
Patient	I really don't know. I just need to do it.
Provider	It seems like you think you need to do it, and it's also been challenging. What has been challenging about it?
Patient	I just get frustrated. Maybe I need therapy or something.

Provider	So you might consider therapy, and you might be a little doubtful about it as well.
Patient	I mean, I guess it could be fine. Everyone in my family yelled all the time. Maybe a therapist could help me see other ways.
Provider	You think that there are other ways of managing conflict, and you'd like to learn more about them.
Patient	Yeah.
Provider	So what do you think you'll do now?
Patient	I think I could give my old counselor a call, but I don't know if she still works at the same place.
Provider	That sounds like a good plan to start with. When do you think you'll do that?
Patient	I could dig up the number this week. I also live nearby, so maybe I could just swing by.
Provider	So you had a counselor before who you'd like to see again soon to discuss some healthy ways of managing conflict. You seem to have some ideas already, and a counselor might be able to help you build on those. This is important to you because you want your son to be able to learn about healthy relationships. Did I get all that right?
Patient	Yeah.
Provider	Good. Now I'm wondering if it's okay with you if we change gears a little and talk about your drinking.
Patient	Sure, but there isn't really much to say.
Provider	What connection do you see between the times when you and your partner argue and the times when you're drinking?
Patient	Connection? I don't know. When I drink it's usually with my friends.
Provider	Tell me more about what your drinking usually looks like.
Patient	I just have a few to unwind on the weekends when we go out. Nothing serious.
Provider	So your drinking is not really concerning to you.
Patient	Not really, no.
Provider	Would it be okay with you if I gave you some feedback about your drinking, based on what we know from research?
Patient	Ok.
Provider	We usually recommend that safe levels of drinking are: no more than 4 on any occasion for a man and no more than 14/week total (no more than 3 on one occasion and no more than 7 drinks in a week for a women). You told me that you'll have 5 or 6 drinks a couple of nights a week, which puts you outside this safe limit. What do you make of that?
Patient	I don't know. I don't really think my drinking is a problem.
Provider	What I told you surprises you.
Patient	Yeah. I mean, it's not like I'm always drunk. I go to work, and I usually feel fine.
Provider	You're able to function and you usually feel ok, and on the other hand, there are times when you don't feel okay.
Patient	I guess.
Provider	What happens during times when you don't feel okay?
Patient	I guess I just get hung over. You know, headaches, stomachaches.
Provider	Sounds uncomfortable. Do you see any connection between your drinking and your health care visit today?
Patient	I have abdominal pain. I never really thought about that being related to alcohol.
Provider	So your pain today might be related to some of your drinking.
Patient	Maybe.
Provider	One thing we know about alcohol is that drinking beyond the limits we talked about before can make certain health problems – like abdominal pain – even worse. What do you think about that?
Patient	I guess I hadn't thought about it until now.
Provider	But it makes some sense to you.
Patient	Yeah, I didn't realize my drinking could be a problem.
Provider	But now you're thinking about it.
Patient	Yeah.
Provider	What do you think you will do?
Patient	I guess I could cut down to the limits. What did you say – (4 male; 3 female)?
Provider	Right, three/*four* in a day is considered safe for a woman/man as long as you don't exceed 14 in a

	week.
Patient	That should be fine. It's not much less than what I drink now.
Provider	Cutting down your drinks seems realistic to you.
Patient	Sure. My friends don't care. We just like to have a good time.
Provider	Can you imagine any situations where it might be hard to cut down?
Patient	Not really. I think it will be fine.
Provider	You feel confident that you can do it.
Patient	Yeah.
Provider	That's great! I really want to thank you for talking with me today. I'd also like to plan for us to follow up in about a week by phone and see how you're doing and what you think about some of the things we discussed today. When is a good time for me to call you so we can speak again?
Patient	Next Thursday is fine. In the morning.
Provider	How is 10:00?
Patient	That's fine.
Provider	If someone other than you answers or if I need to leave a message, is it safe for me to identify myself as calling from the Social Health Study?
Patient	That's fine.
Provider	Let's set up a code word or phrase in case I call at a time when you can't talk. For example, you could simply say "no, I don't want to buy insurance" or something like that.
Patient	We always get calls for Main St. Pizza. I'll just say 'this isn't Main St. Pizza.'
Provider	Sounds good. I'll give you a reminder call the day before. I look forward to speaking with you Thursday! Thanks so much for taking the time to talk with me today.

