NATIONAL SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)

TRAINING OF TRAINERS MANUAL

National Screening, Brief Intervention & Referral to Treatment

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

INSIDE FRONT COVER

NATIONAL SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT) TRAINING OF TRAINERS

The National Screening, Brief Intervention and Referral to Treatment (SBIRT) Addiction Technology Transfer Center (National SBIRT ATTC) prepared this training and SBIRT Training of Trainers Manual with funding from a cooperative agreement between the Institute for Research, Education and Training in Addictions (IRETA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) (TI024239).

Peter F. Luongo, PhD, served as the Principal Investigator of the National Screening, Brief Intervention and Referral to Treatment (National SBIRT) ATTC, Holly Hagle, PhD, served as the Director of the National SBIRT ATTC and Suzan Swanton, LCSW-C served as the CSAT Project Officer to the ATTC Network.

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Screening, Brief Intervention and Referral to Treatment – SBIRT Training of Trainers Manual

Background:

SBIRT is a comprehensive public health approach for delivering prevention, early intervention and referral to treatment services to people using substances in a harmful or risky way.

Studies show the need for a tool such as SBIRT:

Results of the most recent National Survey on Drug Use and Health (NSDUH) show that an estimated 22.1 million people aged 12 or older have a diagnosable alcohol or illicit drug use disorder.[1]

In 2010, according to NSDUH, 8.1 percent of the population aged 12 or older—about 20.5 million people—needed but did not receive substance use treatment at a specialty facility in the past year.[2]

In 2006, excessive drinking cost the United States $223 billion.[3]

References

1. Substance Abuse and Mental Health Services Administration, 2011. Results from the 2010 National Survey on Drug Use and Health: Volume 1. Summary of National Findings. DHHS Publication No. SMA 10-4856.

2. Substance Abuse and Mental Health Services Administration, 2011. Results from the 2010 National Survey on Drug Use and Health: Volume 1. Summary of National Findings. DHHS Publication No. SMA 10-4856.

3. Bouchery, E., Harwood, H., Sacks, J., Simon, C., Brewer, R. (2011). Economic Costs of Excessive Alcohol Consumption in the U.S., 2006. American Journal of Preventive Medicine, 41(5), 516-524.

Goals:

The goal of this training course is to help participants develop their knowledge, skills, and abilities as Substance Use Screening, Brief Intervention, and Referral to Treatment (SBIRT) Trainers. At the end of this training participants will be able to:

- Identify SBIRT as a system change initiative.
- Compare and contrast the current system with SBIRT.
- Introduce the public health approach.
- Discuss the need to change how we think about substance use behaviors, problems, and interventions.
- Understand the information screening does and does not provide.
- Define brief intervention/brief negotiated interview.
- Describe the goals of conducting a BI/BNI.
- Understand the counselor's role in providing BI/BNI.
- Develop knowledge of Motivational Interviewing.
- Describe referral to treatment
- Conduct teach-backs of various modules of the training curriculum

Trainers and providing SBIRT training.

The training is designed to be two and a half days long and all participants must attend all days and complete all assignments. The learning activities use didactic teaching, role plays, group discussion, and peer feedback. Throughout the training the participants are encouraged to interact, dialogue, and practice the skills.

The training is designed to be conducted in small- to medium-sized groups (10 to 40 people) depending on the number of trainers leading the program.

The training materials consist of the SBIRT Training of Trainers Manual, slides, and handouts for the role plays and cases, copies of screening tools, education materials, and other materials used by the trainers. All training events require the completion of a registration form to enroll and an evaluation at the conclusion of training.

KEY TO ICONS

The icon above relates to additional instructions for the trainer.

The icon above relates to activities for the group.

Slide animation or video.

The icon above relates to additional reference material provided by the trainer.

TABLE OF CONTENTS

The training curriculum consists of the following:

WELCOME, GOALS, AGENDA

1. TRAINER NOTE:

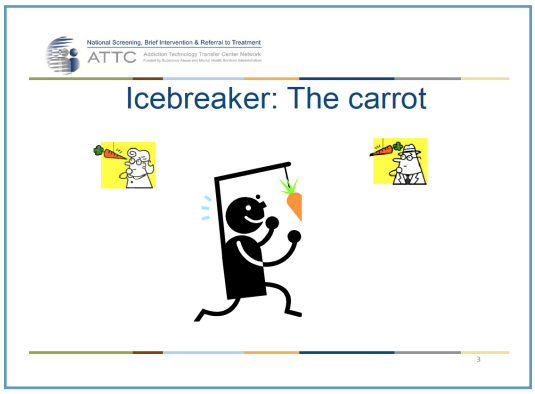
2. TRAINER NOTE:

Read the slide.

Begin by introducing yourself, then ask each participant to introduce themselves.

Respond to each bullet.

If the group is large and/or time is more limited, reduce the number of bullet responses as necessary.



3. TRAINER NOTE:

INSTRUCTIONS:

The purpose of icebreakers is to create interaction among participants. For this icebreaker:

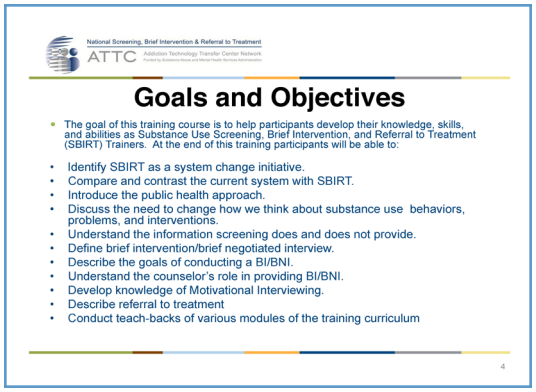
1. Ask participants to stand up and move to the end of the room.
2. Tell them that you will name a list of things that might be motivating or not to them at the current moment. They should choose to move, or not, depending on how motivating that thing is for them. If they move, they can move from 1 to 3 steps forward (1 step if it is a little motivating, 3 steps if it is very motivating to them). They also may choose to move back (1 step if it is a little discouraging to 3 steps if it is very discouraging).
3. As an alternative, you could ask each participant to name something that is motivating for them and then have group members respond.

FOR EXAMPLE:

Motivating things you could name: water, ice-cream, donuts, coffee, tea, getting news of an extra day of vacation, $10 (cash), playing with your child, hugging your best friend, learning something new for your career, dancing, meeting new people, etc…

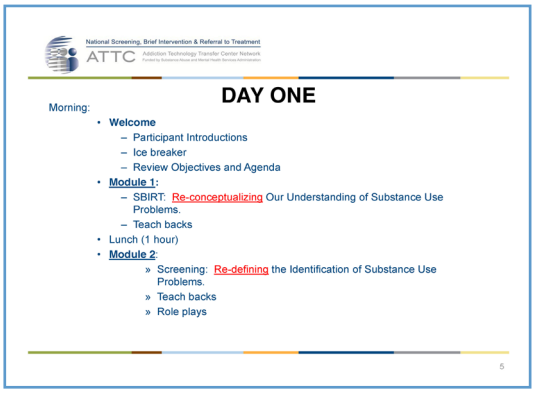
Once you have named around 8-10 items, ask them to observe their positions in the room, and have them reflect on how rewards have different effects on each of us.

Source: United National (2008). Treatnet Training Volume A: Module 1 Screening, Assessment, and Treatment Planning.



4. TRAINER NOTE:

The overall goal for this training is to help you develop the knowledge, skills and abilities you will need to effectively train others on the various tasks involved in providing SBIRT services. In general we will be discussing the conceptual framework of SBIRT as a public health model and its impact as a system change initiative. We will also review and practice the skills necessary to provide screenings, brief interventions, and extended brief interventions. Finally, we will talk very briefly about the business of SBIRT and provide you with information on reimbursement for services.

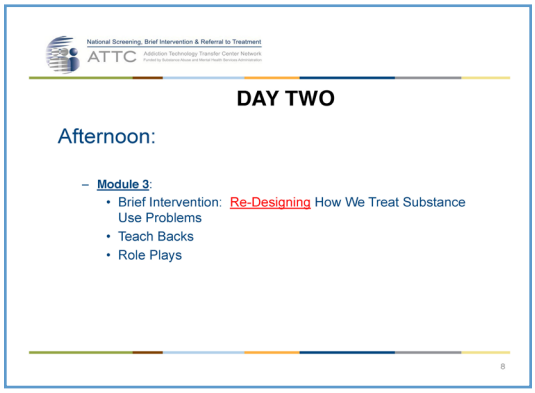


5. TRAINER NOTE:

You will need to insert the agenda for the SBIRT training you are presenting, based on the amount of time available for the training.

6. TRAINER NOTE:

7. TRAINER NOTE:



8. TRAINER NOTE:

9. TRAINER NOTE:

MODULE ONE:

Re-conceptualizing Our Understanding of Substance Use Problems

10. TRAINER NOTE:

Let's spend a few minutes talking about how SBIRT requires us to think differently about substance use problems.

MODULE 1:

Re-conceptualizing Our Understanding of Substance Use Problems

OBJECTIVES:

- Identify SBIRT as a system change initiative.
- Compare and contrast the current system with SBIRT.
- Introduce the public health approach.
- Discuss the need to change how we think about substance use behaviors, problems, and interventions.
- Encourage active participation.

INSTRUCTIONAL METHODS (IM):

Didactic – the instructor explains the content knowledge.

Collaborative – the instructor asks the learners to process the content knowledge through facilitated discussion.

Practice:

Direct delivery – There are no practice opportunities as the information is didactic and collaborative.

Training-of-Trainers (TOT) – This module includes 3 teach backs

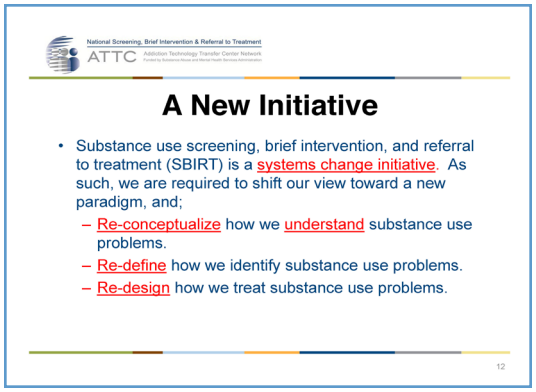
Animated Slides: Yes

Video: No

Materials: copies of the slides

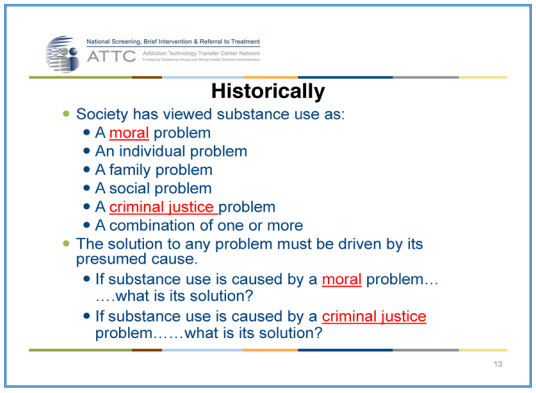
11. TRAINER NOTE:

Ask the participants to be open minded regarding this information. SBIRT will likely be new and unique to many individuals and some will have biases or beliefs that SBIRT will challenge. It is important to be open to thinking and doing things differently. To make that easier ask them to forget everything they know about substance use problems, how they are identified, and how they are treated.



12. TRAINER NOTE:

SBIRT isn't just a new service added to an old system. The system itself must change to accommodate a new approach to providing substance use services. By changing how we understand, identify, and treat substance use problems we can expand the continuum of care to more appropriately provide services to those who are at risk for psycho-social and health care problems related to their substance use choices as well as those who are substance dependent. Because SBIRT approaches substance use from a different perspective from that used in the past it requires us to change our understanding as well as the system that supports it. In general SBIRT asks us to re-conceptualize how we understand substance use problems, re-define how we identify substance use problems and re-design how we treat substance use problems.



13. TRAINER NOTE:

Provide these as examples of how our societal understanding of substance use has changed over time. Note that our understanding will continue to change and expand. SBIRT is an outgrowth of our increased knowledge.

Point out that how we perceive the cause of the problem is how we will seek to solve it. An example would be if your car won't start. If you presume it's an electrical problem what do you do? (Responses will include check the battery, check to see if you left the lights on). You don't check the gas gauge. It's the same with substance use.

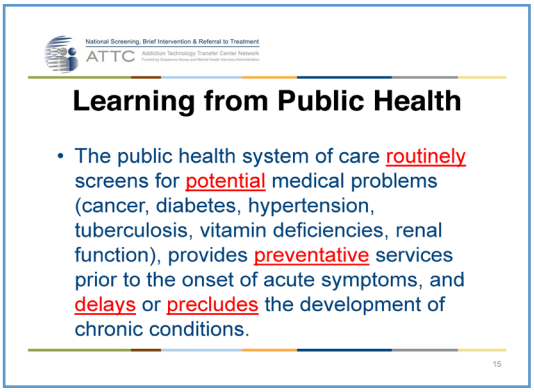
Ask the question: "For example, if substance use is caused by a moral problem what is the solution?" (answers will include religion, prayer, etc).

"If substance use is caused by a criminal justice problem what is the solution?" (answers will include arrest, incarceration, etc).

This exercise exemplifies the fact that as our understanding of the problem changes our response to a solution changes.

14. TRAINER NOTE:

In SBIRT we believe that substance use is a public health problem and we arrive at solutions using a public health approach.



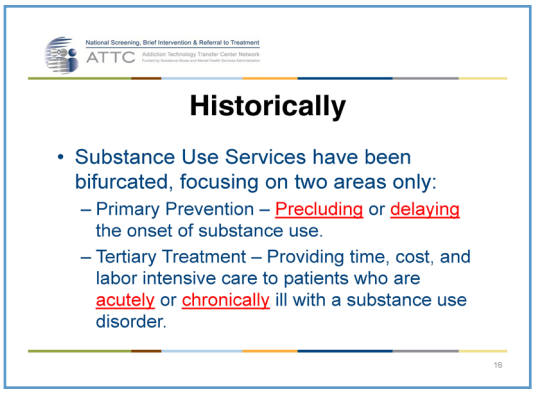
15. TRAINER NOTE:

SBIRT mirrors what the health care system has always done by seeking to identify potential problems via screening for them before they are acute or chronic (and become more difficult and more expensive to treat). This allows us to intervene earlier. Examples from health care include getting your blood pressure checked (screening for hypertension), getting a Mammogram (screening for breast cancer), getting your blood drawn (screening for vitamin deficiencies, etc.) Note that these screenings do not provide a diagnosis (if a problem is suspected based on the screening results more tests may be necessary, i.e., referral to a specialist to assess and diagnose). Since we understand substance use as public health problem it follows that we would model what the health care system does. We want to provide universal screening to identify potential substance use problems, intervene prior to the onset of anything acute, and as a result delay or preclude a chronic problem.

"Let me ask you a question. What is a blood pressure test?"

ELICIT RESPONSE. *(Responses will vary).*

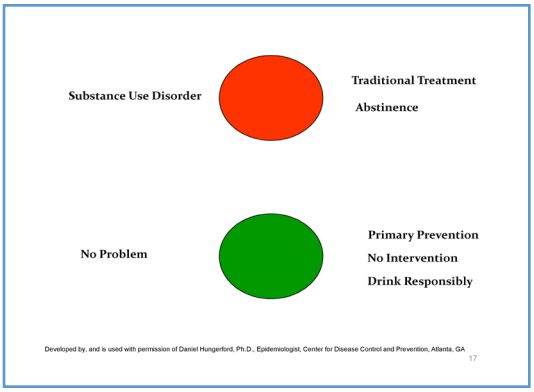
ANSWER: A universal screen for hypertension. It does not diagnose heart disease. It gives the physician an indication of a potential problem. If the patient's blood pressure is high the physician can intervene at that point to identify what may be causing the problem (stress? smoking? diet?), assist the patient in lowering their blood pressure (exercise, smoking cessation, medication, etc.), or refer for additional tests and treatment if necessary.



16. TRAINER NOTE:

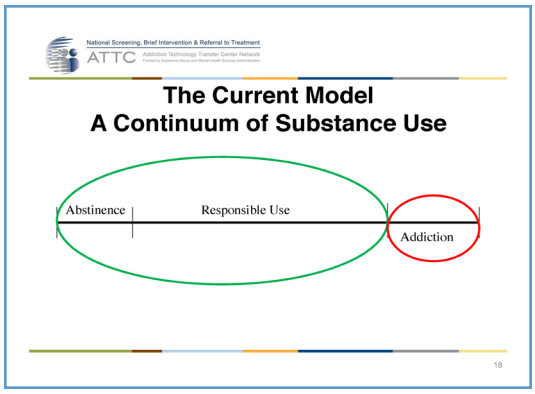
The current system focuses on primary prevention for youth intended to preclude or delay onset of use. There are no life long prevention activities for substance use (as opposed to those for obesity, heart disease, cancer, diabetes, etc).

Once prevention activities are provided to youth the system is designed to wait until individuals have a substance use disorder prior to providing services (and services are structured and reimbursed in such a way that only individuals with a diagnosis are able to access or pay for services). Generally those who are dependent are identified through the criminal justice system.



17. TRAINER NOTE:

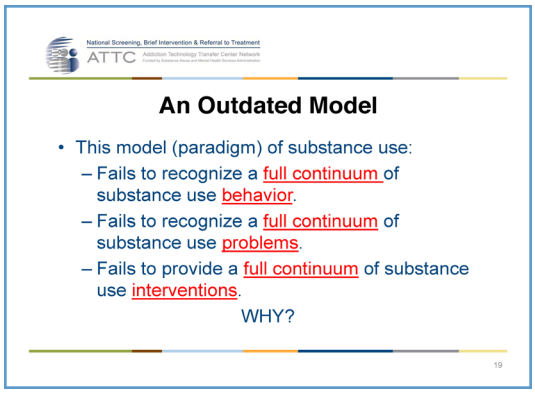
This is a graphic representation of the current system. Individuals are basically divided into two groups. Red light people who are substance dependent and green light people who aren't. For red light people the solution is treatment and the goal is abstinence. For green light people there is no intervention and the goal is to drink responsibly. Ask the participants what responsible drinking means to them (answers will be don't drink and drive, don't drink so much that you can't walk, etc). Note who promotes responsible drinking… The alcohol companies.



18. TRAINER NOTE:

This is an animated slide. Click to start the animation sequence.

This is another graphic representation of how we classify those who use substances along a continuum. The current model recognizes abstinence and "responsible use" (green light) and addiction (red light).



19. TRAINER NOTE:

The current model is outdated as it only accounts for abstinence/responsible use and addiction (the two ends of the continuum of substance use). As a result it doesn't account for all of the problems that substance use can cause, and therefore doesn't provide a full continuum of care (treatment for dependent individuals only).

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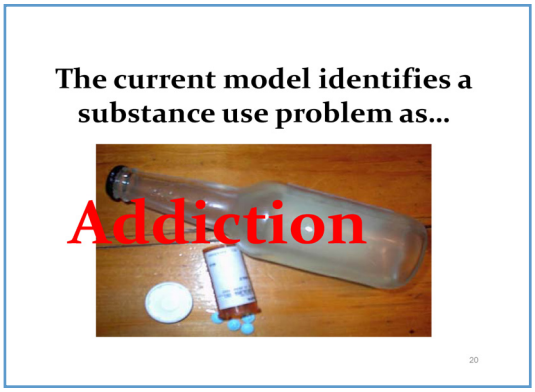
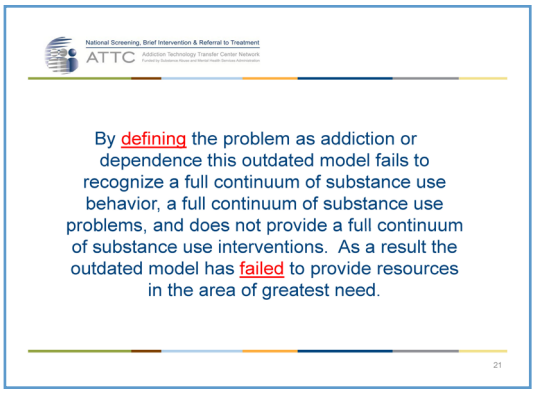


20. TRAINER NOTE:

This is an animated slide. Click to start the animation sequence.

The outdated model only identifies the problem in terms of addiction or having substance use disorder. As a result the entire system is geared toward finding and treating individuals at the far end of the continuum after they are already acutely or chronically ill.



21. TRAINER NOTE:

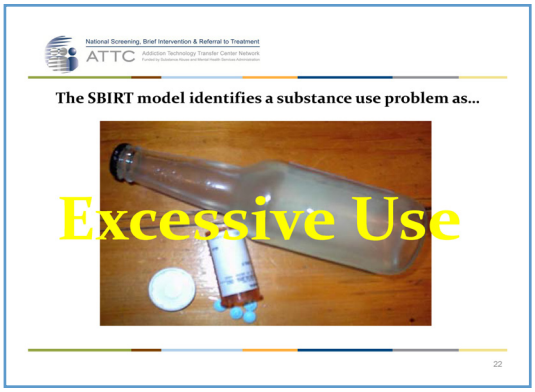
There is a broader continuum of substance use behavior, problems, and interventions that address the areas that have historically been disregarded by the current system.

The recent changes in the DSM V – indicate a newer approach to viewing substance use. In the DSM V use of the word “abuse” has been replaced with mild substance use disorder, moderate substance use disorder and severe substance use disorder. This is combining 11 criteria into a single continuum of criteria.

The 11 criteria are:

1. Use in larger amounts or longer than intended
2. Desire or unsuccessful effort to cut down
3. Great deal of time using or recovering
4. Craving or strong urge to use
5. Role obligation failure
6. Continued use despite social/interpersonal problems
7. Sacrificing activities to use or because of use SUD Criteria
8. Use in situations where it is physically hazardous to be impaired
9. Continued use despite knowledge of having a physical or psychological problem caused or exacerbated by use
10. Tolerance
11. Withdrawal

It will take a while for the conversational language to change around terminology like using the term substance use disorders, dependence or addiction.



22. TRAINER NOTE:

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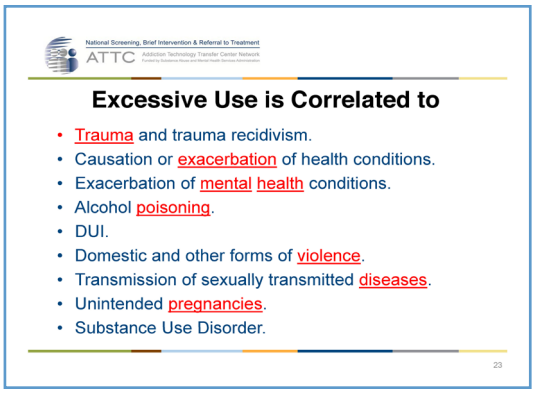
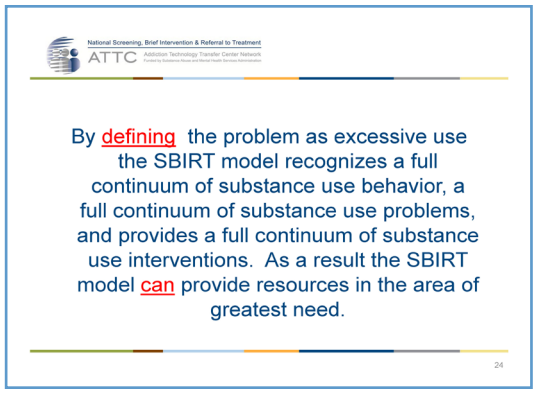
Rather than just defining use as addiction or having a substance use disorder SBIRT identifies the problem as excessive use of substances which results in various negative outcomes including having a substance use disorder.



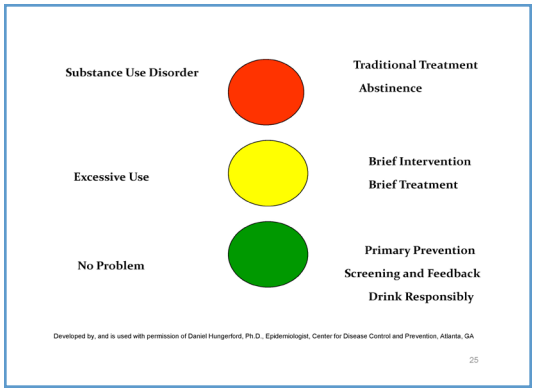
23. TRAINER NOTE:

Ask the participants if there are other examples of problems that can result from excessive use.



24. TRAINER NOTE:

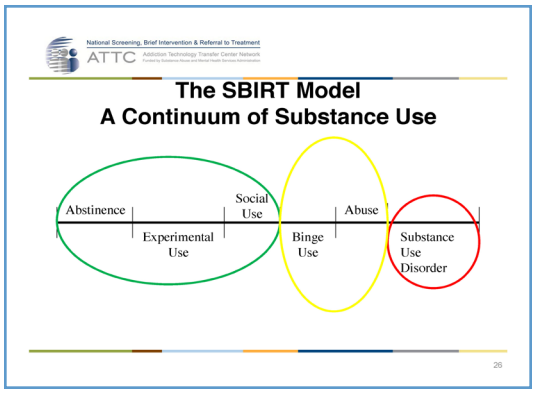
By acknowledging the broader continuum of substance use behavior, problems and interventions SBIRT can provide and focus resources in areas not addressed by the current system.



25. TRAINER NOTE:

This is an animated slide. Click to start the animation sequence.

This is a visual representation of the SBIRT model. Note that there is now a group of yellow light people who are using excessively. These are people who are at risk for psycho-social or health care problems related to their current substance use choices but aren't dependent.



