

Screening, Brief Intervention, and Referral to Treatment for Substance Abuse

*... bringing
substance abuse counseling
to acute medical care*



sbirt

MAY 2010

**A training manual
for staff in acute medical
settings**

This training manual is dedicated to the WASBIRT substance abuse counselors who have advanced their field by learning to do Brief Interventions in a very challenging environment.

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About this manual

What is the purpose of this manual?

This is a “how to” manual to guide clinicians who have some experience in patient counseling to perform Screening, Brief Intervention, and Referral to Treatment (SBIRT). It’s like a book of recipes for chefs who already know how to cook. It is not a book about how to perform basic counseling techniques.

Who is this manual for?

It is written for acute medical care staff as well as for state-certified substance abuse counselors without experience in acute medical settings, who want to learn protocols for SBIRT in acute care. Due to the cross-disciplinary nature of this manual’s audience, it necessarily provides some information about acute medical care that is elementary for some medical workers.

What this manual is not:

It is not a book about how to perform basic counseling techniques or have discussions with patients about sensitive topics. It is not a manual for learning Motivational Interviewing, which is one method of behavior change counseling (one possible “style” of doing Brief Intervention [BI]) that requires extensive coaching and practice to learn.

How to learn to do Brief Interventions:

To learn BI, we recommend attending an intensive SBIRT workshop, followed by lots of practice. Workshops can be found via resources listed on the next page of this manual. Practice can include role-playing with friends, family, or colleagues and listening to audiotapes of these practice sessions. These practice sessions are basically “walk-throughs” of the basic BI tasks to enable learners to become more fluent with the language and steps involved in BI. It is best to practice (if possible) with a colleague who will also perform Brief Interventions in the acute care setting where you work. Regular meetings with a supervisor trained in SBIRT are very helpful. Although learners should read, study, and then reread this manual, they should not have it with them for BIs with real patients. The manual does, however, provide a Brief Intervention Checklist and patient handouts that learners have found helpful to refer to during patient encounters.

Internet resources for SBIRT that are beyond the scope of this manual:

<http://www.ed.bmc.org/sbirt/>

The BNI ART Institute prepares health care providers, peer educators and social service professionals to screen patients for substance abuse and other behaviors that compromise health, motivate them to change behavior through a brief negotiated interview, and refer them to resources that will support their agenda for change. The Institute offers expert technical assistance and consultation for needs assessment, project development, implementation, billing, data collection and evaluation.

<http://www.motivationalinterview.org/>

Extensive information about Motivational Interviewing outcome literature and currently scheduled trainings.

<http://sbirt.samhsa.gov/about.htm>

The Substance Abuse and Mental Health Services Administration offers a repository of SBIRT resources.

http://dsibmeetings.westat.com/listserv/reg/public_meetinglist.asp

Announcements of upcoming SBIRT trainings offered in the U.S.

<http://www.jointogether.org/>

A comprehensive information source on substance abuse policy, prevention and treatment.

<http://sbirt.samhsa.gov/coding.htm>

Reimbursement for SBIRT services is available through commercial insurance CPT codes, Medicare G codes, and Medicaid HCPCS codes. Information regarding these codes can be found on this website.

<http://www.ena.org/IPINSTITUTE/SBIRT/Pages/video.aspx>

Emergency Nurses Association website providing demonstration videos of SBIRT.

<http://www.sbirtraining.com/>

For physicians, a website that will soon offer online continuing medical education credits in SBIRT knowledge and skills.

<http://www.cdc.gov/InjuryResponse/alcohol-screening/resources.html>

Website from which one can download “Screening and Brief Intervention (SBI) for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide for Trauma Centers”, by John Higgins-Biddle, PhD; Dan Hungerford, DrPH; & Kathryn Cates-Wessel.

<http://www.cdc.gov/InjuryResponse/alcohol-screening/index.html>

Website by Center for Disease Control offering background on SBI and downloadable proceedings of a 2003 conference organized by CDC on SBIRT.

http://www.ensuringsolutions.org/resources/resources_list.htm?cat_id=986

Offers Alcohol Exclusion Law toolkits. In some states, insurance policies can block SBIRT efforts, if their state governments allow insurers to deny payment for injuries that occur while the insured person is under the influence of alcohol. These *alcohol exclusion laws (AELs)* can interfere with effective treatment via SBIRT.

http://www.ensuringsolutions.org/resources/resources_list.htm?cat_id=989

Research-based information about drug/alcohol treatment and recovery.

SBIRT terms

SBIRT Screening, Brief Intervention, and Referral to Treatment is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance abusers before more severe consequences occur.

ED The correct term for the Emergency Department of a hospital, same thing as “Emergency Room”, which is an outdated term. Now that Emergency Medicine is a bona fide area of medicine (like primary care, surgery, or gynecology), ERs are now called EDs.

Hazardous Substance Users These are people who drink or use drugs hazardously but are not yet chemically dependent. They are at high risk of getting injured or ill from their drinking or using. They are our prime targets for BI.

Substance Abuser A more severe but less prevalent substance disorder describing patients who are addicted to alcohol or drugs.

S Screening all patients with questionnaires to find out which ones use drugs or alcohol in a risky way and patients with more severe problems who may need a referral to treatment. Screening means giving brief drug and alcohol questionnaires to every patient. Patients scoring above the cutoff score on these questionnaires are called “positive screens.” Patients scoring under the cutoff are “negative screens.”

BI Brief Intervention. This means giving immediate counseling, at bedside in the ED, to all patients who screen positive. This counseling usually lasts from 5-20 minutes.

MI Motivational Interviewing, a very effective style of counseling that can be used to perform the BI. MI helps patients prepare for change, and to uncover motivation in patients who aren’t sure they want to change. Learning MI takes lots of commitment, training, supervision and practice. All MI literature is accessible from the MI web page listed on previous page.

Change Talk Statements made by patients during a BI in favor of change.

Status quo Statements made by patients during a BI in favor of not changing.

RT Referring certain patients to treatment after the BI happens. Either these patients score very high on screening questionnaires and/or you may assess during the BI that they need more than a BI. RT happens at bedside, usually toward the end of the BI. To help the most patients, RT should not monopolize your time. RT should take up less of your day than SBI does.

BT Brief Treatment. One-on-one outpatient counseling with a substance abuse counselor, by appointment, after the patient leaves the ED. Usually 1-4 sessions, maximum. Less intensive than American Society of Addiction Medicine Level 1. BT is a new treatment level and is not yet commonly offered. If you have a BT program to refer lower severity patients to, please make the most of it.

Questions and answers that gave rise to SBIRT

Do hazardous substance users outnumber the dependent (addicted) ones?

Yes. Researchers have discovered that the sheer number of hazardous substance users in the world is far greater than the number of people who are substance abusers (addicted). Why does this surprise so many clinically-trained providers? On any given day, nurses and doctors will see many chemically dependent patients but not know that they are also seeing many more hazardous substance users. After all, hazardous substance users don't usually show up severely intoxicated or suffering withdrawal; nor do they present with obvious medical problems caused by severe addiction. This discovery has made us painfully aware that many patients who are in danger of harm were falling through the cracks because they received no services.

So how can we identify hazardous substance users who are not clinically obvious?

We have to go looking for them proactively. This means giving screening questionnaires to all patients, even though they may appear to be unaffected by drug or alcohol problems. This is called screening (the S in SBIRT). This involves approaching patients in the ED as they lie on gurneys and asking them questions about alcohol and drug use. It takes skill to do this without offending patients or making them uneasy. Trained counselors are particularly good at this type of screening, because they usually have excellent people skills.

Is mainstream alcohol/drug treatment overkill for hazardous substance users?

Yes. Addiction researchers have found that chemical dependency treatment works well for people who are substance abusers. But they also found that it is over the top for hazardous substance users, because it takes longer and costs more than necessary to treat less serious problems. To refer hazardous substance users to addiction treatment would be to recommend a mismatched service and to waste resources. Sometimes a BI is all hazardous users need to quit or cut down to safer levels of consumption. Some may need only a few more hours of counseling, and that is why BT was developed. This means that a very large number of people could be helped with relatively few resources—if only those resources were made available.

