

# 5

## Understanding Risky Use Patterns

### LEARNING OBJECTIVES

The learner will be able to

- define risky use;
- list at least three important factors counselors should consider in understanding risky use patterns; and
- discuss two main contributors to binge drinking by college students.

### Knowledge

For a number of years, precious resources in the substance abuse field were mainly used for primary prevention efforts or intensive addiction treatment. Research, too, focused on work to prevent substance use, especially in youth in elementary schools, or on counseling services after addiction took its toll on the individual and family. Imagine on the spectrum of use, one end representing prevention of first use and, at the far end of the spectrum, intensive inpatient specialized addiction treatment. Sparse attention was given to the area in the middle of that vast spectrum between prevention and intensive treatment. Yet, in recent years, addiction specialists have begun to understand the greater issue for those who use mood-altering substances in risky ways but are not yet addicted. The college student who binge drinks for perhaps their first time ever and then engages in unsafe sex, for example, typifies a risky drinker. Another example might include the woman prescribed pain medication after a minor surgery

who then takes one extra pill from her prescription because she has noticed it has relieved her focus on work and family, allowed her to put her cares aside, and she wants that particular type of escape. Attention by more researchers and counselors has begun to expand to this middle part of the spectrum, the risky user. You might ask why. The person does not meet criteria for a substance use disorder. The person is still quite functional, does not exhibit symptoms of clinically significant impairment, is not seeking help for substance use, and is not considered chemically dependent. The questions of why to examine and why address risky users are increasingly important and some of the recent research studies help us look at the answers.

## Risky Drinking

The substance abuse field has learned of the volume of those who are considered risky users. In examining risky drinkers, for example, calculations by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) show approximately 28% of alcohol use by adults in the United States is putting risky drinkers at increased risk for alcohol use disorders, liver complications, and other problems (NIAAA, 2013). It is also noted that approximately 37% of drinkers in the United States consistently drink at low-risk levels and are not the focus of risky drinker interventions. Additionally, 35% of adults in the United States do not drink at all. Of the 28% who are drinking at risk, 9% exceed both daily and weekly limits as outlined by the NIAAA and are at highest risk to develop an alcohol use disorder; the American Psychiatric Association (APA) calculates that approximately 8.5% of adults in the United States currently meet criteria for an alcohol use disorder (2013). The approximately 19% of drinkers who exceed either daily or weekly limits consume alcohol in risky patterns, yet have largely been ignored since their drinking often did not meet the level of concern as did those seen with alcoholic drinking patterns. However, we have learned that drinking at risky levels can be hazardous to health, well-being, and longevity.

For a number of individuals who use mood-altering substances, their use of mood-altering chemicals could be best categorized as risky use when they do not meet the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition, *DSM-5*) criteria for a diagnosis of a substance use disorder yet drink in ways that are a risk to health, such as infrequent binge drinking putting the drinker at increased risk of injury, for example. In recent years increasing attention has been given to risky users and how to best define a pattern of risky use. According to NIAAA, a leading national resource for helping professionals regarding information pertaining to alcohol research, “for healthy adults in general, drinking more than the single-day or weekly amounts . . . is considered ‘at-risk’ or ‘heavy’ drinking” (2013, p. 4). Single-day advisories include for men less than 65 years of age and in good overall health, no more than four standard alcoholic beverages on any one day and no more than 14 standard drinks total per week; for women (and men over age 65 or in poor health), no more than three standard alcoholic beverages on any one day and no more than seven standard drinks total per week (NIAAA, 2013).

Information, as of 2012 regarding lifespan drinking prevalence, indicated that nearly 90% of individuals 18 or above noted they had consumed alcohol at least once in their

lifetime, 71% had done so in the recent year, and over half (56.3%) drank alcohol in the past month (NIAAA, 2017). Of particular concern when examining first use and experimentation, more information is added to that picture when examining patterns of use among youth. Any use, even alcoholic beverages, by youth can be considered risky as that use is illegal, therefore, risks of negative consequences are a given but regular use is of particular concern. Reports from NIAAA show two of five teens aged 15 have had at least one drink, yet 9.3 million youth aged 12 to 20 (approximately 24%) consumed alcohol within the recent month (SAMHSA, 2014). Perhaps of more concern for the professional who is learning effective helping strategies in the area of treating substance use disorders pertains to an estimated 15% of youth aged 12–20 reporting risky drinking with almost equal distribution between males (16.5%) and females (14%). Further, it is estimated that almost 1 million youth had already developed a diagnosable alcohol use disorder—that is approximately 4.6% of youth aged 12 to 17 (APA, 2013). For comparison, those aged 65 years and beyond have approximately 1.5% with a diagnosable alcohol use disorder (APA, 2013). These statistics make efforts to intervene with risky users more compelling in helping staunch the incidence of addiction in youth.