26. TRAINER NOTE:

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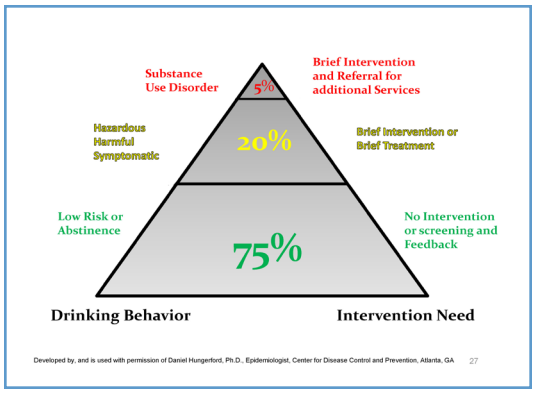
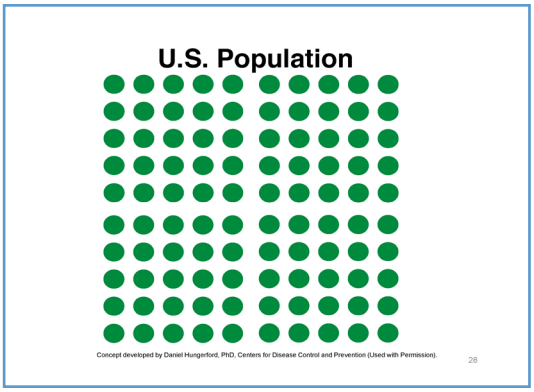
This is a visual representation of the broader continuum recognized by SBIRT which accounts for various use patterns and adds yellow light people.



27. TRAINER NOTE:

Reference: World Health Organization Brief Intervention for Hazardous and Harmful Drinking*; Thomas F Babor and John C. Higgins-Biddle, 2001.*

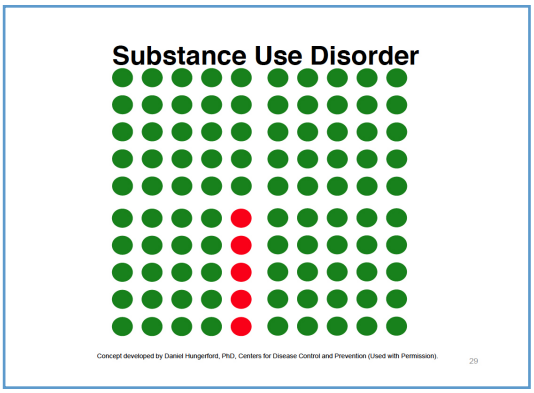
This is another visual representation of the break out of substance use behavior and the types of interventions appropriate to each. Remember the outdated system is focused on the 5% even though 20% are at risk for or are already experiencing problems even though they aren't dependent.



28. TRAINER NOTE:

Reference: World Health Organization Brief Intervention for Hazardous and Harmful Drinking*; Thomas F Babor and John C. Higgins-Biddle, 2001.*

This is a visual representation of 100% of the US adult, non-institutionalized population.



29. TRAINER NOTE:

Reference: World Health Organization Brief Intervention for Hazardous and Harmful Drinking*; Thomas F Babor and John C. Higgins-Biddle, 2001.*

This is an animated slide. Click to start the animation sequence.

Only 5% of the population has a diagnosable substance use disorder.

30. TRAINER NOTE:

Reference: World Health Organization Brief Intervention for Hazardous and Harmful Drinking*; Thomas F Babor and John C. Higgins-Biddle, 2001.*

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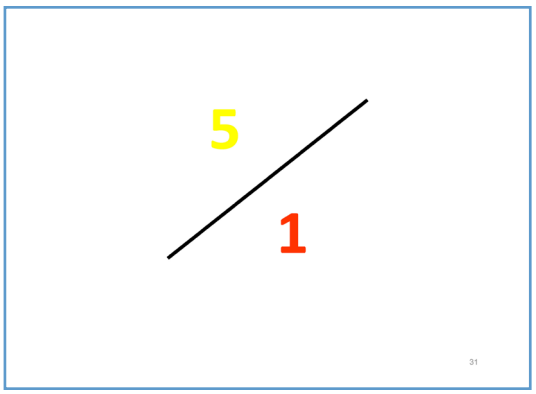
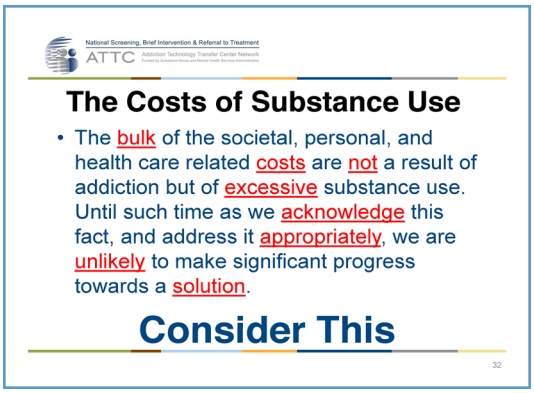
However, 20% of the population is at risk for problems (these are yellow light people).



31. TRAINER NOTE:

Note that there is a 5 to 1 disparity between those who are at risk and those who have a substance use.

NOTE: The intent of these slides to is to break out individuals into 3 distinct groups: Abstinent/Low Risk, Excessive Use, and Addiction or those who have a substance use disorder (Green light, yellow light, red light). Yes, individuals with a substance use disorder are by definition excessive users who are at risk for consequences but for this conceptual framework we are focused on separating the red light people (those with a substance use disorder) from the excessive use yellow light people. The red light people have moved into what the outdated model defines as the addiction. The yellow light people meet the criteria for having a problem in the SBIRT model (excessive use) and are at risk for all of the consequences that can result including being diagnosed with a substance use disorder.



32. TRAINER NOTE:

Most of the costs associated with substance use problems are not a result of addiction but of excessive use. It is not the red light people who are driving the cost of substance use it is the yellow light people.

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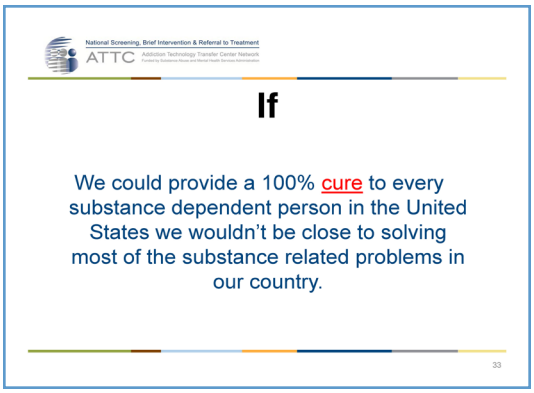
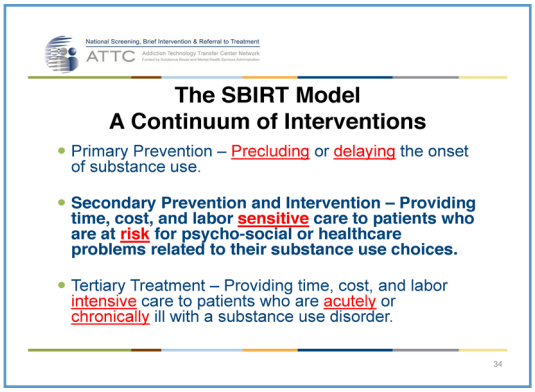


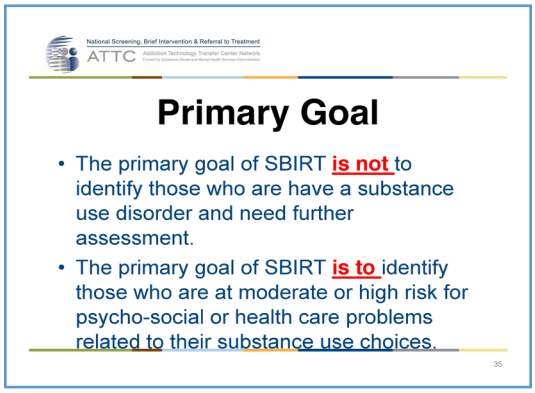
33. TRAINER NOTE:

Even if we could cure every dependent person we would only address 5% of the problem. The remaining 20% who are at risk are unlikely to receive services under the current system.



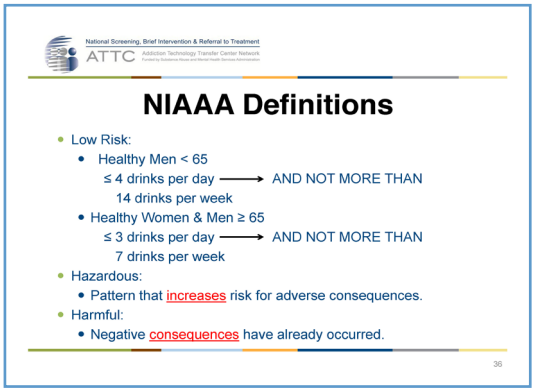
34. TRAINER NOTE:

The SBIRT model retains both primary prevention (green light people) and traditional treatment (red light people) but adds secondary prevention and intervention for those individuals who are at risk (yellow light people).



35. TRAINER NOTE:

The current system identifies and provides services to those with substance use disorders (the 5% red light people). SBIRT identifies and provides services to those individuals as well as those who are at risk (the 20% yellow light people).

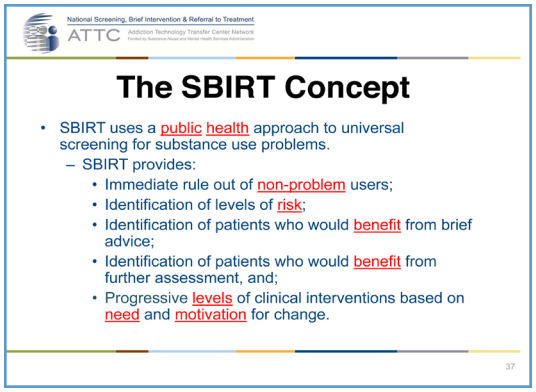


36. TRAINER NOTE:

Reference: National Institute of Alcohol Abuse and Alcoholism; www.NIAAA.nih.gov.

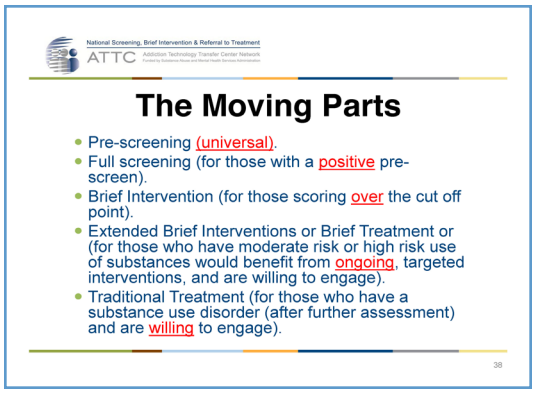
Reference: World Health Organization Brief Intervention for Hazardous and Harmful Drinking; Thomas F Babor and John C. Higgins-Biddle, 2001.

So what constitutes being at risk? The National Institute of Alcohol Abuse and Alcoholism defines low risk for healthy men under 65 as less than or equal to 4 drinks per day (acute measure) AND not more than 14 drinks per week (chronic measure). For healthy women and men 65 and older, the cutoff is less than or equal to 3 drinks per day AND not more than 7 drinks per week. Drinking over these amounts places the individual at risk for psycho-social or health care problem related to their current substance use choices. In addition to being at risk for psycho-social or health care problems SBIRT also recognizes levels of risk (hazardous) and use that is already resulting in problems (DUI, etc.)These are the agreed upon standards for low risk (non-excessive) use. Any use above this amount (and all illicit drug use or use of Rx drugs other than prescribed) constitutes risk. If negative consequences have yet to be experienced the use is hazardous. If negative consequences are occurring the use is harmful.



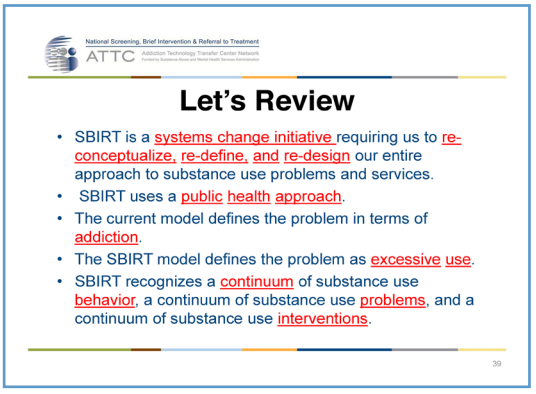
37. TRAINER NOTE:

SBIRT is able to accomplish each of these goals in a time, cost, and labor sensitive way. The concept of SBIRT really is simple. Use a public health approach to universally screen for substance use problems (i.e., excessive use). Screening can immediately rule out non-problem users and easily identify those who are at risk.



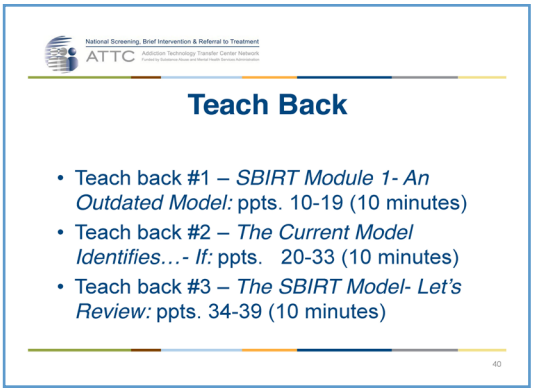
38. TRAINER NOTE:

SBIRT advocates pre-screening all adults (much like everyone is given a blood pressure test when they go to the doctor). For those with a positive per-screen we advocate conducting a full screen using a valid and reliable screening tool (AUDIT, DAST, ASSIST, CAGE, etc). We can then provide a continuum of intervention based on individual need (brief intervention, multiple or extended brief interventions, brief treatment, or referral for traditional care).



39. TRAINER NOTE:

Let's review: SBIRT is a system change initiative that uses a public health approach and requires us to change our approach to substance use problems and services. Remember that the outdated model defines the problem as addiction while the SBIRT model defines the problem as excessive use. SBIRT also recognizes a continuum of substance use behavior, problems, and interventions. Questions or comments?

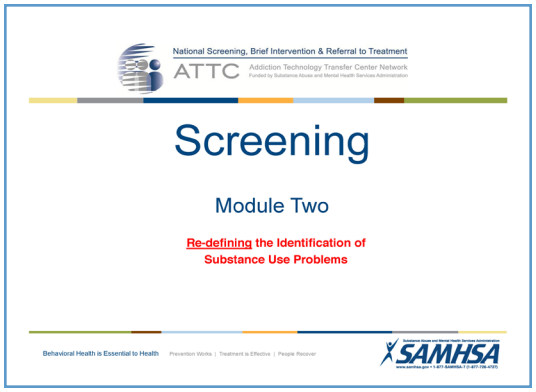


40. TRAINER NOTE:

Allow 30 minutes for this set of Teach Backs. Teach backs are an essential part of any Training of Trainers and teach backs are indicated throughout the curriculum. It is a good idea to email the entire slide set to participants in advance with a note about which slides they will be responsible for presenting. Be sure to keep participants within the time limits suggested, even if they have not completed all their slides, so there will be enough time for you and the other participants to complete the Training Observation Form as each teach back ends (See appendix, page 122-123, and review the instructions printed on the form). When the Training Observation Forms are completed after each teach back, collect the forms, put them in an envelope and give them to the participant who has just completed the teach back. Make sure each participant does at least one teach back. If there are teach backs left over let others volunteer to do them, as the more practice participants have with the content the more comfortable they will be when they are training others.

MODULE TWO:

Re-defining the Identification of Substance Use Problems – Screening



41. TRAINER NOTE:

This module will go over the screening process and specifically address using the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test – 10 (DAST – 10).

Module 2: Re-defining the Identification of Substance Use Problems

OBJECTIVES:

- Understand the information screening does and does not provide.
- Recognize the 2 levels of screening.
- Recognize the 4 interventions based on screening results.
- Become familiar with the AUDT C, AUDIT, and DAST-10 screening tools.
- Encourage active participation.

INSTRUCTIONAL METHODS (IM):

- Didactic – the instructor explains the content knowledge.
- Collaborative – the instructor asks the learners to process the content knowledge through facilitated discussion.
- Role play – participants will practice screening role plays.

PRACTICE:

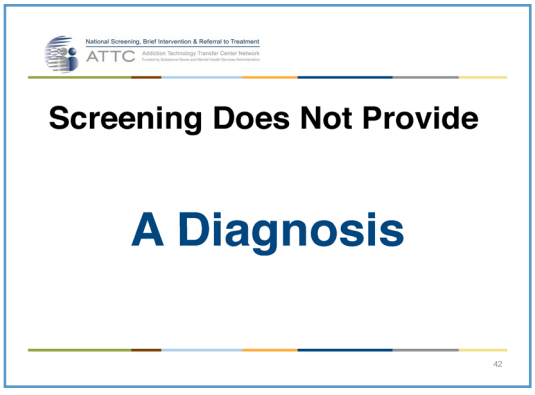
Direct delivery – there are multiple roles plays for participants to practice with the AUDIT and the DAST.

Training-of-Trainers (TOT)- This module includes 3 teach backs

Animated Slides: Yes

Video: No

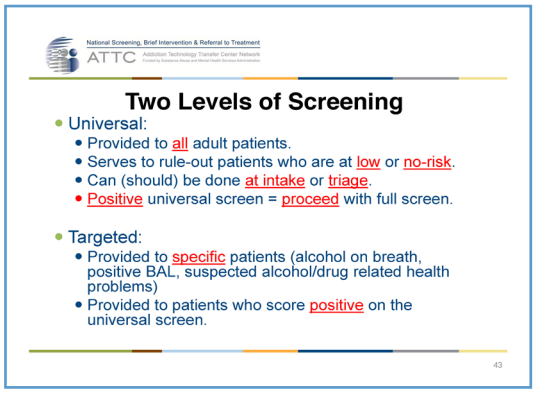
Materials: Copies of slides; copies of standard drink chart, copy of AUDT -C, AUDIT, and DAST-10.



42. TRAINER NOTE:

This is an animated slide. Click to start the animation sequence.

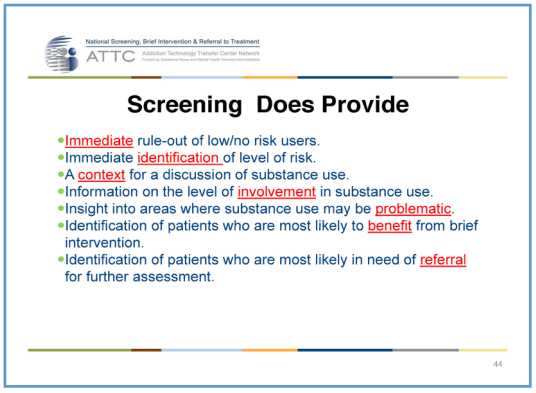
It is important to recognize the difference between an assessment (intended to make a diagnosis) and a screen (intended to identify the potential for problems).



43. TRAINER NOTE:

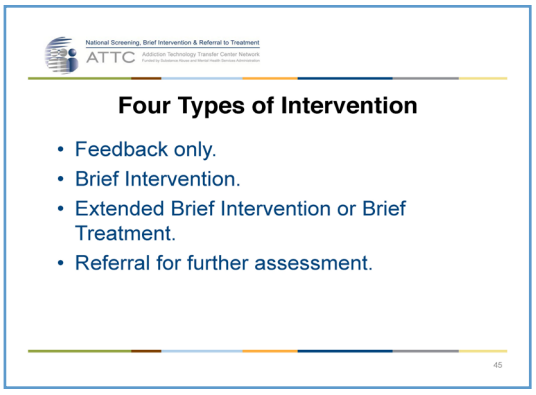
Because we know that approximately 75% of the adult population will "rule out" it is advantageous to provide a simple universal screen (generally 1 to 4 questions) such as the AUDIT-C.

Once those individuals are ruled out the focus can shift to the remaining 25% who are likely at risk for a psycho-social or health care problem related to their current substance use choices.



44. TRAINER NOTE:

In 3 to 5 minutes a valid and reliable screening tool can provide enough information to achieve the 7 goals listed above. Screening provides a number of things that are important in understanding the individual patient and their relationship with substances, their level of risk, the likelihood of benefiting from a brief intervention, and if they are likely to need further assessment.



45. TRAINER NOTE:

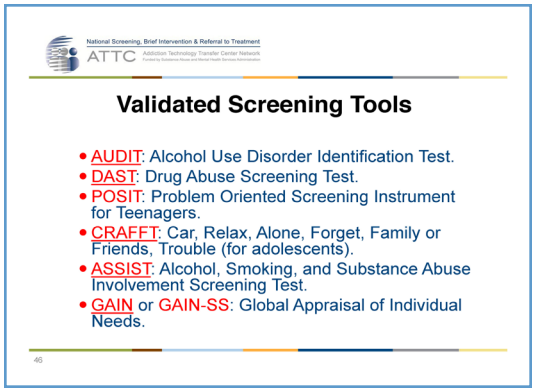
Reference: Substance Abuse and Mental Health Services Administration; www.samhsa.gov.

Individuals who score below the first cut off point of a full screen (such as the AUDIT) receive feedback on their current status and encouragement to stay below the NIAAA guidelines.

Those who score above the first cut off and below the second cut off receive a brief intervention. This is a 5 to 15 minute discussion focused on assisting the individual to recognize their risk and supporting them in making behavioral changes to reduce their risk.

Those who score above the second cut off but below the third cut off receive a brief intervention and are encouraged to have additional (extended) brief interventions or to engage in brief treatment.

Those who score above the third cut off receive a brief intervention and are encouraged to accept a referral for further assessment.



46. TRAINER NOTE:

Each of these screening tools are valid (they measure what we want them to) and reliable (they measure accurately over a broad group of individuals).

The AUDIT was developed by the World Health Organization (WHO) and evaluated over a period of two decades. It has been found to provide an accurate measure of risk across gender, age, and cultures.

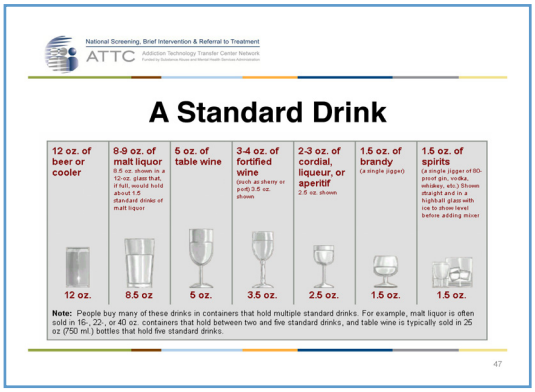
The DAST includes questions about possible involvement with drugs not including alcoholic beverages during the past 12 months. "Drug use" refers to the use of prescribed or over the counter drugs in excess of what's directed and any non-medical and/or illegal use of drugs. While the full DAST consists of 28 questions, this curriculum uses the DAST-10.

The POSIT was designed to identify problems and potential treatment or service needs in 10 areas, including substance abuse, mental and physical health, and social relations.

The CRAFFT is a behavioral health screening tool for use with children under the age of 21 and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents. It is a short, effective screening tool meant to assess whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted.

The ASSIST is a brief screening questionnaire to find out about people's use of psychoactive substances. It was developed by the World Health Organization (WHO) and an international team of substance use researchers as a simple method of screening for hazardous, harmful and dependent use of alcohol, tobacco and other psychoactive substances.

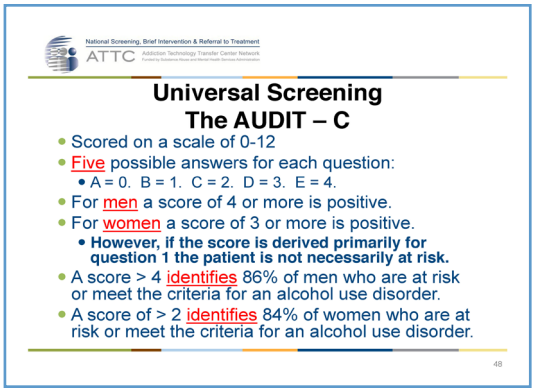
The GAIN is a progressive and integrated family of instruments with a series of measures and computer applications designed to support a number of treatment practices. A GAIN License must be obtained in order to use any of the GAIN family of instruments. The GAIN-SS (Short Screener) is an initial screening instrument.



47. TRAINER NOTE:

Reference: National Institute of Alcohol Abuse and Alcoholism; www.niaaa.nih.gov.

Prior to asking the screening questions it is vital to agree on the definition of "a" drink. When discussing alcohol use with a patient we always explain what we mean by a drink. This chart provides the standard measures of various types of drinks/alcohol.

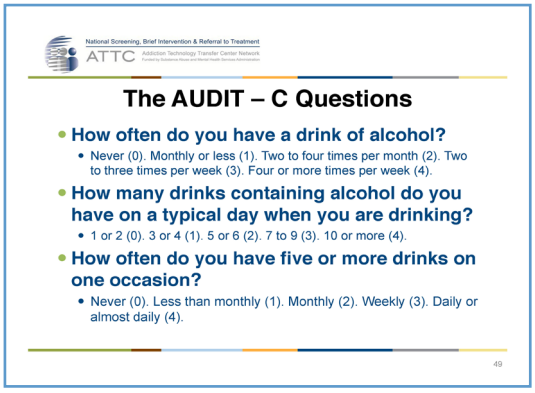


48. TRAINER NOTE:

Reference: World Health Organization, 1982.

This screen is used to "rule out" the 75% of individuals who are low or no risk and to "rule in" the 25% who are at some kind of risk. It is a valid screen for alcohol use.

It is a valid screen for alcohol use. However, when the points are all from question #1 alone (and #2 and #3 are zero), the score would not necessarily indicate that the patient is drinking above the recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months (including the sizes of any drinks consumed) to confirm accuracy.