Why acute care?

Acute care has very high rates of patients who are hazardous substance users. BI is known to be effective with hazardous substance users, it makes sense to deploy BI in settings where we know their prevalence is high. The only public settings in which rates of substance abuse are higher are bars and prisons!

Who are trauma and non-trauma patients

For counselors unfamiliar with acute medical care

In the ED, there are 2 types of patients:

1. Trauma patients, and
2. Non-trauma patients.

“Trauma patient” means injured patient (falls, cuts, bruises, gunshot, burns, car crashes, etc).

“Non-trauma” means all other patients who were not injured (illness, fever, chest pain, etc).

Brief Interventions for both types of patients are similar, but the strategies may differ. During a brief intervention, it may not always be possible to link the patient's drinking or drug use to the patient's chief medical concern which is the purpose of that medical visit. But interventionists usually explore this possibility with patients during a BI.

Trauma BI strategy: Try to link drug/alcohol use to current injury (if possible) or to future injury.

Non-trauma BI strategy: Try to link drug/alcohol use to their current illness (if possible) or to future illness.

► ***In either case, the focus of the interview is on direct consequences of drug or alcohol use, not on whether or not the patient has a “problem.”***

What to expect in the ED

Of acute care settings, Emergency Departments are one of the most common locations in which SBIRT programs are being started up in the U.S. In some SBIRT programs, the interventionists are hired from outside the hospital, and their only purpose is to provide SBIRT to acute care patients. This section is written for those clinicians unfamiliar with the ED environment.

The environment

EDs are fast-paced, crowded, tense, distracting, smelly, noisy environments packed with tragedy, joy, and passion. You will find people at their worst and people at their best in EDs, and this rule includes patients and ED staff. Designated interventionists who join the medical staff only for the purpose of providing SBIRT are at first guests in the hospital. Although they will eventually be valued for what they do, it can take several months for staff to understand what they actually do.

Many staff members do not understand what BI is, and many of them doubt that BI helps patients. Some staff may think that the interventionist's only job is to place severely addicted patients in treatment, and they may refer only severe addiction cases to their interventionist, who must continually remind staff daily that placing severely addicted patients in treatment is only a part of what they do in the ED.

Cold calling patients

You will be approaching patients “cold” in the ED, that is without an introduction by someone else. So, you’ll need to develop a smooth approach. *“Hi, my name is _____, and I am a counselor here in the Emergency Department. My job is to spend a few moments with each patient in order to ask several routine screening questions about alcohol and drugs. These questions are asked to all patients; it’s not the case that you have been singled out. Would it be okay to do this now?”*

If patients refuse, simply leave on good terms. Screening is voluntary, just like the rest of medical care.

Some patients are defensive

You will need to reassure patients occasionally: *“Our drug and alcohol screening program is a bit like screening all patients for high blood pressure. We do not assume that you have a drug problem, or even that you use drugs or alcohol. We are simply checking for anything that could harm your health or safety”*



PHOTO BY CHRIS DUNN (With Permissions)

Reminding staff that you are not God

Medical staff tend to believe that medical care should be available to all patients, and they believe this is also true of chemical dependency treatment. It simply makes no sense to them that addiction treatment is not always available to those who need it most. Therefore, when it comes to placing severely addicted patients in treatment, you may need to continually educate staff that treatment attendance is voluntary, and that even then, many patients have no way to pay for treatment. As you know, counselors can only refer patients to treatment; they can't make them go. Fortunately, working on this willingness is something you will do during the BI, thus raising the chances that a given patient will follow through on your referral.

Permitting interruptions

Occasionally, you may be in the middle of an interview that is going along beautifully, and a nurse or doctor may step in to do something with your patient. When this happens, it is best to promptly and politely step aside. Simply tell the patient that you will return later. This will make staff appreciate you more, because they won't have to worry that you are going to impede them from carrying out their medical responsibilities.

So where's the good news?

When you perform screening and brief interventions in the ED, you have the privilege of meeting people who are in the midst of a personal crisis. "Crisis" comes from a Chinese word meaning "danger" and "opportunity." Patients in crisis are in danger, but there is also the opportunity to help them link their drug or alcohol use to these immediate and tangible concerns. Patients in crisis are often more open to the possibility of change than they might otherwise be. This makes for fertile counseling ground.

Screening patients for drugs and alcohol in acute care

Why we need routine screening for all patients

Suppose there are 100 typical acute care patients inside the circle

Let's see how many need help:



About 75 will not have any substance abuse issues.



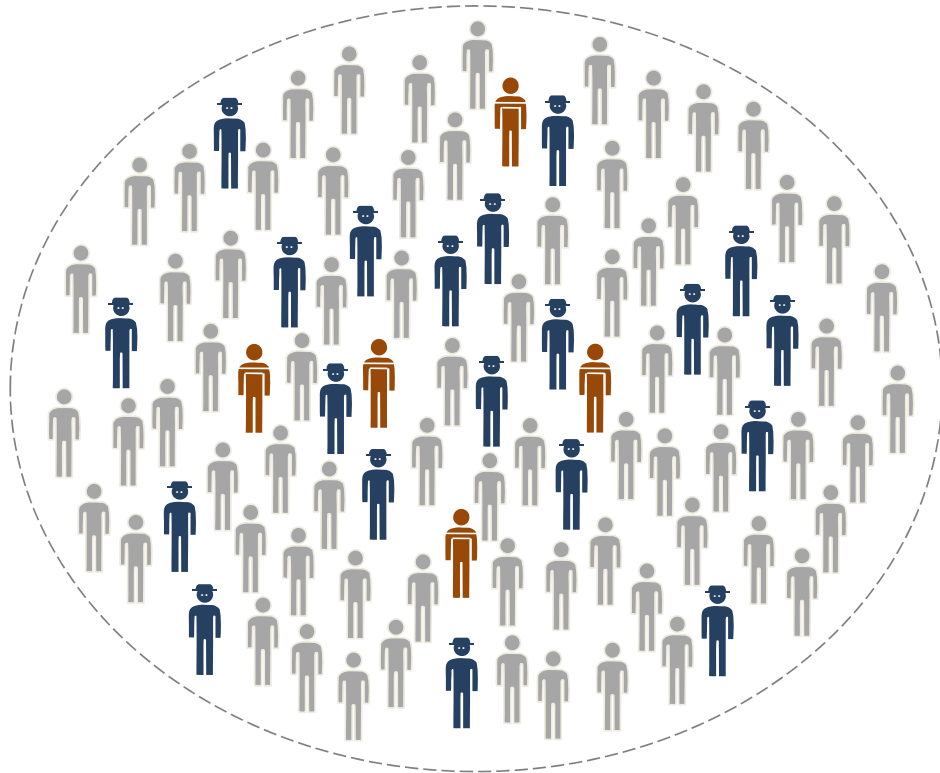
About 5 (orange with "stripes") are severely dependent (obvious to the clinical staff).



About 20 (blue, wearing hats) are hazardous substance users who need a BI (not obvious to clinical staff).

Hazardous substance users are not clinically obvious.

If we don't screen to find them, they will fall through the cracks



NOTE: This is only an example of alcohol prevalence rates for EDs, according to Stewart et al. (2010)¹ Rates for other drugs in other acute care settings vary, but the principle of hazardous substance users outnumbering severely afflicted holds in all cases.

FAQs on screening for drugs and alcohol

Q. Which screening questionnaires work well for EDs?

For alcohol, the Alcohol Use Disorders Identification Screening Test (AUDIT)² consists of 10 questions that have been asked to hundreds of thousands of patients in medical settings. AUDIT scores range from 0 to 40 and can be scored in less than a minute by the substance abuse counselor. Men who score under 8 (under 7 for women) are immediately informed that their screen is negative, and they are encouraged to keep their drinking within low risk guidelines recommended by the NIAAA. Men who score 8 or higher (7 or higher for women) are positive screens, meaning they should immediately undergo a BI at bedside. Patients above 15 on the AUDIT generally also receive RT. This is a recommended guideline only, not a rigid rule; clinical judgment should prevail.