Example #2: High Risk IPV Victimization and Drinking in Excess of Safe Levels

SPEAKER	DIALOGUE
Provider	Thank you so much for completing the Social Health Survey. Now I'd like to spend about 15 minutes talking with you about two of the areas that were brought up in the questionnaires – your relationship conflict and your use of alcohol. Is that okay with you?
Patient	That's fine.
Provider	Great, thank you. Which of these would you like to discuss first?
Patient	I guess the drinking. I mean, I don't drink all that much, but it's getting a little worse lately.
Provider	What are your drinking habits usually like?
Patient	I have maybe two drinks a night…just to help me unwind.
Provider	You need alcohol to unwind.
Patient	I guess, yeah. Things are pretty stressful right now.
Provider	Tell me more about the stress.
Patient	Just things at home.
Provider	Things at home are stressful.
Patient	Yeah. I mean, my husband/wife is out of work. We don't have any money. And s/he doesn't always treat me the best. We have trouble getting along, but when I agree to drink with him, s/he stops bothering me…for a little while. Sometimes s/he can get kind of nasty, but usually I just fall asleep and s/he leaves me alone.
Provider	Drinking is a way to get away from the stress at home.
Patient	Yeah. S/he's just mean.
Provider	Can you tell me what "being mean" is in your relationship?
Patient	Oh, it depends. Sometimes s/he just tells me I'm fat and ugly, and don't deserve him/her. That hurts my feelings but I can usually ignore it because s/he's been drinking. But then s/he can lose his temper and accuse me of sleeping with all these other men/women, and that makes me mad. I've haven't been with anyone else. But s/he's so jealous s/he doesn't want me to go anywhere. S/he calls me constantly when I do.
Provider	I'm so sorry you're going through this. Has s/he ever hurt you physically, or made you do something sexually that you didn't want to?
Patient	S/he pushes me sometimes. And once s/he punched me. But I had made him/her really mad. I guess I deserved it. He/she really had to do something about it.
Provider	You feel like s/he had no other choice but to punch you.
Patient	I mean, s/he did have a choice. You always have a choice I guess.
Provider	You see that there might have been another way.
Patient	Yeah. I wish we could have dealt with it a different way, but drunk people aren't the easiest to talk to.
Provider	You see a connection between your arguing and the drinking.
Patient	I do. Like I said, sometimes I can just go to sleep. But if we're drinking and something sets him/her off, it's hard to get him/her to calm down.
Provider	That scares you.
Patient	Kind of. There's like this look in his/her eyes sometimes – like nothing I could do could make him stop.
Provider	S/he sounds pretty dangerous. I wonder what ideas you have about ways you can keep yourself safe when you two argue.
Patient	Well, when I'm drinking, I'll yell back. That gets him/her really mad.
Provider	So drinking sometimes makes things worse.
Patient	Yeah. So I guess if I were more sober things wouldn't be as much of a mess.
Provider	Drinking less might help.
Patient	Yeah.
Provider	That's a pretty strong insight – and the experts agree with you. We know that couples who drink together are more likely to get into serious conflict, and the conflict is much more likely to be dangerous if there's drinking involved. What do you think about that?
Patient	That makes sense.
Provider	So what do you think you'll do now?
Patient	I guess I can cut down my drinking. Or maybe just go to my mom's or something when s/he's drinking.
Provider	Those sound like strong ideas. What does 'cutting down' mean to you?

Patient	Truthfully, there are some nights I don't need a drink. It's just a habit. So I could just not drink on those nights.
Provider	And the nights when you do feel like you need a drink?
Patient	I probably shouldn't drink then either. It never ends up well.
Provider	So it sounds like you're ready to make some changes. What supports do you think you'll need to be able to make these changes?
Patient	Well, I used to go to AA. I liked that. But I'm a little nervous about being in a group again. I'm afraid I'll say something stupid or get angry. Some of those folks are intense.
Provider	So you liked AA and saw lots of good things about it,and you're a little apprehensive.
Patient	Yeah.
Provider	I think a lot of people are nervous about groups, but you also seem like a pretty strong, insightful person. It seems like people would really appreciate hearing you talk.
Patient	Maybe.
Provider	You've had a good experience at AA in the past.
Patient	That's true. It's just embarrassing talking about my husband/wife. People don't want to hear about all that.
Provider	You feel like they might judge you.
Patient	Yeah.
Provider	It seems like you're interested in being in a group, and it's also important to you that people don't judge you. Is that right?
Patient	Yeah.
Provider	Would you like to hear about some resources in the area that can support women/men with similar concerns as you've expressed – some relationship conflict and drinking?
Patient	There are services like that?
Provider	Definitely.
Patient	Ok, tell me.
Provider	*(shares referral information)* What are your thoughts about all this?
Patient	I think I'll call them.
Provider	When do you imagine doing that?
Patient	Probably this week.
Provider	Sounds like a plan! I really want to thank you for talking with me today and for being so open. I'd also like to plan for us to follow up by phone in about a week and see how you're doing and what you think about some of the things we discussed today. When is a good time for me to call you?
Patient	Evenings are best. I have to go to work.
Provider	How about Wednesday at 5:00?
Patient	That's fine.
Provider	Ok. Your safety is really important to me, so I also want to talk with you about a safe way for me to contact you. If we're talking and you feel unsafe, please just hang up. I'll give you my number and you can call me back, or I'll try the next day.
Patient	That's fine.
Provider	If someone other than you answers or if I need to leave a message, is it safe for me to identify myself as calling from the Social Health Study?
Patient	Sure, that's no problem.
Provider	Ok, and if you feel like you're in danger when we're on the phone and you'd like me to call the police for you, what's something you could say to let me know?
Patient	How about, 'it's about that time.'
Provider	That works. Thanks again for talking with me. I look forward to speaking with you on Wednesday.
Patient	Me too.