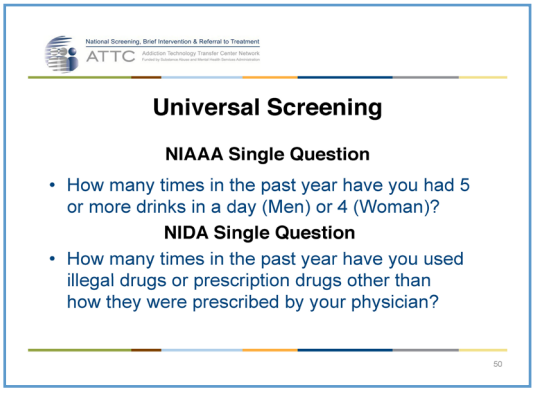


49. TRAINER NOTE:

Reference: World Health Organization, 1982.

The AUDIT-C consists of 3 questions with 5 possible answers for each question.

Read each question and response.

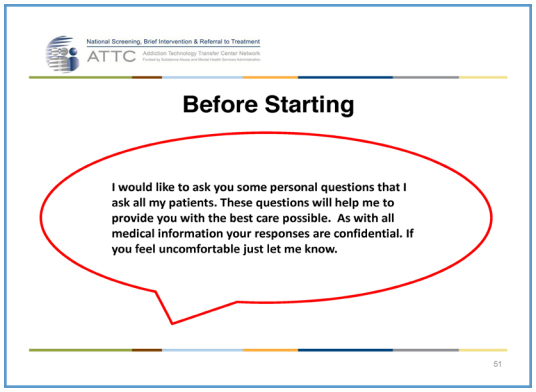


50. TRAINER NOTE:

References: National Institute on Alcohol Abuse and Alcoholism. (2007). Helping Patients Who Drink Too Much: A Clinician's Guide (NIH Publication No. 07-3769)

National Institute on Drug Abuse. (2011). Screening for Drug Use in General Medical Settings: Quick Reference Guide (NIH Publication No. 11-7384)

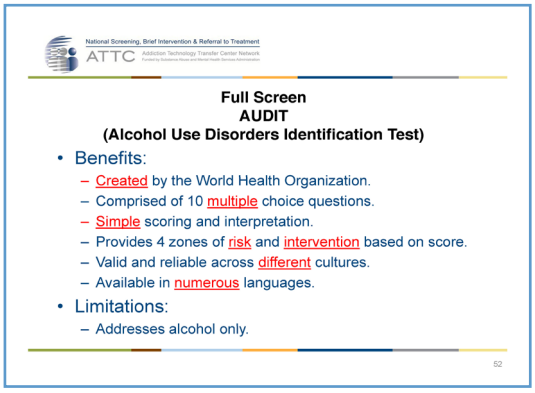
These are single question universal screens that can also be used to "rule out" those who are not at risk. Any affirmative answer indicates the need to conduct a full screen.



51. TRAINER NOTE:

This is an animated slide. Click to start the animation sequence.

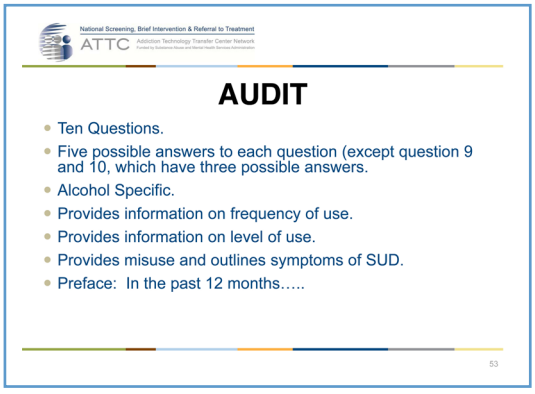
This is an example of language that can be used to introduce the process of screening. Before starting use an introduction such as this one which will help "normalize" this process ("I ask all my patients'), frame the questions as medical in nature, and highlight the confidentiality of the responses. It may help some patients if you frame these as "lifestyle" questions rather than "personal" questions. It's an option here for the trainer to ask the participants to take a few minutes to write an introduction that they might feel covers the essentials but reflects their own style and approach to introducing the screen.



52. TRAINER NOTE:

Reference: World Health Organization, 1982.

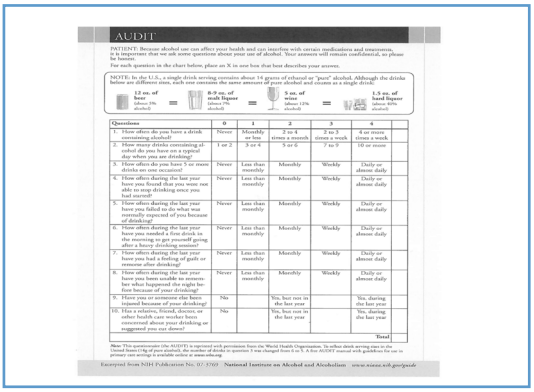
There are both benefits and limitations to any screening tool. The benefits of the AUDIT are…..and the limitation is…..



53. TRAINER NOTE:

Reference: World Health Organization, 1982.

The AUDIT consists of ……and provides….. Always clarify that we are interested in substance use behavior over the past 12 months.



AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol) = 8-9 oz. of malt liquor (about 7% alcohol) = 5 oz. of wine (about 12% alcohol) = 1.5 oz. of liquor (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

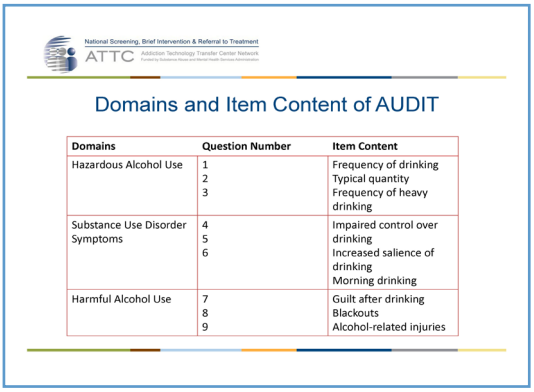
Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at www.who.org

Excerpted from NIH Publication No. 07-3769 National Institute on Alcohol and Alcoholism www.niaaa.nih.gov/guide

54. TRAINER NOTE:

Review the note at the bottom of the AUDIT: "This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5…"

Ask one of the participants to read each question and responses.



National Screening, Brief Intervention & Referral to Treatment

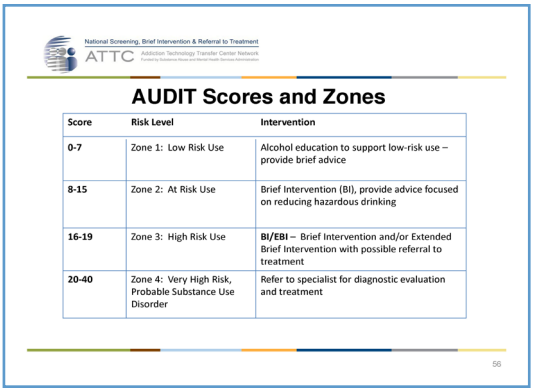
ATTC Addiction Technology Transfer Center Network

Domains and Item Content of AUDIT

Domains	Question Number	Item Content
Hazardous Alcohol Use	1 2 3	Frequency of drinking Typical quantity Frequency of heavy drinking
Substance Use Disorder Symptoms	4 5 6	Impaired control over drinking Increased salience of drinking Morning drinking
Harmful Alcohol Use	7 8 9	Guilt after drinking Blackouts Alcohol-related injuries

55. TRAINER NOTE:

World Health Organization. (2001). The alcohol use disorders identification test: Guidelines for use in primary care. Retrieved from http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf. Identifies the types of questions on the AUDIT used to identify hazardous, harmful and dependent alcohol use.



National Screening, Brief Intervention & Referral to Treatment

ATTC Addiction Technology Transfer Center Network

AUDIT Scores and Zones

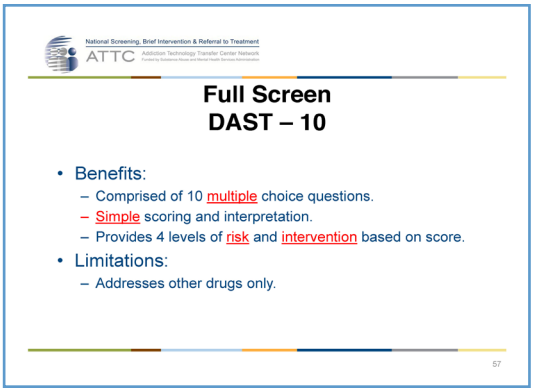
Score	Risk Level	Intervention
0-7	Zone 1: Low Risk Use	Alcohol education to support low-risk use – provide brief advice
8-15	Zone 2: At Risk Use	Brief Intervention (BI), provide advice focused on reducing hazardous drinking
16-19	Zone 3: High Risk Use	**BI/EBI** – Brief Intervention and/or Extended Brief Intervention with possible referral to treatment
20-40	Zone 4: Very High Risk, Probable Substance Use Disorder	Refer to specialist for diagnostic evaluation and treatment

56

56. TRAINER NOTE:

Reference: World Health Organization, 1982.

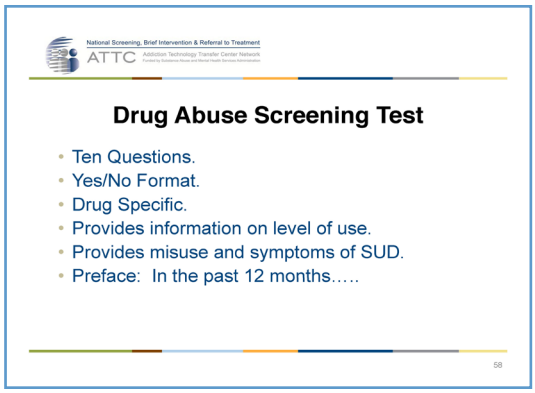
This is the scoring sheet that indicates level of risk and indicated intervention.



57. TRAINER NOTE:

Reference: The Addiction Research Foundation, 1982.

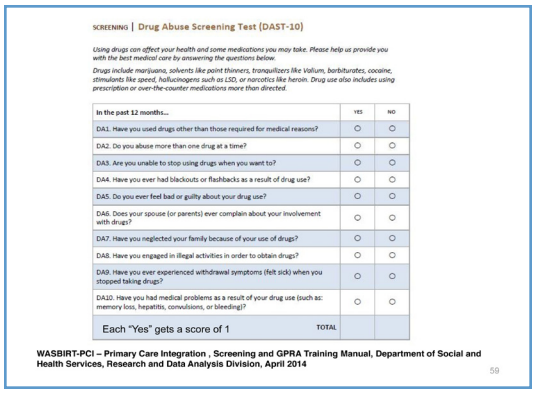
As noted before there are both benefits and limitations to any screening tool. The benefits of the DAST-10 are….. and the limitation is…..



58. TRAINER NOTE:

Reference: The Addiction Research Foundation, 1982.

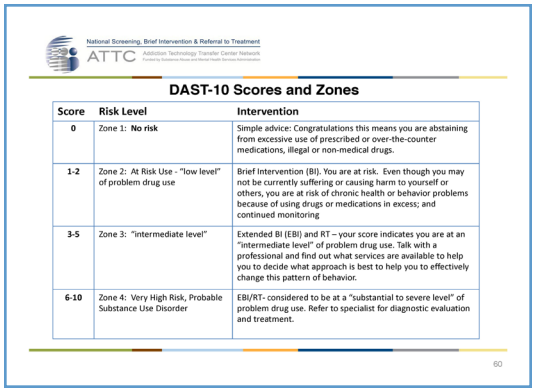
The DAST-10 consists of ……and provides…..Always clarify that we are interested in substance use behavior over the past 12 months.



59. TRAINER NOTE:

Reference: WASBIRT-PCI – Primary Care Integration , Screening and GPRA Training Manual, Department of Social and Health Services, Research and Data Analysis Division, April 2014

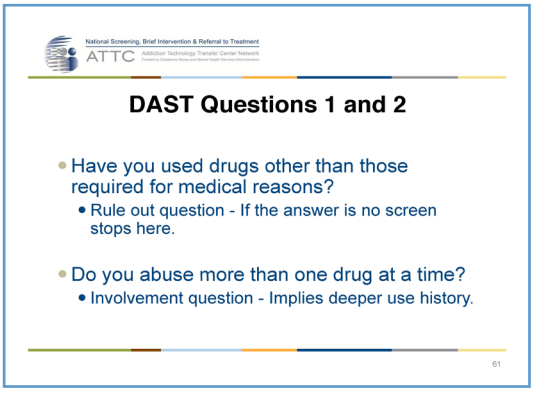
This is how the paper copy of the DAST-10 looks. When giving the screen remember to ask each question precisely as written. Again, this could be given to the patient to fill out as a questionnaire.



60. TRAINER NOTE:

Reference: The Addiction Research Foundation, 1982.

This is the scoring sheet that indicates level of risk and indicated intervention.

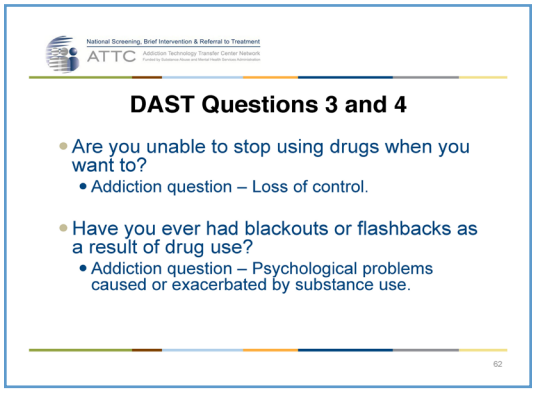


61. TRAINER NOTE:

Reference: The Addiction Research Foundation, 1982.

Let's spend a few minutes going over the DAST-10 questions in depth and discussing what information we are trying to gather.

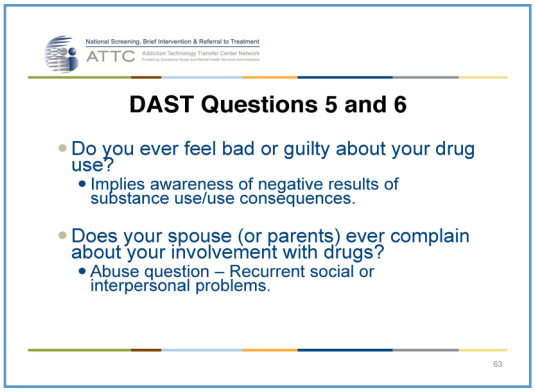
Discuss each question individually.



62. TRAINER NOTE:

Reference: The Addiction Research Foundation, 1982.

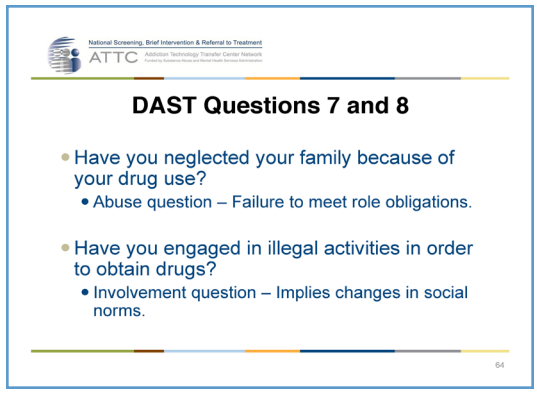
Discuss each question individually.



63. TRAINER NOTE:

Reference: The Addiction Research Foundation, 1982.

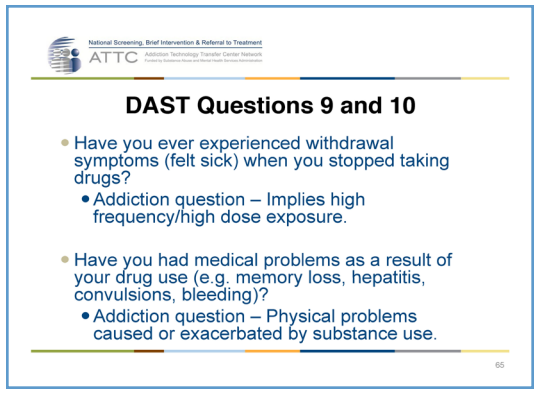
Discuss each question individually.



64. TRAINER NOTE:

Reference: The Addiction Research Foundation, 1982.

Discuss each question individually.



65. TRAINER NOTE:

Reference: The Addiction Research Foundation, 1982.

Discuss each question individually.

Screen	Target Population	# Items	Assessment	Setting (Most Common)	URL
ASSIST (WHO)	-Adults -Validated in many cultures and languages	8	Hazardous, harmful, or dependent drug use (including injection drug use) [interview]	Primary Care	http://www.who.int/substance_abuse/activities/assist_test/en/index.html
AUDIT (WHO)	-Adults and adolescents -Validated in many cultures and languages	10	Identifies alcohol problem use. Can be used as a pre-screen to identify patients in need of full screen/brief intervention [Self-admin, Interview, or computerized]	•Different Settings •AUDIT C- Primary Care (3 questions)	http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf
DAST-10	Adults	10	To identify drug-use problems in past year [Self-admin or Interview]	Different Settings	http://www.integration.samhsa.gov/clinical-practice/screening-tools
CRAFFT	Adolescents	6	To identify alcohol and drug abuse, risky behavior, & consequences of use [Self-admin or Interview]	Different Settings	http://www.ceasar-boston.org/CRAFFT/
CAGE	Adults and Youth >16	4	-Signs of tolerance, not risky use [Self-admin or Interview]	Primary Care	http://www.integration.samhsa.gov/clinical-practice/sbirt/CAGE_questionaire.pdf
TWEAK	Pregnant Women	5	-Risky drinking during pregnancy. Based on CAGE. -Asks about number of drinks one can tolerate, & related problems [Self-admin, Interview, or computerized]	Primary Care, Women's Organizations, etc.	http://www.sbirttraining.com/sites/sbirttraining.com/files/TWEAK.pdf

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

66. TRAINER NOTE:

Here is a chart that provides information on 6 different screening tools. We've provided the websites so you can check them out. 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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

National Screening, Brief Intervention & Referral to Treatment
ATTC Addiction Technology Transfer Center Network

Let's Review

- Screening does not provide a diagnosis.
- Screening does provide immediate rule-out of no risk/low risk users.
- Screening does provide immediate identification of level of risk.
- There are 2 levels of screening:
  - Universal.
  - Targeted.
- There are 4 types of intervention:
  - Feedback.
  - Brief Intervention.
  - Extended Brief Intervention or Brief Treatment.
  - Referral for further assessment.

67

67. TRAINER NOTE:

Remember that screening does not provide a diagnosis but does provide information to immediately rule-in or rule-out patients who could benefit from a BI, extended BI, or referral to treatment. There are 2 types of screening; universal and targeted and 4 types of intervention; feedback, brief intervention, extended brief intervention or brief treatment, and referral for further assessment.

National Screening, Brief Intervention & Referral to Treatment
ATTC Addiction Technology Transfer Center Network

Teach Back

- Teach back #4 – *Screening- A Standard Drink:* ppts. 41- 47 (10 minutes)
- Teach back #5 –*Universal Screening, The AUDIT C- AUDIT Scores and Zones:* ppts. 48- 56 (10 minutes)
- Teach back #6 – *Full Screen, DAST 10- Let's Review:* ppts. 57 – 67 (10 minutes)

68

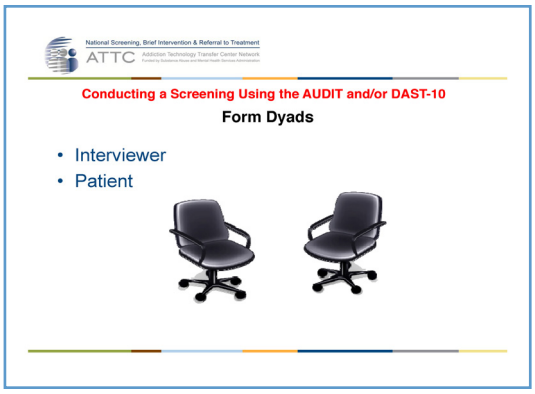
68. TRAINER NOTE:

Allow 30 minutes for this set of Teach Backs.

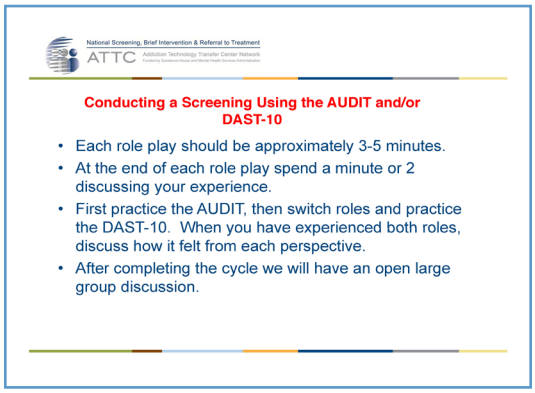
69. TRAINER NOTE:

Let's spend some time doing a screening. We will take turns interviewing each other using both the AUDIT and the DAST. Break into dyads with a interviewer and a patient. The patient can answer the questions as they see fit. Make sure to score the test when your done. First practice the AUDIT, then switch roles and practice the DAST-10. Be sure to think thru how you are going to introduce the questions to the patient.

This role play will give participants the opportunity to practice introducing and asking the AUDIT and/or DAST screening questions in an interview format.



70. TRAINER NOTE:

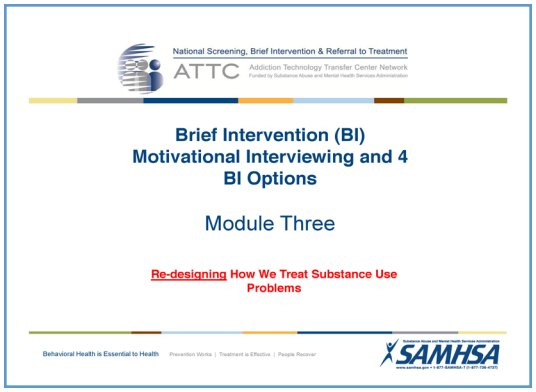


71. TRAINER NOTE:

72. **TRAINER NOTE:**

MODULE THREE:

Re-designing How We Treat Substance Use Problems



73. TRAINER NOTE:

This module presents information on how to conduct a brief intervention (BI) and defines and provides an overview of Motivational Interviewing (MI) which is the clinical approach used to provide SBIRT services.

Module 3 – Re-designing How We Treat Substance Use Problems

Objectives:

- Define brief intervention/brief negotiated interview.
- Describe the goals of conducting a BI.
- Understand the counselor's role in providing BI.
- Develop knowledge of Motivational Interviewing.
  - Describe 4 SBIRT Brief Intervention models
  - Discuss how to make a Referral to Treatment
  - Define Extended Brief Intervention/Brief Treatment
  - Discuss SBIRT cost effectiveness and reimbursement

INSTRUCTIONAL METHODS (IM):

Didactic – the instructor explains the content knowledge.

Collaborative – the instructor asks the learners to process the content knowledge through facilitated discussion.

Role Plays connected with each of the 4 Brief Intervention models

Video: Yes

PRACTICE:

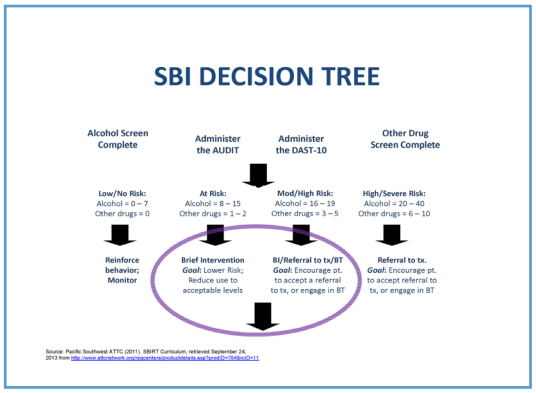
Direct delivery – there are multiple role plays connected to each of the for Brief Intervention models.

Training of Trainers (TOT): This module includes 10 Teach Backs

Animated Slides: Yes

Video: Yes

Materials: Copies of slides; copies of ancillary tools.

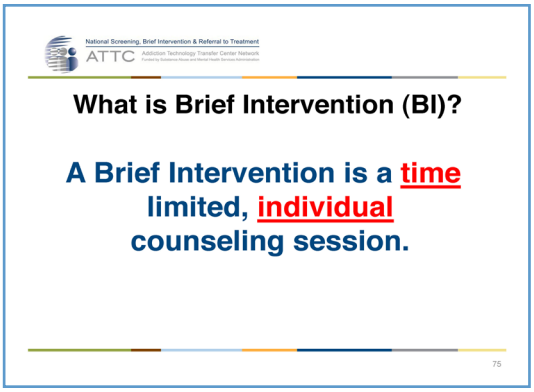


74. TRAINER NOTE:

We will begin 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.

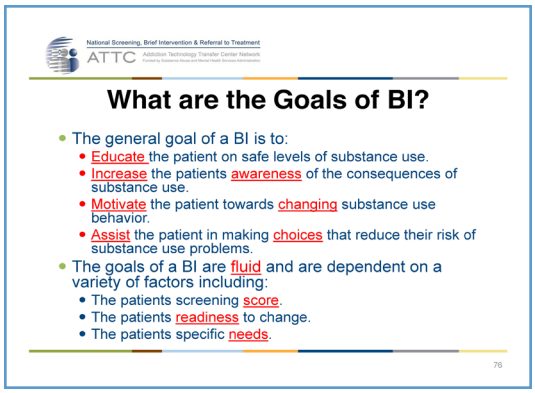
Are there any questions?

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



75. TRAINER NOTE:

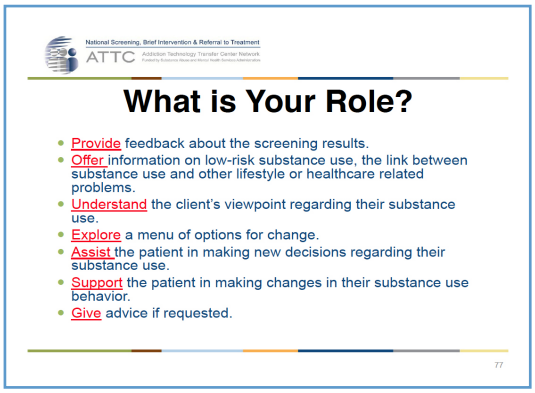
A BI is really just an individual counseling session that takes place in a very short amount of time.