Other useful screening instruments for alcohol are the CAGE, CRAFT, or single Binge Drinking Question. Sources for these tools can be found in the Committee on Trauma Quick Guide for SBIRT, available at www.sbirt.samhsa.gov.³

For drugs, the Drug Abuse Screening Test-10 consists of 10 questions about drug use^{4,5}. DAST scores range from 1 to 10. Patients whose score is 0 are encouraged to maintain their healthy lifestyles. Patients who score greater than 0 are positive screens and those patients should receive a BI. Patients above 3 on the DAST generally also receive RT. The DAST-A has been developed for adolescents.⁶ For very rapid screening, a 2-item screening tool has also been developed for drugs.⁷

Q. Why do we need routine screening for all patients?

Hospital staff cannot identify which patients have high blood pressure or fever unless they proactively screen all patients. Likewise, we cannot identify which patients are hazardous substance users unless we routinely screen all patients. Without routine screening, a huge number of acute care patients would fall through the cracks and never get a BI, because they are not severe enough to be recognized during standard medical care.

Q. What about patients who are too young to screen?

Do not withhold screening from any patient, regardless of age, gender, sexual orientation, or any other demographic. If the patient is an adolescent, use an adolescent screening tool.

Q. Are there any patients who should not be screened?

Yes. Various screening exclusions always occur in public health screening programs across different sites. However, it is difficult to generalize about which patients a particular hospital might decide to exclude from screening. Who to screen versus who not to screen should not be established by a universal rule but rather be decided among a particular hospital's stakeholders such as clinical supervisors and risk management professionals. Examples of a few common—but not universal—exclusions are patients with severely compromised mental status, those with profound developmental delay, and victims of sexual assault.

Q. What does one do with the screening results?

All patients who screen positive should immediately get at least a BI, and they may also be referred to Brief Treatment if it is available. If a given patient's score is very high or if during the BI, you assess a more serious problem, then you should consider referring them to chemical dependency treatment.

Q. What about patients already in recovery?

Because drug and alcohol problems can be chronic relapsing conditions, it is very important to perform BI with patients identified as having a past problem from which they are recovering. Do not withhold BI from these patients, because it can help them re-establish their commitment to preserving the change they have started.

Q. What about underage patients who screen negative but still drink or use drugs?

You should perform BI with these patients, regardless of their screening scores.

Q. Why not simply wait for medical staff to refer patients to us?

The fraction of all ED patients who are chemically dependent is small. The fraction of all ED patients who are hazardous substance users is much larger. If we stand by like other hospital consultants and wait for the ED staff to request our expert services, we will most likely be referred only the most severe cases of addiction, and the hazardous substance users will fall through the cracks. The staff typically recognizes only clinically obvious cases and the only way to find risky users is to use screening questionnaires on all patients.

Q. But don't most patients lie on the screening questionnaires if they have a problem?

Hospital patients are free to disclose as little or much personal information to doctors and staff as they wish, including personal facts about drug and alcohol use. Missing a small fraction of patients who underreport their use doesn't hurt a large SBIRT program—there are plenty of positive screens to keep interventionists busy. The advantage of using standardized screening questionnaires is that they were developed on large numbers of patients in acute medical settings, including those patients who chose to lie on the questionnaires. Standardized questionnaires such as the AUDIT and DAST-10 allow patients to compare their drug or alcohol use to that of many other people, so they can decide for themselves whether they should be concerned.



Jerry Lubeck, CDP, who worked in Harborview's ED for 8 years.
PHOTO BY CHRIS DUNN (With Permissions)

What are the goals of a BI?

Generally, the goal is to first elicit from each patient his/her reasons for change, and to highlight those reasons with an accurate summary. Then, one offers the patient a menu of options for change and helps them to explore those options and ideally pick one. You must always be prepared to accept patients' choices in this regard.

What are the BI tools?

To help clinicians to learn the brief intervention counseling process and to help them stay on task while performing interventions, a useful tool is the acronym, "FLO," representing the three main tasks of a BI. We will first describe each task, then offer tips for performing them. Finally, a "FLO checklist" is provided to serve as a guide during a BI.

The F in "FLO" stands for Feedback on screening results, because public health screening programs (e.g., hypertension, diabetes) typically notify patients of their screening results. Giving patients feedback about abnormal screening results can help them to answer the question, "Would it be important for me to change?" In SBIRT, this feedback usually consists of giving patients normative feedback so they can understand how their use of alcohol or drugs compares to that of the population as a whole. Sometimes, for example, just telling a patient that their alcohol use is higher than average and places them in harm's way is enough to cause change.

The L in "FLO" stands for Looking for patient's reasons for change. This involves helping patients to answer the question, "What might my reasons be for wanting to change?" Most people have their own, unique reasons for wanting to change, even if they are not ready to go into immediate action. During a BI, the interventionist actively searches for these reasons and summarizes them. At this point, interventionists can offer patients new information not mentioned by the patient about why change might be important for a given patient.

The O in "FLO" stands for discussing Options for change. This involves helping patients to answer the question, "HOW would I change?" This task involves the interventionist presenting patients with a menu of options for change (e.g., no change, cut back, quit, get counseling). The interventionist helps the patient rule out certain options and choose others.

In cases where patients are actually ready to take immediate action, a discussion of concrete plans follows. At this point, interventionists can offer advice about actions the patient might take to be successful. Finally, the interventionist ends the interview on good terms in an effort to make the encounter a pleasant one.

First, be prepared to listen to and address the patient's more immediate concerns:

Avoid having the patient think that you see the BI as more important than his/her other concerns. Often, patients have more pressing concerns than discussing their alcohol or drug use—at the very moment you wish to discuss this topic—and these should be respected. For example, a number of issues commonly emerge for patients at the start of or during a BI, such as acute pain ("The nurse hasn't given me anything for pain yet"), emotional discomfort ("I can't believe my stepfather hasn't shown up here; after all, I AM in the emergency room..."), or need for medical information ("I've been here for 4 hours and nobody has told me what's wrong with me yet.") Regardless of whether you are qualified by training to fix any of these problems, you should in all cases make an effort to help, such as bringing a patient another blanket or relaying a message from the patient to a nurse or physician. This builds rapport in service of when you decide to raise the topic of the BI.

How does one get a BI started?

The BI is usually part of the same patient encounter as the screening, unless the screening and BI are performed by two different staff members, in which case the screener would notify you of a patient who has screened positive and needs a BI. Often but not always, the screening results are a nice way to start a productive interview:

- *“Thank you for answering all those questions. I wonder if you would be interested in learning what your scores were on those screening questionnaires . . . ?”*
- *“I appreciate your answering those drug and alcohol questions How was it for you to answer those questions . . . ?”*
- *“Thanks for answering those questions. If it’s okay with you, I would like now to go over your scores on those two questionnaires . . . ?”*

Tips for “F” (giving feedback)

The goal for “F” is simply to help the patient to understand his/her screening score in a way that makes sense to them, not to convince patients that they should change. Visual guides are provided in the Patient Handouts section of this manual, to help patients better understand the meaning of their screening feedback.

Set the stage for Feedback:

- Ask permission to give feedback.
- Assure the patient that you are not judging him/her nor trying to get them to change anything that they are not ready to change.
- Tell your patient that it is up to them to decide whether they are concerned.

Tell the patient the following so they will understand their score (RANGE):

- R RANGE:** The range of possible scores (0-40 on the AUDIT, 0-10 on the DAST).
- A ASK:** Ask the patient what he or she thinks her score might be.
- N NORMAL:** Tell the patient what normal scores are (below 7 for women or 8 for men on the AUDIT, below 1 for men and women on the DAST).
- G GIVE** patient their score.
- E ELICIT** patient’s reaction and avoid argument. (*“What do you think about that?”*)

After giving patient the score:

Say nothing except making reflections back to the patient about his/her reactions. (*“I can see you’re surprised to hear your screening results were so high.”*)

- Do not argue that the test is correct or valid.
- Do not get into debates about whether the patient is an “alcoholic” or “addict.” It is not necessary for patients to accept a label before they can change. They just have to become concerned with the status quo to become motivated to change. (*“I’m less concerned about labels and more concerned whether you think your use of cocaine is hurting you at all.”*)
- Stay on message. (*“Your score simply tells us that you are risking harm from drinking; the test is really about risk and harm, not labels.”*)
- Argue not. (*“It’s really up to you to decide to believe or be concerned about these screening results. I certainly can’t tell you how you should feel about it.”*)
- Your job is to deliver the message; the patient’s job is to decide what he/she thinks about it.

