Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training

Trainer Guide
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Trainer Guide
The Pacific Southwest ATTC prepared this SBIRT training product under a special project supplement from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (5 UD1 TI013594-09S2).

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The opinions expressed herein are the views of the authors and do not reflect the official position of the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. No official support or endorsement of the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment for the opinions described in this document is intended or should be inferred.
# Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training

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Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training

Background Information

The goal of this training course is teach participants how to develop their skills to deliver Screening, Brief Intervention, and Referral to Treatment (SBIRT). The assumption in designing this course is that participants have already completed the self-paced online course (Foundations of SBIRT) that introduced the topic of SBIRT. The aim of this training course is to help participants to (1) develop skills related to SBIRT, and to (2) begin a conversation around implementation of SBIRT in standard practice. The learning activities that are presented include didactic teaching, role plays, group discussions, and peer evaluation. In terms of other resources, this course depends on participants’ active participation and expertise, as well as a wide array of materials that have been assembled from many centers throughout the U.S. who have experience using SBIRT.

The full SBIRT training package includes a self-paced online Foundations of SBIRT course, a 94-slide PowerPoint presentation, this Trainer Guide, a Participant Guide (with handouts), a slide-by-slide reference list, and the World of SBIRT blog. The duration of the face-to-face training presentation is approximately 120 minutes.

A pre- and post-test has been developed to assess a change in the participant’s level knowledge after the information has been presented. An answer key is provided in the Trainer’s notes in slide 93.

As an alternative to administering paper-and-pencil pre- and post-test questionnaires, you may use an Audience Response System (ARS). If interested, please contact the Pacific Southwest ATTC at pacificsouthwestca@attcnetwork.org for information on the ARS.

What Does the Training Package Contain?

- Self-paced online Foundations of SBIRT course (visit http://www.attcelearn.org for enrollment information)
- PowerPoint Training Slides (with detailed notes)
- Trainer Guide with detailed instructions for how to convey the information and conduct the interactive exercises
- Participant Guide (with handouts)
- Slide-by-Slide Reference List
• Pre- and Post-Test (with answer key)

• World of SBIRT blog (visit http://worldofsibirt.wordpress.com/ for more information)

What Does This Trainer Guide Contain?

• Slide-by-slide notes designed to help the trainer effectively convey the content of the slides themselves

• Supplemental information for select material to enhance the quality of instruction

• Suggestions for facilitating the pre- and post-test questions and interactive exercises

How is This Trainer Guide Organized?

For this guide, text that begins with a bolded word and is shown in italics is “Instructions or Information for the Trainer.” Text that is shown in normal font relates to the “Trainer’s Script” for the corresponding slide.

It is important to note that some slides in the PowerPoint presentation contain animation. Animations are used to call attention to particular aspects of the information or to present the information in a stepwise fashion to facilitate both the presentation of information and participant understanding. Getting acquainted with the slides, and practicing delivering the content of the presentation are essential steps for ensuring a successful, live training experience. In addition, slides 9 and 11 contain audio voice overs, and slides 46 and 47 contain embedded video clips. Please refer to the instructions that accompany slides 9, 11, 46, and 47 for additional information regarding playing the audio voice overs and video clips.

What Interactive Activities are Included?

A series of interactive exercises are included throughout the presentation. Following is a list of activities, and corresponding slide number(s):

• Activity #1: Reflection (Slide 5)

• Activity #2: Adoption of SBIRT (Slide 13)

• Activity #3: AUDIT Practice (Slides 30-31)
• Activity #4: Video Example 1 and 2 (Slides 46-47)
• Activity #5: Reflective Listening (Slide 53)
• Activity #6: Role Play – F (Slide 68)
• Activity #7: Role Play – L (Slide 76)
• Activity #8: Role Play – O (Slide 84)
• Activity #9: Putting it All Together – FLO (Slide 85)
• Activity #10: Wrap-Up (Slide 92)

Getting acquainted with the interactive activities, and practicing delivering the content of these activities are essential steps for ensuring a successful, live training experience.

General Information about Conducting the Training

The training is designed to be conducted in small- to medium-sized groups (10-25 people). It is possible to use these materials with larger groups, but the trainer may have to adapt the small group interactive exercises to ensure that there is adequate time to cover all of the material.

Materials Needed to Conduct the Training

• Computer with PowerPoint software installed (2003 or higher version) and LCD projector to project the PowerPoint training slides.
• Computer speakers to play the videos and audio voice overs.
• Participant guide (with handouts) for each training participant.
• Flip chart paper and easel/white board, and markers/pens to write down relevant information, including key interactive activity discussion points.
Overall Trainer Notes

It is critical that prior to conducting the actual training, the trainer practice using this guide while showing the slide presentation in Slideshow Mode in order to be prepared to use the slides in the most effective manner.
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training

Slide-By-Slide Trainer Notes

The notes below contain information that can be presented with each slide. This information is designed as a guidepost and can be adapted to meet the needs of the local training situation. Information can be added or deleted at the discretion of the trainer(s).

Slide 1:
Hello, my name is [ ] and I’d like to welcome you to the Screening, Brief Intervention, and Referral to Treatment or SBIRT training. We are very happy that you have joined us. Before we begin, let’s briefly introduce ourselves. Let’s go around the room and have each person state their name, their place of employment, and their line of work, e.g., nurse, social worker, psychologist. Also, tell us what you hope to gain from this course.

Note: If there are more than 15 participants, individual introductions will not be possible due to time constraints. In this case, ask participants to stand or raise their hand if they are a nurse, social worker, etc., through the various lines of work represented. Always end this activity by asking if there is anyone that you missed and include these people as well.

Slide 2:
The goal of this course is to develop your skills to deliver SBIRT. Our assumption in designing this course is that you have already completed the self-paced online course (Foundations of SBIRT) that introduced the topic of SBIRT. If you look at the desired outcomes for today’s course on the right-hand side of the slide, you can see that our aim is to develop your skills related to SBIRT and to begin a conversation around implementation of SBIRT in standard practice. The learning activities that we will use to develop your skills include some didactic teaching, role plays, group discussions, and peer evaluation. In terms of our resources, this course depends on your participation and expertise, as well as a wide array of materials that we’ve assembled from many centers throughout the U.S. who have experience using SBIRT.

If you haven’t taken the self-paced online course, we recommend that you do so following this training to gain more background on SBIRT. The link to that course can be found at The World of SBIRT blog (http://worldofsbirt.wordpress.com/) or the ATTC Network’s online learning portal (http://www.attcelearn.org).
Please complete the pre-test. Thank you!!

**Please complete the pre-test.**

Thank you very much.

*The answer key for the pre- and post-test is included in the notes for Slide 93.*

**Note:** As an alternative to paper-pencil questionnaires, you may use an Audience Response System (ARS). If interested, please contact the Pacific Southwest ATTC at pacificsouthwestca@attcnetwork.org for information on the ARS.