Example #3: High Risk of Perpetration and Drinking in Excess of Safe Levels

SPEAKER	DIALOGUE
Provider	Thank you so much for completing the Social Health Interview with me. Now I'd like to spend a few minutes talking with you about two of the areas that were brought up in the interview – your relationship conflict and your use of alcohol. Is that okay with you?
Patient	Sure.
Provider	Which of these would you like to discuss first?
Patient	I have been getting into it with my wife/husband recently.
Provider	You've been fighting.
Patient	We've been arguing a lot recently –s/he gets on me about my drinking and not having a job.
Provider	What happens when you're arguing?
Patient	I get angry. Things can get pretty heated.
Provider	You've noticed that when you feel angry, the situation escalates beyond what you're comfortable with.
Patient	Yeah – but s/he really pushes my buttons!
Provider	You ands/he both recognize that there are some things that make you particularly angry and you wonder if s/he's focusing on them on purpose.
Patient	Oh yes s/he does…when I've been drinking, the last thing I want to hear is her nagging me about how much s/he's worried about me.
Provider	She cares about you, and when s/he expresses her concern, the two of you are more likely to get into an argument. What does s/he worry about?
Patient	Sometimes when I go out drinking I get into fights or I come home and s/he and I can get into it. I think s/he's worried something is going to happen to me or to her. The police came last time we got into an argument.
Provider	So it's gotten so bad that the police have been called.
Patient	Yeah – I guess it has gotten pretty bad. I hit him/her to get him/her to stop nagging me and s/he started screaming and throwing things at me. The neighbors were pounding on the walls and I guess one of them called the cops. I don't really remember everything that happened…I was pretty drunk.
Provider	I'm sure that must have been scary for both of you, but for different reasons.
Patient	Yeah, it's pretty bad. I really can't go to jail. And I don't want to hurt him/her.
Provider	Sounds like you worry a little bit too.
Patient	Yeah, I know things aren't right.
Provider	You seem aware of what the problems are.
Patient	Yeah, but nothing ever changes.
Provider	It sounds like you want this to change, but you're not sure how to go about it.
Patient	Yeah, of course I do. We can't keep on going like this.
Provider	I get the feeling that you have a different plan in mind for how you'd like your relationship to look in the future.
Patient	*(Patient nods head)*
Provider	Tell me about your view of the future. What might your relationship look like if things change?
Patient	We'd just be happier. That's all.
Provider	What would it take for you and your husband/wife to feel happier?
Patient	I guess I would have to keep it cool when s/he tells me s/he worries. But s/he needs to take it easy too!
Provider	You believe you both have a role in improving the relationship. What would it look like if your relationship didn't change in the future?
Patient	Oh, wow. (Pause). I don't know. It's like one of us is going to get hurt or go to jail.
Provider	You took a pause there. You're thinking about this pretty seriously, and you're hoping things don't go that far. If we focus on the things you can control, what could you do to prevent these

	situations from getting out of control or escalating?
Patient	I could cut back on my drinking.
Provider	If you drank less, you might not get into these situations.
Patient	Maybe…I don't know.
Provider	You're not sure, but you're wondering if decreasing your alcohol use might help.
Patient	I could try it.
Provider	You're willing to try, but you're not sure how it will turn out. What have you thought of that might help you reduce your drinking?
Patient	I don't know…I never really thought about it like that.
Provider	How would you feel if I shared some information with you about how some other people have reduced their drinking?
Patient	That would be okay.
Provider	Well, there are a number of different options. Some people decide they would like to limit the number of drinks they have, so they keep track of them. For people who drink in bars, one way to do this is to only carry a certain amount of money with you, so that you cannot spend too much.
Patient	But I don't really drink in bars. I usually drink at home.
Provider	It is possible to keep track of your drinks at home too. Also, there are some other strategies people use when they are trying to cut back. Are you interested in hearing some more?
Patient	Actually, I just thought of one. One time, I was drinking with my brother, and we had to be careful not to drink too much because we had to drive, so we decided to go kind of slow.
Provider	You paced yourself so that you did not feel too drunk.
Patient	Yeah, that worked pretty well. I could try that. Like maybe instead of drinking the whole six pack, I will just have 2 or 3 and I'll space them out.
Provider	I think that's a great idea if you're goal is to cut down. Because you said you were interested in learning more strategies, I would like to offer you this resource guide with lots of information about places you can go for extra support. Would you be interested in this?
Patient	Sure
Provider	Let's take a minute to go over what we have talked about…things get bad between you and your husband/wife and they get physical. You have hurt him/her in the past and things have gotten to the point where the police have been called. You've recognized this as a serious problem and it you have identified that your drinking is part of the problem. Now you're wondering if things might get better if you cut down your drinking, but you're not interested in stopping your alcohol use completely. What have I missed?
Patient	Nothing. I think you got it.
Provider	So what will be your first step toward reducing your drinking?
Patient	I'm going to cut back to 2 or 3 a day, and pace myself. I'll also take a look at this list you showed me. I'm not sure if I'll call any of these places, but I'll hang on to it just in case.
Provider	Sounds like a plan! I really want to thank you for talking with me today and for being so open. I'd also like to plan for us to follow up in about a week and see how you're doing and what you think about some of the things we discussed today. Would you be interested in that?
Patient	That's fine. Evenings are best. I have to go to work.
Provider	How about Wednesday at 5:00?
Patient	That's fine.
Provider	Ok. Your safety and the safety of your family is really important to me, so I also want to talk

	with you about a safe way for me to contact you. If we're talking and you feel unsafe, please just hang up. I'll give you my number and you can call me back, or I'll try the next day.
Patient	Sure.
Provider	If someone other than you answers or if I need to leave a message, is it safe for me to identify myself as calling from the Social Health Study?
Patient	Sure, that's no problem.
Provider	Ok, and if you feel like you're in danger when we're on the phone and you'd like me to call the police for you, what's something you could say to let me know?
Patient	How about, 'it's about that time.'
Provider	That works. Thanks again for talking with me. I look forward to seeing you on Wednesday.
Patient	Me too.