► **It’s up to your patient to decide if they are concerned . . .**

Tips for “L” (looking for change talk)

Using the following **IMPORTANCE** and **CONFIDENCE** questions will:

- Keep the conversation positive and reduce push-back from the patient
- Make the interview more like dancing than wrestling
- Help us assess what things patients value or cherish, that may be threatened by drinking and using (e.g. *Being a good father? Having fun? Getting physically healthy? Looking good? Staying out of legal trouble? Keeping a job? Getting a job? Staying in a relationship?*).
- Identify the drivers that may eventually motivate them to change.

The **IMPORTANCE** questions:

- “On a scale of 1 to 10, how important is it to you to make a change in your drinking or using?”
- “Why didn’t you give it a lower number?” (Elicits Change Talk)
- “What would make you give it a higher number?” (Patient explores the future)

The **CONFIDENCE** questions:

- “If you decided to make a change in your drinking or using, on a scale of 1 to 10, how confident are you that you would succeed?”
- “Why didn’t you give it a lower number?” (Elicits Change Talk)
- “What would make you give it a higher number?” (Patient explores the future)

Now, summarize both sides of the patient’s view:

On one had, you don’t think you’re addicted . . .

. . . on the other hand, your legal problems make you think you will do something different fairly soon.



Useful questions:

- Ask about the link between what is precious and drugs/alcohol: “I heard you say that the most important thing for you now is keeping a paycheck coming in . . . How does your marijuana use fit in with that goal, given your company’s drug testing practices?”
- Ask about the future: “How would you like your drinking or drug use to look 5 years from now? Be gone? Be less? Be the same?”

Tips for “O” (Options for change discussed)

Following these **FLO** guidelines will:

- Reduce push-back from patients who often get told they must abstain from all substances.
- Guide patients to explore options that they have never before considered.
- Reduce status quo talk (*I’m not an addict, therefore I don’t need to change . . .*).
- Encourage patients to consider each substance that they use separately, and avoid the “quit everything” or “quit nothing” conflict.

First, ask about the future:

Q. “So where does that leave you?”

Q. “So what do you think you will do?”

Q. “So, what are your options for the future?”

Don’t forget!

Take one drug at a time; don’t lump “drugs and alcohol” together. Doing this prevents confusion when discussing options, because sometimes patients choose different options for different drugs. (“Seems like you are most concerned about cocaine, and less so about alcohol or marijuana . . . Is it okay if we just focus on cocaine for now?”)

Start with a menu of options:

- M MANAGE YOUR USE:** Cut down to within low risk guidelines for alcohol, or reduce drug use. (“One thing you might try is cutting down on how often you get high, like try doing it only on weekends, instead of on workdays.”)
- E ELIMINATE USE:** Quit drugs or alcohol or both (“Another option might be to stop using marijuana altogether.”)
- N NEVER TAKE CERTAIN RISKS:** Drive after using, share needles, mix drugs and alcohol (“Some people don’t want to cut down or quit, but they are willing to take a look at some of the risks they incur when they do use.”)
- U UTTERLY NO CHANGE:** Don’t quit, don’t cut down, don’t avoid harm (“You might decide not to make any changes at all in your lifestyle right now.”)
- S SEEK HELP** (“Some people decide they need to get help.”)

Example: “Seems to me there are several ways you could go with drinking in the future: you could cut down to within low-risk guidelines; you could quit; you could neither cut down nor quit but try to drink more safely; you could make no change, or you could seek counseling. Which of those makes the most sense to you?”

What to do with patients high in CONFIDENCE but low in IMPORTANCE? (“I can change if I want but it’s not important”):

- **Ask hypothetically:** “If for some odd reason you someday decided to change, what would you do? M? E? N? U? S?”
- **Prove to them that you respect their choice not to take action yet:** “I can see although you’re taking this seriously, you’re not entirely ready to take action right away.”
- **Try to “leave a pebble in their shoe” by planting doubt about the status quo:** “I hear that you don’t think that alcohol caused you to be stabbed, but I can’t help but wonder if you would even be here if you weren’t drinking that night, because you might have gone somewhere else instead of the club. What do you think?”

- **Remind patients of their autonomy:** “Nobody can decide this for you. It’s completely up to you to choose what you will do . . .”

What to do with patients low in CONFIDENCE?

(“I need to change, but it’s too hard”):

- **Be optimistic: loan patients your confidence until they have their own:** “I believe that your chances are actually better than you think . . .”
- **Tell them about the success of others:** “I can tell you that many people have successfully quit drugs, despite not believing at first that they could do it. They tell me they enjoy life much more, compared to when they were using.”
- **Tell them that most people have to try to change several times before it sticks:** “The fact that you’ve tried several times to quit bodes well for your success. Actually, it’s the people who fail once and never try again who don’t make it.”

Tips for closing on good terms

Why it is important to close on good terms

- So the next interventionist will have it easier than you did.
- Because if you close on bad terms, they will remember the conversation as unpleasant and therefore discount your message.
- Because you will enjoy your work more.
- It will promote better relationships within the ED if you’re seen as a positive addition, and not someone who angers/upsets patients.

Examples:

“I think you did a great job talking about this, under very tough circumstances.”

“Thanks for taking the time to discuss this matter. You really kept an open mind throughout.”

“I admire your honesty and determination. I believe that you will know what the right thing to do is, once you make up your mind.”

- ▶ **People are most likely to change if they like you and if they feel that you value them.**

F•L•O checklist⁸

Use this to practice BIs

Thank you for answering our drug and alcohol questions. If you are interested in knowing your scores, I would like to go over them with you now. But I won't be pushing you to change; no one can decide that but you.

Feedback on alcohol screening results:

RANGE: AUDIT scores can range from 0-40

ASK: What would you guess your score was?

NORMAL: Normal scores are below 8 for males (7 for females)

GIVE SCORE: Your score was . . .

ELICIT REACTION: What do you make of that?

Feedback on drug screening results:

RANGE: DAST scores can range from 0-10

ASK: What would you guess your score was?

NORMAL: Normal scores are 0 on the DAST

GIVE SCORE: Your score was . . .

ELICIT REACTION: What do you make of that?

(Summarize patient's reactions to their feedback)

Now I would like to ask you a few more questions to better understand how you see things. Is that okay?

Listening for Change Talk:

How **IMPORTANT** is it to change your drinking, 1-10?

Why didn't you give it a lower number?

What would it take to give yourself a higher number?

How **CONFIDENT** are you that you could change, 1-10?

Why didn't you give it a lower number?

What would it take to give yourself a higher number?

So, how do you want your drinking to be in the future?

There are several options:

Options for change discussed:

MANAGE YOUR DRINKING/DRUG USE (*cut down*)

ELIMINATE DRINKING OR USING (*abstain*)

NEVER DRIVE AFTER USING ALCOHOL OR DRUGS

UTTERLY NOTHING (*no change in the status quo*)

SEEK HELP (*counseling, AA, family, church*)

Close on good terms:

In summary, your reasons to make a change are . . .

You have decided to do the following . . .

And I think you can do it because . . .

► **Thank the patient and end on good terms.**

FAQs on doing Brief Interventions

Q. How do I know when a BI is going well? When patients make "Change Talk:"

"I really want to make a change. I know I can do it."

"I need to take a new direction in my life. If I don't change, bad things could happen."

"I'm going to make this happen."

"Even though I don't think I'm addicted, some bad things are happening when I use."

"I'll do whatever it takes to cut down. I really want some help."

"I'm sick and tired of being around druggies."

"I don't have to drink to have fun."

"I've decided to cut down and I really mean it."

"My wife would definitely be happy if I quit."

"I've got to change, or I could lose my kids."