For the most abused drug, alcohol, definitions of risky use include information about patterns of use. For example, for adults without other health problems, risky drinking exceeds standards developed from research conducted in the National Institutes of Health, particularly the NIAAA. Based on recent recommendations, risk levels increase, for men 65 years of age and younger, if they drink five or more drinks on any day and if they consume a total of 15 or more standard alcoholic drinks per week. In reviewing standard drink definitions, as this text utilizes measurements, one standard drink equals a 12-ounce beer, 8 ounces of malt liquor, 5 ounces of wine, or 1.5 ounces of 80-proof liquor, such as vodka (NIAAA, 2013). For women, risky drinking involves lower amounts of alcohol due to physiological differences as women have less water in their bodies than men, leading to higher concentrations of alcohol when consumed. Risky drinking for women involves drinking four or more drinks on any given day, eight or more drinks in a week, or exceeding both the daily and weekly limits (NIAAA, 2013).

The example in Figure 5.1 depicts information that is shared with individuals who may be exploring their alcohol use patterns. It is important to note that this publication highlights that 70% of Americans typically drink at low-risk levels or not at all. Focus on the 30% who are drinkers has been an added area of work in the field of substance use.

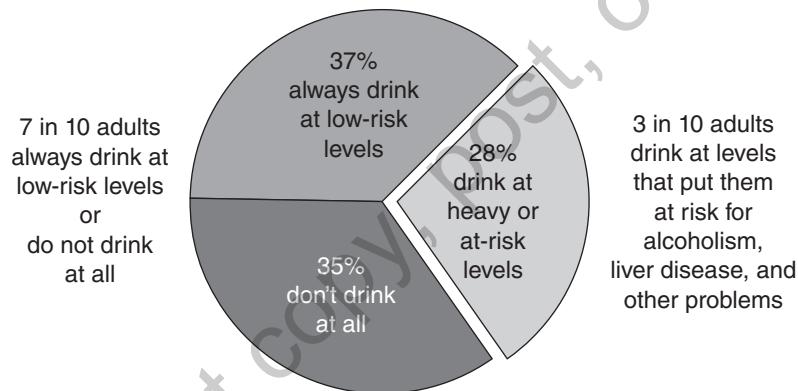
Additional findings suggest risk is heightened when mixing alcohol with high-energy drinks, especially in relation to medical care involving traumatic injuries from falls, motor vehicle collisions, or pedestrians being struck due to an observed dulling of awareness when energy drinks (acting as a stimulant) serve to mask the level of alcohol intoxication to the drinker, often providing an inaccurate sense of alertness, attention, and coordination (O'Brien, McCoy, Rhodes, Wagoner, & Wolfson, 2008). Based on knowledge gained when studying risky drinkers, it is highlighted that by intervening before a person develops addiction but while a person may be exhibiting risky drinking patterns, it is believed that the number of individuals who may become addicted can be substantially reduced. Further, certain studies have shown a reduction in related health risks such as reinjury in an alcohol-related car crash or subsequent driving-while-impaired (DWI) behaviors when alcohol screening and brief interventions have been

**Figure 5.1** Rethinking Drinking

Do you enjoy a drink now and then? Many of us do, often when socializing with friends and family. Drinking can be beneficial or harmful, depending on your age and health status, the situation, and, of course, how much you drink.

Do you think you may drink too much at times? Do you think "everyone" drinks a lot? See below for results from a nationwide survey at 43,000 adults by the National Institutes of Health on alcohol use and its consequences.

#### Alcohol Use by Adults in the United States\*



SOURCE: NIAAA, 2013, p. 1.