76. TRAINER NOTE:

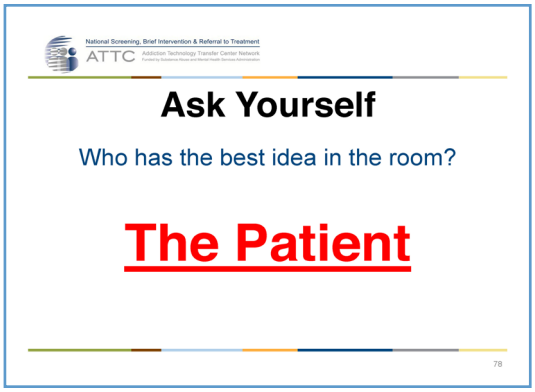
Many patients don't know the low risk limits, may be unable to link their substance use behavior to consequences, have little motivation to change their substance use behavior, or know what choices to make. We can assist the patient in all of these areas during a BI. It is important to remember that these goals are fluid and depend on a variety

of factors. Since no two patients are the same the practitioner must remain open-minded and fluid in what they attempt to accomplish.



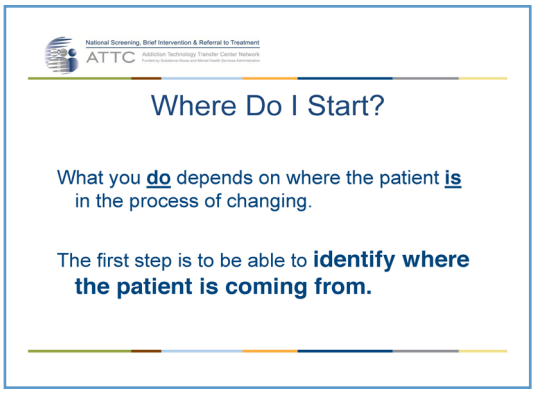
77. TRAINER NOTE:

When doing a Brief Intervention the role of the practitioner is well defined.



78. TRAINER NOTE:

It is always better to let the patient come up with the plan for change than to impose it on the patient. No one likes being told what to do. When the patient comes up with their own answer they are much more likely to be receptive to change.



79. TRAINER NOTE:

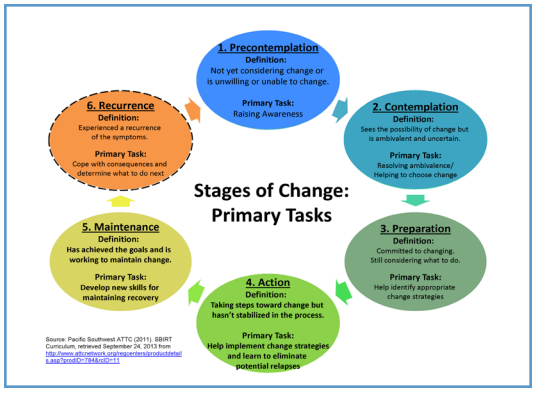
We have to start by assessing how aware the patient is of his or her substance use and the consequences.

Click to animate first sentence.

What we do depends on where the patient is in the process of changing. Most of the time patients are coming to us for other concerns and have not thought about changing their substance use.

Click to animate second sentence.

The first step, then, is the 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.



80. TRAINER NOTE:

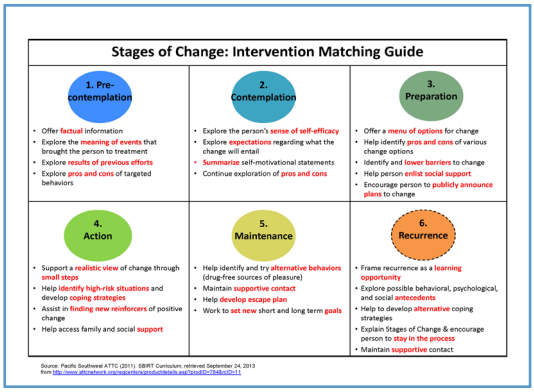
The Stages of Change is a theoretical perspective that we can use to understand where a person is coming from in terms of their substance use. At the top in blue is the first stage called precontemplation. At this stage people do not see a problem with their use and are not considering change.

Use the pointer so participants can follow along on screen.

The stages that follow are contemplation, preparation, 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 preparation 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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



81. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

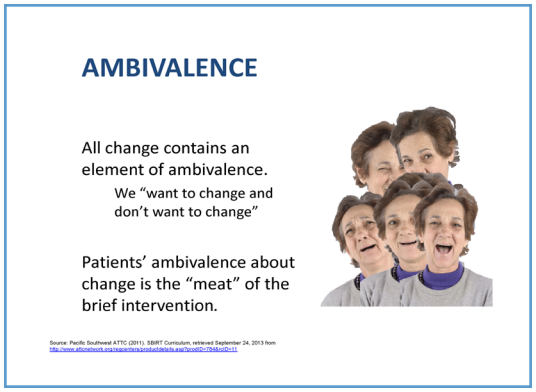
82. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



83. TRAINER NOTE:

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.

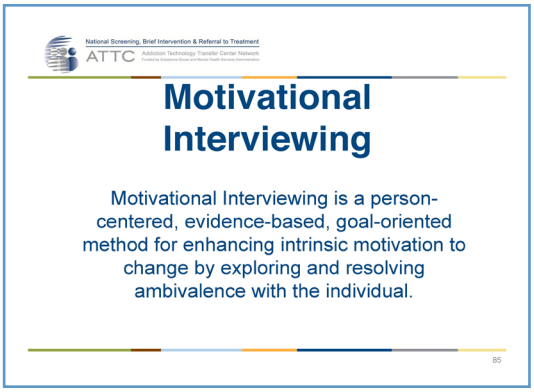
What is ambivalence? It's when we feel two ways about something. We may like to drink, but we also don't like having a hangover. Exploring a person's ambivalence about change is one way of assessing where they are in the change process.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

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.

84. TRAINER NOTE:

Motivational Interviewing is the backbone of SBIRT. It is MI that assists the patient to make positive behavioral changes.



85. TRAINER NOTE:

Patient-centered refers to a fundamental collaborative approach to the practitioner/Patient relationship. Patient-centered specifically refers to Carl Rogers (1946) reflective listening which is a central skill for a Motivational Interviewing practitioner. The practitioner follows the patient's thoughts, feelings and perceptions and responds with reflective statements. Reflective statements include degrees of complexity such as possible meaning behind the patient's statement and reflection of possible patient feelings.

Evidence-based includes practices that are shown to be successful through research. Models that have shown the greatest levels of effectiveness have the ability to replicate successful outcome with different populations, over time.

Person-centered: Person-centered is a transition of the term patient-centered. It is advocated for use by those who believe it is less clinical, less role defining, more equalizing and more personable than the term patient-centered. The term person-centered also serves to broaden MI's relevance beyond the clinical setting.

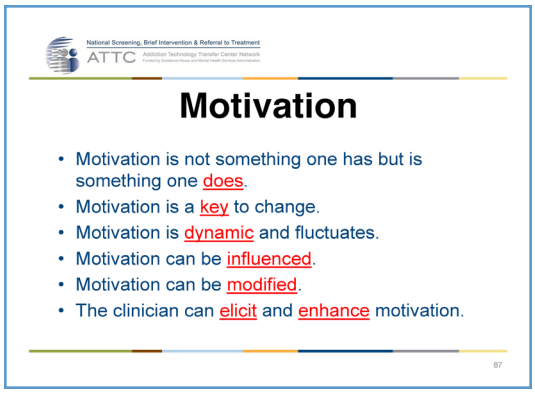
Directive: MI is both patient-centered meaning it follows the patient's thoughts, feelings and perceptions, and directive. Directive refers to the use of specific strategies and interventions that may facilitate the patient's movement toward exploration, change talk, problem recognition (resolving ambivalence) or the decision to change. The practitioner guides the discussion towards the possibility of change.

Intrinsic Motivation: The motivation that comes from the patient. It's in there somewhere, and it's the practitioner's job to find out what it is and amplify it, reflect it back.

Ambivalence: This refers to the patient's experience of conflicting thoughts and feelings about a particular behavior or change – advantages and disadvantages. The MI practitioner listens for and evokes the Patient's reasons for concern and arguments for change (change talk), while also accepting and reflecting perceived disadvantages of change (sustain talk). The practitioner reflects both sides, sometimes in the form of a double sided reflection. The recognition of ambivalence may add clarity where the patient has not been ready to move forward or reach a decision. The MI practitioner listens for and evokes the patient's own arguments for change and assists the patient to keep moving in the direction of change.

86. TRAINER NOTE:

Ask the participants to think about something they want to change. After a few moments elicit a response to this question: "How long have you thought about changing the thing you are thinking about"? Responses will range from days, to weeks, to months, to years…..This exercise demonstrates how difficult change really is even when you want to change.

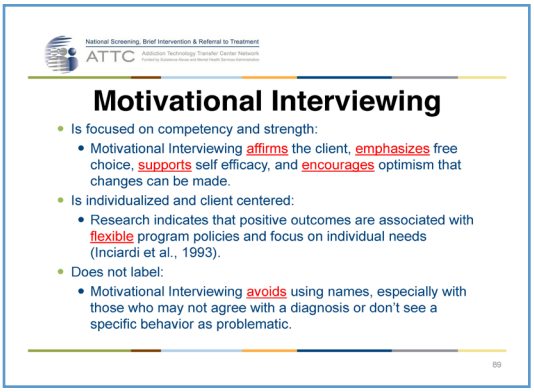


87. TRAINER NOTE:

Motivation is not static but changes from day to day or even moment to moment. "Do you ever get up some mornings and feel excited about going to work and then on other days get up and think going to work sounds terrible? That's how motivation changes; sometime day to day…. sometime minute to minute." However, motivation can be influenced, enhanced, and elicited by the practitioner (think personal trainer).

88. TRAINER NOTE:

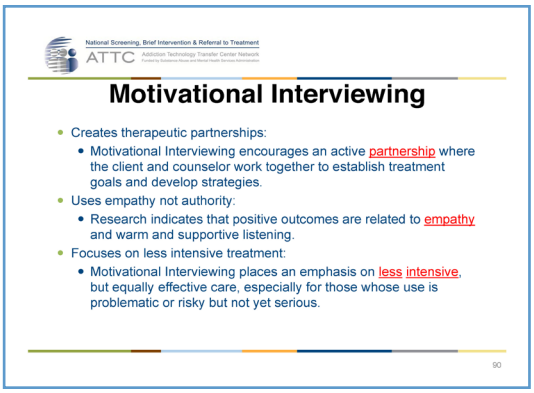
MI asks us to create a relationship with the patient based on trust and the autonomy of the patient.



89. TRAINER NOTE:

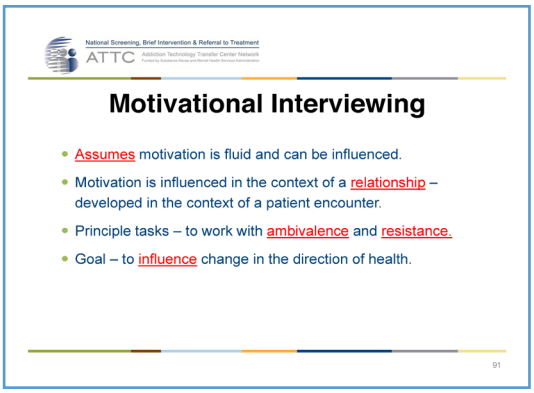
MI is a strength based approach as opposed to a weakness based approach and seeks to build on the patient intrinsic abilities.

Review each bullet point. Encourage the participants to discuss how they understand each of these concepts.



90. TRAINER NOTE:

MI seeks to create a partnership with the patient and empathize with their situation. This is a key concept in SBIRT. The provider and patient are on the same side in an effort to help the patient identify and achieve goals related to improved health and social well-being.

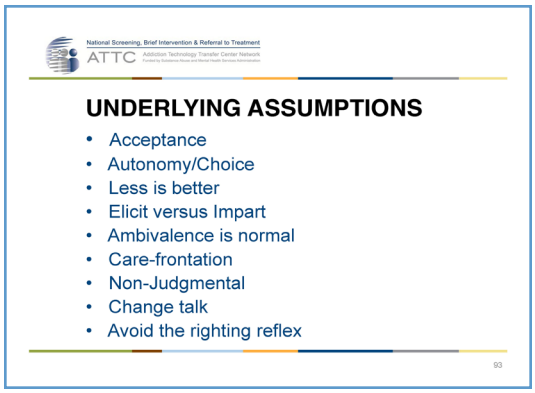


91. TRAINER NOTE:

Change is difficult. Often the practitioner will create resistance by their approach to the patient. Judging, labeling, and demanding are counter productive and never a part of the MI spirit.

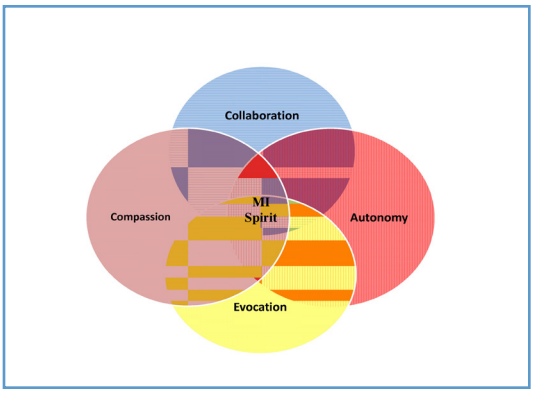
92. TRAINER NOTE:

This slide represents the central clinical goal of using MI. Creating discrepancy between the patient's goal or values ("My marriage is important to me") and their current behavior ("My wife hates my drinking"). The goal of most treatment is to "comfort the afflicted". The goal of SBIRT is to "afflict the comfortable" by helping the patient recognize the distance between where they are and where they want to be.



93. TRAINER NOTE:

Like all clinical approaches MI assumes a number of things.



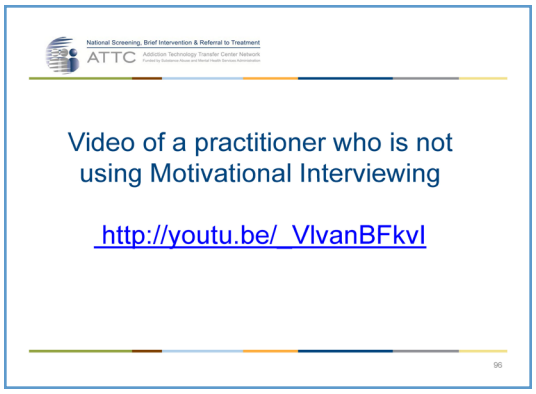
94. TRAINER NOTE:

This Venn diagram shows how collaboration, compassion, autonomy, and evocation come together to create to MI spirit.

95. TRAINER NOTE:

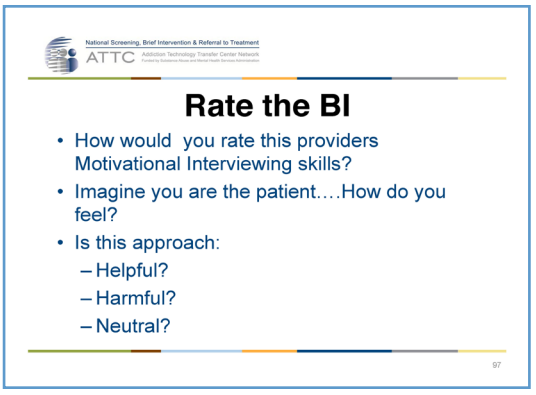
MI places the impetus for change directly on the patient. The practitioner's job is to support the patient in reaching their own conclusions about change.

It is our job to elicit and support change not to force or demand it.



96. TRAINER NOTE:

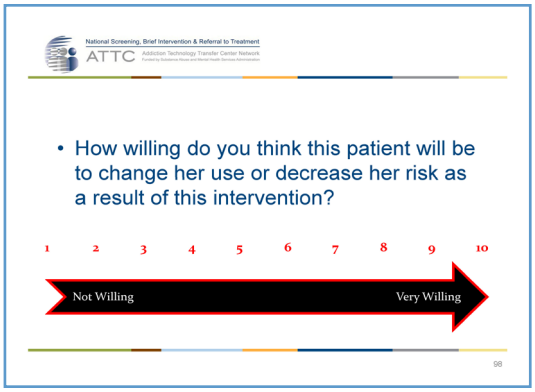
This video will give an example of a brief intervention conducted in a confrontational, non-MI style.



97. TRAINER NOTE:

Go through this exercise with the participants. Open a brief discussion by eliciting responses from the participants.

Encourage dialogue and participation.



98. TRAINER NOTE:

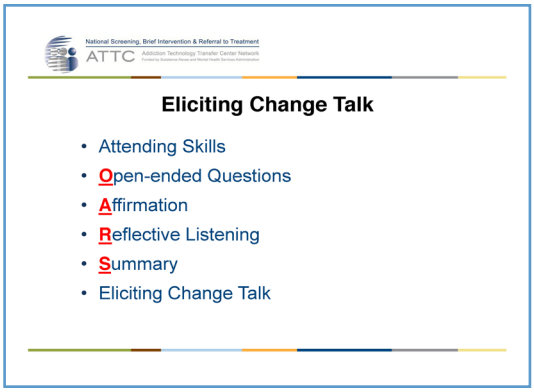
Choose one (or more) participant and have them discuss the likelihood of patient change base on the video. Discuss in some detail what went on in this session and ways in which the interviewer violated the principles of MI.

99. TRAINER NOTE:

Here are a number of acronyms that we work with when doing MI.

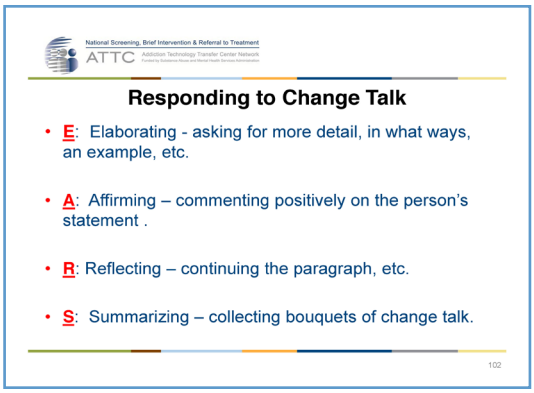
100. TRAINER NOTE:

DARNCAT is acronym we use to remind us to listen for specific words that imply that the patient is moving toward change.



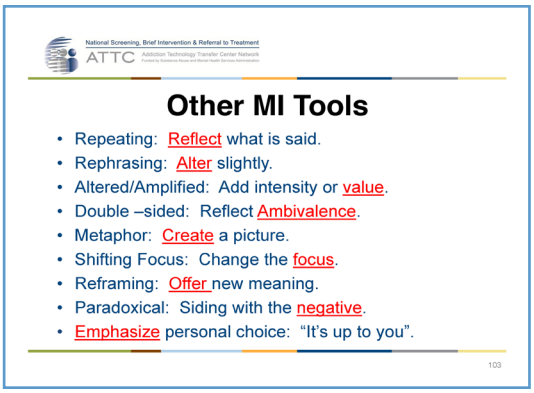
101. TRAINER NOTE:

Change talk is patient speech that favors movement in the direction of change. Using the OARS approach gives patients the opportunity to talk themselves into considering making behavior changes.



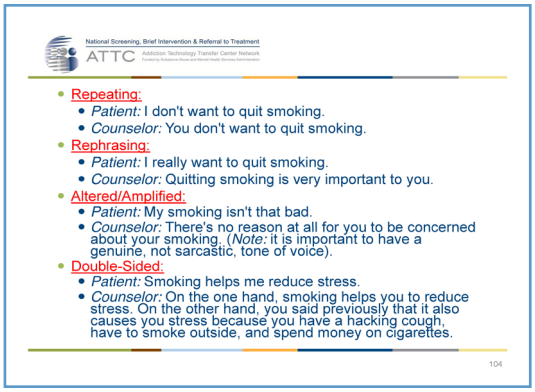
102. TRAINER NOTE:

EARS reminds you to **elaborate** by asking for more detail, **affirm** by making a positive comment, **reflect** what the patient says or **summarizing** the patients comments.



103. TRAINER NOTE:

All of these tools are important to MI.

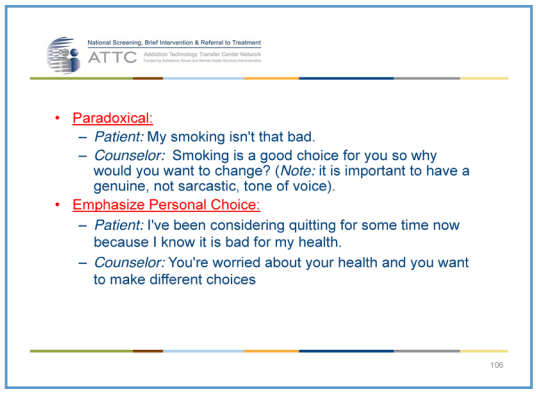


104. TRAINER NOTE:

Go through each of these examples and ask participants to offer their own counselor responses.

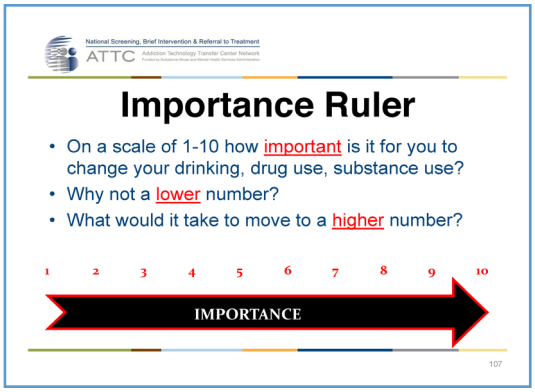
105. TRAINER NOTE:

Go through each of these examples and ask participants to offer their own counselor responses.



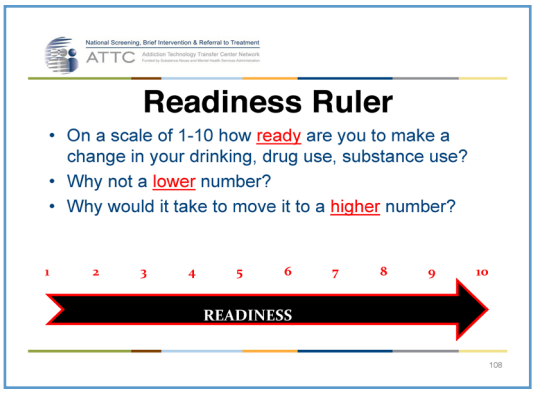
106. TRAINER NOTE:

Go through each of these examples and ask participants to offer their own counselor responses.



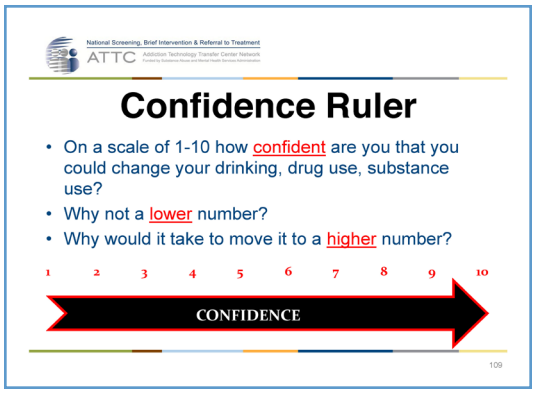
107. TRAINER NOTE:

Humans seldom do anything that they don't believe is important. The importance ruler requires patients to state specifically how important a change is to them. Asking them to explain why they didn't choose a lower number will require them to discuss the reasons that change is important. Asking them to explain what it would take to move to a higher number provides you with information that can be reflected back. Often the responses are about additional negative consequences.



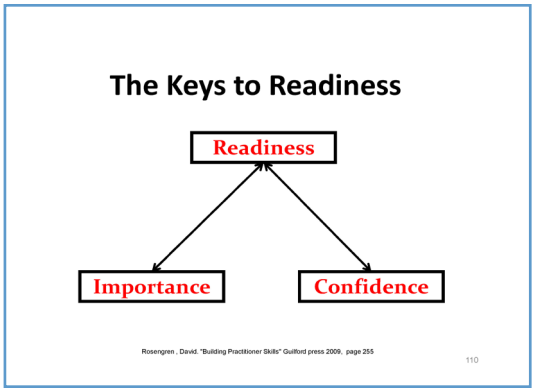
108. TRAINER NOTE:

This is a question about motivation. The readiness ruler provides patients with an opportunity to explore their readiness to make a change in their substance use behavior. Asking them to explain why they didn't choose a lower number they require them to discuss the reasons why they are ready. Asking them to explain what it would take to move to a higher number provides you with information that can be reflected back to help them define ways that their readiness can be increased.



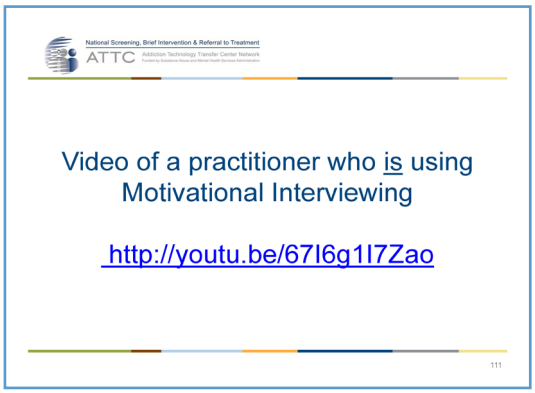
109. TRAINER NOTE:

The more confident a person is the more likely they are to try something. The confidence ruler provide patients with an opportunity to explore their level of confidence related to changing their substance use behavior. Asking them to explain why they didn't choose a lower number will require them to discuss the reasons they feel confident. Asking them to explain what it would take to move to a higher number provides you with information that can be reflected back and helps them define ways that their confidence could be increased.