This course will teach you how to:

• Administer screening
• Deliver a brief intervention
• Employ a motivational approach, and
• Make referrals to specialized treatment.

At this point, I’d like to ask you to join me in an exercise. What we’re going to do is reflect on a difficult change that we made in our lives. You will not be asked to share the details of this change with anyone. What is something you really struggled with? Let’s take a few minutes to think about this time and to think about how this change came about and how long it took you to take action.

**Allow the audience about 1 minute.**

Did everyone think of something?

In my experience, any change takes time to commit to it. Even though a person may be thinking about changing, actually doing something about it or making an effort to change is really hard. Would anyone like to share how long it took from the point of considering a change to the point of taking action towards change?

**Allow 2-3 minutes for discussion.**

It is not uncommon for people to ponder change for a very long time before taking action—often years. SBIRT provides a way to speed this process up and help someone see the need for change and begin to do something about it.
Slide 6:
Let’s review a few key terms.

1. Screening is a brief method of identifying individuals at risk for potential substance use related problems by asking them a few validated questions. Screening is a population-based approach to increase safety of individuals and populations.

2. Brief interventions consist of short-term, low-intensity counseling. Most brief interventions are 1 or 2 sessions that may last 10-20 minutes. The goal of a brief intervention is to raise awareness of substance use risks and to move people to a place where they can draw a connection between their substance use and the concerns that they come to us with.

3. Brief treatments include more in-depth counseling, typically cognitive behavioral therapy for people who are experiencing substance use related problems and would like help managing, reducing, or stopping their substance use.

4. Lastly, referrals are a set of procedures that we use to help patients access and receive services through a specialized care provider such as an addiction treatment program.

Slide 7:
Screening and brief intervention is an effective public health response.

- SBI may reduce alcohol and drug use and, as a result, prevent individuals from developing a disorder that requires specialized treatment.

- SBI can reduce accidents, injuries, HIV infection, and overuse of emergency care services.

- Studies have shown that SBI can be cost effective.

- Lastly, reduction in heavy alcohol and/or drug use can lead to other improvements in people’s lives, such as their relationships and productivity at work or school.

Slide 8:
SBIRT has some benefits for clinicians.

- The process of learning about SBIRT increases clinicians’ awareness of substance abuse in various populations.

- The use of screening as a source of objective information can help some clinicians approach the subject of substance use in a more systematic way.
Slide 9:
Here is a quote from a mental health clinician who used SBIRT in the UCLA Access to Care study.

*Click the speaker icon for voiceover.*

Slide 10:
As I mentioned before, the goal of the brief intervention is to help the patient or client to see a connection between their use and their health and wellbeing.

Slide 11:
In this comment, another UCLA clinician describes how she broaches the subject of substance use risk with students.

*Click the speaker icon for voiceover.*

Slide 12:
Deciding who to screen will depend on your setting and your goals. Here is a partial list of candidates: college students who go to campus health centers, primary care patients, mental health clients, patients treated in infectious disease clinics, as well as people with DUIs or other alcohol- or drug-related offenses.
Can SBIRT work in your setting?

I would now like for you to identify the barriers and facilitators you may face when implementing SBIRT in your practice. Try to identify 1 or 2 barriers and 1 or 2 facilitators (i.e., resources or aspects of your practice that would support the use of SBIRT).

Form pairs; you will have 3 minutes for this discussion.

Allow 3 minutes and then ask the audience to share their ideas.

Ok, let’s hear what you came up with for barriers.

Use newsprint or a whiteboard to document barriers and facilitators as participants identify them. Post the newsprint on the walls for the remainder of the training.

How about facilitators?

Now we are going to move into talking about screening tools, and we will practice using a brief screening tool for alcohol use.

Click to animate in first picture

What’s going on in this picture?

Allow audience to make comments.

Click to animate the word “screening”

Like screening at the airport, our goal with substance use screening is safety. To make a difference at a population level, substance use screening needs to be universal or given to everyone.

Click to animate in second picture

So, why do we have to pat down this guy?

Allow audience to make comments.

Click to animate the word “assessment”

One reason could be that an alarm went off. When screening indicates the possibility of a problem, a provider must follow up by assessing for a potential threat to safety. In the airport, we want to know if he has a bomb; in our program, we want to know if his substance use is risky or if he could have severe problems.
Slide 16:

_Self-report_: Most of the time when we talk about alcohol and drug screening in primary care or mental health, we are referring to short questionnaires with a maximum of 10 questions. We call these questionnaires self-report because they are based on what patients tell us. Does anyone recall filling out a few questions about alcohol and drug use the last time you saw your primary care physician? Do any of you already use screening questionnaires in your practice?

_Access responses._

_Biological markers_: There are also biological markers such as breathalyzers, blood alcohol concentration tests, urine testing, etc. Blood alcohol concentration tests are the most common biological marker used in medical settings. For example, in the UCLA trauma department, every patient who comes in gets a BAC test. The department also later does a self-report questionnaire after patients are stabilized.

Having biological information can be very useful, but it only tells us about very recent use. In addition, biological information do not indicate how problematic an individual’s substance use may be.

**Note:** Biological markers can detect recent use of drugs such as cocaine, opioids, cannabis, benzodiazepines, and barbiturates. Common tests for substance use are blood, urine, and hair tests.

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Slide 17:

The best screening tools are those that are very brief, easy to use, address alcohol, illicit drugs, and prescription medications, tell us whether further assessment is needed, and have good sensitivity and specificity. Sensitivity refers to the ability of a test to correctly identify those people who actually have a problem, in other words, “true positives.” Specificity is a test’s ability to identify people who do not have a problem—“true negatives.” Good screening tools maximize sensitivity and reduce “false positives.” Self-report screens allow for more contextual information about the frequency and quantity of use. They are inexpensive, non-invasive, and highly sensitive for detecting substance use related problems.

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Slide 18:

Self-report screens allow for more contextual information about the frequency and quantity of use. They are inexpensive, non-invasive, and highly sensitive for detecting substance use related problems.
Screen Target

Population

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<tr>
<td>Items</td>
</tr>
<tr>
<td>Assessment Setting (most common)</td>
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<td>Type</td>
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ASSIST (WHO)

- Adults
- Validated in many cultures and languages

8 Hazardous, harmful, or dependent drug use (including injection drug use)

Primary Care Interview

AUDIT (WHO)

- Adults and adolescents
- Validated in many cultures and languages

10 Identifies alcohol problem use and dependence. Can be used as a pre-screen to identify patients in need of full screen/brief intervention

- Different settings
- AUDIT C- Primary Care (3 questions)
  - Self-admin, interview, or computerized

DAST-10

Adults

10 To identify drug-use problems in past year

- Different settings
  - Self-admin or interview

CRAFFT Adolescents

6 To identify alcohol and drug abuse, risky behavior, & consequences of use

- Different settings
  - Self-admin

CAGE Adults and youth >16

4 - Signs of dependence, not risky use

Primary Care

Self-admin or interview

TWEAK Pregnant women

5 - Risky drinking during pregnancy. Based on CAGE.