Appendix B: MET AND SPECIAL CIRCUMSTANCES

A patient discloses major depression/suicidal ideation:

- Thank the patient for sharing this information, and affirm the patient's choice to disclose.
- Calmly express empathy, and validate that their feelings and concerns are important. Let them know that you will come back to address these feelings at the conclusion of the conversation.
- Proceed with the MET intervention, unless there appears to be eminent danger.
- Let the patient know you will be notifying the Principal Investigator and/or attending physician to help ensure that s/he receives the necessary assessment and support for their depression.

Example response to a person who brings up depression/suicidal ideation while discussing their drinking/relationship:

- "I'm so glad you told me."
- "I'm really sorry you are feeling so sad. It's not unusual for someone who is struggling with [drinking or their relationship] to have these feelings. Before I leave I will make sure that you get the help you need to sort out some of these feelings. I will need to let the doctor taking care of you know how depressed you are feeling. Do you think that these feelings relate to what's going on with your [drinking/relationship]?

- Notify the PI and/or attending physician of the patient's disclosure of co-morbid depression and/or suicidal thoughts.

Note: If the patient's expressions seem to intensify or affect worsens when discussing suicidal ideation/depression, conclude the MET regardless of whether or not it is finished and proceed with the above steps as appropriate.

A patient expresses major psychosocial concerns/risks OTHER than IPV or alcohol use:

- Name the patient's concern using reflective listening to ensure you understood it properly.
- Thank the patient for sharing with you.
- Ask the patient what connections they see between the concern they raised and IPV and/or alcohol use.
- If the patient connects the concern to IPV or alcohol use, proceed with the MET. If not, let the patient know that you will return to discussing the concern with them following the MET.
- At the conclusion of the MET, let the patient know that if they would like, you can refer them to the hospital social worker, who is an expert in addressing patients' other concern(s). Highlight relevant referrals for the patient on the Social Health Resource Guide and ensure they take the guide home with them.

A patient is already in the action or maintenance phase of change:

- Support and affirm the efforts that the patient has made thus far.
- Spend some time discussing the patient's motivations/reasons for making the changes they have made.
- Move toward a very specific action plan: discuss additional or next steps the patient plans to take, and elicit a commitment to specific action(s).
- Help the patient identify situations that would make it difficult to maintain the change.. Assist them in planning ahead for these circumstances.
  - "What do you see coming up that could get in your way?"
  - "What are high-risk situations?"
  - "What may be a sign that you need to do more than you're already doing?"
  - "You've probably learned some important lessons about __. What are they?"
  - "I know your partner is not in a relationship with you anymore, but what might you do if your partner comes back?"

- Work with the patient on a relapse prevention/safety plan.
- Identify sources of social support that might help them maintain their resolve for change or help them in an emergency.

A patient is particularly challenging or committed to the status quo:

Important to the spirit of MI, is that the provider must resist the "righting reflex," in which the provider tries to fix the patient's problems until the patient asks for assistance or gives permission for the help (Miller & Rollnick, 2002). The danger in not respecting the patient's autonomy is that the provider can inadvertently stimulate resistance to change. In addition, for victims of IPV, controlling behavior on the part of the provider can replicate the controlling behaviors of the abusive relationship (Wahab, 2006). It is also important to realize that a victim of violence who chooses to stay in an abusive relationship may have accurate knowledge that leaving may put them –or their children - in increased danger from separation violence.

If the patient shows resistance, the provider should focus on the patient's strengths and building self-efficacy. With the caveat that a victim of abuse can only control their own behavior, even multiple negative outcomes can be reframed – they suggest persistence and a strong desire to make changes. And patients who are committed to things staying as they are often have significant strengths as well. Drawing on these strengths can help build rapport and increase patient engagement. Challenging patients may have the following strengths that you can point out to help build their self-efficacy:

- The ability to observe how systems function
- The ability to perceive opportunities
- The ability to make active decisions on their own behalf
- Independent thinking
- Determination/fortitude

Patients usually respond well to hearing good things about themselves and may be more receptive to change talk and less resistant if they feel you value their strengths.

Appendix C: SAFE CONTACT PLAN

University of Pennsylvania
Social Health Study
INDIVIDUALIZED SAFE CONTACT PLAN

Participant Name: _____
First Middle I. Last

Date of Contact Plan____/____/ _____

□ Check Here if Participant does NOT want to be contacted during follow-up.

"Your safety is our primary concern. We need to make a safe plan for contact. We do not want to call when your partner is around or can listen in on the conversation. Is it safe for you if someone from this study calls your home or cell phone? Is it safe to leave a message from 'the University of Pennsylvania's Social Health Study'? Is there another way you'd like us to identify ourselves or something else you'd like us to say if someone else answers the phone? We will not give any other information to someone other than you. Please provide information about the best ways and times to reach you."

1. When is the best time to contact you by phone? Day (please circle): M T W Th F Sa Su
   Time (please circle): Mornings Afternoon Evenings
2. Is it ok for us to mail you generic health tip reminders to your home address? □ Yes □ No
3. Is it ok for us to send you text messages with study reminders using generic messages? □ Yes □ No

   Sample Text Messages:
   "Penn Medicine cares about your health. This is a friendly reminder. Call to schedule your next visit: 215-573-3055. Do not reply to this text."