Music to your ears? That's "change talk." Change talk is usually not abundant, even during a successful BI. But if listened for carefully, these statements usually occur several times during the interview. They are highlights that should be stored and summarized by the interventionist, so the patient can hear them again near the end of the interview. ("You mentioned that it's time for you to take new direction in your life, and one of the things you're contemplating is quitting drinking.")

Q. What can I do if my patient is “in denial”?

Most patients feel two ways about change: 1) they want to change, and at the same time, 2) they don't want to change. This is why, during the same interview, you will usually hear patients make statements both for and against change. Statements against change, “status quo statements,” are not usually attempts to deceive you, nor are they lies or attempts to manipulate you. For most patients, both sides are true. Some clinicians believe that statements against change constitute “denial” or “resistance.” However, the view from a Motivational Interviewing perspective is that these statements are not manipulative or self-delusional. Instead, they are simply one side of a patient's ambivalence—the other side being a desire to change. So ambivalence is a normal part of lifestyle change, and for interventionists, it is actually an opportunity to enhance rapport.

A simple way to enhance rapport in the face of “status quo talk” is to “*reflect and find the good news*” in the patient's statement. When one hears status quo talk, it is best to summarize it and try to find the good news in it—instead of arguing with it. Below are a few examples of “status quo talk,” followed by a few choices for ways to reflect and find the good news in what the patient is saying.

STATUS QUO STATEMENT: “*I don't see why everybody is making such a big deal about my drinking. I have a few beers after work to relax, that's all.*”

Response: “*You work hard, and you need to unwind so you can get your energy back after work.*”

Response: “*You've taken a good hard look at your drinking and in your opinion, it's not something to worry about.*”

Response: “*Seems like you're looking for a healthy way to chill out after work.*”

STATUS QUO STATEMENT: “*You might think that my drinking is risky, but I don't drink as much as my friends. You should be talking to them instead of me!*”

Response: “*Compared to the people you drink with, you're much healthier.*”

Response: “*When you compare yourself to some of your friends, you're actually more responsible.*”

Response: “*It's important to you to control your drinking, and you know some people who aren't in good control.*”

STATUS QUO STATEMENT: “*I'm not a drug addict.*”

Response: “*You're being careful to keep your drug use under control.*”

Response: “*You work hard to remain aware of where your drug use is going.*”

Response: “*You're a responsible, happy person.*”

STATUS QUO STATEMENT: “*Marijuana is not a drug. It's an herb that I use for my chronic pain. It's way safer than alcohol, and they should make alcohol illegal, not marijuana.*”

Response: “*You're pretty careful about what you put in your body.*”

Response: “*You've been thoughtful about how and why you use marijuana.*”

Response: “*So you don't use marijuana to get high.*”

Q. How do I know when the BI is finished?

Beginners tell us that it is often difficult to know whether to stop or keep going.

- Have you given screening feedback **(F)** and summarized your patient's responses?
- Have you elicited and summarized your patient's reasons for change **(L)**?
- Have you explored options for change **(O)**?
- Is the patient becoming less involved in the conversation?

If so, you should end on good terms. Patients sometimes signal that they wish to end the interview *before* these tasks are complete—and this should be respected. Common signals include shutting the eyes, making obvious efforts to change the topic, eagerly answering their phone and seeming relieved to greet the caller, or even asking, “*So, is there anything else?*”

These behaviors should be seen not as evidence that you have done something wrong or the interview has failed so much as signals that patients simply have very limited energy and attention while undergoing acute medical care. Such signals are common in Brief Interventions, and when you recognize them, close on good terms.

FAQs about Motivational Interviewing:

What is Motivational Interviewing (MI) and is it the same thing as BI?

Motivational Interviewing is a style of counseling that can be used to perform the FLO tasks of a BI, but MI is not the same thing as the FLO tasks, which can be done without using MI. MI is a patient-centered style of counseling that empowers patients to explore their ambivalence about change. It demands advanced listening skills on the part of the counselor as well as strategies of motivational psychology to elicit and highlight the patient's reasons for change. MI helps patients to resolve their ambivalence and move toward change. As such, MI requires relatively advanced counseling skills that not all brief interventionists have.

Is it necessary to learn MI in order to perform BI?

No. MI is not the only way to interact with patients during a BI, nor is it clear that MI is the best way. Other styles of counseling have worked well in BI studies, including Cognitive Behavioral counseling as well as simple, brief advice. This manual does not teach any particular style of interacting with patients, although several suggestions in the section, How to do a BI, are informed by and congruent with the spirit and methods of MI.

How would the style of a BI differ when using MI versus not using MI?

MI has been shown to elicit less status quo talk and more change talk than a more confrontational style.⁹ (See the two tables on page 20 contrasting two styles of interacting with patients.) The MI style is more quiet and eliciting than most other styles, because it does not emphasize educating patients about substance abuse. The most common thing that an MI interventionist does is ask open questions and reflect the patient's answers, in an attempt to help patients gain perspective on how alcohol or drugs fit into their lives.

What is involved in learning MI?

It takes more than a workshop to become proficient at MI. In general, a counselor with good baseline listening skills can attain basic MI proficiency from a 2-day group workshop plus several months of weekly supervision and coaching. It can take longer for medical providers without counseling backgrounds to learn MI.¹⁰

We have included the following synopsis of MI by Bill Miller, PhD, not to teach MI to the reader of this manual, but for readers who are potentially interested in learning MI to see at a glance the philosophy, strategies, and style that they would have to learn. The reader can find resources for learning MI in the Reference section.

Things to know about Motivational Interviewing (MI)

Adapted from condensed notes by Bill Miller¹¹

MI is a patient-centered approach

- Working in partnership and with the patient.
- Listening happens much more than telling.
- Eliciting happens much more than “installing correct ideas.”
- Honoring the person's autonomy and ability to choose happens instead of deciding for the patient.

Ambivalence is the key

- “Lack of motivation” is really just ambivalence: Both sides are already within the person.
- If you argue for one side, an ambivalent person is likely to defend the other.
- As a person defends the status quo, the likelihood of change decreases.
- Resist the “righting reflex”—to take up the “good” side of the ambivalence.

Four essential micro-skills: OARS

- Ask **OPEN** questions—not short-answer, yes/no questions.
- **AFFIRM** the person—comment positively on strengths, effort, and intention.
- **REFLECT** what the patient says (“mini summaries”).
- **SUMMARIZE**—collect the patient’s perspectives on change (“maxi summaries”).

Reflective listening: A valuable skill in itself

- A reflection seeks to summarize what the person means; it makes a guess.
- A good reflection is a statement, not a question.

Levels of reflection:

- **Repeat**—Direct restatement of what the person said.
- **Rephrase**—Saying the same thing in slightly different words.
- **Paraphrase**—Making a guess about meaning, continuing the paragraph, usually adds something that was not said directly.

Other types of reflection:

- **Double-sided reflection**—Captures both sides of the ambivalence (. . . AND . . .)
- **Amplified reflection**—Overstates what the person says.

Change Talk

- Invite the person to make the arguments for change.
- Ask about desire (“Want to change?”), ability (“Can you change?”) reasons (“Why do it? What would be good?”), need (“Important to do it?”).
- Commitment language—the bottom line (“I will do it!”). This predicts actual change.

Eliciting Change Talk

- The simplest way: Ask for it, in open questions to elicit desire, ability, reasons, and need:

“In what ways would it be good for you to . . . ?”

“If you did decide to . . . , how would you do it?”

“What would be the good things about . . . ?”

“Why would you want to . . . ?”

Importance and confidence rulers

- “On a scale from 0 to 10, how important is it for you to”
- “And why are you at ____ and not zero?” (The answer is change talk.)
- “On a scale from 0 to 10, how confident are you that you could”
- “And why are you at ____ and not zero?” (The answer is ability talk.)

What to do when you hear Change Talk?

- When you hear change talk, don’t just sit there!
- Reflect it—Restate it back to the person.
- Ask for examples/elaboration: “When was the last time? In what ways?”
- Ask for more: “What else? What other reasons?”
- Affirm change talk—reinforce, encourage, support it.
- Summarize—“Collecting flowers into a bouquet.”

Looking forward

- “If you don’t make any change, what do you think will happen?”
- “Where would you like to be in ____ years? What do you hope will be different?”
- “And how does drinking fit into that?”