- Asks about number of drinks one can tolerate, alcohol dependence, & related problems

Primary Care, Women’s organizations, etc.

Self-admin, interview, or computerized

---

Slide 19:

Here is a chart that provides information on 6 different screening tools. Some are very broad in scope like the ASSIST, which covers alcohol, tobacco, and illicit drugs. Others are very specific like the TWEAK, which was developed for use with pregnant women and only assesses alcohol use. Has anyone heard of any of these? Which ones?

**Allow 1 or 2 minutes for discussion.**

For those of you who work on college campuses, I’d like to mention that you may be interested in looking at the CRAFFT, which was developed for adolescents and has been used with college students.

In this training, we will focus on the AUDIT (the Alcohol Use Disorders Identification Test). We chose to focus on the AUDIT for this training because it is the most common screening tool used in SBIRT programs in the U.S. It is straightforward, quick, and can be administered as an interview or by questionnaire. The AUDIT only covers alcohol. A commonly used screen for illicit drugs is the Drug Abuse Screening Test or the DAST. You can access all of these screens online.

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Slide 20:

We do screening to identify risk. But how is risk defined? The U.S.-based National Institute on Alcohol and Alcoholism (NIAAA) defines risk as drinking more than the recommended limits. So, if you look at this chart, the recommended limit for men is no more than 4 drinks per occasion and no more than 14 drinks per week. For women, the limit is no more than 3 drinks per occasion and no more than 7 drinks per week. Notice that for individuals 65 and older, the limits are lower.

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Slide 21:

Not everyone uses the same definition of “a drink” when they talk about how much they have consumed. When we do screening, we use the NIAAA definition of a standard drink: a 12-oz size beer, a jigger (1.5 oz) of hard alcohol, a 5 oz glass of wine, and a small glass of liqueur.

So, a drink for one person may be a “40-ouncer” of beer. How many drinks would that be?

**Allow responses. Correct answer: 3.5 drinks.**

It’s very important for the patient to understand what you mean by “a drink” when you start screening.
Pre-screening is a very quick approach to identifying people who need to do a longer screen and brief intervention.

- **Self-report, 1-4 questions**
- **Biological, blood alcohol level test**

**Slide 22:**
At times we may want to do something very quick with patients to identify who may benefit from additional screening. This is like when we go through the initial screening at the airport security check and when the metal detector alarm beeps. The TSA agent may then do a more thorough assessment (by searching your bags or doing a “pat down”). The idea is the same. Pre-screens identify people who are potentially at risk and help save time by not requiring a more thorough screening of everyone.

Typically, pre-screens are self-report and consist of 1 to 4 questions.

**Slide 23:**
NIAAA has a single-item pre-screener for alcohol use: “How many times in the past year have you had X or more drinks in a day?”

X equals 5 for men and 4 for women. This pre-screen has been shown to identify unhealthy alcohol use. A positive screen is any response greater than 1 and should be followed by further screening or, in some cases, a brief intervention.

**Slide 24:**
There is a parallel validated pre-screening question for illicit drug use: “How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?” A score of 1 or more is considered a positive result and should trigger more in-depth screening and possibly a brief intervention.

**Pose the following question in neutral, matter-of-fact way; you want to get people thinking:**

What is the safe limit for drugs, say, cocaine? How much crack is OK for people to use?

Any illicit substance use is problematic because a person is putting him or herself at risk by using them.

How easy or difficult do you think it is to identify overuse or misuse of prescription medications?

**Allow a couple of responses from participants.**

This can be complicated, because many people, including college students, view prescriptions as safe—and legal—because a doctor wrote a prescription for the medication to someone.
Slide 25:
Let’s look at this detailed flow chart that depicts an SBI decision tree. Imagine we start with a pre-screen. If we have a positive score on the pre-screen for alcohol or drugs, we would typically proceed to a full screen such as the AUDIT or the DAST. It is important to note that a pre-screen is not required. There are many operational SBIRT programs that do not use a pre-screen, but rather administer a full screening with all patients.

Slide 26:
The Alcohol Use Disorders Identification Test or AUDIT was developed in the 1980s to identify alcohol use, abuse, and possible dependence. The AUDIT has 10 questions. It has been validated for use with diverse groups of people. It was originally designed for use in primary care settings, but can be used in mental health and college/university campus settings, as well.

Slide 27:
The AUDIT assesses alcohol across three domains. First, hazardous levels of use are assessed through questions related to quantity and frequency of use, including frequency of heavy or binge drinking.

Slide 28:
Second, dependence symptoms are assessed by DSM-4 criteria such as impaired control over drinking, failure to meet expectations because of drinking, and needing to drink first thing in the morning.

Slide 29:
Finally, the last four questions of the AUDIT address harmful consequences of use. Indicators include feeling guilty after drinking, having blackouts, causing injury to self or others, and having others express concern about one’s drinking.
Slide 30:

I’d like to discuss ways of introducing the screening process to the patient.

1. It is critical to provide a gentle introduction to talking about substance use—which may be awkward or embarrassing for patients. It is important to tell the patient that some questions are personal.
2. And that the information is confidential.
3. Patients may be surprised by your desire to ask them questions about substance use, so your job is to normalize this procedure as much as you can. You can do this by being straight-forward about the screening, e.g., “This is part of routine care that we provide.” You want to tell the patient that you are asking the questions in order to provide the best possible care.
4. Also, you want to tell the patient that he or she doesn’t have to answer a question if they are uncomfortable.

If you create a comfortable environment for your patients, most will respond well to the screening and will provide you with honest answers. Even if patients underestimate their use, you still have a very good chance of identifying their risk level.

Now we are going to get acquainted with the questions on the AUDIT. We are going to do a brief exercise in which one person will play the clinician and one person will play the patient. Please turn to the blank AUDIT form on the next page (page 17) for the next exercise.

What I’d like you to do is to introduce the AUDIT as described here and then run through the questions of the AUDIT. For the person playing the clinician, you need to ask the questions as written and read the response options to the patient. For those of you playing the patient, you can make up your own answers; just don’t make them tricky or hard!

Allow the audience a minute to form pairs and locate the AUDIT in their materials.