COMMENTS / NOTES:_____

_____

_____

"If you are speaking with us and it suddenly becomes unsafe, you can just hang up, or say anything you want. We will understand that you cannot talk anymore at that time. You do not have to explain. If this happens, would it be okay for us to call you again? If this happens, how should we reach you afterwards? Do you want to use particular code words to indicate that it is not safe for you to continue the call at that time? Please provide any information that might be helpful."

_____

_____

_____

"If you want us to call the police, what code words would you like to use? If we call the police, where would you like us to send them?" _____

_____

_____

"If at any point, you would like to contact us or have any questions or concerns, please call the confidential study hotline at: 215-573-3055" [give Social Health Study card]

1. What is your phone number?

Home (__ __ __) __ __ __-__ __ __ __ Okay to leave a message? □ Yes □ No

Work (__ __ __) __ __ __-__ __ __ __ Okay to leave a message? □ Yes □ No

Cell (__ __ __) __ __ __-__ __ __ __ Okay to leave a message? □ Yes □ No Okay to text? □ Yes □ No

2. What is your current address? Okay to send newsletter? □ Yes □ No

_____

_____

_____

"In the event that we are unable to get in touch with you we may, with your permission, contact people you trust who may be able to help us reach you. We will not share any information with anyone we contact about the natures of the study or information you share with use. Please provide contact information for anyone you would be willing to allow us to contact in an effort to reach you."

3. Contact Person 1

Name: _____ Relationship: _____

Address: _____

_____

_____

Phone # (__ __ __) __ __ __-__ __ __ __ Home

(__ __ __) __ __ __-__ __ __ __ Work

(__ __ __) __ __ __-__ __ __ __ Cell

4. Contact Person 2

Name: _____ Relationship: _____

Address: _____

_____

_____

Phone # (__ __ __) __ __ __-__ __ __ __ Home

(__ __ __) __ __ __-__ __ __ __ Work

(__ __ __) __ __ __-__ __ __ __ Cell

5. Contact Person 3

Name: _____ Relationship: _____

Address: _____

_____

_____

Phone # (__ __ __) __ __ __-__ __ __ __ Home

(__ __ __) __ __ __-__ __ __ __ Work

(__ __ __) __ __ __-__ __ __ __ Cell

Note: it is helpful to let participants know about times when study personnel will be in the project office and how the participant can reach us. Tell the participant that s/he can call the project office and ask to speak with someone from the "Social Health Study." Encourage participants to call or drop in with new contact information or to check in at any time by calling the study hotline number 215-573-3055.

Appendix D: SAFETY PLAN

SAFETY PLANNING

IDENTIFYING TRIGGERS (both victims and perpetrators)
I know my partner and I are about to get into an argument when:
The argument tends to lead to violence when:
If I sense that things are about to get dangerous, I will:
Something I can do to help myself remain calm is:

VIOLENCE PREVENTION AND REDUCTION (focused on perpetrators)
I have noticed the following changes in my body whenever I get mad *(hint: consider things like your body temperature, heart rate, feelings of tightness or tingling sensations)*:
When I begin to feel those sensations, I will practice the following coping strategy:
If I initiate conflict with my partner more frequently following substance use, I will try the following strategy to reduce my drug and alcohol consumption:

RELOCATING FOR SAFETY (both victims and perpetrators)
If we are going to have a fight, I will try to move to a space that is safer, such as:
I will avoid more dangerous areas such as:

CONTACTING HELP OR SUPPORT (both victims and perpetrators)
My emergency contacts when I need immediate help or support are:
This is how I plan to contact my emergency help:

LEAVING YOUR PARTNER (focused on victims)
If I am a victim of abuse, and I decide to leave my partner, these are the important documents I would need to have available to me:
This is my plan for accessing those important documents:
I could leave a suitcase of belongings with this person to hold for me:
I would need these items to be in the suitcase:
This is how I plan to secure the safety of my children:
This is how I plan to secure the safety of my pets:
I could stay with this person if I needed a place to go:
This person's address/ phone number is:
If my children ask questions, I am comfortable telling them this:
If the administrators at my son/daughter's school needs information, I am comfortable telling them this:
If my employer asks questions, I am comfortable telling him/her this:
Once I have found safety for myself, my children, and my pets, I need to consider the following safety measures in my new living space (consider things like filing for a PFA, inserting a peep hole in the door, installing an alarm system, getting a watch dog, increasing lighting outside):

EMOTIONAL SUPPORT (both victims and perpetrators)
These are the people I could talk to about my feelings:
This is a place I could go to for support, if my friends and family cannot provide it:
I will know that counseling is a good idea for me when:
These are activities I can do to help me cope with my emotions:

Appendix E: SAFETY TIPS

I. For Victims

a. Safety at Home
   i. When the abuser is there
      - Avoid rooms with no exit (like the basement)
      - Avoid room that may have weapons (like the kitchen)
      - Select a code word that alerts friends and children to call the police
      - Make copies of all important documents in case you either decide to leave, or in case your abuser destroys the originals.
   ii. When the abuser no longer lives there
      - Obtain an order of protection
      - Change locks on doors and windows
      - Insert a peep hole in the door
      - Change telephone number, screen calls, and block caller ID.
      - Increase outdoor lighting
      - Consider getting a guard dog.
      - Inform landlord or neighbor of the situations, and ask that police be called if abuser is seen around the house.

b. Safety at Work
   - Tell your employer.
   - Give security a photo of the abuser and order of protection.
   - Screen your calls, if possible.
   - Request an escort to your car or bus.
   - Vary your route home.
   - Consider a cell phone for your car.
   - Carry a whistle, noisemaker, or personal alarm.

c. Safety in the Community
   - Carry your cell phone in your hand so that you can quickly call the police if necessary.
   - Disable the password feature of your phone so that you can quickly call for help without having to enter a code first.
   - Vary your route to work and to home.
   - Walk in pairs.
   - Avoid deserted or dark streets.
   - Stay focused and be aware of your surroundings. Do not make phone calls or text because it will distract you from your environment.