\*Although the minimum legal drinking age in the U.S. is 21, this survey included people aged 18 or older.

conducted with risky drinkers (Gentilelo et al., 1999; Schermer, 2005). Data that are reviewed showed that drinking is associated with 60% of fatal burn injuries, 60% of drownings, and 60% of murders; approximately half of all traumatic injuries and sexual assault cases; and approximately 40% of fatal motor vehicle collisions, completed suicides, or fatal falls (NIAAA, 2013).

#### Box 5.1: Alcohol Use and PTSD

In a recent National Epidemiologic Survey, the lifetime prevalence of co-occurring posttraumatic stress disorder (PTSD) and alcohol dependence was 1.59% (Blanco et al., 2013). These diagnoses are believed to have a bidirectional relationship where the presence of PTSD increases the risk for substance abuse and vice versa (Lockwood & Forbes, 2014). The theory is that individuals abuse substances to alleviate PTSD symptoms and, by abusing substances, increase their chances of being exposed to traumatic events. This is due to the fact that accidents are more likely to happen when

individuals are under the influence. Medical providers are becoming increasingly aware of the existence of PTSD in their patients, and of the cost to the medical system of delayed diagnosis and treatment (Love & Zatzick, 2014). Beyond considering patients who may walk in the door with PTSD, medical care can be traumatizing in and of itself, particularly in more critical cases where intensive care is needed, as is the case with significant burn injuries (McKibben, Bresnick, Wiechman Askkay, & Faurbach, 2008). One example of a strategy for addressing this issue is a program that was developed by mental health counselors working at the Burn Center at Wake Forest Baptist Hospital, which has made screening patients for PTSD part of the standard of care. This program ensures that patients who screen positive are visited by a mental health counselor who can offer debriefing, psychoeducation, and referral for ongoing care. By addressing PTSD that results from medical care or that is worsened by medical care, patients face less risk of abusing substances and thereby less risk of ending up back in the hospital from an accident.

Lindsay M. Shearer, MS, LPC, LCMHC, NCC, PhD candidate, is a licensed professional counselor and is completing her doctoral studies in counselor education and supervision at the University of North Carolina at Charlotte.

## Risky Use of Other Mood-Altering Substances

Looking at other mood-altering substances and use, in 2014 the Substance Abuse and Mental Health Services Administration (SAMHSA) produced their 2013 National Survey on Drug Use and Health in the United States (NSDUH); the report noted that almost 10% of the U.S. population 12 years of age and older had used an illegal mood-altering substance within the previous month; further, nearly double the number of 18- to 20-year-old individuals (19.9%) reported using such substances within the previous month (2014). From a risk perspective, 39% of youth 12–17 years old who were surveyed perceived a greater risk if drinking five or more drinks on a weekly basis or smoking marijuana weekly; however, in 2007, the perception of risk was much greater at 54.6% when gauging weekly marijuana use (SAMHSA, 2014). As was highlighted in Chapter 3, the adolescent brain is still developing and the use of alcohol or other drugs, especially in binge patterns, can put the young person at additional risk for developing substance use disorders and having more alcohol-related complications in legal, educational, health, and family areas.

## Risky Use of Prescription Medication

Another type of risky use that has gained national attention involves prescription drugs used in non-prescribed ways. Taking medication in prescribed ways can then change to using the medication in non-prescribed ways to achieve a desired effect, such as euphoria. Often, the term non-medical prescription drug use (NMPD) is the term given to this type of risky use. This risky use pattern can include, for a few examples, taking medications that were prescribed to someone else, taking more