Leave this slide up during the run-through so people can refer back to these statements. Give the participants 5 minutes to complete the activity.
1. How often do you have a drink containing alcohol (Score)

   Never (0)
   Monthly or less (1)
   Two to four times a month (2)
   Two to three times a week (3)
   Four or more times a week (4)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

   1 or 2 (0)
   3 or 4 (1)
   5 or 6 (2)
   7 to 9 (3)
   10 or more (4)

3. How often do you have six or more drinks on one occasion?

   Never (0)
   Less than monthly (1)
   Monthly (2)
   Weekly (3)
   Daily or almost daily (4)

4. How often during the last year have you found that you were not able to stop drinking once you had started?

   Never (0)
   Less than monthly (1)
   Monthly (2)
   Weekly (3)
   Daily or almost daily (4)

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

   Never (0)
   Less than monthly (1)
   Monthly (2)
   Weekly (3)
   Daily or almost daily (4)

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?

   Never (0)
   Less than monthly (1)
   Monthly (2)
   Weekly (3)
   Daily or almost daily (4)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

   Never (0)
   Less than monthly (1)
   Monthly (2)
   Weekly (3)
   Daily or almost daily (4)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never (0)
   Less than monthly (1)
   Monthly (2)
   Weekly (3)
   Daily or almost daily (4)

9. Have you or someone else been injured as a result of your drinking?

   No (0)
   Yes, but not in the last year (2)
   Yes, during the last year (4)

10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking, or suggested you cut down?

    No (0)
    Yes, but not in the last year (2)
    Yes, during the last year (4)
Slide 31:
Are there any thoughts about the items on the AUDIT? What are your initial reactions to the questions as written?

**Note:** You may receive a comment about question 3 and the reference to “6 drinks or more.” This question has to do with binge drinking; in the U.S., the definition of binge drinking is 5 or more for men in a single setting/occasion and 4 or more drinks for women in a single setting/occasion. The reason the question reads “6 or more” is because in some countries, such as Australia, the standard drink size is smaller than in the U.S.

Some people may comment that a question is vague or poorly worded. You can acknowledge their feedback and reassure them that no instrument is perfect, but the AUDIT has undergone a tremendous amount of research cross-nationally and, as a whole, has very good reliability and validity. This means that it works well to identify risky drinking.

Slide 32:
Like most screens, the AUDIT gives you a score. Take a minute with your partner and add up the score from your run-through. Looking at this slide, you can see how the scores correlate to risk levels (low, moderate, and high).

For example, a score of 0 to 7 is considered low risk and the appropriate response from the provider is to tell the patient he/she is at low risk, which is great. They should then encourage them to continue these low-risk behaviors.

Scores between 8 and 19 suggests low to moderate risk. People in this risk range should receive a brief intervention focused on lowering their risk.

People at the higher end of the moderate risk range—people who score 16 to 19—should be given a brief intervention and possibly the opportunity for brief treatment, which means additional counseling sessions. Again the goal is to help them to identify strategies to lower their risk of developing problems.

A person at the very high end, with a score of 20 or higher, may have alcohol dependence. This person needs a referral to specialized care. A brief intervention should be conducted, but now the focus should be on helping the person to choose to accept and follow through on a referral to treatment.
Slide 33:
Previously, we discussed the importance of setting a non-judgmental atmosphere for screening, but there are additional tips for ensuring accuracy of self-report responses.

1. For example, if possible, interview patients when they are sober.
2. Tell patients that the information is confidential.
3. Ask clearly worded, objective questions that are free from judgment.
4. Provide memory aids such as calendars, if needed. You can also have patients look at the response options to the questions to make it easier for them to use the appropriate response categories.

Slide 34:
We will end this section by seeing how certain screening scores may lead to a brief intervention. If you look at the boxes in the middle of the flow chart, you can see how the scores point to various interventions. If the score on the AUDIT is less than 8, for example, the patient is considered low risk. Support the current behaviors; no follow-up is needed. If the score falls in the “at-risk” or higher levels, the patient is given a brief intervention. A high to severe risk score indicates a need for a referral to specialized treatment.

Are there any questions?

Slide 35:
Now we are going to discuss brief interventions, and learn to use a specific brief intervention known as “FLO” or Feedback, Listening, and Exploring Options.
Slide 36:
We defined brief interventions earlier, but I’d like to share with you a quote by Dr. Craig Field, from the University of Texas:

*Read quote on slide.*

What do we mean by “teachable moment“?

*Encourage ideas, and then summarize with the following:*

Teachable moments are when patients come in with problems and there is an opportunity to explore connections between the patients’ problems and their substance use. Think of a student coming into the campus health center with a head injury. The student fell at a party and reported drinking heavily. This can be a teachable moment because the provider can help the student make a connection between his drinking and his head injury.

Slide 37:
Most brief interventions are based on the FRAMES model, which includes giving our patients personalized feedback, giving them responsibility for change, offering advice about health and social risks associated with substance use, providing a menu of options about cutting down or seeking help, responding with empathy and without judgment, and working to increase patients’ self-efficacy or the belief that they can make changes.
Slide 38:

**Note:** With this slide, you will use animation to highlight one idea at a time, starting first with the goal of behavior change, then awareness, and then motivation.

**Click to animate in “Behavior change” box on far right**

We know the overall goal of brief interventions is to promote positive behavior change, such as reduced consumption and reduced harm.

To reach this goal, brief interventions work to

**Click to animate in “Awareness of problem” box on far left**

raise individuals’ awareness of their substance use and how it impacts their lives.

**Click to animate in “Motivation” box in the middle**

We then work to enhance individuals’ motivation to make changes regarding substance use.

**Click to animate in “Presenting Problem.”**

An individual’s presenting problem can be used to raise awareness if there is a possible connection with substance use.

**Click to animate in “Screening Results.”**

Likewise, the screening results can also raise awareness. To achieve our objectives in the brief intervention, it is necessary to use a motivational interviewing style. We will learn how to use this style later in this workshop.
Brief interventions trigger change. A little counseling can lead to significant change, e.g., 5 min. has same impact as 20 min. Research is less extensive for illicit drugs, but promising.

For instance, a randomized study by Bernstein and colleagues found that when cocaine and heroin users seen in primary care received a brief intervention, the patients had a 50% higher odds of abstinence at follow up compared with controls.

What you do depends on where the patient is in the process of changing. The first step is to be able to identify where our patients are coming from. We want to know how substance use fits into people’s lives so we can understand their situation.
The Stages of Change is a theoretical perspective that we can use to understand where a person is coming from in terms of their substance use. At the top in blue is the first stage called precontemplation. At this stage people do not see a problem with their use and are not considering change.

**Use the pointer so participants can follow along on screen.**

The stages that follow are contemplation, determination, action, maintenance, and recurrence.

Contemplation is a stage that we strive to move patients to if they are at risk for substance use related problems. Patients in the contemplation stage can see the possibility of change, but they are ambivalent about changing. The determination stage is where we begin to identify strategies for change. Action is where changes are taking place. Maintenance is where patients have achieved their goal and are working to maintain their new behaviors. Recurrence is when patients may relapse or go back to their old behaviors. Recurrence is part of the process of changing.