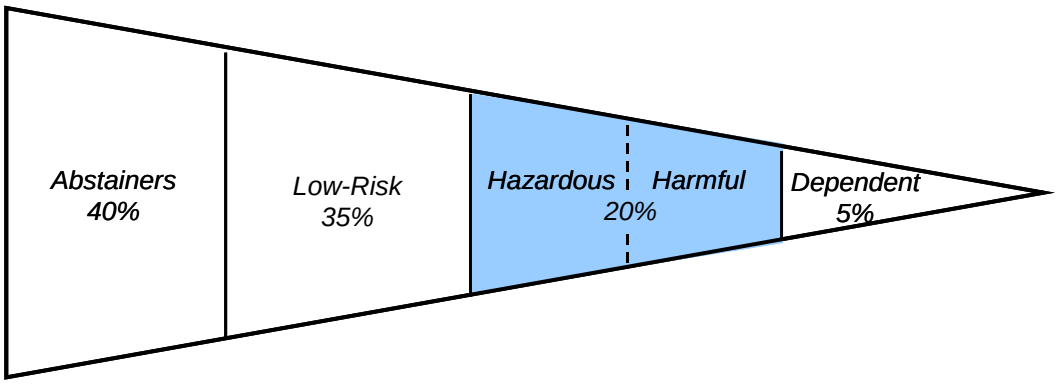
d. Protecting your Children
   - Plan and rehearse an escape route with your children.
   - Teach them a code word to call 911, and how to use a public phone.
   - Let school personnel know to whom children can be released.
   - Give school personnel a photo of the abuser.
   - Warn school personnel not to divulge your address and phone number.
   - Prepare in advance what to say to your children if they ask you questions about your relationship, or about the abuse.

II. For Perpetrators

- Eliminate weapons from your home.
- Eliminate drugs and alcohol from your home. Or, if you continue to use drugs and alcohol, consider reducing the amount that you use those substances.
- Become aware the situations that tend to trigger your violence or abuse (i.e. after work, after a stressful day, more often in the morning than at night, etc.).
- Notice any signals that tend to lead to your violence or abuse (i.e. "I know I am about to get really mad, or even violent, when I feel a tightness in my stomach and my hands start to sweat.")
- Elect a friend, family member, counselor, doctor, mentor, spiritual healer, or someone else with whom you can talk about your anger or behavior. Seek support from someone you trust to hold you accountable for your choices.
- Sign a safety contract with your partner, agreeing that you will not use physical violence (Appendix H).
- Connect with your children and learn how your behavior may be affecting them negatively. Try being a positive role model for them.
- Express your feelings. Sometimes when we feel sad, embarrassed, ashamed, confused, abandoned, rejected, or frustrated, the feelings can surface as anger. Try expressing your feelings for what they really are.
- Remove yourself from potentially violent situations. If you suspect you are in a situation, which may lead to violence, walk away. For example, maybe you've noticed that you become particularly angry and volatile when your partner has been drinking. If that is true, it may be a good idea to remove yourself from the situation when you smell alcohol on your partner's breath. Walk away, and face your partner at another time when you are both calmer.
- Practice self care. Take walks, read a book, write in a journal, play a sport, listen to music, take a long bath, talk with an old friend. Do whatever it takes to provide some nourishment to your self. You may find that you treat others better, if you treat yourself well too.
- Educate yourself about Intimate Partner Violence. Maybe you recognize that you have a problem but you do not know why you have this problem. Read some books or articles about this problem. You may just learn something about yourself!

Appendix F: RESOURCES RELEVANT TO ALCOHOL USE

FIGURE 1: THE SPECTRUM OF ALCOHOL USE (NIAAA, 1995)



TYPES OF DRINKERS:

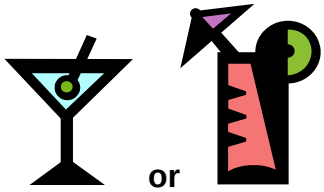
Abstainers	Drink no alcohol.
Low-risk	Drink within NIAAA guidelines. Alcohol use does not affect health or result in problems.
Hazardous (At Risk)	Exceed NIAAA consumption guidelines. Alcohol use puts them at risk for injury/illness or social problems. .
Harmful (Problem)	Currently experiencing problems (medical/social) related to alcohol; often exceed NIAAA guidelines for low-risk drinking.
Dependent	Physically dependent on alcohol (experience withdrawal symptoms); meet clinical criteria for dependence based upon assessment criteria such as DSM-IV

TABLE 1: NIAAA LOW-RISK DRINKING GUIDELINES

# STANDARD DRINKS FOR LOW-RISK DRINKING		
	Per Week	**Per Occasion**
Men	14	4
Women	7	3
All > 65	7	3

WHAT IS A STANDARD DRINK?

1 Standard Drink equals:



or

drink made with 1.5 oz. of alcohol (whiskey, gin, etc.)