than was prescribed to achieve a desired mood change, or combining medications in ways that were not advised. Too often the naïve person may develop a preference for taking prescription medication in increasing amounts without awareness about the risky patterns that may develop in as little as 10–14 days of prescribed use, especially regarding opiates. The opiate-naïve individual, then, may begin to develop more reliance on the associated mood changes without an understanding of the physical impact and begin to use the medication in increasing amounts thereby developing a pattern of risky use. More recent studies suggest that youth, especially college-age youth, may be at higher risk for NMPD use of stimulants and pain medicines particularly if they are regular users of energy drinks (Arria et al., 2010). Further, risks may be minimized or poorly understood by the risky user due to perceptions of the NMPD use as “utilitarian (e.g., as a study aid) or status-oriented, such as among the ‘self-treatment’ subtype of nonmedical users” (Arria et al., 2010, p. 77). A link between NMPD use and other high-risk behaviors is evident as one of many studies highlights increasing NMPD use as over one-third of participants indicated NMPD use among a survey of undergraduate college students (Benotsch, Koester, Luckman, Martin, & Cejka, 2011). The study findings also included higher risky use rates of alcohol, marijuana, ecstasy, cocaine, methamphetamine, and other stimulants by those who engaged in NMPD use. The study authors noted particular concerns seen in risky use patterns that increase the potential for addiction as well as increased risk of sexually transmitted disease due to increased rates of unprotected sex by NMPD users (Benotsch et al., 2011). It is also important to note that there appears to be less negative risk associated with NMPD use (stimulants) by college students as suggested in one study: “negative consequences may be seen as unlikely or if they are expected to occur, they are not considered overly bad” (Lookatch, Dunne, & Katz, 2012). Risky use is associated with additional risks to health behaviors.

Risk of death is another heightened concern related to risky use of NMPDs. For the 11th year in a row, overdose deaths in the United States showed an increasing trend. In the United States in 2010, according to a review of death certificates by Jones, Mack, and Paulozzi (2013), 38,329 drug overdose deaths occurred. On average, 105 individuals died from overdoses every day, and of the 16,451 pharmaceutical-related overdose deaths, nearly 73% were unintentional/accidental overdoses, primarily because of opiates (Jones et al., 2013). Additionally, it was noted that individuals with mental health treatment are at a higher risk of overdose. A pattern of binge use may be involved in these risks of overdose, but much more research needs to be conducted to ascertain key factors related to increasing NMPD overdoses. An additional concern centers on risky use related to overdoses involving alcohol. Recent data from the Centers for Disease Control and Prevention (CDC) in 2015 describe an alarming increase in deaths by alcohol poisoning. It is estimated by the CDC that on any given day in the United States at least six people die due to alcohol poisoning (2015a). In addition, unlike other trends discussed in this chapter that pertain to young adults, increasingly alcohol poisoning is associated with older adults. It is reported that 3 out of 4 (76%) alcohol poisoning-related deaths in the United States are adults aged 35–64, primarily non-Hispanic white males (CDC, 2015a). While the reader might suspect

that alcoholism is the cause of the poisoning, the CDC notes that alcoholism is a factor in only 30% of the deaths related to alcohol poisoning; risky binge drinking is a primary contributing factor (2015a).

Other categories of risky drug use include hallucinogens, such as ecstasy; heroin; marijuana; stimulants, like cocaine or methamphetamine; and other designer drugs as noted in earlier chapters. Most health problems, such as overdose, are related to the inexperienced user taking larger-than-planned amounts of these types of mood-altering drugs.

### Box 5.2: Violence and Alcohol

Only in the 1990s has violence become a public health problem that could be addressed through the social and behavioral sciences. Additionally, the first trauma centers in San Francisco and Chicago became prominent organizations in urban centers that cared for those injured by high urban violence. Today many trauma centers recognize the need to intervene and prevent future violent injury during hospital stays. Cornwell et al. (1998) reported that 67% of the patients admitted to a Level I Trauma Center had consumed alcohol prior to a stab wound and 47% prior to a gunshot wound. Cherpitel found that those injured by violence were more likely to have drunk alcohol an hour before injury, 35% indicated drinking more than seven drinks, and nearly half of the violently injured participants feeling drunk (1993).

Studies indicate that perhaps addressing violence alone is not enough. Without intervention, alcohol misuse and abuse can become alcohol dependence and leave individuals more vulnerable to injury or even death (Dischinger, Mitchell, Kufera, Soderstrom, & Lowenfels, 2001). Moreover, injury recidivism is twice as likely in those patients that misuse alcohol than those who do not consume alcohol (Dischinger et al., 2001; Worrell et al., 2006). In a 2006 study researchers found that females involved in gun violence were also associated with high-risk alcohol use (Erickson, Butters, Cousineau, Harrison, & Korf, 2006). Within the emergency care setting, Choo and colleagues (2014) proposed that the most effective approach to reduce violent injury is by also addressing substance use simultaneously. Since alcohol misuse and abuse is such a prominent mitigating factor in violent injury, it is important to continue to investigate the ways to address the reduction of alcohol consumption, thereby reducing violent injury.