This chart shows what strategies we can employ with patients at the different stages of readiness to change. If we look at the first two stages—which are most relevant for people engaging in at-risk levels of substance use—we can see that our goals are just to offer information or feedback, explore the meaning of events, explore pros and cons of substance use, and build self-efficacy.

Patients may not be ready to make a change at the time of this brief intervention. However, they may be willing to explore the pros and cons of their use, or track levels of use to see if they may have a more significant problem than they realized. By linking the interventions to where they are in the stages of change, we can help to move them forward in the stages and increase the likelihood that they will take action.

If we get ahead of them (ask them to take action before they have identified that they even have a problem), we are likely to stimulate resistance.
Slide 43:
This quote by Blaise Pascal sums up the motivational theory of change: “People are better persuaded by the reasons they themselves discovered than those that come into the minds of others.”

Our immediate goal with the brief intervention is to help our patients or clients gain insight about their substance use and develop their own intrinsic motivation toward change.

*Note:* Blaise Pascal was a 17th century French mathematician, physicist, inventor, writer, and philosopher.

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Slide 44:
*Note:* This slide contains automatic animation. As you are reviewing the bullet points the image of the woman should advance automatically to demonstrate a variety of different emotions. Participants may chuckle or become slightly distracted by the images. They are very effective in making the point about ambivalence.

The first thing to recognize with change is that we all have feelings of ambivalence.

What is ambivalence? It’s when we feel two ways about something. We may like to drink, but we also don’t like having a hangover. Exploring a person’s ambivalence about change is one way of assessing where they are in the change process.

An individual’s ambivalence about taking action is rich material that we can use as the basis for the brief intervention. If we can get an individual to talk about his or her ambivalence about making a change, we gain access into their world and can better understand their perspective.

- Use reflective listening and empathy
- Avoid confrontation
- Explore ambivalence
- Elicit “change talk”

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Slide 45:
Motivational interviewing strategies help raise awareness and enhance motivation. Reflective listening, showing empathy, avoiding confrontation, exploring ambivalence, and eliciting change talk are core strategies. Let’s take a look at a couple videos that demonstrate a motivational interviewing style.
Slide 46:

Note: Be sure to practice with the video ahead of time. If you have difficulty playing the video, see the trainer’s guide for alternate ways of accessing it.

We are going to watch two videos of doctors talking to a patient in an emergency room setting. The patient is a young man who had been drinking heavily and was involved in a bad car accident. These videos demonstrate different styles of talking to patients.

Hover over the video image to make the video controls appear. Click on the play button to show the “bad example” video. The video should display full screen.

Facilitate a 5-minute discussion with participants using the following questions:

What did you notice about the doctor’s approach? How did the patient react? Was it effective? Why or why not?

In the discussion, make sure that the following are covered:

• Angry and judgmental tone
• Telling the patient what to do
• Specific judgmental statement (e.g., “I know when someone is an alcoholic and I think that you have a serious drinking problem.” “Have some common sense.”)
• Finger-wagging
• Patient is frustrated, defensive, and just wants to get out of there
Slide 47:
The second video involves the same patient but a different doctor. Let’s look at how this doctor approaches the patient.

Hover over the video image to make the video controls appear. Click on the play button to show the “good example” video. The video should display full screen.

Facilitate a 5-minute discussion with participants using the following questions:

What did you notice about the doctor’s approach? What did the doctor do that worked well? How did the patient respond?

In the discussion, make sure that the following are covered:

• The doctor style was respectful, nonjudgmental, and conversational
• He explored the pros and cons of his drinking
• Offered reflections of emotions and content
• Involved the patient in the discussion and explored options
• Offered options if his strategy to cut down did not work
• Was encouraging about patient’s plan
• Patient was willing to engage in discussion and generated solutions for behavior change
Reflective listening is one of the most important motivational interviewing micro-skills and it is essential to ensuring a successful brief intervention.

**Bullet 1.** Reflective listening is listening to what people say and to what they mean; it’s a means of gaining access into someone’s world. The doctor in the second video used reflective listening with his patient. He didn’t judge the patient’s comments. Instead, he reflected back what the patient was saying and feeling. For example, when the patient in the video said that he couldn’t remember what happened after leaving the bar, the doctor reflected back by stating, “So you’re having trouble remembering what happened last night. Sounds frightening.” The doctor confirmed both the stated content and the unstated feeling (fear) that the patient experienced.

**Bullet 2.** The doctor directly empathized with the patient several times. For example, “I can understand that. You want to enjoy yourself with friends.” What we are trying to do is create an environment of non-judgment so that patient feels comfortable being honest with us.

**Bullet 3.** It is important to be aware of intonation. When you reflect back what a person says and it sounds like a question, this can come off as judgmental. Try to make a statement as opposed to asking a question. For example, “You are having a lot of emotions.” Statements can be powerful, because they force people to look in the mirror and observe what is happening. Also, watch for nonverbal cues. Judgment can show on your face. If a patient says, “I didn’t feel well yesterday.” If I answer, 
[**say this with a Suspicious tone and expression**] “You didn’t feel well yesterday,” my nonverbal expression of disbelief would be heard much louder than the actual words that I say. We need to watch our tone and our facial expressions so we don’t let our own feelings and judgments show.
Slide 49:

There are a few different ways of doing reflective listening.

Repeating is the simplest form of a reflection, but not necessarily the most interesting. For example, if a person says, “I’m angry,” the clinician would say, “You’re angry.” Simple reflections are good for confirming understanding to content, but they do not convey understanding of deeper, more emotional meaning.

Amplified reflections are designed to highlight the emotional content of the communication. In our SBIRT example, the doctor responded to the patient’s statement that he could not remember his accident by stating, “That sounds scary.” Even though the patient never said it, the doctor introduced this emotional content using an amplified reflection and deepened his understanding of the patient.

Finally, a double-sided reflection is designed to highlight the patient’s ambivalence. This helps the patient see both the positive and the negative from a more objective perspective. The doctor says, “On the one hand, drinking is a way for you to relax and enjoy your time with friends... On the other hand, it makes getting up in the morning difficult...” By seeing his or her own attitudes in a new way, the individual may become more motivated to reduce the negative consequences.

Slide 50:

Confrontation is counterproductive to enhancing people’s motivation to change. When we confront people about their substance use, we are arguing with them, or trying to convince them that they have a problem. Arguing with our patients is going to make them defensive, which is the opposite of what we want to accomplish during a brief intervention.

**Bullet 1.** When we confront people we can challenge them, “What do you think you are doing?”

**Bullet 2.** Warn them, “You are going to damage your liver.”

**Bullet 3.** And tell them what to do, “If you want to be a good student, you must stop drinking on school nights.”

What other types of confrontational statements could we make when talking to someone about their substance use?

*Elicit* a few responses from participants.