12 oz. Beer

5 oz. wine

TABLE 2: NATIONAL DRINKING NORMS

Alcohol Consumption Norms for U.S. Adults

Drinks per week	Total %	% Men	% Women
0	35	29	41
1	58	46	68
2	66	54	77
3	68	57	78
4	71	61	82
5	77	67	86
6	78	68	87
7	80	70	89
8	81	71	89
9	82	73	90
10	83	75	91
11	84	75	91
12	85	77	92
13	86	77	93
14	87	79	94
15	87	80	94
16	88	81	94
17	89	82	95
18	90	84	96
19	91	85	96
20	91	86	96
21	92	88	96
22	92	88	97
23-24	93	88	97
25	93	89	98

Source: 1990 National Alcohol Survey, Alcohol Research Group, Berkeley, Courtesy of Dr. Robin Room

FIGURE 2: PROS AND CONS

Reasons to Quit or Cut Down on Drinking

To live longer, and feel better
To consume fewer empty calories (alcohol has no nutritional value)
To sleep better
To be less likely to have a stroke
To improve blood pressure control
To reduce the possibility of death from liver disease
To prevent problems with medications
To decrease the likelihood of falls or other injuries
To prevent memory loss that may lead to loss of independence
To be able to care for myself longer
To be a better parent or grandparent
To reduce the possibility that I will die in a car crash
Other reasons:_____

Reasons for Drinking

I enjoy the taste
It enhances meals
For pleasure in social situations
To more easily socialize
Other people expect that I will drink with them
To relax or relieve stress
To cope with feelings of anger
To cope with feelings of boredom
To deal with momentary feelings of depression
To deal with momentary feelings of loneliness
To deal with feelings of frustration
To relieve the stress of arguments with family members or friends
It's something I do when I'm smoking
It's something I do when I'm watching T.V.
It's something I do with certain friends or relatives
To help me sleep
To relieve pain
To make me feel better
Other reasons:_____

Appendix G: IMPORTANCE AND CONFIDENCE RULERS

IMPORTANCE OF CHANGE RULER

Not important									Very important
1	2	3	4	5	6	7	8	9	10

CONFIDENCE RULER

Not confident									Very confident
1	2	3	4	5	6	7	8	9	10

Appendix H: PATIENT AGREEMENT

PATIENT AGREEMENT

Date:_____

I, _____, agree to the following drinking limit:

Number of drinks per week: _____

Number of drinks per occasion: _____

I also agree to use the following coping strategies when I sense that conflict is about to happen between me and my partner:

_____

_____

Patient signature: _____

Remember: It is never a good idea to drink and drive and it's Illegal to drink if you're under the age of 21.

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eTable1. Demographic comparison of eligible patients, enrolled vs not enrolled

	Eligible, Not Enrolled (n=645)	**Eligible, Enrolled (n=600)**	***P* Value**
Age			.03
Mean (95% CI)	30.8 (29.9, 31.6)	31.6 (30.7, 32.4)	
Median (IQR)	27 (22 – 38)	28 (16 – 23)	
Race, No. (%)			
African-American/Black	437 (67.8)	488 (81.3)	<.001
Caucasian/White	172 (26.7)	101 (16.8)	
Asian/Asian-American	10 (1.6)	0 (0.0)	
Other	18 (2.8)	9 (1.5)	
Unknown	8 (1.2)	2 (0.3)	
Ethnicity, No. (%)			.13
Hispanic Origin	12 (1.9)	10 (1.7)	
Non-Hispanic Origin	624 (96.7)	588 (98.0)	
Unknown	9 (1.4)	2 (0.3)	
Chief Complaint, No. (%)			.51
Injury	97 (15.0)	79 (13.2)	
Medical	449 (69.6)	425 (70.8)	
Gynecological / Urinary	76 (11.8)	81 (13.5)	
Psychiatry / Substance Abuse / Overdose	9 (1.4)	4 (0.7)	
Other	14 (2.2)	11 (1.8)	
Disposition Status, No. (%)			.26
Treated and discharged	573 (88.4)	513 (85.5)	
Admitted to inpatient	42 (6.5)	41 (6.8)	
Assigned to observation	21 (3.3)	37 (6.2)	
Left prior to discharge	6 (0.9)	7(1.2)	
Transferred	2 (0.3)	1 (0.2)	
Other	1 (0.2)	1 (0.2)	
Marital Status, No. (%)			.92
Married	85 (13.2)	71 (11.8)	
Single	532 (82.5)	500 (83.3)	
Divorced	13 (2.0)	13 (2.2)	
Widowed	3 (0.5)	3 (0.5)	
Unknown	10 (1.6)	13 (2.2)	
Eligibility Criteria			
CTS2S Score [a]			.001
Mean (95% CI)	7.8 (7.3, 8.4)	10.1 (9.3, 10.9)	
Median (IQR)	6 (3 – 10)	7 (3 – 13)	
AUDIT Score [b]			
Mean (95% CI)	7.2 (6.9, 7.6)	8.2 (7.8, 8.7)	<.001
Median (IQR)	6 (4 – 8)	6 (5 – 10)	

[a] CTS2S is a 16 item assessment with a score ranging from 0-96; No IPV in the past 3 months is a score of zero on the CTS2S (note: all participants had a score of 1 or more to be eligible for study enrollment)

[b] The AUDIT consists of 10-items with scores ranging from 0 to 40;