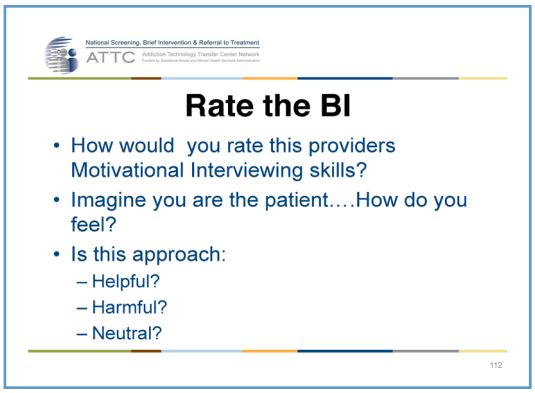
110. TRAINER NOTE:

The more important a change is perceived to be and the more confident patients are that they can achieve a change, the readier they will be to actually change.



111. TRAINER NOTE:

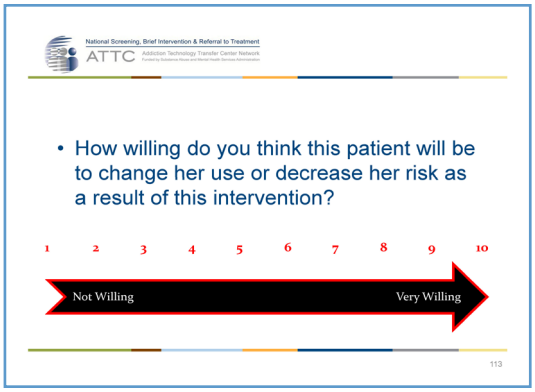
Here is a video that shows a the practitioner using the MI style and tools.



112. TRAINER NOTE:

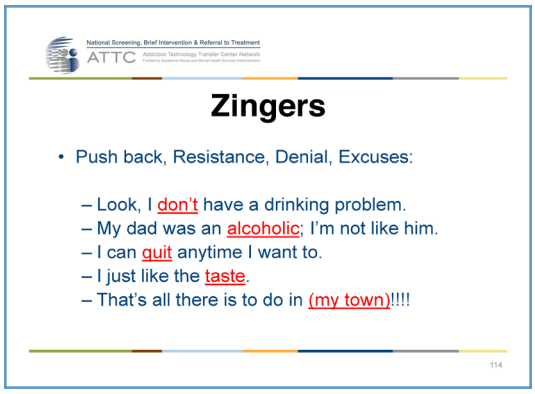
Go through this exercise with the participants. Open a brief discussion by eliciting responses from the participants.

Encourage dialogue and participation.



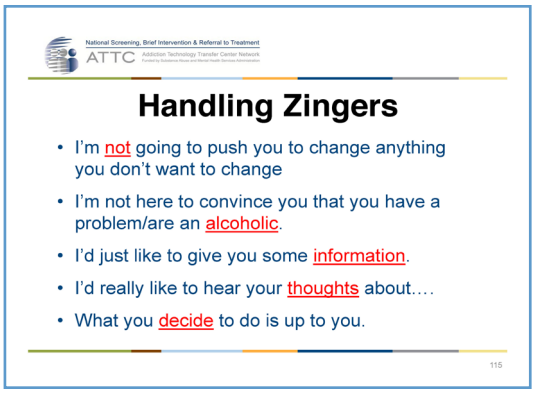
113. TRAINER NOTE:

Choose one (or more) participant and have them discuss the likelihood of patient change base on the video. Discuss in some detail what went on in this session and ways in which the interviewer demonstrated the principles of MI.



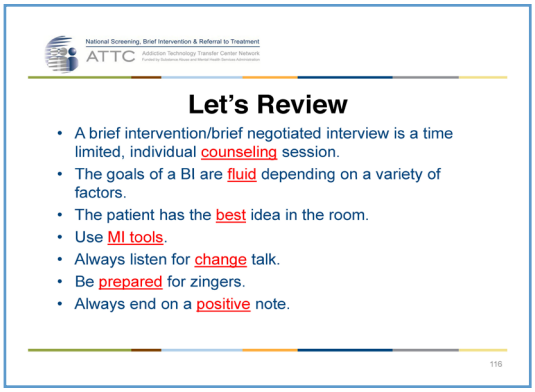
114. TRAINER NOTE:

Zingers can take innumerable forms. Have the participants give examples from their own experience.



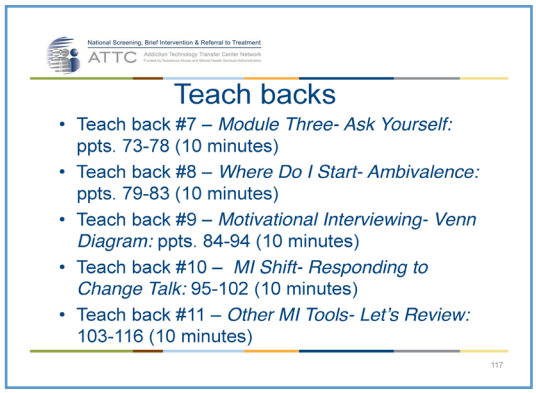
115. TRAINER NOTE:

Review some strategic responses that reduce resistance. Ask participants to come up with some of their own.



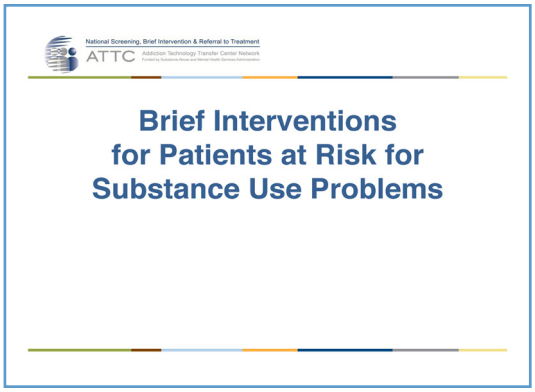
116. TRAINER NOTE:

A BI/BNI is just another name for a time limited individual counseling session that is fluid in its goals depending on a variety of factors (ask participant to mention some of the factors that were discussed earlier). Remind the participants that ideas for change should be generated by the patient and that we can listen for, and hear change talk (ask participants to discuss what change talk should like, what DARNCAT means, and how to encourage change talk). Remember to roll with resistance and deflect zingers. The ancillary tools should be used at the practitioners discretion. Always SEW up the session and end on a positive note.



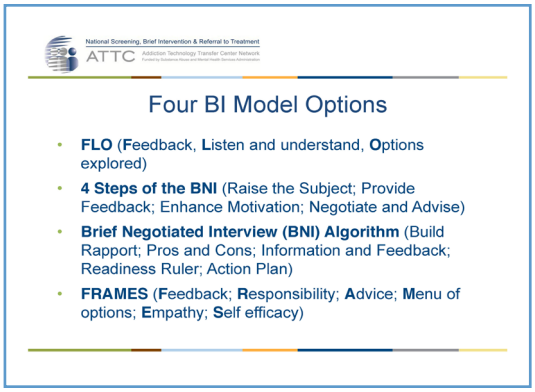
117. TRAINER NOTE:

Allow 50 minutes for this set of Teach Backs.



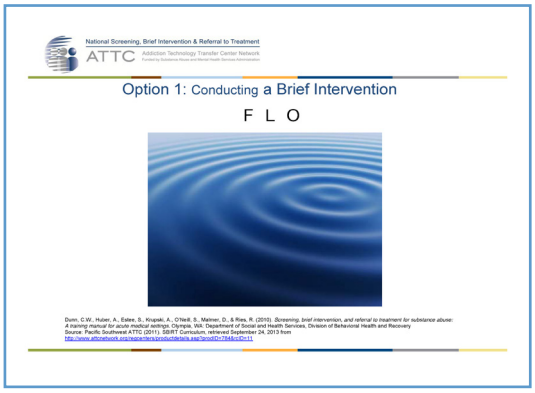
118. TRAINER NOTE:

Now we are going to discuss brief interventions, and present in detail 4 options for conducting a Brief Intervention. As we discuss each of these models, notice the similarities and differences in each approach.



119. TRAINER NOTE:

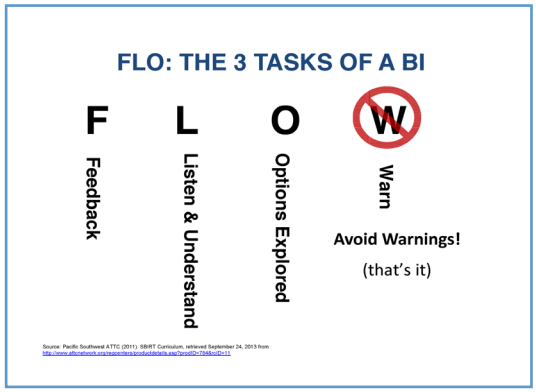
Here are 4 models used to describe how brief interventions can be done. They contain similar elements but are expressed and organized somewhat differently. When doing a training you will select one of the models to explore in more detail. The purpose of this slide is just to let participants know there are several BI models out there.



120. TRAINER NOTE:

Now we are ready to learn how to apply the key Motivational Interviewing concepts in a brief intervention. The trainer may choose to proceed with the FLO model, or select one of the other options instead.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



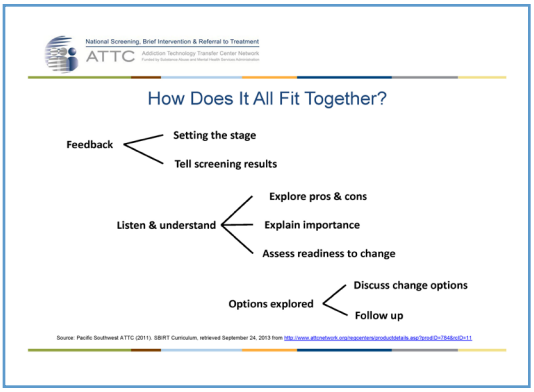
121. TRAINER NOTE:

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!"

The FLO model condenses the main elements of brief interventions in three easy steps.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



122. TRAINER NOTE:

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.

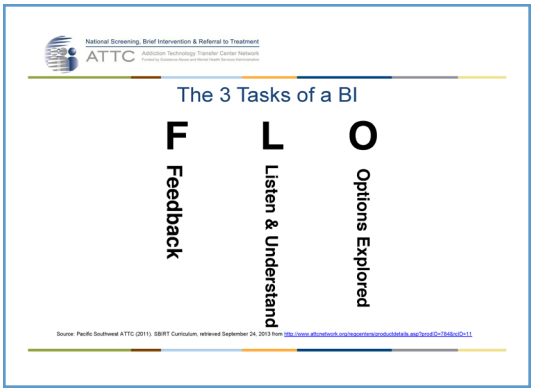
Click to animate in the second step

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.

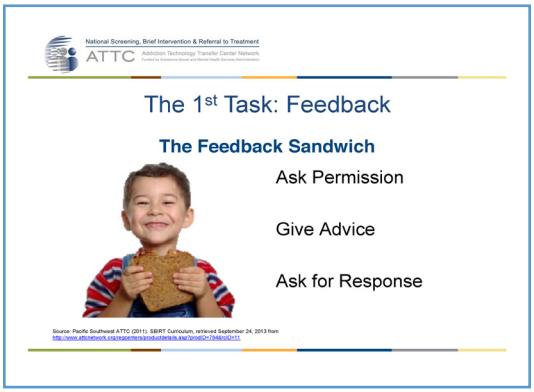
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



123. TRAINER NOTE:

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

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

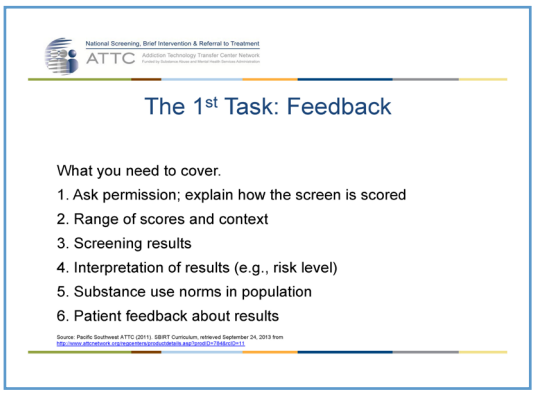


124. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



125. TRAINER NOTE:

Click to animate in Item 1

Once you have permission, you start by helping the patient understand the scoring for the instrument.

Click to animate in Item 2

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

Click to animate in Item 3

Then, give the score

Click to animate in Item 4

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

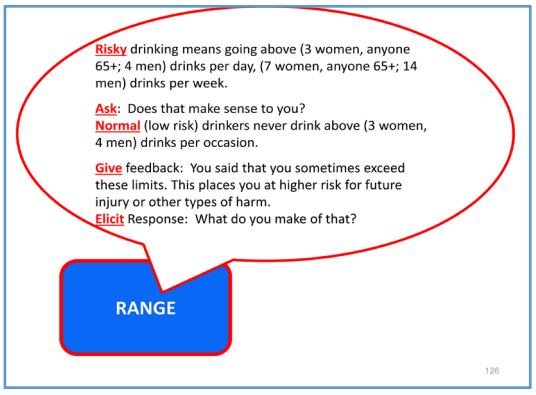
Click to animate in Item 5

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.

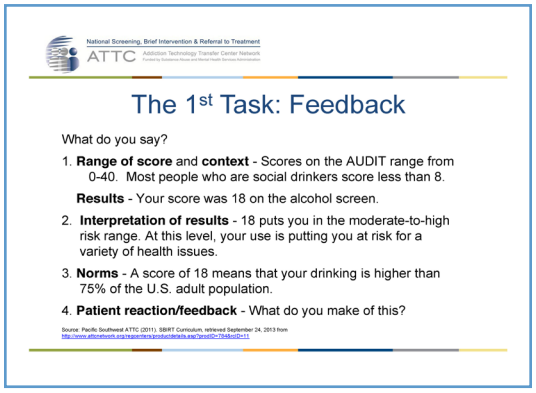
Click to animate in Item 6

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

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



126. TRAINER NOTE:

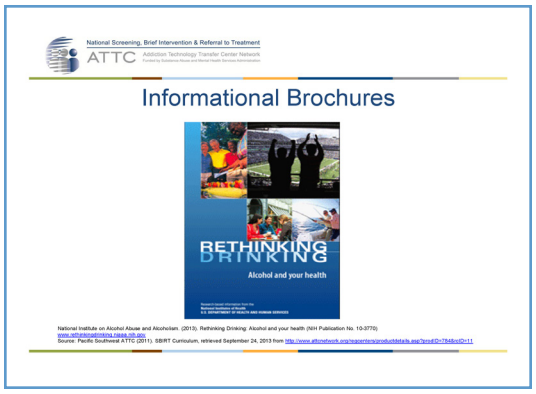


127. TRAINER NOTE:

Here are other examples of what we might 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.

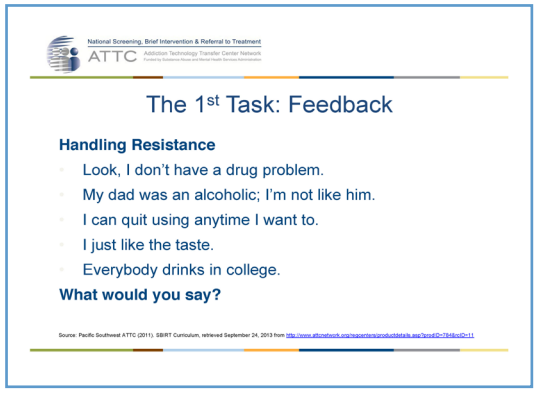
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



128. TRAINER NOTE:

When you share information about the score and health effects, it can be helpful to offer the patient an informational brochure to take home with them. This brochure can be obtained in bulk for free from the NIAAA.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



129. TRAINER NOTE:

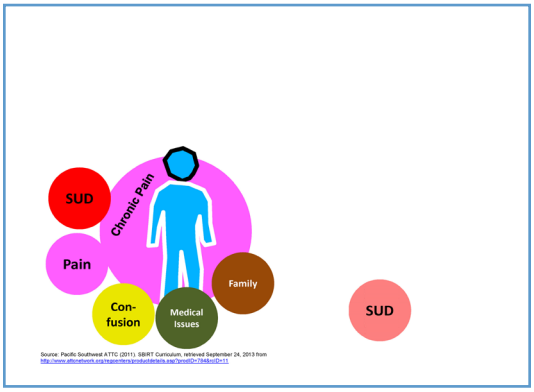
It is possible that you will encounter resistance after giving a patient some initial feedback. This is often the case when patients are using a good deal of alcohol and/or drugs and may feel a bit defensive about it.

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



130. TRAINER NOTE:

NOTE: This slide contains complex animation and it is important to practice with this slide ahead of time to ensure that you understand how the animation works.

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."

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

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-induced hyperalgesia, you state, "Part of the problem with your pain is that you take too many opioids."

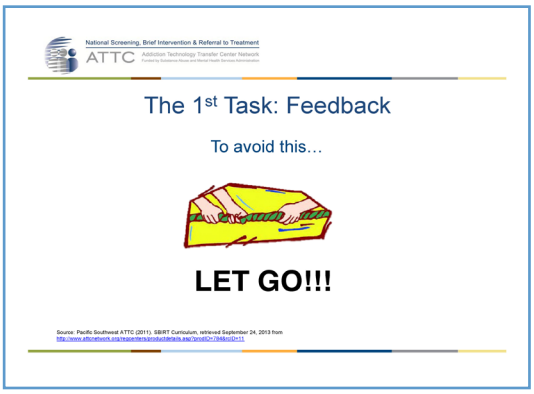
Click to advance animation

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.

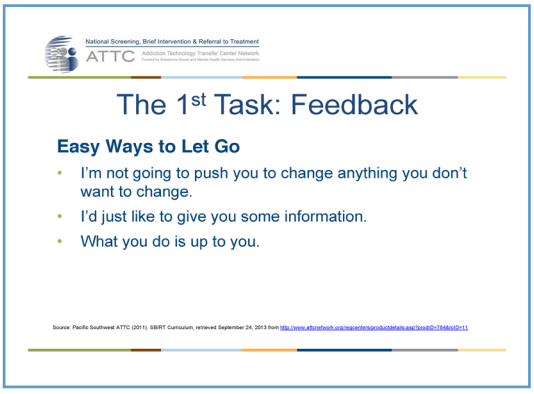


131. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

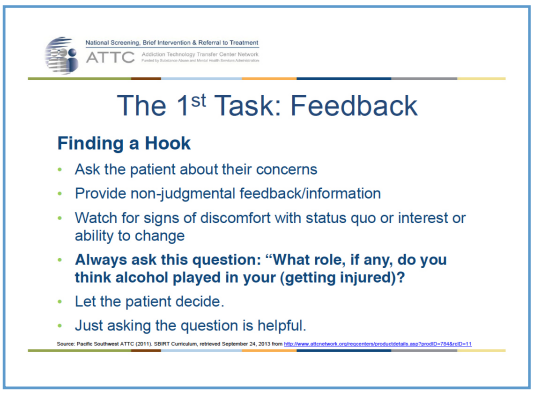


132. TRAINER NOTE:

How do we let go?

We can present the screening information as a means of providing the best care for our patients and let the patients decide what to do with the information. We can say, "I'd like to give you some information that concerns your health. What you do with this is entirely up to you." If you stick to the objective information at hand—the screening results—you can keep your personal judgment out of the picture.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



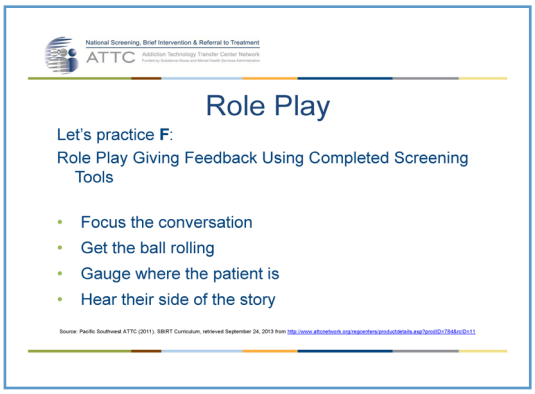
133. TRAINER NOTE:

When we elicit feedback about the screening results, we want to listen intently for a hook or a piece of information that we can use to leverage "change talk."

Ways that we can find the hook include asking the patient about his or her concerns and watching for signs of discomfort with the status quo. For example, a college student may share that partying and drinking a lot is expected when you belong to a fraternity or sorority. The student may have some concerns about keeping up with his or her brothers or sisters because the partying can interfere with studying.

Always ask the 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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



134. TRAINER NOTE:

Now we are going to practice giving feedback—just the Feedback portion of FLO using the sample AUDIT that is in your folder. 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 (18) at the top.

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.

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

SBIRT Role Play Scenarios

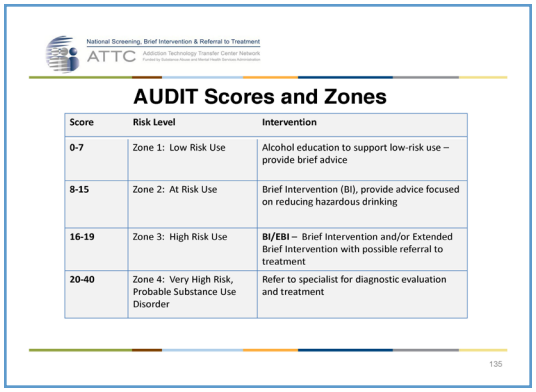
Chris Sanchez - The Man

You are a 40 year old divorced father of 2 boys, age 9 and 7. You have your own catering business, which is struggling. You have high blood pressure, feel stressed and have bouts of depression from time to time. You are mostly a beer drinker, but occasionally add hard liquor to the mix. You find that drinking is both a social activity and a stress reducer. However, it has had some negative effects on your work and your relationship with your sons and your ex-wife. You have driven after drinking on more than one occasion but have never been arrested for DUI. Your doctor is concerned about your stress and how it is affecting your blood pressure, so he recommended some counseling to address your stress and depression.

Chris Sanchez - The Woman

You are a 38 year old married mother of 3 children between the ages of 7 and 11. You have a part-time job as a waitress, working 24 hours a week. Your husband drives a bus for the local transit authority and works a variety of shifts. You have a lot of stress balancing the needs of your family with your work, and you experience occasional bouts of depression. You drink mostly wine at home to relax but enjoy a "night out with the girls" when you get the chance. You often find it difficult to get up in the morning to get your kids off to school. Your husband has sometimes complained about your drinking, which makes you angry, since he drinks too. Your doctor recently diagnosed you with early stage type 2 diabetes. He recommended that you get some counseling to help you deal better with your stress and depression.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



135. TRAINER NOTE:

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 zone 3. 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/she drinks between 15 and 20 drinks per week, and 5 or more drinks on at least 1 day per week, his/her 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.

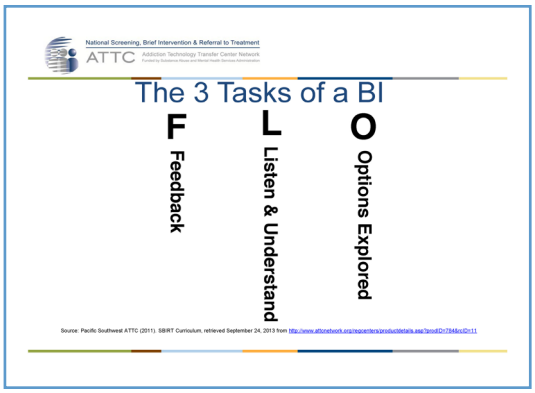
All you are doing here is asking permission to share the results, giving feedback, and asking for the patient's views. Listen for Chris's concerns and find the hook that will allow you to continue the conversation. Once you do that you are done with "F".

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.

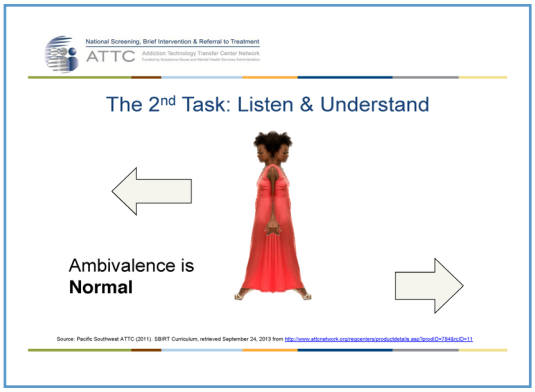
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



136. TRAINER NOTE:

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

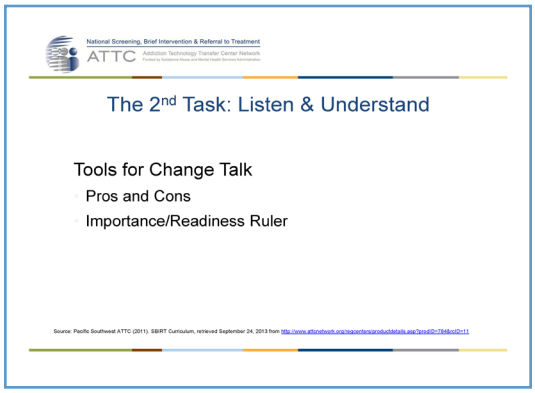
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



137. TRAINER NOTE:

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.