*Note: Other ways of confronting someone include moralizing, giving unwanted advice, shaming, and being sarcastic.*
We talked earlier about ambivalence being a central force in the change process. In brief interventions, we want to explore people’s ambivalence about making a change. The way we do this is to encourage the patient to weigh the costs and benefits of changing his or her substance use against the costs and benefits of continuing to use alcohol or other drugs. In other words, what are the pros and cons of using alcohol or drugs? Likewise, what are the pros and cons of reducing use of alcohol or drugs?

Avoid questions that inspire a yes/no answer.

The good things about ______
The not-so-good things about _ _ _ _
The good things about changing
The not-so-good things about changing

The way we explore ambivalence in motivational interviewing is to ask open-ended questions. Use pointer to direct attention to related boxes

Upper Left: For example, “What are the good things about your substance use?”

Upper Right: “What about the not-so-good things?”

Lower Left: “What would be good about using less?”

Lower Right: “What would be not so good about cutting back?”

Someone tell me if this is an open or a closed question, “Do you drink when you are alone?”

Elicit responses. Correct answer: This is a closed question.

How could you make it an open-ended question?

Suggestion: Who do you drink with on a typical day?

Now we are going to pair up again and talk to our partner about a change we want to make in our lives. This should be a personal change, but something that you are comfortable sharing. One person will talk first and the other person should use reflective listening. Remember you can repeat what your partner says or amplify it by rephrasing it in order to capture underlying feelings. You can reflect back to your partner the good and the not-so-good aspects of the situation that your partner wants to change by offering double-sided reflections. I’ll let you know when it’s time to switch roles. Any questions?

Allow about 5 minutes for the activity, notifying participants to switch roles halfway through. Then ask the participants to share with the group what it was like to engage in reflective listening. Was there anything hard about doing reflective listening? When they were being listened to, what was good about the reflections?
Slide 54:
Another key strategy in motivational interviewing is eliciting change talk. Change talk consists of self-motivational statements that people make in relation to behavior change.

**Bullet 1.** Patients may say things that suggest they recognize the problem,

**Bullet 2.** have concerns about not changing,

**Bullet 3.** have some intention to change, and

**Bullet 4.** feel optimistic about their ability to make change.

When patients make these statements, they are moving in the direction of being more willing or motivated to change.

Slide 55:
Now we are ready to learn how to apply the key motivational interviewing concepts in a brief intervention.

Slide 56:
The model we will learn is called FLO, which stands for Feedback, Listen & Understand, and Options Explored.

*Use a lighthearted tone to add the following line:* We dropped the ‘W’ because we did away with using warnings like “Just say no!”

There are many models for brief interventions; for instance, many SAMHSA-funded programs use the Alcohol, Smoking, and Substance Use (ASSIST) model, which was tested internationally by the World Health Organization and a team of researchers. We chose FLO because it condenses the main elements of brief interventions in three easy steps.
Slide 57:
Here is an outline of the three steps of the FLO brief intervention and what happens at each step.

**Click to animate in the first step**
We start the conversation with Feedback, which involves giving patients their screening results and explaining what the results mean.

**Click to animate in the second step**
Listen and Understand is where we get into the motivational interviewing work of exploring the meaning of patients’ substance use, the pros and cons of using, and the important concern patients’ bring to the visit (which may or may not be substance use). We also assess what kinds of changes patients want to make and their level of readiness.

**Click to animate in the third step**
Lastly, Options Explored is where we discuss options that patients themselves identify to support change. We always want to encourage a follow up appointment so that we can check on the patients’ progress and provide support.

Slide 58:
We are going to walk through these steps one by one, starting with Feedback.

Slide 59:
Before we launch into providing the feedback, we need to get the patient’s permission. It is inherently respectful to ask permission and willingness of the individual to hear your feedback. Once you have permission, give the feedback as described below. After you have given the feedback, ask for response/reaction to your feedback. Do she agree or disagree? Was it useful or not?

Providers should be aware that engaging the individual in this way gives that patient control over whether or not to hear your feedback. While rare, a patient may say that they don’t want to hear it. In this case the provider can explore the reason why, or simply tell the individual that they will ask again at a later appointment.
Once you have permission, you start by helping the patient understand the scoring for the instrument.

At minimum, provide the range of scores and some context for understanding them.

Then, give the score and explain what the score means in terms of their relative level of risk.

Next, relate the patient’s substance use (drinking or drug use) to the norms in the larger population. Normative information can be powerful because many people, particularly college students, believe that everyone in college drinks a lot when in fact many students do not drink or use drugs. Sharing information about norms can help patients get an accurate picture of social norms and realize that their level of use may be above average.

Finally, ask your patient for her reaction to the score and any feedback.

Here are examples of what we say when we give feedback. We will use the AUDIT screen in our brief intervention today, so here I’ve included the score that you will see in a little bit.

Read each bullet and provide an opportunity for discussion.

When you share information about the score and health effects, you can offer the patient an informational brochure to take home with them. This is the first page of a brochure, which is in your folder.
The 1st Task: Feedback
Handling Resistance
• Look, I don’t have a drug problem.
• My dad was an alcoholic; I’m not like him.
• I can quit using anytime I want to.
• I just like the taste.
• Everybody drinks in college.

What would you say?

Slide 63:

It is possible that you will encounter resistance after giving a patient some initial feedback. This is often the case when patients are using a good deal of alcohol and/or drugs and may feel a bit defensive about it.

Here are some examples of what patients may say to you. For example, “I don’t have a drug program.” “This is college. This is our time to party.”

With motivational interviewing, we want to reduce resistance and make the patient feel at ease. What would you say if a patient started getting defensive?

Elicit a few examples from the audience and then move onto the next slide.
Here is a concrete example. Patients often present for treatment with a variety of issues across a number of domains. For example, a patient may be experiencing a variety of family, medical, mental health, and substance use issues.

Click to start animation

...but today when she comes in for service, she says, “I’m really hurting.”

Click to advance animation

You, the clinician, know that she is misusing opioids.

Click to advance animation

You say to your patient, “I want to talk about your use of opioids.”

Click to advance animation

The patient, however, doesn’t want to talk about opioids (unless perhaps to get more). The patient says, “I’m here because of my pain. I’m not a drug addict.”

Click to advance animation

Concerned about opioid hyperalgesia, you state, “Part of the problem with your pain is that you take too many opioids.”

Click to advance animation

You and the patient continue this chase. This does not help you get to the substance use issue, nor does it help the patient deal with her pain.