Heavy Episodic Drinking is single item on the AUDIT that indicates the frequency (on a likert scale) of heavy drinking episodes, which for females is 4 or more drinks on any single occasion. (note: all participants had a score of 4 or more to be eligible for study enrollment)

eTable 2. Treatment effect on the change in Experiencing IPV[a] and Heavy Drinking over the first 12 weeks (p-values)[b]

	Any episode of experiencing IPV (Yes/No)		**Heavy drinking days (Yes/No)**	
Covariate	**Odds Ratio (95% CI)**	***P* value**	**Odds Ratio (95% CI)**	***P* value**
Intercept	1.62 (1.30, 2.30)	<0.001	0.83 (0.66, 1.05)	0.12
Week	0.93 (0.91, 0.95)	<0.001	0.99 (0.97, 1.02)	0.65
Treatment Group (ref=ACG) [c]	0.86 (0.62, 1.18)	0.34	0.99 (0.72, 1.36)	0.96
Week*Treatment Group Interaction [d]	1.02 (0.98, 1.06)	0.33	0.99 (0.96, 1.03)	0.74

[a] Experiencing IPV is defined as answering yes to one or more of the questions coded as "Victimization" questions on the CTS2S Assessment

[b] Hierarchical Generalized Linear Models (HGLM) were used to accommodate the clustering of the weekly repeated measures, as well as the binary nature of the outcomes, (at least one heavy drinking event and at least one incidence of IPV during the week), analyzed with the Genmod procedure in SAS (Cary, NC 2011), which applies a Generalized Estimating Equations (GEE) method to account for the within subject correlation. A binomial distribution was specified using a logit link function and an exchangeable correlation structure, using alpha = 0.025 threshold for statistical significance. The baseline value was added to part of the dependent vector.

[c] Reference group ACG is the Assessed Control Group

[d] the p-value for the interaction is testing for a treatment group difference in the change in the outcome variables overtime.

eTable 3. Parameter estimates for longitudinal analysis of IPV and Drinking Outcomes over 12 months[a]

	CTS2S Score [c]		Composite Abuse Total Score [d]		Audit Score [e]		Heavy Drinking [f]	
	Zero	Count	Zero	Count	Zero	Count	Zero	Count
Group ACG (Ref: BIG)	-0.005 (-0.356, 0.346)	0.254 (-0.107, 0.615)	0.553 (-0.394, 1.499)	-0.010 (-0.418, 0.398)	-0.001 (-0.116, 0.105)	0.066 (-0.030, 0.182)	0.136 (-0.115, 0.387)	0.028 (-0.148, 0.204)
Month	-0.169 (-0.194, 0.144)	-0.088 (-0.115, -0.061) [b]	-0.176 (-0.237, -0.115) [b]	-0.077 (-0.106, -0.048) [b]	-0.017 (-0.027, -0.007) [b]	-0.008 (-0.018, 0.002)	-0.052 (-0.077, -0.027) [b]	-0.043 (-0.063, -0.023) [b]
Group*month ACG (Ref: BIG)	-0.006 (-0.045, 0.033)	-0.019 (-0.058, 0.020)	-0.051 (-0.135, 0.033)	0.012 (-0.031, 0.055)	0.004 (-0.010, 0.018)	-0.007 (-0.021, 0.007)	0.016 (-0.019, 0.051)	0.003 (-0.026, 0.032)

Abbreviations: ACG = Assessed Control Group; BIG = Brief Intervention Group

Column Descriptions: Zero – provides beta coefficients and standard errors for the binomial component (zero vs >zero); Count – provides the beta coefficients for the Poisson distribution of the ZIP analysis.

Row Descriptions: Group = indicator group variable comparing Assessed Control Group (ACG) to the Brief Intervention Group (BIG). Month = continuous variable representing overall change over time. Group*Month = interaction term comparing change over time by group.

[a] Hierarchical Generalized Linear Models (HGLM) are used to assess for treatment effects for the intervention compared to the assessed control group, using longitudinal (3, 6, and 12 month, controlling for baseline) comparisons to accommodate the clustering of the monthly repeated measures, as well as the nature of the outcome, which counts the number of heavy drinking days and the incidences of IPV. In the presence of a large proportion of zeroes, we implemented a zero-inflated Poisson (ZIP) regression analysis with an unstructured covariance matrix, which accommodates the clustering as well as the stack of zeroes present across the repeated assessments. The baseline value of the outcome variable was included in the model as a covariate.

[b] There was a significant (p-value < 0.001) decrease in outcome over time; the change over time did not differ statistically by group, as no interaction term demonstrated significance in the models.

[c] CTS2S is a 16 item assessment with a score ranging from 0-96 with higher scores indicating more instances of violence; No IPV in the past 3 months is a score of zero on the CTS2S (note: all participants had a score of 1 or more to be eligible for study enrollment); Victimization (8 items; Range 0-48) and Perpetration Scores (8 items; Range 0-48) are sub-scores of the full CTS2S Score.

[d] The Composite Abuse Scale contains 30 questions and scores range from 0 to 150; Specific individual items are used to determine if results indicate the presence of physical, emotional, stalking, or severe combined abuse.

[e] The AUDIT consists of 10-items with scores ranging from 4 to 40; Heavy Episodic Drinking is single item on the AUDIT that indicates the frequency (on a likert scale) of heavy drinking episodes, which for females is 4 or more drinks on any single occasion.

[f] The Timeline Follow-back data is collected using a calendar to record the number of drinks each day for the past month (28 days); instances of heavy drinking are indicated as 4 or more drinks on any one day.