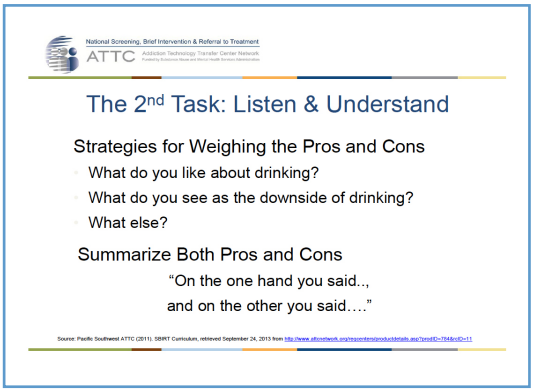
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



138. TRAINER NOTE:

We'll now look at effective tools to get the conversation going: identifying pros and cons and using a readiness ruler.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



139. TRAINER NOTE:

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?

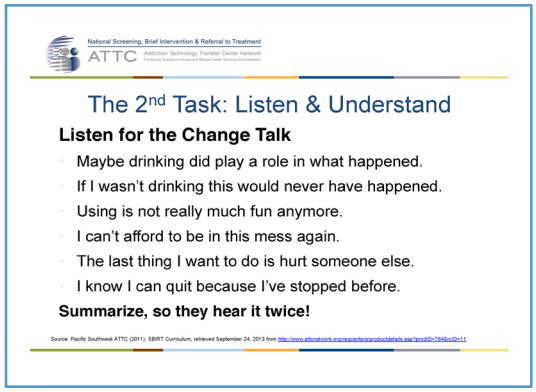
When you hear ambivalence in their remarks, reflect it using a double sided-reflection.

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



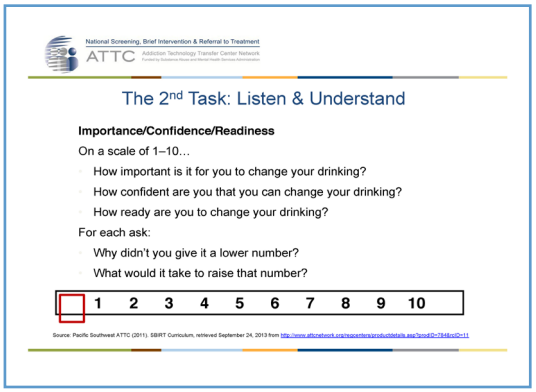
140. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



141. TRAINER NOTE:

Another tool is the importance, 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 use 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.

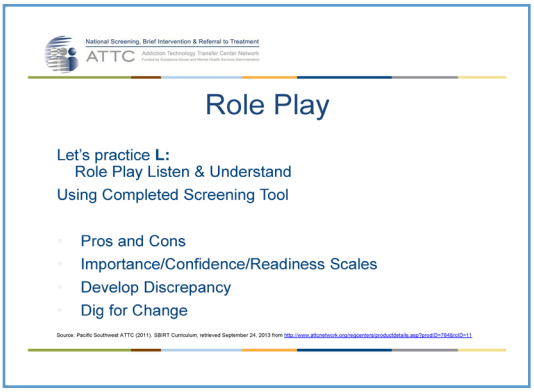
Show the patient the ruler and ask him or her, "On a scale of 1 to 10, with 1 being not at all ready and 10 very ready, how ready are you to… change your drinking/work on your relationship/try another strategy for your pain, whatever you think the issue is they want to talk about. Only focus on one issue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

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

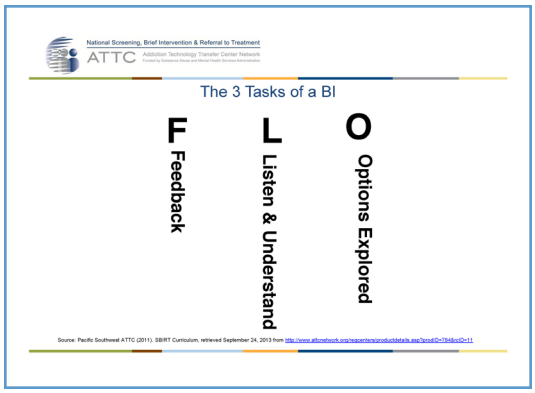


142. TRAINER NOTE:

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 the F role play. 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.

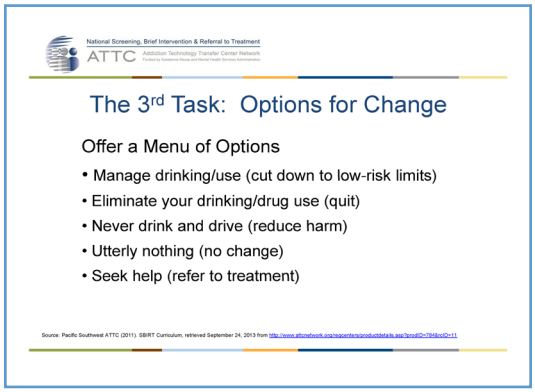
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



143. TRAINER NOTE:

Now, we will move to the Options Explored step.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

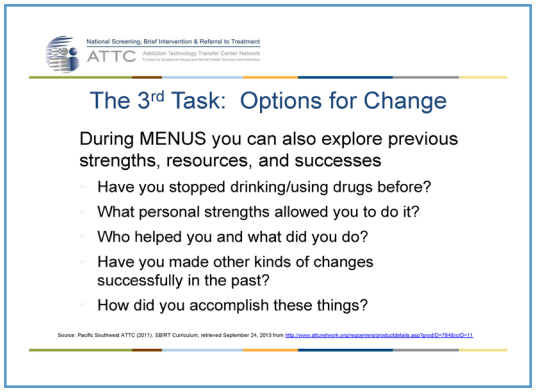


144. TRAINER NOTE:

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?

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

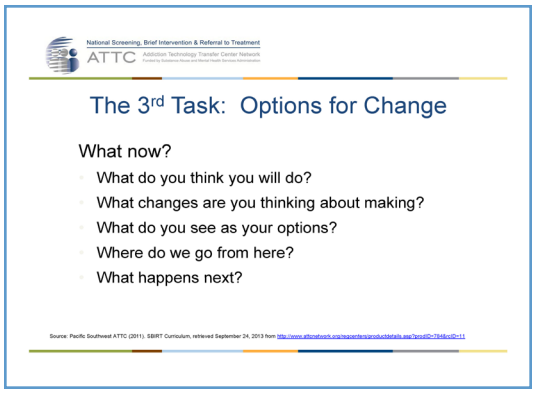


145. TRAINER NOTE:

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.

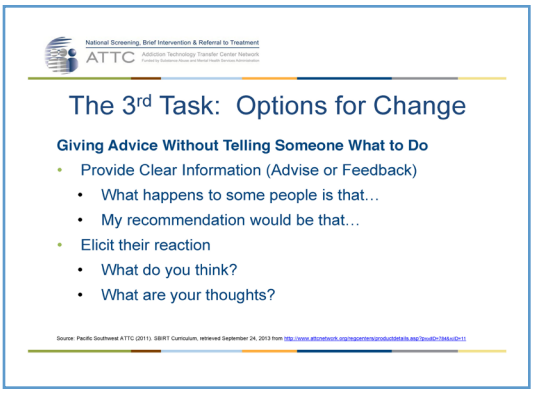
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



146. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



147. TRAINER NOTE:

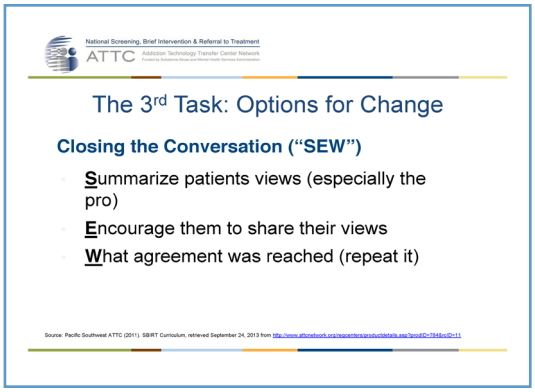
There are ways of giving advice without telling someone what do to.

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.

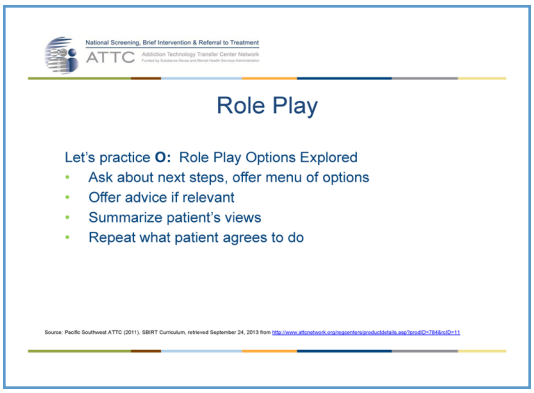
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



148. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

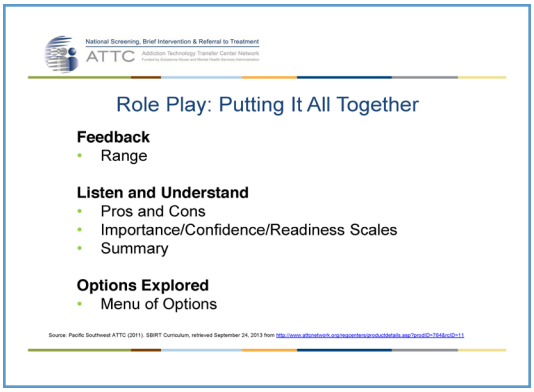


149. TRAINER NOTE:

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.*

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

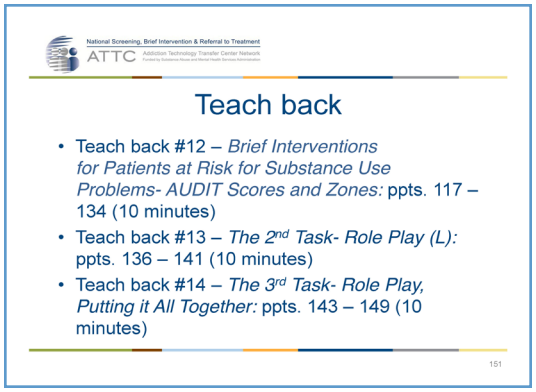


150. TRAINER NOTE:

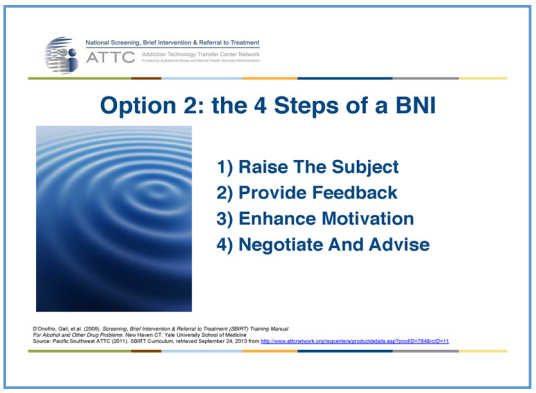
Now we are going to role play the full FLO, but we are going to switch roles with our partners. The person playing the patient will now be the clinician or counselor. Start again with the AUDIT score and go through the feedback, listen and understand, and options explored. Let's take 10 to 15 minutes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

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



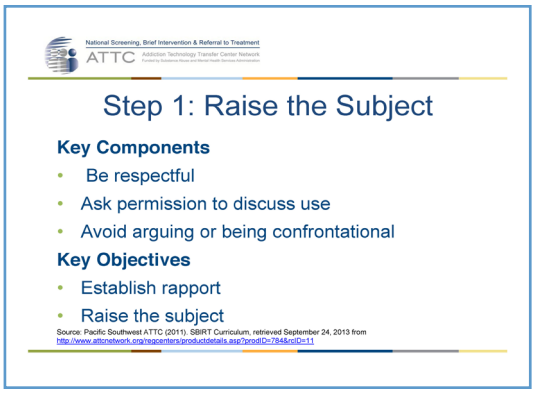
151. TRAINER NOTE:



152. TRAINER NOTE:

This model is called the 4 Steps of the Brief Negotiation Interview (adapted from and related to the BNI Algorithm). It consists of 4 easy to remember steps which serve as a guide to the practitioner when conducting a brief intervention. We will discuss the steps and then practice them.

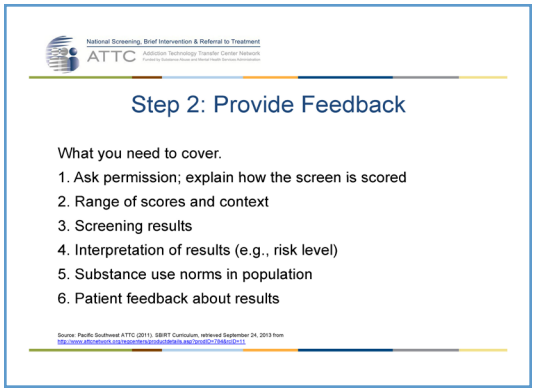
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



153. TRAINER NOTE:

Establishing rapport right from the beginning is important. Respectfully raise the subject of alcohol or drug use by asking the patient's permission. Avoid confrontation or judgmental statements. Stress that you are raising the subject in order to help the patient consider making healthier lifestyle choices. If you are working in a healthcare setting, link the discussion to health related issues that may be negatively effected by risky drinking or drug using behavior.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



154. TRAINER NOTE:

Click to animate in Item 1

Once you have permission, you start by helping the patient understand the scoring for the instrument.

Click to animate in Item 2

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

Click to animate in Item 3

Then, give the score

Click to animate in Item 4

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

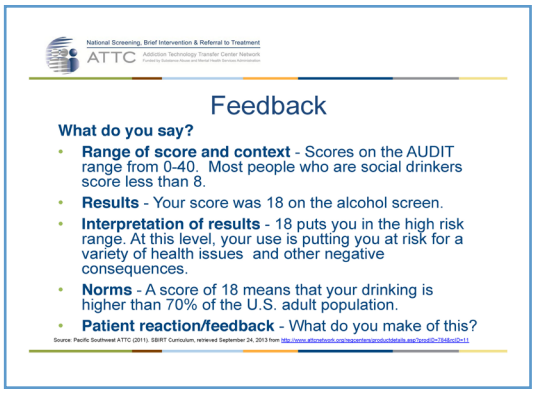
Click to animate in Item 5

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.

Click to animate in Item 6

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

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

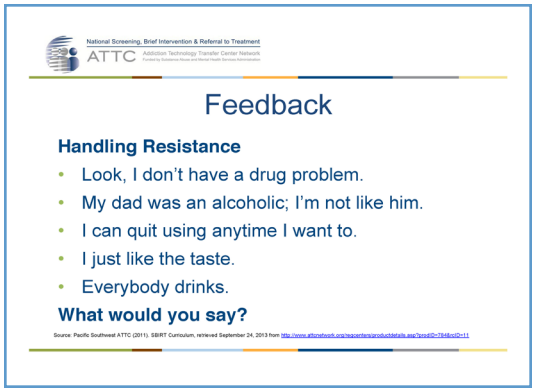


155. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



156. TRAINER NOTE:

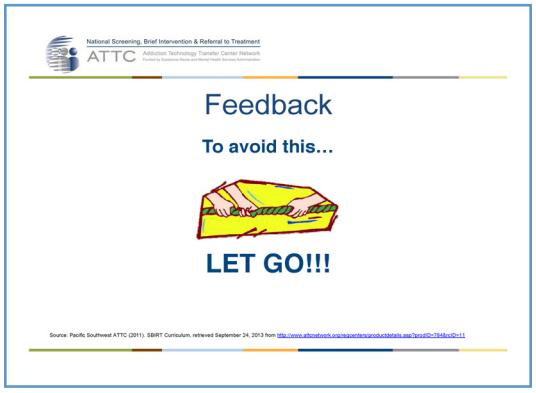
It is possible that you will encounter resistance after giving a patient some initial feedback. This is often the case when patients are using a good deal of alcohol and/or drugs and may feel a bit defensive about it.

Here are some examples of what patients may say to you. For example, "I don't have a drug problem." "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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

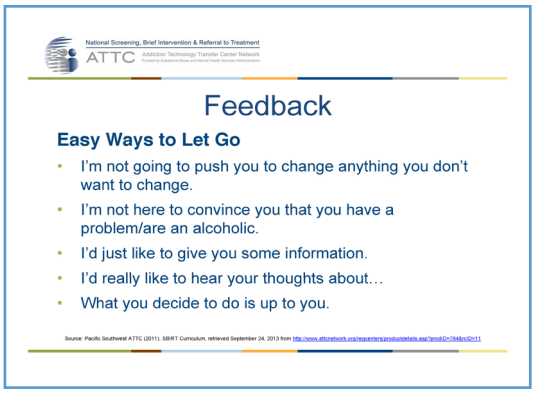


157. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

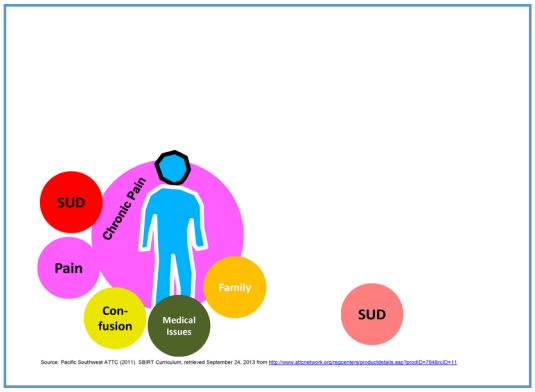


158. TRAINER NOTE:

How do we let go?

We can present the screening information as a means of providing the best care for our patients and let the patients decide what to do with the information. We can say, "I'd like to give you some information that concerns your health. What you do with this is entirely up to you." If you stick to the objective information at hand—the screening results—you can keep your personal judgment out of the picture.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



159. TRAINER NOTE:

NOTE: This slide contains complex animation and it is important to practice with this slide ahead of time to ensure that you understand how the animation works.

Here is an example of a typical conversation in which we can easily get in a power struggle with the patient over. 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-induced hyperalgesia, you state, "Part of the problem with your pain is that you take too many opioids."

Click to advance animation

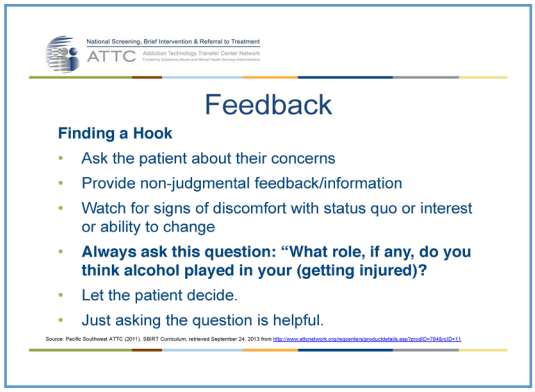
You and the patient continue this chase. This does not help you get to the substance use issue, nor does it help the patient deal with her pain.

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



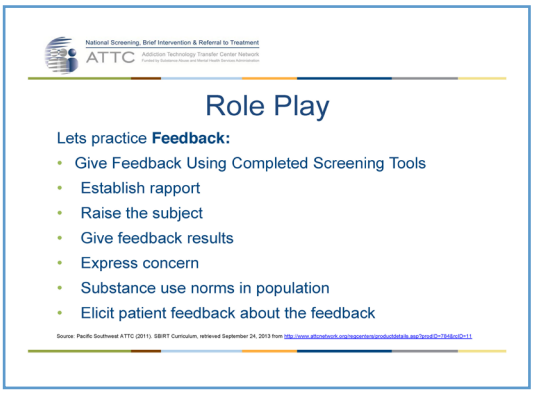
160. TRAINER NOTE:

When we elicit feedback about the screening results, we want to listen intently for a hook or a piece of information that we can use to leverage "change talk."

Ways that we can find the hook include asking the patient about his or her concerns and watching for signs of discomfort with the status quo. For example, a college student may share that partying and drinking a lot is expected when you belong to a fraternity or sorority. The student may have some concerns about keeping up with his or her brothers or sisters because the partying can interfere with studying.

Always ask the 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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



161. TRAINER NOTE:

Now we are going to practice giving Feedback using the sample AUDIT that is in your folder. 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 (18) at the top. 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.

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

SBIRT Role Play Scenarios:

Chris Sanchez: The Man

You are a 40 year old divorced father of 2 boys, age 9 and 7. You have your own catering business, which is struggling. You have high blood pressure, feel stressed and have bouts of depression from time to time. You are mostly a beer drinker, but occasionally add hard liquor to the mix. You find that drinking is both a social activity and a stress reducer. However, it has had some negative effects on your work and your relationship with your sons and your ex-wife. You have driven after drinking on more than one occasion but have never been arrested for DUI. Your doctor is concerned about your stress and how it is affecting your blood pressure, so he recommended some counseling to address your stress and depression.

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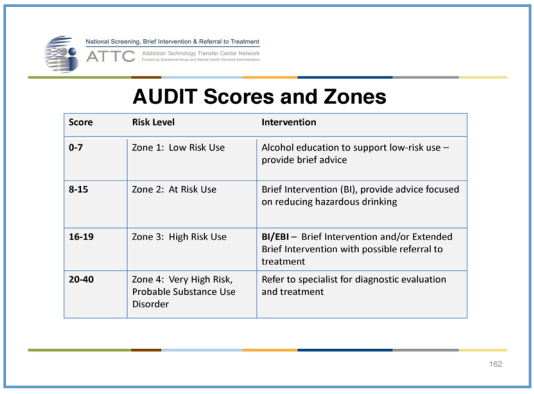
161. CONTINUED:

Chris Sanchez: The Woman

You are a 38 year old married mother of 3 children between the ages of 7 and 11. You have a part-time job as a waitress, working 24 hours a week. Your husband drives a bus for the local transit authority and works a variety of shifts. You have a lot of stress balancing the needs of your family with your work, and you experience occasional bouts of depression. You drink mostly wine at home to relax but enjoy a "night out with the girls" when you get the chance. You often find it difficult to get up in the morning to get your kids off to school. Your husband has sometimes complained about your drinking, which makes you angry, since he drinks too. Your doctor recently diagnosed you with early stage type 2 diabetes. He recommended that you get some counseling to help you deal better with your stress and depression.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



162. TRAINER NOTE:

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 zone 3. 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/she drinks between 15 and 20 drinks per week, and 5 or more drinks on at least 1 day per week, his/her 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.

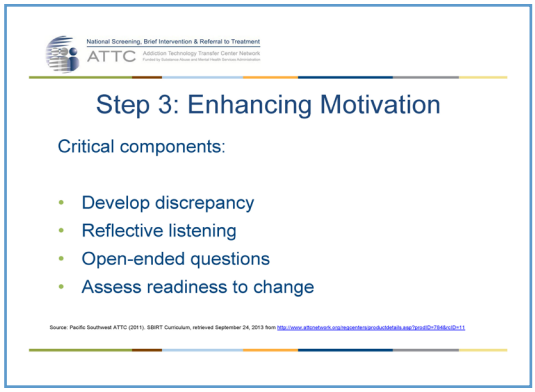
All you are doing here is asking permission to share the results, giving feedback, and asking for the patient's views. Listen for Chris's concerns and find the hook that will allow you to continue the conversation. Once you do that you are done with "F".

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.

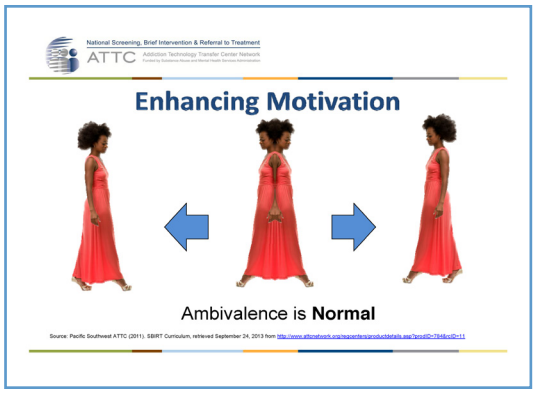
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



163. TRAINER NOTE:

Motivation for change starts to develop when the patient begins to think about why their current choices to use alcohol or drugs may have a downside.

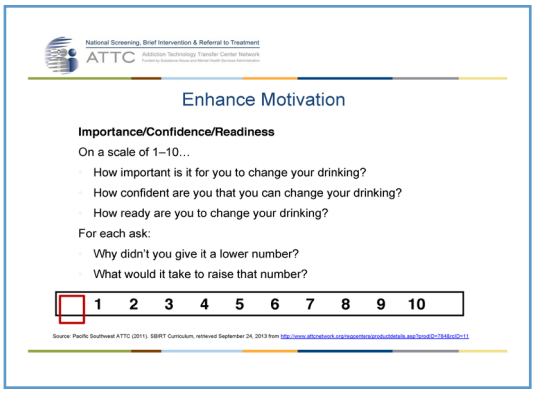
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



164. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



165. TRAINER NOTE:

Another tool is the importance, 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 use 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.

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.

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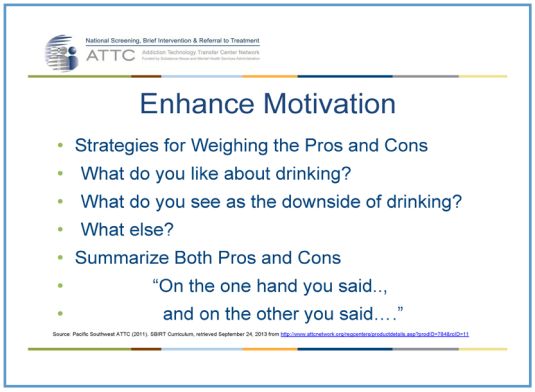
165. CONTINUED:

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.

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



166. TRAINER NOTE:

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?

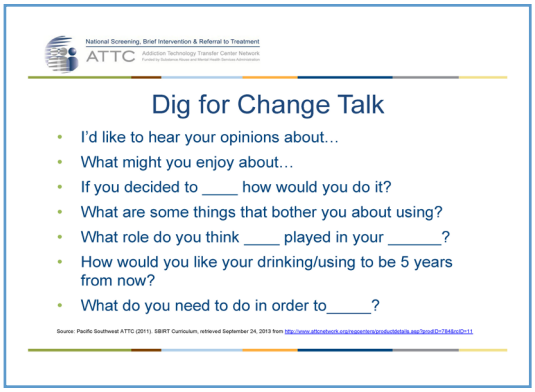
When you hear ambivalence in their remarks, reflect it using a double sided-reflection.