If, instead of pressing our issue (the opioid use), we listen for what patients see as their issue

Click to advance animation

we can find ways of connecting our goal with theirs. This allows us to build rapport. If the patient says, “I need help with my pain,” we can work with that by saying, “Ok, let’s find a way to help you deal with your pain.” Eventually, we want to bring the pain issue and the substance use issue together. If we focus on the patient’s pain, we can still ask how her medications are working out, and, once we gain access into her world, we can begin to provide information about the impacts of taking too much medication. We know the two issues are related, so if we focus on the patient’s concern first (the pain), we will undoubtedly be able to introduce our concern (the SUD issue) in a way that is respectful and natural.
Slide 65:

**Click to start and advance animation**

So the goal is to avoid a tug of war with patients. Instead, remember that they are experts who know more about their situation than anyone else.

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Slide 66:

**The 1st Task: Feedback**

**Easy Ways to Let Go**
- I'm not going to push you to change anything you don't want to change.
- I'd just like to give you some information.
- What you do is up to you.

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Slide 67:

**Finding a Hook**
- Ask the patient about their concerns
- Provide non-judgmental feedback/information
- Watch for signs of discomfort with status quo or interest or ability to change
- Always ask this question: “What role, if any, do you think alcohol or drugs played in your getting injured or depressed or sanctioned? You can fill in the last part of the question with the specific situation of your patient.

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Slide 68:

**Activity 6: Role Play**

Let's practice F: Role Play Giving Feedback Using Completed Screening Tools
- Focus the conversation
- Get the ball rolling
- Gauge where the patient is
- Hear their side of the story

**Check to see that everyone has a copy of the AUDIT.**

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Now we are going to practice giving feedback—just the Feedback portion of FLO using the **Scored AUDIT and Scoring Interpretation found on pages 36-37.** The patient is named Chris and can be a man or a woman. The AUDIT has been filled out for you and you will see the score at the top.
1. How often do you have a drink containing alcohol (Score)
   - Never (0)
   - Monthly or less (1)
   - Two to four times a month (2)
   - Two to three times a week (3)
   - Four or more times a week (4)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   - 1 or 2 (0)
   - 3 or 4 (1)
   - 5 or 6 (2)
   - 7 to 9 (3)
   - 10 or more (4)

3. How often do you have six or more drinks on one occasion?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

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?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   - Never (0)
   - Less than monthly (1)
   - Monthly (2)
   - Weekly (3)
   - Daily or almost daily (4)

9. Have you or someone else been injured as a result of your drinking?
   - No (0)
   - Yes, but not in the last year (2)
   - Yes, during the last year (4)

10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking, or suggested you cut down?
    - No (0)
    - Yes, but not in the last year (2)
    - Yes, during the last year (4)
Scoring the Audit

Score Level Action
0-7 Low Encouragement
8-15 Low/Moderate Advice
16-19 Moderate Brief Counseling
20+ High Further Evaluation for Dependence

Further Evaluation for Dependence

Encouragement

Advice

Brief Counseling

Moderate

High

Low/Moderate

Low

0-7

8-15

16-19

20+
Before we start, let’s review the AUDIT score and the risk level.

You will see on the AUDIT that Chris has a score of 18. This score falls in the high end of the moderate range. On the AUDIT, Chris reported drinking 4 or more times per week and 3 or 4 drinks on a typical day. This means that if, for example, Chris drinks 5 days a week, then he drinks between 15 and 20 drinks per week, and 6 or more drinks on at least 1 day per week, his consumption, then, is above the recommended safe drinking limits.

Form pairs. One person should play the clinician or counselor and one the patient. We’ll stay in these roles through a few activities and I’ll let you know later when it’s time to switch.

All you are doing here is asking permission to share the results, giving feedback, and asking for the patient’s views. Listen for Chris’s concerns and find the hook that will allow you to continue the conversation. Once you do that you are done with “F”.

You will have 5 minutes to do the role play.

Allow 5 minutes for the activity. Walk around the room to observe and answer questions, if needed. After the time is up, ask the participants to describe how it went for them. Ask for feedback from the people playing the clinician and then the patients. Ask how many people went into solving the problem. People tend to want to go straight to finding solutions to the problems. Caution against this tendency. Encourage participants to focus only on the feedback, while appreciating how hard this may be for some. Reflect back what the participants describe and affirm their reactions.

Now, we will move to the Listen and Understand step.

As we discussed earlier with reflective listening, listening to and understanding the patient is the core of the brief intervention. Our objective at this point is to identify and resolve any ambivalence the patient may have about his or her problematic substance use. Helping the patient move toward the side of the ambivalence that wants change is helping the person to increase motivation.
Slide 72:
We’ll now look at effective tools to get the conversation going: identifying pros and cons and using a readiness ruler.

Slide 73:
We want the patient to discuss the pros and cons of using alcohol and/or drugs. This is unusual for many of us because as health providers and educators, we tend to only talk about the negative aspects of alcohol and drugs. If we can appreciate the good things about using, we can understand the underlying need of using (feeling less depressed, increased social interactions). This can help point the way to solutions once we get to that point. Discussing the positive effects of use can also help to build rapport.

Ask the participants:
Who here likes chocolate chip cookies? What do you like about them?
Reflect their feelings in order to demonstrate understanding.
What else is good?
You want to push the limits of the conversation.
Are there any downsides?
When you hear ambivalence in their remarks, reflect it using a double sided-reflection.
To do a double-sided reflection, use this formula.

Click to advance the animation
On the one hand you like...; on the other hand... You want to reflect both sides of the statement to highlight the patient’s ambivalence.

Slide 74:
We want to listen for any connections patients make between their presenting problem and their substance use. Also, we want to listen for any reasons they may give for why they should cut down on their use, as well as any prior experiences with cutting down can be highlighted, particularly if they were successful.

Click to advance the animation
When you hear change talk, summarize for the patient what you are hearing because this will shine a mirror on the patient’s thought pattern and help to increase their awareness.
Another tool is the confidence or readiness ruler. This is really just a number line from 1 to 10. You can preprint one or simply draw one on a piece of paper. To use the ruler, you need to pick the issue that the patient is most concerned about.

The ruler can be used to determine how ready the person is to make a change, how important making a change is to them or how confident they are that they will be able to make the change. In our example below we will use readiness.

**Bullets 1-3.** You show the patient the ruler and ask him or her, “On a scale of 1 to 10, with 1 being not at all ready and 10 very ready, how ready are you to... change your drinking/work on your relationship/try another strategy for your pain, whatever you think the issue is they want to talk about. Only focus on one issue in the intervention.

More than likely, people will not choose 1, but will aim a little higher. If they choose 1, it is not an issue that they are willing to talk about at all which probably means that you are not focusing on the issue that is most important to them. Refocus and try another issue.

**Bullets 4-5.** After the patient responds, you counter by asking why they didn’t chose a lower number, e.g., “Why not 2?” You want them to defend the higher number. Their responses will be very informative and will likely contain some change talk.

You should never go more than two points below the number they originally select. This ensures that you do not minimize too dramatically the number they select, or make them feel as if they need to make huge changes to reach a new number. You can also ask them to explain why they have not chosen a number that is 2 above the number they selected, as this can provide relevant information as well.