#### Youth and Violent Injury

Each day in the United States, 16 youths between the ages of 10 and 24 are murdered. Nearly half of youth who die annually from trauma die from violence-related injuries. Health services are challenged to address this public health crisis by reducing future violence-related incidents, recidivism, and retaliation. Youth that have sustained a previous intentional injury have an approximately 20% chance of dying due to violence. Likewise, victims with previous violent injuries will have a 10% to 50% chance of being reinjured through violent means. Youth violence is described as "the intentional use of physical force or power, threatened or actual, exerted by or against children, adolescents or young

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adults, ages 10–19, which results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (Butchart, Farrington, & Cerda, 2002). Violence might include community violence, gang violence, dating violence, and bullying. Researchers believe that increasing resources such as brief intervention can serve to support these youth and thereby reduce violent injury recidivism (Goins, Thompson, & Simpkins, 1992; Shibru et al., 2007).

In recent years, youth violence has become a monumental concern in health care. Medical institutions have been encouraged to provide violence prevention and intervention into the medical care of youth. Also, views on youth violence have shifted from being viewed as a justice system problem to a medical issue (Cunningham et al., 2009). Accordingly, medical institutions, such as emergency departments, trauma centers, and primary care offices, have taken action. In a randomized control trial conducted at an urban emergency department, researchers studied if brief intervention for youth who reported alcohol use and violence in the past year would be effective and feasible. Brief intervention effectiveness was based on behavioral changes such as attitude, self-efficacy, and readiness to change alcohol consumption and violent acts. The researchers determined that the brief interventions were effective in attitudes and self-efficacy. However, readiness to change alcohol use and violence was not statistically significant (Cunningham et al., 2009). Further examination of the relationship between age and alcohol brief counseling intervention with counselors in a trauma center is needed.

Leigh Zick Dongre, PhD, LPCA, LCASA, completed her doctoral studies at the University of North Carolina at Charlotte.

## College Students and Binge Patterns: Chemical and Process

The culture as a college student within a center of higher learning, such as undergraduate, graduate, or community college setting, is often described as its own special culture. Increasingly, attention has been directed at a better understanding within the college culture about risks to the learner’s health. It is no surprise that mood-altering drugs capture an important amount of focus in this examination of college culture and health. Statistics show a higher than average amount of experimentation, misuse, and harmful, risky use of mood-altering substances than in the average American culture. For the college student, for example, an Internet search can produce a number of sites that explain how to get drunk very fast or unexpected learnings from being a heroin addict. Hingson, Zha, and Weitzman (2009) conducted research specifically looking at the alcohol-related problems associated with 18- to 24-year-old college students and found disturbing trends: *every year* almost 2,000 students die from alcohol-related injuries, almost 700,000 are assaulted by another intoxicated student, and 97,000 report sexual assault that is specifically alcohol related. Often, this type of alcohol use pertains to even riskier binge drinking patterns. Binge drinking as defined by the CDC consists of rapid consumption in a concentrated time period: for males, five or more standard drinks are consumed; with females, binge drinking involves consuming four

or more standard drinks at one drinking episode (CDC, 2015a). It is important to note that the lesser volume of alcohol designated as a binge limit for females is lower than males. Research has substantiated that females process alcohol differently and an increased effect is achieved with lower amounts of alcohol (NIAAA, 2013). Further, it is noted that the average amount of standard drinks consumed during a binge drinking episode is approximately eight drinks (CDC, 2015a).