Is it OK to give advice?

- **Yes.** But the person is more likely to heed your advice if you have permission to give it:
“There’s something that worries me here. Would it be all right if I”
“Would you like to know?”
“Do you want to know what I would do, if I were in your situation?”
“I could tell you some things other patients have done that worked”
“This may or may not be important to you”
“I don’t know if this will make sense to you”
“You may not agree”
“I don’t know how you’ll feel about this”
“Tell me what you think of this”
- It’s better to offer several options, rather than suggesting only one.

Responding to resistance

- Remember that “resistance” is just the other side of the ambivalence.
- Don’t argue against it. Pushing against resistance entrenches it.
- Respond in way that does not increase resistance. Roll with it.
- Some effective responses that tend to defuse resistance and refocus on change:
 - Reflection**—Simply acknowledge it by reflecting it back.
 - Amplified reflection**—Overstating it a bit.
 - Double-sided reflection**—“*On the one hand . . . And on the other . . .*”
Emphasize the person’s ability to choose, to be in control, to have autonomy.
- It’s not something the client does that’s bad. It’s a result of the interaction, of the chemistry between you and your patient. It usually predicts a poor outcome. So it is a sign for you to switch strategies.

Strengthening commitment

- Change talk (desire, ability, reasons, need) increases commitment. Commitment language signals behavior change.
- Encourage even low-strength commitment language: “*I’ll think about it. I might. I’ll try. I could.*”
- High-strength commitment language: “*I will. I’m going to. I promise. I’ll do my best.*”

Closing. Complete a consultation by giving a summary:

- **Bouquet:** Draw together the person’s desire, ability, reasons, need themes.
- Briefly acknowledge areas of reluctance, if appropriate.
- Summarize the person’s commitment strength.

► **If commitment is strong, elicit/negotiate a change plan.**



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MI-consistent and MI-inconsistent responses

MI-Consistent responses (these tend to increase patient change talk)

- Open questions** “What are your concerns about alcohol?”
“What role did alcohol play in your injury?”
- Reflections** “You’re really surprised to hear how high your alcohol level was.”
“So you don’t think alcohol is hurting you all that much.”
“I can see that your AUDIT score is higher than you expected”
- Summaries** “So you don’t think you’re an alcoholic and at the same time you’re concerned about some of the risks you have taken with alcohol.”
- Screening feedback** “Your alcohol level was .15 when you came in...what do you make of that?”
“Your AUDIT score was 15, placing you in the very high-risk zone.”
- Emphasize control** “It’s totally up to you whether you make a change.”
“I’m not here to tell you how to live.”
“You may decide to change after we talk, you may not.”
- Give advice** “If I may, I’d like to suggest you consider cutting down or quitting, to prevent future injury.”
- Affirmations** “I appreciate your honesty.”
“You’re a person who really does follow through once you make up your mind.”

MI-Inconsistent responses (these tend to increase patient status quo talk—you want to avoid these)

- Closed questions** “Do drugs cause problems in your life?”
“Do you think you have a problem with drugs?”
“Do you think alcohol caused your crash?”
“How much did you drink the night you were injured?”
- Confronting** “You said you only had 2 beers, but that’s impossible.”
“You say it’s not hurting you, but I can see that it really is.”
- Warning** “If you don’t change, you could be killed next time.”
- Interpret reality** “This is a lot more serious than you think.”
- Giving approval, appeasing** “Good for you, that’s the right thing to do.”
“We often tell ourselves that to seek comfort.”

Referring patients from acute care to substance abuse treatment

Either BT or community substance abuse treatment

Which patients should be referred to treatment?

No universal formula should dictate the answer to this question. In the Washington SBIRT project, we used the guidelines in the table below to determine which patients received a BI and/or were referred on for BT or intensive treatment.¹³ However, our interventionists sometimes referred lower-scoring patients to treatment if during the screening or BI interviews, their clinical judgment suggested that this was appropriate. The following are only general guidelines that should be adjusted by individual SBIRT programs after considering issues such as treatment availability and a given hospital’s populations served.

General Guidelines for Referral to Treatment

BASED ON BI SCREENING SCORES

		Refer to intensive community substance abuse treatment		
		Refer to BT*		
Provide BI only in the ED				
Considered a negative screen, no further counseling needed				
AUDIT-Female	Less than 7	7-15	16-19	20-40
AUDIT-Male	Less than 8	8-15	16-19	20-40
DAST	0	1-4	5-7	8-10

*BT is not commonly available in many states as a routine level of intervention.

The question of which patients to refer on for treatment—and how much time to invest in making these referrals—is a cost-benefit issue that every SBIRT program should carefully consider, given its unique environment. Is BT available to refer patients to? (see BT description below) Is intensive treatment reasonably accessible by your patients? Are your patients mostly Medicaid/Medicare, or are they privately insured? Is your hospital committed to a public health screening program to identify hazardous substance users, or is the culture of your hospital more committed with trying to place severely addicted patients in treatment?

How much time should be spent referring patients to intensive treatment?

Doing a good job of helping a patient to enter treatment is a time-consuming case management effort consisting of far more than merely giving patients a list of treatment agencies and phone numbers. Consider a clinical example:

A patient was found down in the street extremely intoxicated and injured from an assault. He was brought to the ED, where a minor scalp laceration was sutured and he was then held until sober enough to be discharged. The ED’s designated brief interventionist was asked by an ED nurse to see the patient, who was at first too intoxicated to undergo a brief counseling intervention. Five hours later, the patient was sober enough to talk, so the interventionist met with the patient for 20 minutes.

During this BI, the interventionist learned that the patient had had multiple prior treatment episodes and routinely suffers alcohol withdrawal symptoms when he stops drinking. The interventionist then contacted the ED physician (30 minutes to find the doctor and wait until she was available).

The physician asked the interventionist to try placing the patient in the local public detox program to manage his anticipated withdrawal—preferably before he went into withdrawal in the ED—in which case he might then have had to stay for 2 or 3 more days in the ED while his acute withdrawal was managed. The interventionist then had to coordinate with the ED social worker to discuss the patient (30 minutes) and contact the detox program to see if a bed was available for which the patient would qualify clinically and financially.

During this time, the interventionist had to update nurses, physicians, and social workers on the patient’s disposition status, which changed from time to time, depending upon the patient’s motivation for entering detox and bed availability. Finally, the interventionist coordinated transportation by walking the patient out of the hospital and waiting 20 minutes for a cab to take the patient to detox.

Finally, the interventionist coordinated transportation by walking the patient out of the hospital and waiting 20 minutes for a cab to take the patient to detox.

NOTE: This was a successful effort because the patient actually went to detox. However, more often than not, case management time is spent and then the patient decides not to go at the last minute. The only way to know this is to try to get the patient help and hope that he/she agrees to go to treatment.

- Total face-to-face time with patient: **40 minutes**
- Total time spent case managing one patient, spread over one day: **2-4 hours**
- Number of Screens and BIs that could have been done in 2-4 hours: **4-6**

Before devoting precious resources to treatment referral that might otherwise be devoted to performing BIs, SBIRT program administrators should consider how likely it is that referred patients will actually enter treatment as a result of a referral from their acute medical settings. Different SBIRT programs serve very different populations in terms of their attitudes toward substance abuse treatment and the availability of their public or private resources to pay for it.

Research on referring patients from acute medical care to treatment has yielded markedly different outcomes. For example, one SBIRT program referring to treatment well-insured patients who mostly view treatment as a medical necessity might enjoy a high show-up rate for treatment, whereas another SBIRT program might have poor outcomes with a population of mostly uninsured patients who view treatment not as a medical service but as legal punishment.

What is BT and when available, how should it be used?

BT is a stand-alone treatment for hazardous substance users who don't need more intensive substance abuse treatment. Please note, however, that BT is not part of the "traditional" SBIRT model, nor is it well established yet as a treatment element in most states. One thing that makes BT a new element of substance abuse treatment is the size of the BT "dose": it is more intensive than a BI (more sessions) and less intensive than traditional community substance abuse treatment, which can last more than a year in some cases. BT has been funded in some states by the U.S. federal government specifically to treat hazardous substance users. BT can last from 1 to 4 sessions, usually weekly one-on-one counseling sessions with substance abuse counselors or other mental health clinicians trained in substance abuse.