Now we are going to get back into our same pairs and practice doing **L, Listen and Understand.** Let’s take 5 minutes to do the activities we’ve just gone over.

**Allow 5 minutes for the role play.** Each participant should be in the same pair and playing the same role (clinician/counselor or patient) as in Activity 4. Walk around room to observe and assist. When finished, ask audience to report how the exercise went. Ask for feedback from the people playing the clinician and then the patients. Reflect back what the participants describe and affirm their reactions.

Now, we will move to the **Options Explored** step.
The 3rd Task: Options for Change

Slide 78:
Exploring options is the third task in the FLO brief intervention and this is where we talk about what happens next for our patients. We can ask questions like “What do you think you will do? What changes are you thinking about making?” With a brief intervention, the responsibility is on the patient to decide what to do. And again, what they choose to do with the information that you provide is completely up to them.

The 3rd Task: Options for Change

Slide 79:
The goal is for the patient to generate acceptable options toward change and then to select one that they are willing to try. You can offer menu options if the patient has difficulty coming up with their own ideas.
Try to provide concrete examples of things they can do to reduce their risk of harm, e.g., not drinking and driving and cutting back on the number of drinks per day. For patients in the high risk range, seeking professional help from a specialist is an option that should be discussed. Remember that patients have a choice. Of course, doing nothing is also an option. But in addition to doing nothing, you can suggest to the patient that you monitor how things are going. Are there any questions about this?

The 3rd Task: Options for Change

Slide 80:
You can try asking the patient about previous successes they had with making a difficult change. How did they do it?
You can use these questions to start the conversation. You want to highlight past successes with change, no matter how small, and suggest that the patient can try using those same strategies to reduce their substance use.

The 3rd Task: Options for Change

Slide 81:
There are ways of giving advice without telling someone what to do.
First, ask for permission by saying something like, “I have a recommendation for you. Would it be ok if I shared it with you?”
Before giving specific recommendations, give the patient permission to disagree by saying, “This may or may not be helpful to you.”
Then, if we ask the patient for their feedback, we allow the patient to feel in control and that he or she is smart enough to figure this out.
Slide 82:
You can think of the “advice sandwich” approach: Ask permission first, then give your advice, and lastly ask for a response to the advice.

Slide 83:
Now we are ready to wrap up the brief intervention and close the conversation. We do this by summarizing the patient’s views, encouraging them to share any additional views, and repeating whatever agreement was reached during the discussion about options.

Slide 84:
Now we are going to role play O. You want to pick up where you left off with the listening step and start exploring options. Ask about next steps, offer advice if relevant, and summarize patient’s views. Finally, end by repeating what the patient agreed to do. Let’s take 5 minutes.

Allow 5 min. for the role play. Walk around the room to observe and assist. Again, each participant should be in the same pair and playing the same role (clinician/counselor or patient) as before. Ask participants to report how the exercise went. Ask for feedback from the people playing the clinician and then the patients. Reflect back what the participants describe and provide encouragement.

Slide 85:
Now we are going to role play the full FLO, but we are going to switch roles with our partners. The person playing the patient will now be the clinician or counselor. Start again with the AUDIT score and go through the feedback, listen and understand, and options explored. Let’s take 10 to 15 minutes to run through this.

Allow 10-15 minutes for the full role play. Walk around the room to see how people are doing how. Take another 5 minutes to debrief with the audience at the conclusion of the role play, asking for feedback from the people playing the clinician and then the patients. Reflect back what the participants describe and validate their experiences or concerns.
Encouraging Follow-Up Visits

At follow-up visit:
• Inquire about use
• Review goals and progress
• Reinforce and motivate
• Review tips for progress

See reference list

Slide 86:
Encourage a follow-up visit with the patient. This way you can monitor their substance use, review progress toward any goals the patient may have agreed upon during your initial brief intervention session, reinforce their movement toward change, and provide tips for making additional changes.

Enhancing Motivation for Change Inservice Training
Based Treatment Improvement Protocol (TIP) 35
Published by the Center for Substance Abuse Treatment
www.samhsa.gov

See reference list

Slide 87:
If you are interested in learning more about motivational interventions for substance use, this is a free resource you can order online. This manual is part of a free series of clinical guides called Treatment Improvement Protocols.

Slide 88:

Referral to Treatment for Patients at Risk for Substance Dependence

Slide 89:
Approximately 5% of patients screened will score in the high-risk range for a potential substance use disorder. These patients have experienced serious medical, social, legal, or interpersonal problems associated with their substance use.

Even though these patients have serious issues with substance use, it is still advisable to conduct a brief intervention with these patients before making a referral to specialty care. The reason for this is that the brief intervention can help the patient become more open to making a change.
Slide 90:
In order to help patients initiate treatment for substance use disorders, clinicians need to take an active role in the referral process. By “warm hand-off” we mean that clinicians make the transition to the treatment facility as smooth as possible for the patient.

**Bullet 1.** When we discuss options for specialty care with patients, we need to describe what treatment entails and the types of available resources in the community.

**Bullet 2.** To be able to do this, we need to get to know some of the local treatment facilities in our area so that we can describe what treatment entails. We also need to have the treatment facilities’ contact information and address on hand when we make referrals.

**Bullet 3.** There are several things we can do to facilitate the hand-off:

- **Bullet 4.** call around to find a facility with availability, call to make the appointment for the patient before he or she leaves your office,

- **Bullet 5.** give the patient directions to the facility, and

- **Bullet 6.** help the patient with transportation if needed. Some treatment facilities offer transportation, so this is something to inquire about when meeting with treatment facility staff.

*Ask the audience if they know of other referral strategies that are helpful.*

Slide 91:
Homework: Try this with your clients. Spend a few days providing feedback only. Then add the listening and understanding step. Visit The World of SBIRT where you can share your experience with FLO and ask questions.

Slide 92:
Before we end today’s training, I’d like to ask you all to take a couple minutes and think about what you would like to do with this SBIRT training. Write down one thing that you learned and one thing you’d like to work on as a next step. After you’ve written down a few ideas, discuss them with your partner. Let’s take 5 minutes.

*Allow 5 minutes for writing and discussion. After the time is up, ask if anyone would like to share what they’d like to work on as a next step. Offer suggestions for finding additional resources from the ATTC and other websites.*
Slide 93:
Ask the audience to complete the post-test and GPRA evaluation, included in their folder.

Answer Key for Post-Test:
Q1: C (14)
Q2: D (4)
Q3: B (7)
Q4: C (3)
Q5: B (Alcohol Use Disorders Identification Test)
Q6: C (Cutting down or abstaining are equally good goals)
Q7: C (More information is needed to make a determination)
Q8: A (Determination/action)
Q9: D (B and C only)
Q10: E (All of the above)

Slide 94:
Thank you all very much for participating in the training.