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

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



167. TRAINER NOTE:

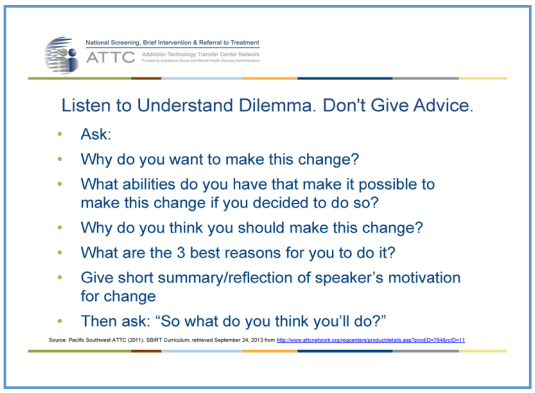
167

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



168. TRAINER NOTE:

Guide the patient in a discussion of why it would be useful for them to consider making changes to reduce their risk. At the end of the discussion, be sure to ask "So what do you think you will do?"

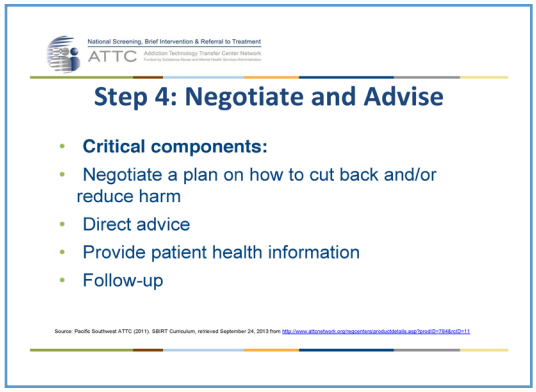
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

169. TRAINER NOTE:

Now we are going to role play Enhance Motivation. You want to pick up where you left off with the Feedback step and start exploring the reasons why a patient might want to make risk-reducing changes. Ask the patient what they think they will do, offer advice if relevant, and summarize patient's views.

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



170. TRAINER NOTE:

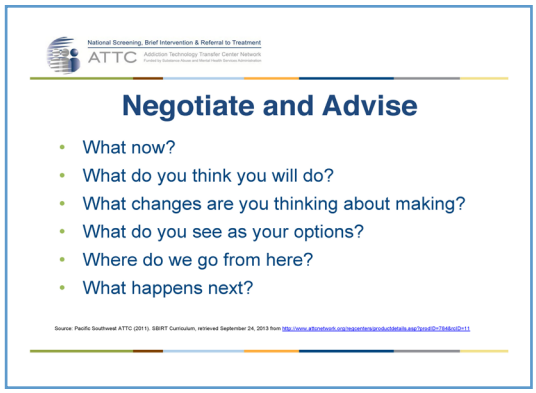
This is a critical step. We want to make sure that the patient develops a realistic change plan that they can commit to and implement. We can give advice in this step, but the plan must be articulated by the patient. They have to own the plan and feel they have a chance to succeed. Even if the plan moves only slightly in the direction of healthy change you can endorse the plan as a good "first step", while stating that, in your opinion, greater change would be preferable.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

171. TRAINER NOTE:

You can think of the "advice sandwich" approach: Ask permission first, then give your advice, and lastly ask for a response to the advice.

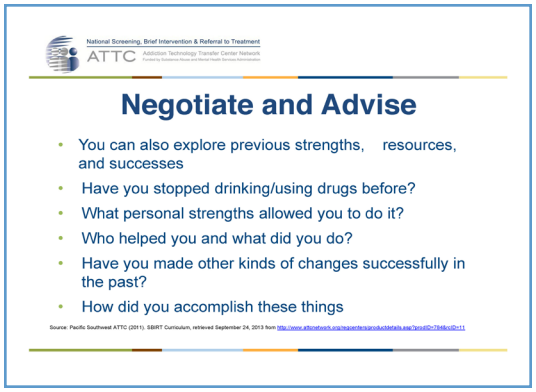
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



172. TRAINER NOTE:

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. Your job is to give patients the opportunity to think through and articulate the changes they are willing to make.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



173. TRAINER NOTE:

You can ask 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. This can also help the patient build their confidence that they are capable of making healthy changes.

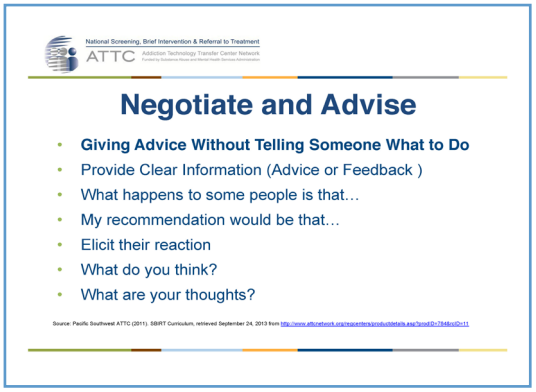
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

174. TRAINER NOTE:

The goal here 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?

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



175. TRAINER NOTE:

There are ways of giving advice without telling someone what do to.

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.”

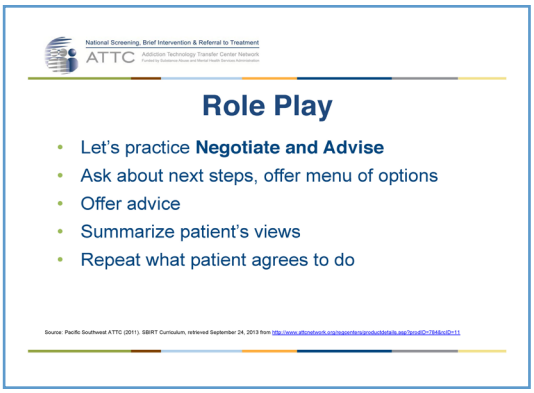
Then, if we ask the patient for their feedback, we allow the patient to feel in control and that he or she is smart enough to figure this out.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

176. TRAINER NOTE:

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. It can also be helpful to have the patient write down the change plan they have articulated, as a way of setting up a kind of contract with themselves to follow through.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



177. TRAINER NOTE:

Now we are going to role play Negotiate and Advise. You want to pick up where you left off with Enhance Motivation 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. Make sure the steps the patient agrees to take are realistic and that the patient shows a commitment to taking them. Writing the plan down can be a useful exercise. 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.

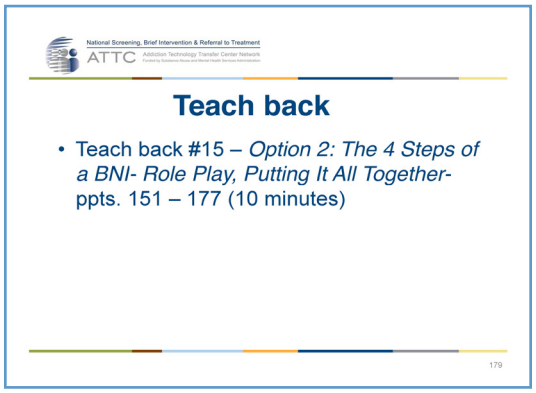
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

178. TRAINER NOTE:

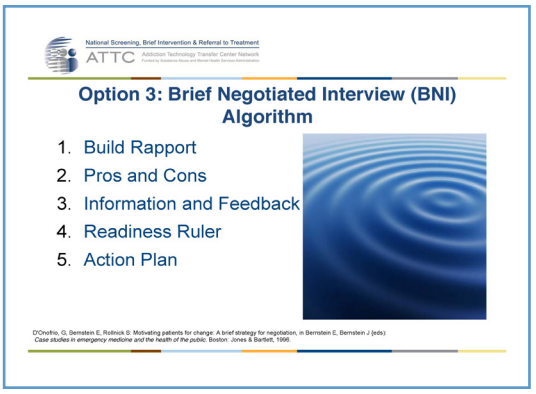
Now we are going to role play the 4 Steps, but we are going to switch roles with our partners. The person playing the patient will now be the clinician or counselor. Start again with the AUDIT score and go through the feedback, listen and understand, and options explored. Let's take 10 to 15 minutes 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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



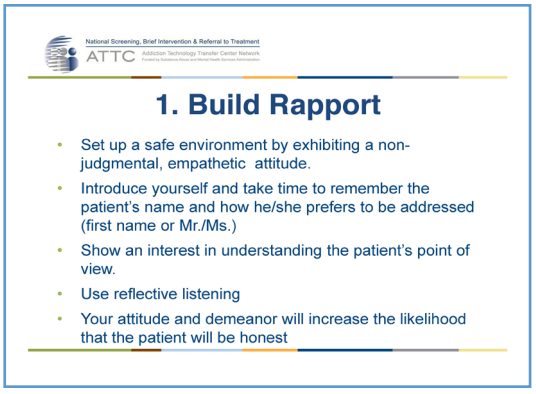
179. TRAINER NOTE:



180. TRAINER NOTE:

The BNI Algorithm helps health care providers explore health behavior change with patients in a respectful, non-judgmental way within a finite time period. Instead of telling the patient what changes he/she should make, the BNI is intentionally designed to elicit reasons for change and action steps from the patient. It gives the patient voice and choice, making any potential behavior changes all the more empowering to the patient. The handout section includes the BNI-ART "Brief Intervention and Referral: Adult Interview Scoring Sheet". This form can be used by an observer if you break the group into 3s instead of 2s for the role plays, or participants can use it back at their work sites as part on the SBIRT implementation process.

Image Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



181. TRAINER NOTE:

Building rapport is very important to this model. Say to the patient something like: "Help me understand what life is like for you- what do you do on a typical day?" Showing interest in the patient's perspective is a way of showing respect and letting the patient know that you are not there to judge them.

182. TRAINER NOTE:

Let's do a brief role play, practicing building rapport. Remember that the goal is to "join" the patient, letting them you know that you are on their side as they begin to consider the need for making healthy changes. Be aware of your own body language and demeanor as you practice building rapport. If you are relaxed and welcoming it puts the patient at ease and encourages them to be more open and honest. The patient's name is Chris Sanchez (there is a man and a woman scenario), with a previously filled in AUDIT with a score of 18.

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.

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.

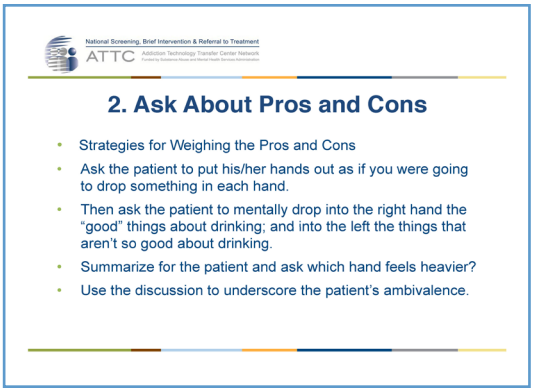
SBIRT Role Play Scenarios

CHRIS SANCHEZ: THE MAN

You are a 40 year old divorced father of 2 boys, age 9 and 7. You have your own catering business, which is struggling. You have high blood pressure, feel stressed and have bouts of depression from time to time. You are mostly a beer drinker, but occasionally add hard liquor to the mix. You find that drinking is both a social activity and a stress reducer. However, it has had some negative effects on your work and your relationship with your sons and your ex-wife. You have driven after drinking on more than one occasion but have never been arrested for DUI. Your doctor is concerned about your stress and how it is affecting your blood pressure, so he recommended some counseling to address your stress and depression.

CHRIS SANCHEZ: THE WOMAN

You are a 38 year old married mother of 3 children between the ages of 7 and 11. You have a part-time job as a waitress, working 24 hours a week. Your husband drives a bus for the local transit authority and works a variety of shifts. You have a lot of stress balancing the needs of your family with your work, and you experience occasional bouts of depression. You drink mostly wine at home to relax but enjoy a "night out with the girls" when you get the chance. You often find it difficult to get up in the morning to get your kids off to school. Your husband has sometimes complained about your drinking, which makes you angry, since he drinks too. Your doctor recently diagnosed you with early stage type 2 diabetes. He recommended that you get some counseling to help you deal better with your stress and depression.



183. TRAINER NOTE:

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, etc.). 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. It also gives the patient the opportunity to talk out loud about the downsides about using and to assess for themselves whether these negative consequences outweigh the positives they have listed. Developing discrepancy- or ambivalence- is an important step on the way to change.

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?

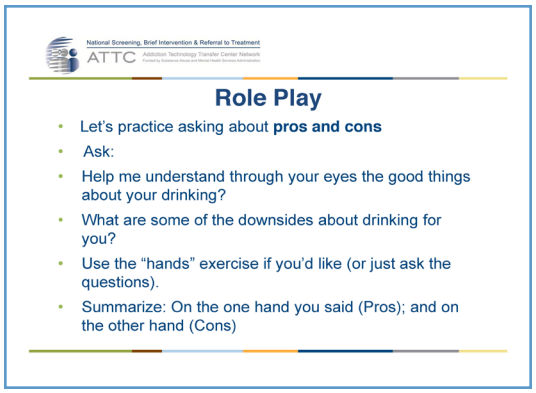
You want to push the limits of the conversation.

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.

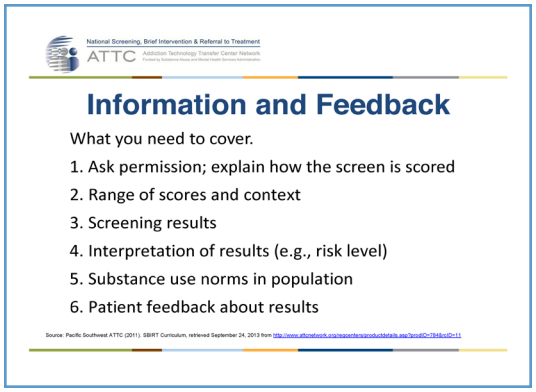
On the one hand you like…; on the other hand… You want to reflect both sides of the statement to highlight the patient's ambivalence. It can be helpful with some patients to ask them to extend their hands, palms up. As they name the positive and negative things about their drinking they can imagine each thing as an object being dropped into one hand or the other. At the end of the exercise, ask the patient which hand feels heavier.



184. TRAINER NOTE:

Building on "building rapport", let's see if we can get the patient to begin to weigh the pros and cons of current behavior and of change behavior.

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.



185. TRAINER NOTE:

Click to animate in Item 1

Once you have permission, you start by helping the patient understand the scoring for the instrument.

Click to animate in Item 2

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

Click to animate in Item 3

Then, give the score

Click to animate in Item 4

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

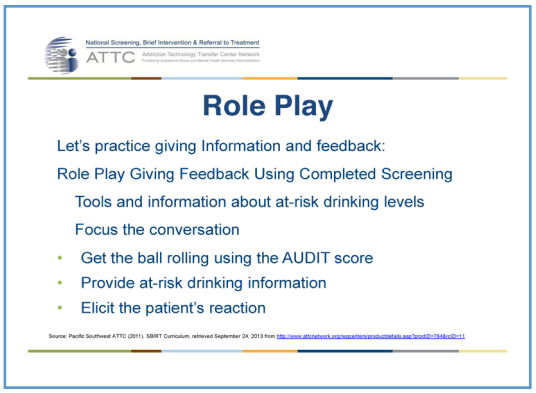
Click to animate in Item 5

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.

Click to animate in Item 6

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

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

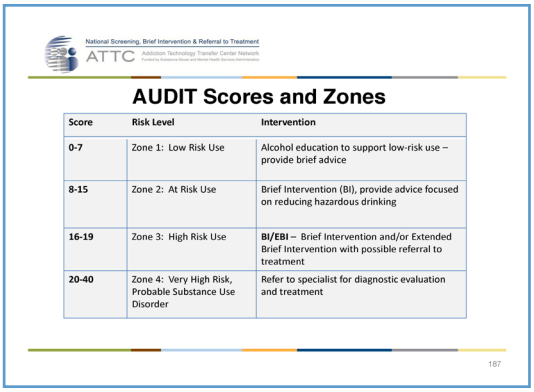


186. TRAINER NOTE:

Now we are going to practice giving feedback and information—using the sample AUDIT that is in your folder, and informing the patient about at-risk drinking levels (for men- no more than 4 drinks per day/14 drinks per week; for women and anyone 65+- no more than 3 drinks per day/7drinks per week). Be sure to include information about what a "standard drink" is. The patients name is Chris and can be a man or a woman. The AUDIT has been filled out for you and you will see the score (18) at the top.

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

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



187. TRAINER NOTE:

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 zone 3. 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/she drinks between 15 and 20 drinks per week, and 5 or more drinks on at least 1 day per week, his/her 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.

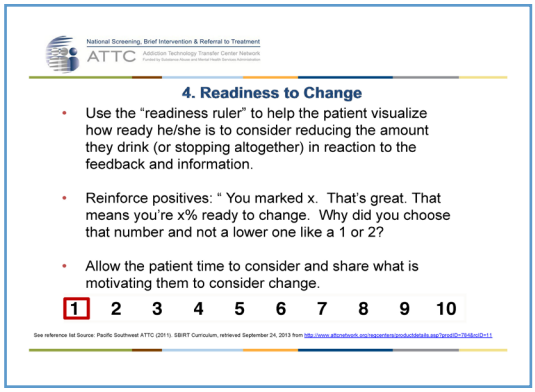
All you are doing here is asking permission to share the results, giving feedback, and asking for the patient's views. Listen for Chris's concerns and find the hook that will allow you to continue the conversation. Once you do that you are done with "F".

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



188. TRAINER NOTE:

The readiness ruler is 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.

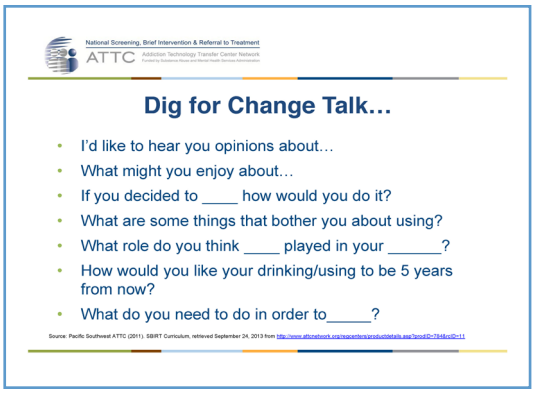
Show the patient the ruler and ask him or her, "On a scale of 1 to 10, with 1 being not at all ready and 10 very ready, how ready are you to… change your drinking/work on your relationship/try another strategy for your pain, whatever you think the issue is they want to talk about. Only focus on one issue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

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



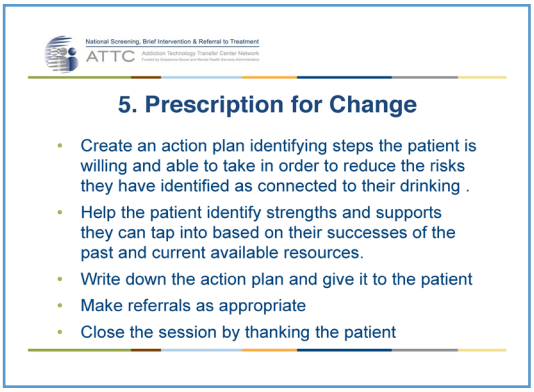
189. TRAINER NOTE:

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

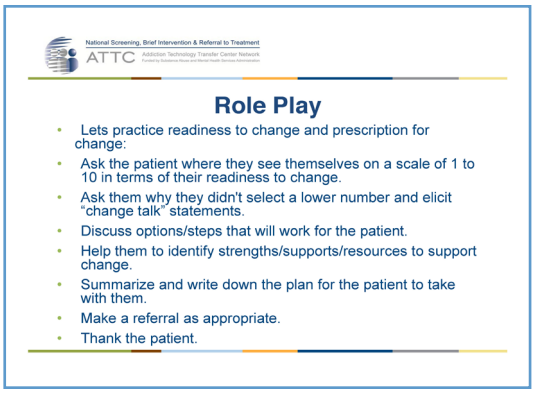
When you hear change talk, summarize for the patient what you are hearing because this will shine a mirror on the patient's thought pattern and help to increase their awareness.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



190. TRAINER NOTE:

The Prescription for Change is the culmination of the BNI. With guidance, the patient develops and writes down a plan of action designed to reduce their risky behaviors related to their use of drugs and alcohol. The plan should be realistic to the patient's situation and one that the patient feels a level of confidence that they can implement.



191. TRAINER NOTE:

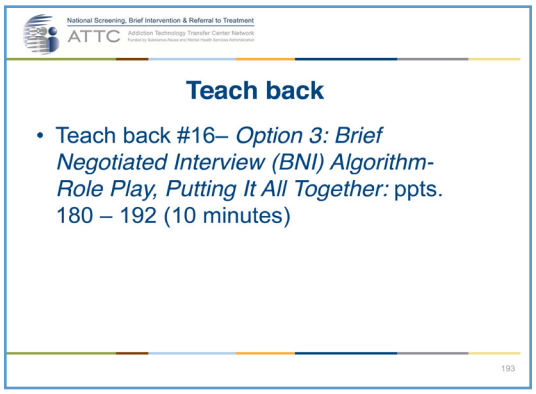
Let's do a role play to practice help the patient assess their readiness to change and to develop a set of action steps they are willing and able to take to move in the direction of reducing their risk. Be sure to write down the plan.

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.

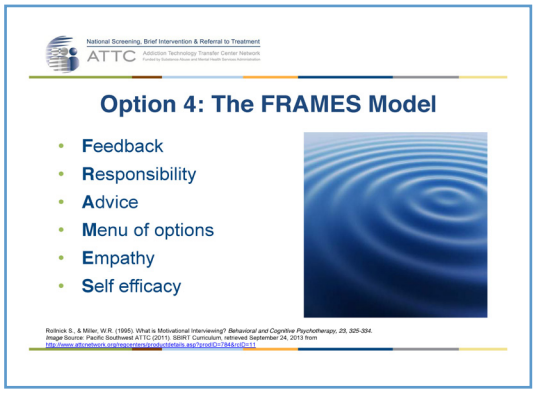
192. TRAINER NOTE:

Now we are going to role play the full BNI Algorithm, but we are going to switch roles with our partners. The person playing the patient will now be the clinician or counselor. Start with building rapport and use the AUDIT score (18) for feedback and the readiness ruler to assess the patient's readiness to change. 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.



193. TRAINER NOTE:

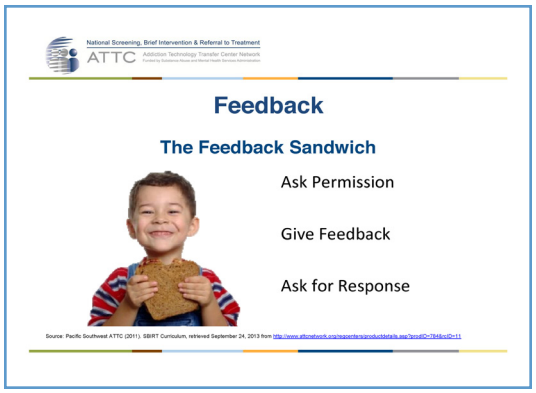


194. TRAINER NOTE:

This model, originally developed by Stephen Rollnick and William Miller, is a helpful outline to follow when conducting a brief intervention. It can be used to help the patient move toward developing a plan for reducing risky behaviors that they can commit to. It is based on the principles of Motivational Interviewing.

Rollnick S., & Miller, W.R. (1995). What is Motivational Interviewing? Behavioral and Cognitive Psychotherapy, 23, 325-334.

Image Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

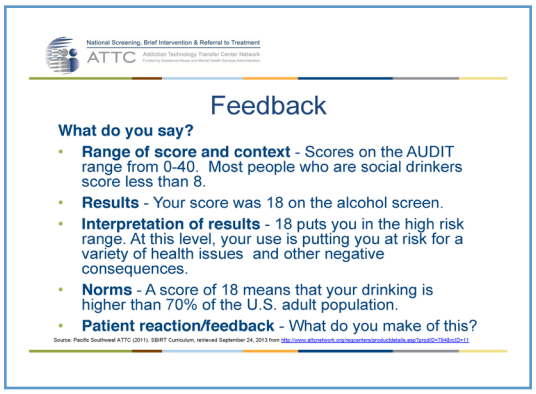


195. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

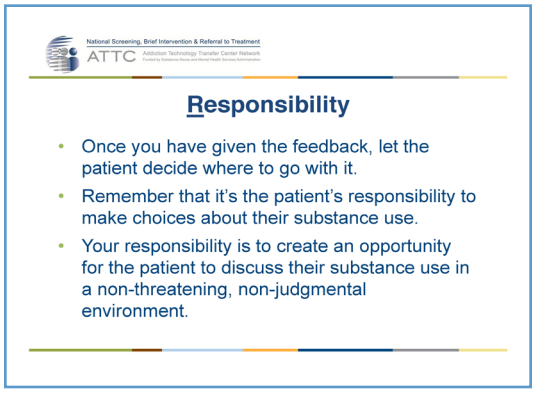


196. TRAINER NOTE:

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.