McMurtrie (2014) highlights findings that try to explain the *why* in these disturbing trends among college students. Her work notes that studies consistently show environmental factors are important, such as proximity of bars and liquor stores and alcohol enforcement of legal identification and age verification. When the bars surrounding campuses make drink specials and drink discounts enticing, this pattern leads to overindulgence. In addition, binge drinking was often found with membership in fraternities and sororities, and a history of binge drinking prior to entering college. Attempts to harness expertise led to the development of many resources for universities including, but not limited to, the Higher Education Center for Alcohol, Drug Use, and Violence Prevention, with extensive research projects and resources to identify ways to intervene effectively to reduce harm to college students seeking mood-altering substances. From findings at 10 different universities that were being studied to see what might be effective at reducing binge drinking on campus, the Harvard Public Health researchers noted small changes at five of the 10 universities: “small improvements in alcohol consumption and related harms at colleges . . . changing alcohol-related policies, marketing, and promotions” (Weitzman, Nelson, Lee, & Wechsler, 2004). Whereas effective measures can help reduce binge drinking, McMurtrie (2014) points out that 750 college presidents, when surveyed, indicated a lack of evidence-based changes that instead showed a reliance on past approaches that did not show efficacy. The University of Minnesota produced an approach using Bronfenbrenner’s social ecological theoretical approach (as outlined in Chapter 2). The approach used provides a comprehensive way of coordinating the amount of work and breadth of foci involved in working to reduce high-risk drinking by college students. Perhaps the conclusions reached by Weitzman and colleagues sum it up best: “Changing conditions that shape drinking-related choices, opportunities, and consequences for drinkers and those that supply them with alcohol appear to be key ingredients to an effective public health prevention program” (2004, p. 195).

## Evidence-Based Practices

### Predisposing Factors

Evidence has identified certain predisposing factors, or aspects that contribute to risky use, that continues throughout the lifespan. It can be helpful when working with clients to highlight these factors that may place the person at even higher risk of developing problems with addictive substances or processes. Genetics and family history are seen as important factors that contribute to health risks around substance use (National Institute on Drug Abuse [NIDA], 2003). Past research highlights negative childhood

events as particularly indicative of future substance use problems, such as a parent with a substance use disorder and substantial dysfunction in the family can put the young child at greater risk for future problems with risky use of alcohol, other drugs, and other addictive behaviors. Aggressive behaviors in early childhood can lead to escalating problems that, without intervention, can spiral further into patterns of addiction (NIDA, 2003). Major life transitions, experimentation at an early age, peers engaging in risky use of substances, increasing family stressors such as poverty or chronic illness, and traumatic experiences add to factors that can predispose an individual to problems in their situation. Even older adults, when facing major life stressors such as retirement or loss of a life partner, are predisposed to develop substance misuse patterns as a maladaptive means of coping if, for example, they are in a retirement community where peers engage in risky use of substances. Hence, throughout the lifespan, factors can predispose individuals to be more at risk for misuse of substances and addictive processes. While predisposing factors are important to explore with clients in order to better identify heightened patterns of risk, it is also important to help clients begin to explore and identify protective factors as discussed in the following section.

## Protective Factors

In efforts to have an impact on the estimated 6 million teens, young adults, and adults born between 1983 and 2000 who are projected to die from smoking-related causes, the Office of Adolescent Health (OAH) has gathered data on protective factors that might have a positive influence to reduce those projections (2015). Since cigarette smoking, including e-cigarette use with nicotine, is considered a risk factor for other substance misuse, it is even more important to examine protective factors that inhibit the use of cigarettes. Several factors are highlighted as protective and hence are important for the substance abuse counselor to explore and assess.

Parental influence remains important; when parents are modeling a tobacco-free home environment, that behavior is protective for the young person in their care. Likewise, if a parent chooses abstinence from tobacco or seeks counseling for smoking cessation, important health decisions are then modeled to the young person. Next, conversations about smoking and parent disapproval are considered important and impactful. Having regular conversations about healthy choices to avoid cigarette use and other drug abstinence are considered effective protective tools. The CDC reports recent trends, such as nearly one-quarter of high school students (24.6%) indicated current use of some form of tobacco, and for the first time e-cigarettes were the leading method by which tobacco was used (2015b). Whereas, those youth who refrain from smoking until the age of 26 are less likely to ever smoke (CDC, 2015b). Intervention with youth who are engaging in risky use of tobacco is an especially important consideration for the counselor. With one-fourth of high school students using tobacco in some form, particularly e-cigarettes, major strategies that address this age group and risk pattern are important. While prevention of first use or experimentation is important, it is the young user who is demonstrating risky use that is of particular concern and who might best benefit from more focused intervention prior to nicotine dependency being triggered.

For example, a sophomore in high school who indicates no harmful side effects of using e-cigarettes, uses e-cigarettes when socializing with other smokers in his or her age group 1–2 times per week, and has not developed nicotine dependency is the very individual a brief intervention by a knowledgeable counselor or health care professional trained in specialized brief intervention techniques might benefit. More in-depth information and examination of clinical tools of brief interventions will be reviewed in later chapters examining clinical interventions.