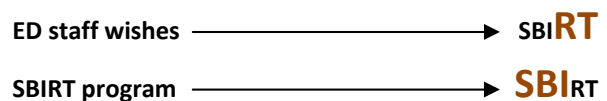
Nurses or other medical workers could provide BT, if also trained in counseling and substance abuse. Abstinence is usually not required (although this could vary by state), and BT is usually not mandated by the courts. BT is an opportunity for some clients to explore their drug and alcohol use and decide whether they want to change. If they decide to change during BT, they choose their own goals, with counselor guidance. This may mean quitting one drug and cutting down on another, using more safely (never before driving, never before work), or total abstinence.

During the Washington SBIRT project, we discovered another value of BT. In addition to being a stand-alone treatment for less severely impacted patients, we discovered that BT worked well as a bridge to more intensive community substance abuse treatment for more severely impacted patients. For example, some severely impacted patients declined a referral to intensive treatment, but agreed to go to BT. Once they become engaged in BT, some of them were subsequently referred to more intensive community treatment as they become ready to deepen their commitment to change. This improved the show-up rate for referrals to intensive treatment.

How much education of hospital staff is needed about SBIRT?

Substance abuse counselors, who sometimes serve as SBIRT interventionists, are very skilled at RT, because they are familiar with the community substance abuse treatment system. Hospital staff deeply appreciate this expertise. However, other interventionists less familiar with substance abuse treatment may be less successful than specialists in making referrals. SBIRT is a new service that is often misunderstood by hospital staff who may think that its sole purpose of SBIRT is RT.

In the Washington SBIRT project, the greatest impact in cost-savings to the state come from the first part (SBI) of SBIRT, and less so from the RT. So until hospitals learn the value of a balanced SBIRT program (one providing BI and RT), interventionists may face a discrepancy between SBIRT program goals and ED staff wishes:



► ***SBIRT jobs entail constant re-education of ED staff. This is true of all acute medical settings.***

Pothole #1: Damned lies

“I don’t drink and drive”

Patient was an intoxicated driver admitted to the ED

“I only had a couple of beers”

Patient’s alcohol level was .25 upon admission

Patients may lie from time to time during BIs. After all, they are talking to strangers about a sensitive topic that they did not ask to discuss, while under stress. When you think that your patient is lying, you are at risk for being distracted (how could his alcohol level be that high if he wasn’t drinking?), and it’s hard to concentrate and stay on task doing FLO. So what should you do? Some patients have good reasons to withhold information (legal, cultural, pride). When you hear a lie, it is your signal to focus on something else.

Remind yourself that:

- Listening and understanding is what makes BI effective—not confronting patients on their lies.
- Lies are like the wind on the golf course . . . you can’t stop it, but you still have to hit your best shot. If you let the wind distract you, you’ll hit a bad shot.
- BI studies were successful even when patients lied some. People can still change even if they don’t tell you the whole truth in the moment.

Workarounds:

Find the good news in the lie:

- If you cannot find any good news in the lie, simply ignore it and refocus yourself.
- Ask yourself which BI task you should be doing (F? L? O?).
- Find the meaning behind the lie (what might the patient really mean by that?)

Examples:

Patient: “I don’t see why you’re making such a big deal about drinking a few beers now and then.”

Response: “This must be a tough topic for you to talk about...”

Patient: “I’m not a drug addict!”

Response: “Seems like you don’t want anybody to label you...”

Patient: “Alcohol never caused me to miss a day of work in my life.”

Response: “You’re a responsible person...”

Patient: “I never drink and drive.”

Response: “You believe it’s wrong to do that.”

Patient: “I hardly ever get very drunk.”

Response: “You don’t think it’s good to get extremely drunk...”

Pothole #2: Unrealistic thinking

“I’m just going to quit, no problem”

Severely addicted patient

“I’m gonna keep hanging with my buddies, but I won’t drink.”

Patient is simply swearing off alcohol or drugs, but with no plan for doing so—and he seems to be avoiding thinking about slippery people, places, or things. So you’re not very confident in his chance for success. And you fall into the pothole of suggesting numerous action plans, which he shoots down one at a time with “yes, buts.” The patient shoots them down, because he doesn’t believe he needs them.

Remind yourself that:

- Swearing off is how people begin the process of quitting. Many smokers swear off and relapse before they discover what works for them. If this is your patient’s first attempt at quitting, you should be celebrating, not feeling discouraged. It’s just a first attempt by somebody who has very little experience in quitting. Most people try to fix the problem with the least amount of effort—all humans do this. People are more likely to commit to making a greater effort (counseling) after they have first tried and failed to do it on their own.
- Acknowledge to that patient that this is actually an experiment in quitting, and the results of the experiment will tell him if his plan is working. You can always ask him what else he would try if for some reason his plan didn’t work
- Many people stop drinking and using without treatment or AA. Some people use church, family, hobbies, and some merely delete drinking from their lives without doing anything else—successfully. Maybe this patient actually intends to do one of these things but just hasn’t said so. Try asking him

Workarounds:

- *“People who succeed at quitting or cutting back often use ‘tools’, such as avoiding certain people or places, having a substitute beverage in mind, or announcing their commitment to a loved one . . . how about you?”*
- Try for a verbal commitment from them as to how they will know if their plan is working or not working. Try for a verbal commitment to ask for help if they relapse.

Examples:

Patient: *“I’m just gonna stop, no problem...”*

Response: *“That’s great news. What sort of situations have you decided to avoid to do that?”*

Patient: *“I’m still going to spend just as much time in bars as I did before, if that’s what you mean. I’m just not going to drink.”*

Response: *“Some people have good luck trying that, some don’t. In addition to going to bars, how else do you enjoy spending time?”*

Patient: *“I don’t need treatment. I’m just going to do it by myself.”*

Response: *“Many people succeed without going to treatment. It’s really just a matter of each person figuring out for himself what works best for him. What sort of things have worked for you in the past?”*

Patient: *“I dunno, I just know I can quit whenever I want.”*

Response: *“You sound determined. Are there any people that you may spend less time with, now that you have quit?”*

Pothole #3: The angry patient

“I don’t have to talk about this”

“What right do you have to judge me?”

“This hospital has no right asking me about all this personal stuff”

“I wish that nurse would get me my pain medicine; she’s delaying intentionally”

Remind yourself that:

- Do not take this personally.
- There is usually good news to be found in anger.
- A little listening goes a long way
- Anger can be defused . . . if not, you can always just leave the room.

Workarounds:

- Back down, give in. Let go.
- Agree to leave it for now, close on good terms.
- Go into customer service mode and try to address the complaint if there is one.
- Acknowledge to the patient that he is in control and nobody can tell him how to live his life.

Examples:

Patient: *“This is stupid, you walking around the emergency room lecturing everybody. Marijuana never hurt anybody!”*

Response: *“It’s totally up to you whether you talk to me, I’m sure not here to make you any more uncomfortable than you already are. You look like you’re in some pain there; is there anything I can do to help?”*

Patient: *“There sure is. You can tell my nurse to get me the amount of pain medicine I need to control my pain.*

Response: *“No wonder you’re feeling lousy. Let me go and find her and see what she says. Of course, I can’t tell her what to do, but I can sure find out for you what’s going on with your pain meds. I’ll be right back once I find out. Is there anything else I can do for you while I’m gone?”*

Patient: *“This hospital has no right asking me about all this personal stuff . . .”*

Response: *“It seems to you that it’s inappropriate for strangers to be prying into your private life.”*

Patient: *“Well, I guess the doctors need to know whether I take drugs or not, but I’m not interested in any treatment, I can tell you that right now.”*

Response: *“I hear you loud and clear. You’re not interested in any treatment and you sure don’t want anybody trying to tell you how to live your life. I can assure you that I won’t be trying to get you to do anything you don’t want to do. I’m just interested in understanding if your drug use is causing you any harm, that’s all. And, it’s totally up to you to decide whether you’re concerned or not. I didn’t single you out; I ask all of our patients these questions.”*

► **These approaches make it easier for patients to discuss it later with another person, if they see that they can control the course of such conversations.**



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Handouts for your patients

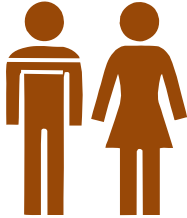
- 1.** Is the way you typically drink within low-risk limits?.....28
- 2.** How risky is your use of alcohol compared to other people?.....29
- 3.** How risky is your use of drugs compared to other people?.....30

Screening tools

- 1.** The Alcohol Use Disorders Identification Test: Interview Version31
- 2.** Drug Abuse Screening Test-1032

Is the way you typically drink within low-risk limits?