Additional protective factors throughout the lifespan include better access to health care and evidence-based approaches to cope with adverse childhood events, improved PTSD and trauma-focused care, effective strategies to manage bullying, support for identifying sexual orientation, healthy relationship skills, improved communication at home or schools or workplaces, media guidelines around advertising, pricing guidelines in communities for alcohol markets, and healthy coping resources to manage stress such as mindfulness approaches. All of these protective factors can involve counselors and advocacy work on behalf of clients engaging in risky substance use. Screening early is stressed as noted by Feinstein and colleagues “given the link between age of initiation and lifetime incidence of addiction, identification and early intervention are vital” (Feinstein, Richter, & Foster, 2012, p. 433).

## Identifying Protective Factors and Advocacy

While a number of protective factors can be identified, far greater research is needed to create effective implementation of enhancing the known protective factors. Clearly, “more research is needed on the effectiveness of promising prevention programs, early interventions, and treatments tailored to teens of high school age, and of best practices for implementation” (Feinstein et al., 2012, p. 434). Additional community and national recommendations to identify protective factors and align care with effective tools involves expansion of billing and reimbursement for counselors providing effective screening and interventions, prevention services that are available to youth and adults at no charge, increased federal funds to provide integrated health care and qualified health centers, and guidelines for equity in care for substance-related issues (Feinstein et al., 2012). Further, improved screening and care of mental health disorders is important to reduce overdose deaths (Jones et al., 2013). Recommendations for protective initiatives and advocacy for effective prescription drug monitoring programs and sharing of electronic health records can help detect and decrease more risky NMPD use, especially for opioids and benzodiazepines.

In summary, as noted in the beginning of this chapter, it is an important time as a counselor to begin to provide much-needed services for those who have been using substances in risky ways but are not yet addicted. Risky use is an important and evolving area of counseling focus at present and for the foreseeable future, especially as an important key to prevent and reduce the incidence of substance use disorders. Further exploration of assessment of risky use and addictive use follows in Chapter 6. Questions about diagnosing and the criteria of substance use disorders and process addiction are further detailed in Chapter 7.

## Skills In Action

### Box 5.3: Case Illustration of Questioning Risky Use

*My name is Nikki. I am here to see you because a friend was injured in a camping trip after we had set up camp for the night. We built a wonderful campfire, grilled dinner over the fire, and continued our night with a few drinks. My friend maybe had more drinks than usual and stumbled getting up to go get a last drink for the evening. Unfortunately she stumbled into the fire, and was burned on her arms and on her chin. We immediately took her to the emergency room at the nearest hospital. During the nurse's assessment, my friend was asked about the amount of alcohol she had consumed and then she was asked if her burn injury might be related to alcohol use. That really got my attention. I wondered about that for a long time. Then, the nurse asked the last question about whether she or anyone else had been injured as a result of drinking in the past year. My heart tumbled then because I was the one who brought the drinks, I was the one who had talked all about us getting super relaxed and partying by the campfire, and I was the one who then began to wonder about my own patterns and what all this means. And most importantly, do I have a drinking problem?*

### Experiential Skills Learning Activity

If you were the counselor for Nikki, how would you go about responding to her last question?

What facts or resources would you want her to explore?

1. Imagine being a counselor working with risky substance users and finding yourself in an elevator with your state senator. Identify at least three talking points from this chapter that you want to be sure to convey to the senator. Practice giving this elevator speech with classmates; reflect on strengths of your speech and changes you want to make.
2. Go to [www.rethinkingdrinking.niaaa.nih.gov](http://www.rethinkingdrinking.niaaa.nih.gov) and practice with the interactive screening tools on the website. Share with classmates your first reactions. How would you prepare a client to go to the same site if they were worried about their alcohol use? List strengths of the website for future clients. List areas of concern.

## RESOURCES FOR FURTHER LEARNING

### Centers for Disease Control and Prevention

<http://www.cdc.gov>

### Higher Education Center for Alcohol and Drug Misuse Recovery and Prevention

<http://hecaod.osu.edu>

## Office of Adolescent Health

<http://www.hhs.gov/ash/oah>

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