Below are the low-risk guidelines for adults



MEN: 3 drinks per day, max, and 14 drinks per week, max.

WOMEN: 2 drinks per day, max, and 9 drinks per week, max.

Any time you exceed these limits, you are at risk of harm

ONE DRINK = One bottle of beer (12 oz)
= One glass of wine (5 oz)
= One “single” drink (1¼ oz of liquor)



No amount of alcohol is safe if you are driving.

No amount of alcohol is safe if you are pregnant or planning to conceive.

How risky is your use of alcohol compared to other people?



RANGE: AUDIT scores can range from 0-40

ASK: What would you guess your score was?

NORMAL: Normal scores on the AUDIT are below 8 for adults.

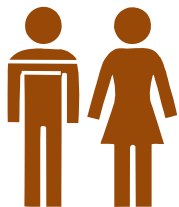
GIVE SCORE: Based on your answers to the audit, your score was _____.

This places you in the following category:

- No/Low-Risk
- At-Risk
- High-Risk
- Severe-Risk

ELICIT: What do you make of that?

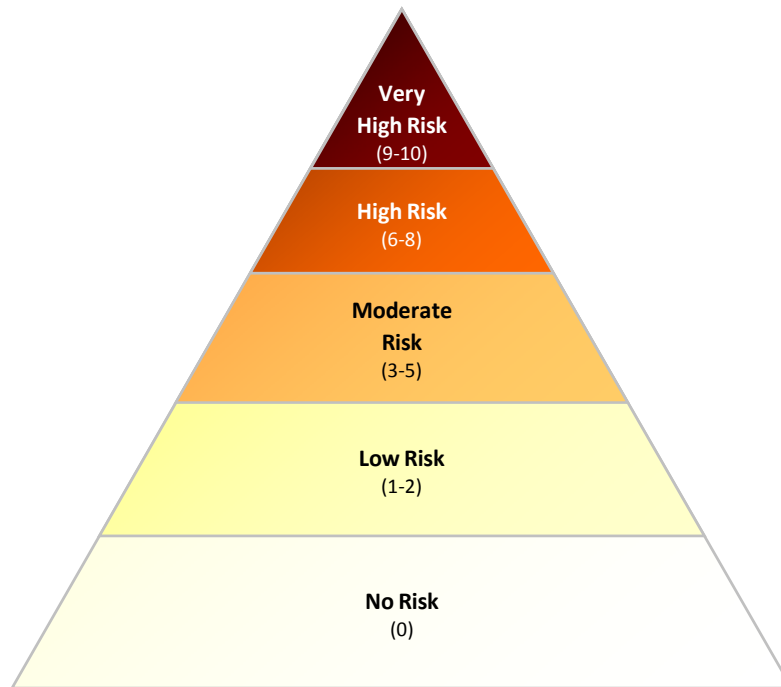
LOW-RISK DRINKING:



MEN: **3** drinks per day, max, and **14** drinks per week, max.

WOMEN: **2** drinks per day, max, and **9** drinks per week, max.

How risky is your use of drugs compared to other people?



- The **DAST-10** (*Drug Abuse Screening Test*) is a questionnaire that has been given to many adults.
- **DAST** scores can range from 0 to 10.
- Based on your answers to the **DAST**, your score was _____.

This places you in the following level of drug risk:

- No risk
 - Low
 - Moderate
 - High
 - Very High
- These problems can include: **medical, injury, mental or emotional consequences.**
 - Health experts advise people to **quit or cut back** in order to get into the **No Risk** zone.

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during the past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks." Place the correct answer number in the box at the right.

<p>1. How often do you have a drink containing alcohol?</p> <ul style="list-style-type: none">(0) Never [Skip to Qs 9-10](1) Monthly or less(2) 2 to 4 times a month(3) 2 or 3 times a week(4) 4 or more times a week <div style="text-align: right;"><input type="text"/></div>	<p>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</p> <ul style="list-style-type: none">(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily <div style="text-align: right;"><input type="text"/></div>
<p>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <ul style="list-style-type: none">(0) 1 or 2(1) 1 or 2(2) 5 or 6(3) 7, 8 or 9(4) 10 or more <div style="text-align: right;"><input type="text"/></div>	<p>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</p> <ul style="list-style-type: none">(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily <div style="text-align: right;"><input type="text"/></div>
<p>3. How often do you have six or more drinks on one occasion?</p> <ul style="list-style-type: none">(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily <p style="text-align: center;"><i>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</i></p> <div style="text-align: right;"><input type="text"/></div>	<p>8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?</p> <ul style="list-style-type: none">(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily <div style="text-align: right;"><input type="text"/></div>
<p>4. How often during the last year have you found that you were not able to stop drinking once you had started?</p> <ul style="list-style-type: none">(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily <div style="text-align: right;"><input type="text"/></div>	<p>9. Have you or someone else been injured as a result of your drinking?</p> <ul style="list-style-type: none">(0) No(1) Yes, but not in the last year(2) Yes, during the last year <div style="text-align: right;"><input type="text"/></div>
<p>5. How often during the last year have you failed to do what was normally expected from you because of drinking?</p> <ul style="list-style-type: none">(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily <div style="text-align: right;"><input type="text"/></div>	<p>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?</p> <ul style="list-style-type: none">(0) No(1) Yes, but not in the last year(2) Yes, during the last year <div style="text-align: right;"><input type="text"/></div>
<p style="text-align: right;">Record total of specific items here</p> <div style="text-align: right;"><input type="text"/></div> <p><i>If total is greater than recommended cut-off, consult User's Manual.</i></p>	

Drug Abuse Screening Test-10

The following questions ask about your possible drug use over the past 12 months. Do not include your alcohol use when answering the questions.

"Drug abuse" refers to:

- The use of prescribed or over-the-counter drugs in a way that does not follow the directions.
- Any non-medical use of drugs.

Drugs may include:

- Cannabis (marijuana, hashish)
- Solvents, such as paint thinner
- Tranquilizers, such as Valium
- Barbiturates
- Cocaine
- Stimulants, such as speed (meth)
- Hallucinogens, such as LSD
- Narcotics, such as heroin

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?

These questions refer to the past 12 months: Yes No

3. Are you unable to stop using drugs when you want to?
4. Have you ever had blackouts or flashbacks as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (for example, memory loss, hepatitis, convulsions, bleeding)?

Scores indicate the degree of problems that drug use may cause:

- **0** = No problems related to drug use.
- **1 to 2** = Low level of problems related to drug use. Talk to your doctor about this.
- **3 to 5** = Intermediate level. Make an appointment with your doctor to discuss this.
- **6 to 8** = Substantial level. Call your doctor now to make an appointment.
- **9 to 10** = Severe level. Call your doctor now to make an appointment.

Adapted from "Drug Use Questionnaire," © Copyright 1982 by Harvey A. Skinner, PhD, and the Centre for Addiction and Mental Health, Toronto, Canada.

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Learning more about MI

- 1 Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.
- 2 Rollnick, S., Mason, P., & Butler, C. (1999). *Health behavior change: A guide for practitioners*. New York: Churchill Livingstone.
- 3 The Motivational Interviewing Page: A repository of resources on motivational interviewing, including links, training resources, reprints and videotapes: motivationalinterview.org.
- 4 A Behavior change counseling training videotape based on *Health Behavior Change* (book by Rollnick, Mason & Butler, 1999) is available from: <http://www.jeffallison.co.uk/index.htm>.
- 5 An international web site where you can get certified in MI: <http://www.mi-campus.com/>.

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