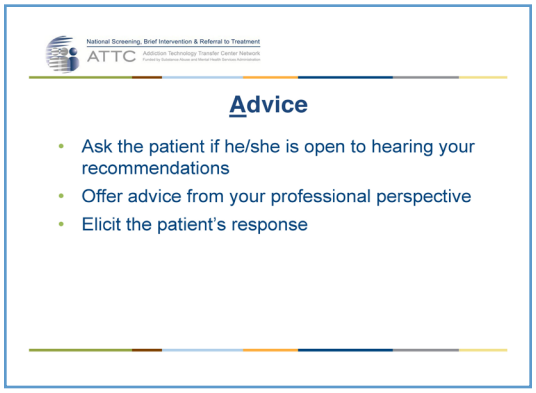
Read each bullet and provide an opportunity for discussion.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



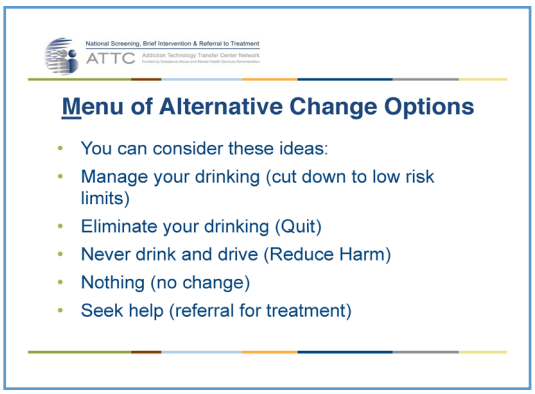
197. TRAINER NOTE:

Responsibility emphasizes that the patient is ultimately in control of the steps toward change they are willing to take. This takes the onus of responsibility from the practitioner and places it on the patient, but it can also increase the patient's trust level since they understand that they are not being forced to do anything they are not prepared to do.



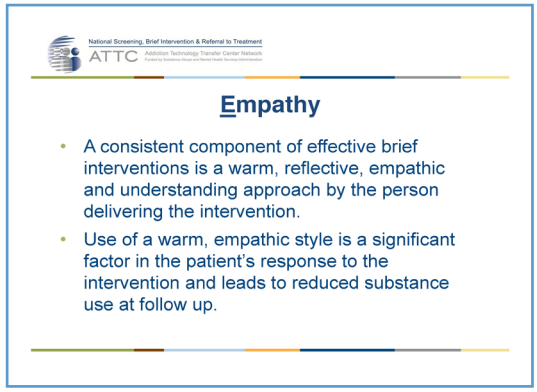
198. TRAINER NOTE:

Here the practitioner can give the patient advice and help them to develop options that can work for them. The advice can be direct, but not forced on the patient. The atmosphere should not be confrontational. In the end, the plan for change that emerges will be the patient's plan.



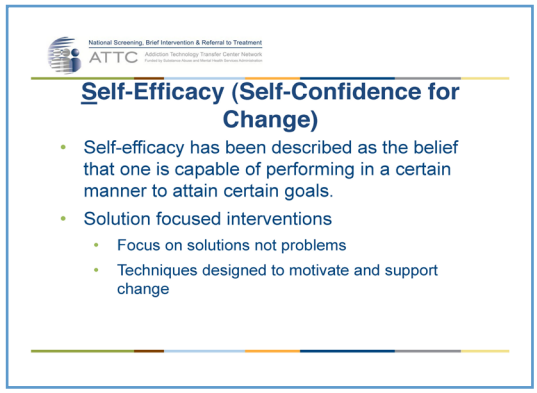
199. TRAINER NOTE:

Use of the "MENU" approach can help guide the patient to make healthier choices. Harm reduction choices can be included, especially if the patient is not ready to cut down or stop using. The "menu" approach can also help the patient to realistically assess their situation and choose changes that they can actually make.



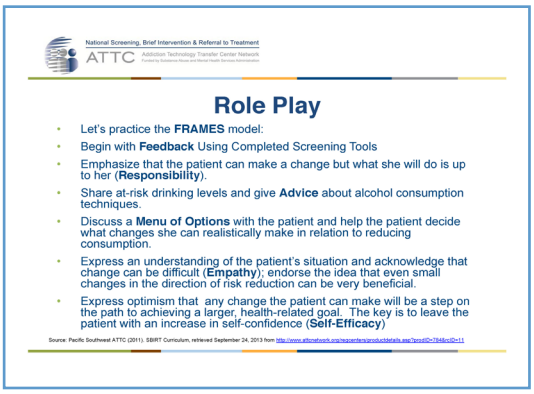
200. TRAINER NOTE:

The whole intervention is conducted with an empathetic approach. The practitioners style is positive, non-judgmental and encouraging- never preachy or confrontational.



201. TRAINER NOTE:

Elicit and reinforce self-motivating statements and encourage to patient to reflect on past success to enhance their confidence that they can make the changes that they have committed to. Make sure you end the session with a plan of action that is consistent with the patient's readiness to change.



202. TRAINER NOTE:

Now we are going to role play the FRAMES model. Form pairs. One person should play the clinician or counselor and one the patient. 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 (18) at the top. Start with Feedback using the AUDIT score. Let's take 10 to 15 minutes to run through this.

Allow 10-15 minutes 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.

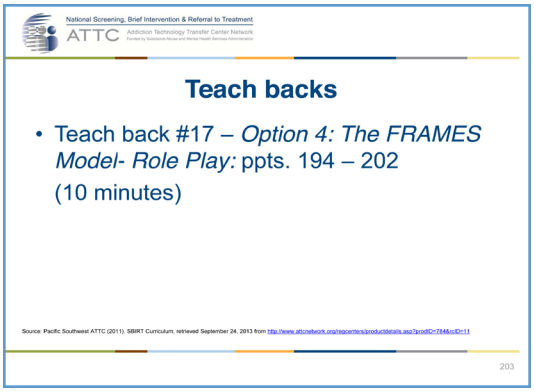
CHRIS SANCHEZ: THE MAN

You are a 40 year old divorced father of 2 boys, age 9 and 7. You have your own catering business, which is struggling. You have high blood pressure, feel stressed and have bouts of depression from time to time. You are mostly a beer drinker, but occasionally add hard liquor to the mix. You find that drinking is both a social activity and a stress reducer. However, it has had some negative effects on your work and your relationship with your sons and your ex-wife. You have driven after drinking on more than one occasion but have never been arrested for DUI. Your doctor is concerned about your stress and how it is affecting your blood pressure, so he recommended some counseling to address your stress and depression.

CHRIS SANCHEZ: THE WOMAN

You are a 38 year old married mother of 3 children between the ages of 7 and 11. You have a part-time job as a waitress, working 24 hours a week. Your husband drives a bus for the local transit authority and works a variety of shifts. You have a lot of stress balancing the needs of your family with your work, and you experience occasional bouts of depression. You drink mostly wine at home to relax but enjoy a "night out with the girls" when you get the chance. You often find it difficult to get up in the morning to get your kids off to school. Your husband has sometimes complained about your drinking, which makes you angry, since he drinks too. Your doctor recently diagnosed you with early stage type 2 diabetes. He recommended that you get some counseling to help you deal better with your stress and depression.

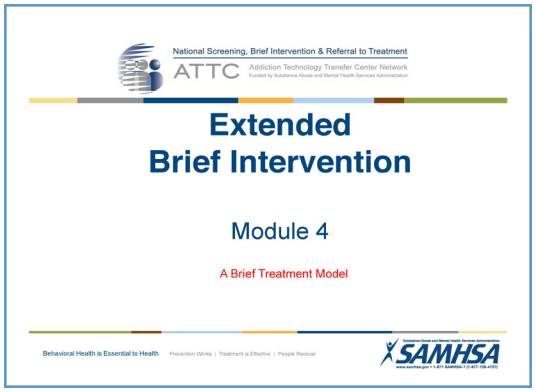
Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



203. TRAINER NOTE:

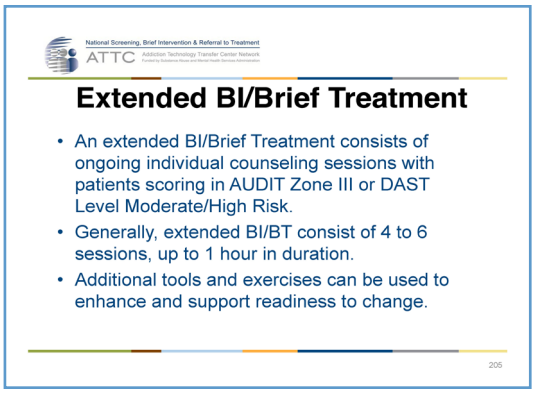
Elicit and reinforce self-motivating statements and encourage to patient to reflect on past success to enhance their confidence that they can make the changes that they have committed to. Make sure you end the session with a plan of action that is consistent with the patient's readiness to change.

MODULE FOUR:
Extended Brief Intervention



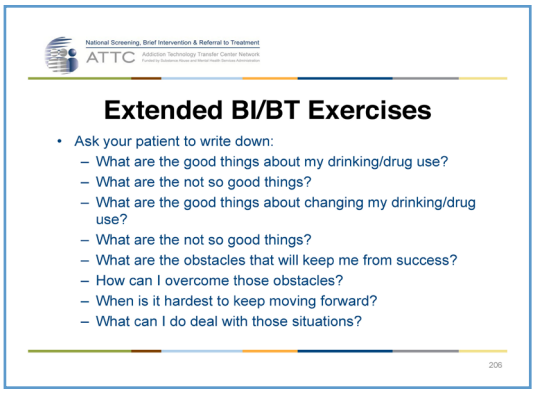
204. TRAINER NOTE:

Practitioners can deliver extended risk-reduction interventions through multiple sessions of motivational counseling termed Extended Brief Intervention (or Brief Treatment). These sessions may also help a more seriously at-risk patient consider whether to seek further evaluation and treatment.



205. TRAINER NOTE:

An extended BI or Brief Treatment is a longer session, using MI skills to assist the patient in achieving behavioral change goals by providing ongoing support. This gives the patient the chance to review their change plans, clarify successes or errors, and make adjustments as needed.

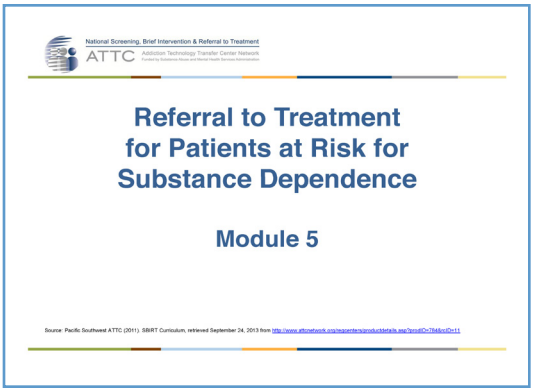


206. TRAINER NOTE:

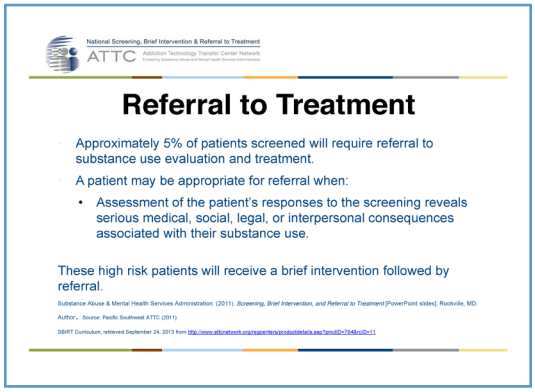
These are some additional exercises the you can use with patients during longer, multiple sessions. These exercises help raise the patient's conscious awareness of their own feelings, needs, barriers, and limitations.

MODULE FIVE:

Referral to Treatment for Patients at Risk for Substance Dependence



207. TRAINER NOTE:

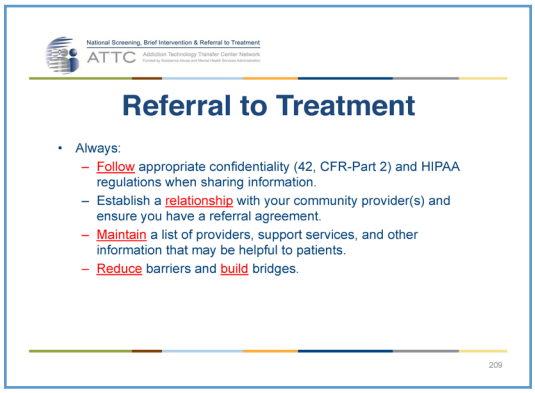


208. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



209. TRAINER NOTE:

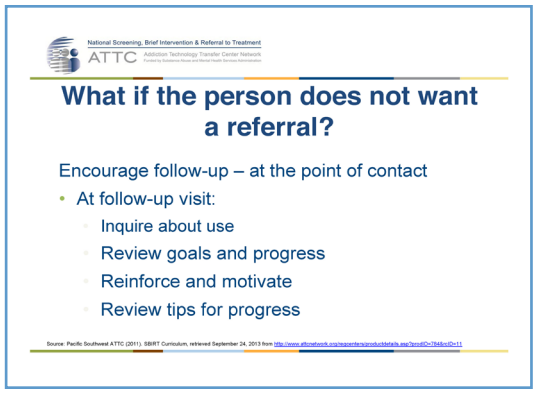
This is an area where most substance use professionals have existing expertise. Encourage dialogue with the participants about their experience, how referrals function in their community, how they have developed relationships and reduced barriers to patient admission.

210. TRAINER NOTE:

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.

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.
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.
3. There are several things we can do to facilitate the hand-off:
   - call around to find a facility with availability, call to make the appointment for the patient before he or she leaves your office,
   - give the patient directions to the facility, and
   - 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.
4. Ask the participants if they know of other referral strategies that are helpful.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11



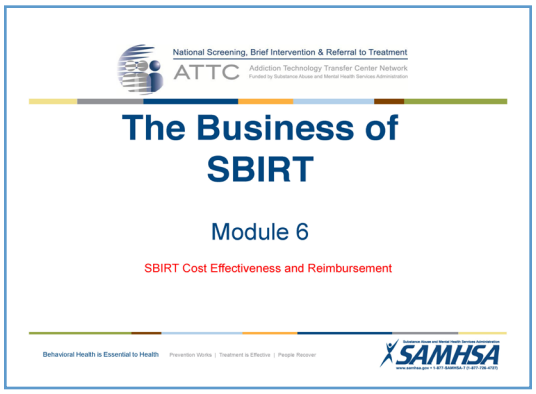
211. TRAINER NOTE:

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.

Source: Pacific Southwest ATTC (2011). SBIRT Curriculum, retrieved September 24, 2013 from http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=784&rcID=11

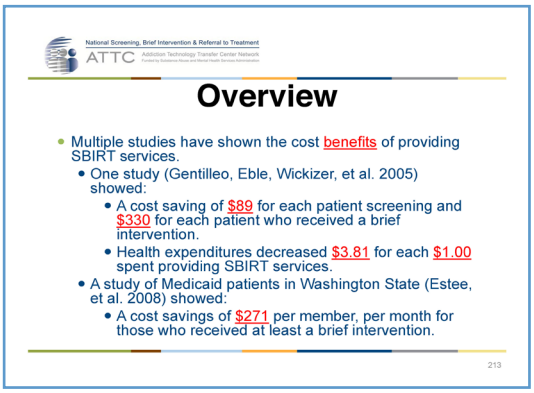
MODULE SIX:

The Business of SBIRT: Understanding Reimbursement for Services



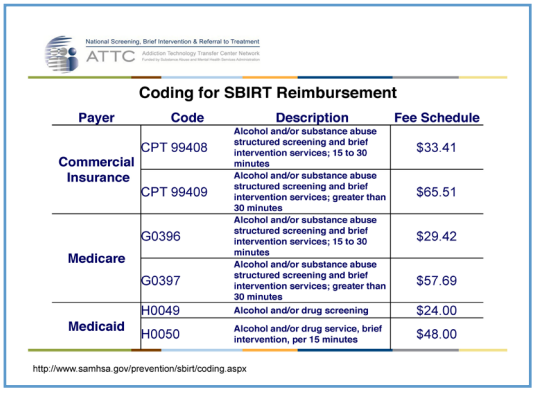
212. TRAINER NOTE:

SBIRT services are reimbursable in some states. This module will provide a general overview of the billing and reimbursement process.



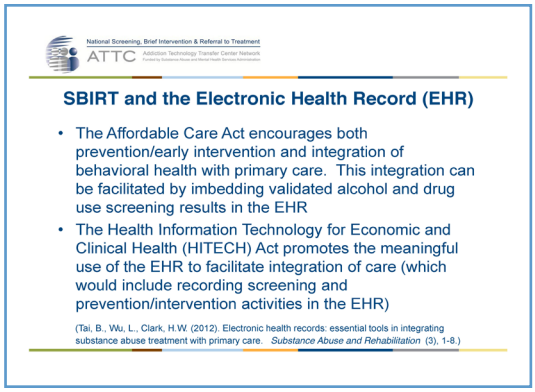
213. TRAINER NOTE:

SBIRT is an evidence-based practice that have been shown to reduce costs to third party payers as a result of reduced trauma recidivism and improved health care outcomes.



214. TRAINER NOTE:

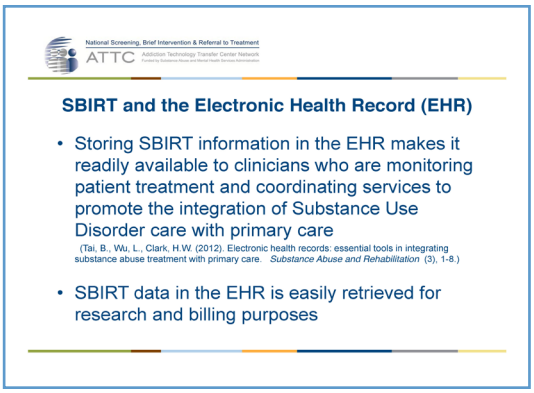
SBIRT billing codes are in place for commercial insurance, Medicare and Medicaid. However, these codes are not active ("turned on") in all states or with all commercial insurers. Check locally to see the status of the SBIRT billing codes in a given state, or go to http://ireta.org/sbirt-reimbursement-map.



215. TRAINER NOTE:

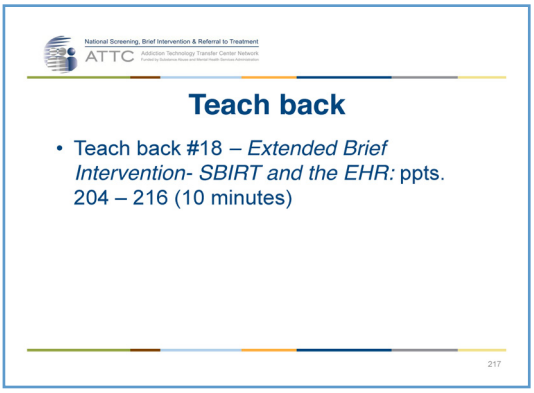
Making the screen and the brief intervention part of the EHR can insure that the provider will be prompted to ask the screening questions to begin with. This will make it more likely that screening will occur on a regular basis and that the information will be gathered and stored so that the appropriate intervention can be conducted by the appropriate clinician.

As the Affordable Care Act continues to advance with an emphasis on adoption of electronic health records it is important to document Screening and Brief Interventions in the HER.



216. TRAINER NOTE:

As the Affordable Care Act continues to advance with an emphasis on adoption of electronic health records it is important to document Screening and Brief Interventions in the EHR to help insure the integration of substance use information and risk-reduction intervention with other primary care activities. Additionally, as SBIRT billing becomes more routine it will be easier to retrieve the information for billing purposes.

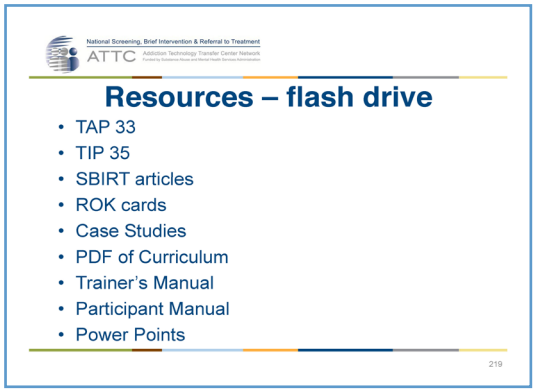


217. TRAINER NOTE:

218. TRAINER NOTE:

This is an opportunity for participants to go back a teach a section of the curriculum they may want more practice.

Allow participants to choose from any of the #1-18 teach backs.



219. TRAINER NOTE:

220. TRAINER NOTE:

This slide contains animation when clicked on a second time.

MODELS

(ALSO AVAILABLE AS INDIVIDUAL SLIDE SETS)

APPENDICES AND HANDOUTS

SAMPLE 2.5 DAY AGENDA

Day 1 - 8 hours total	6 hours of coursework
Day 2 – 8 hours total	6 hours of coursework
Day 3 – 3.5 hours total	3 hours 15 minutes of coursework
Total 2.5 Day Training	**15 hours of coursework**

National Screening, Brief Intervention and Referral to Treatment (SBIRT) ATTC Training of Trainers

AGENDA

Day 1 – Morning	8:30	Welcome, Introductions, Icebreaker
		Review of Objectives
		Review of Agenda
	9:45	Break
	10:00	Module 1: Re-conceptualizing Our Understanding of Substance Use Problems
	11:30	Teach Backs (3)
	12:00	Lunch (on your own)
Day 1 – Afternoon	1:00	Module 2: Screening: Redefining the Identification of Substance Abuse Problems
	2:30	Break
	2:45	Teach Backs (3)
	3:15	Screening Role Plays
	4:15	Wrap-up Day 1, Discuss Day 2
	4:30	Adjourn
Day 2 – Morning	8:30	Module 3: Redesigning How We Treat Substance Use Problems
	9:30	Teach Backs (5)
	10:30	Break
	10:45	Option 1: The FLO model (with 4 role plays)
	12:00	Lunch (on your own)
Day 2 – Afternoon	1:00	Teach Back (1)
	1:15	Option 2: The 4 Steps of a BNI (with 4 role plays)
	2:45	Teach Back (1)
	3:00	Break
	3:15	Option 3: BNI Algorithm (with 5 role plays)
	4:00	Teach Back (1)
	4:15	Wrap-up Day 2, Discuss Day 3
	4:30	Adjourn
Day 3 – Morning	8:30	Option 4: The FRAMES Model (with 1 role play)
	9:15	Teach Back (1)
	9:30	Extended BI/Brief Treatment
		Referral to Treatment
		The Business of SBIRT
	9:45	Teach Back (1)
	10:00	Break
	10:15	Teach Backs
	11:30	Final Question, Comments, Concerns
		GPRA
	12:00	Adjourn

DEVELOPING A 9 HOUR (1-1/2 DAY) AGENDA

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SUGGESTED SAMPLE 9 HOUR (day and a half) AGENDA

Day One

Welcome (45 Minutes)
- Housekeeping
- Participant Introductions
- Ice Breaker
- Review Agenda and Objectives

Module 1 (60 Minutes)
- Include all slides

Break (15 Minutes)

Module 2 (60 minutes)
- Include all slides
- Review and discuss the AUDIT and DAST in some detail. Discuss how to introduce the screens and ask participants to write up their introductions.

Lunch Break (60 minutes)

Module 2 continued (60 minutes)
- Do and process both the AUDIT and DAST role play only (make sure you emphasize the importance of a good introduction). Discuss other screens from the list on slide 60 as appropriate.

Break (15)

Module 3 (75 Minutes)
- Include all slides, videos, MI techniques practice

Questions and Wrap up Day 1 (30 Minutes)

Day Two

Module 3 continued (60 Minutes for the Role Play exercise)
- Brief review of Module 3 elements from Day One
- Do role play for each BI element and then the "Putting It All Together" role play (for the 9 hour training select either the FLO option or the 4 Step option)

Module 4 (30 Minutes)
- Extended BI/Brief Treatment

Break (15 Minutes)

Module 5 (30 Minutes)
- Referral to Treatment

Module 6 (15 Minutes)
- The Business of SBIRT

Questions and Wrap-up (30 Minutes)

DEVELOPING A 6 HOUR (1 DAY) AGENDA

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SUGGESTED SAMPLE 6 HOUR (full day) AGENDA

NOTE: Don't make edits on the original slide sets. Instead, make a copy and remove the slides as suggested, starting with highest number slide in Module 3 and working your way back. This preserves the slide numbers as you are making your edits. The slide edits suggested here can be a guide, but you may decide to make additional, fewer or different edits as your training situation requires. Please feel free to do so.

Welcome (45 Minutes)
- Housekeeping
- Participant Introductions
- Ice Breaker
- Review Agenda and Objectives

Module 1 (60 Minutes)
- Include all slides

Break (15 Minutes)

Module 2 (45 minutes)
- Include all slides
- Review and discuss the AUDIT and DAST in some detail and other screens briefly.

Lunch Break (60 minutes)

Module 2 continued (30 minutes)
- Do and process the AUDIT role play only (make sure you emphasize the importance of a good introduction).

Module 3 (60 Minutes)
- Remove slides 90, 84, 81, 80, 79, 74

Break (15)

Module 3 continued (30 Minutes for the Role Play exercise)
- If you have selected the FLO or 4 Step option and are running out of time, just do the "Putting It All Together" role play at the end.

Final Sections (30 Minutes)
- Do the "Referral to Treatment" section
- Remove Module 4: "Extended BI/Brief Treatment" and Module 6:"The Business of SBIRT"

Questions and Wrap-up (30 Minutes)

DEVELOPING A 3-4 HOUR (1/2 DAY) AGENDA

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SUGGESTED SAMPLE ½ DAY AGENDA (This sample is based on 3 hours. The FRAMES and BNI Algorithm options contain only 1 role play and are well suited to a 3 hour presentation. If you want to extend the presentation to 4 hours, select the FLO or 4 Step model and use some or all of the additional role plays.)

Note: Don't make edits on the original slide sets. Instead, make a copy and remove the slides as suggested, starting with highest number slide in Module 3 and working your way back. This preserves the slide numbers as you are making your edits. The slide edits suggested here can be a guide, but you may decide to make additional, fewer or different edits as your training situation requires. Please feel free to do so.

Welcome (20 Minutes)
- Housekeeping
- Participant Introductions
- Review Agenda and Objectives

Module 1 (15 Minutes)
- Remove slides 34, 28-26, 18, 16, 8, 6, 3

Module 2 (30 minutes)
- Remove slides 61-55, 49, 47, 43, 42, 39
- Review and discuss the AUDIT and DAST but remove the role plays (slides 65-62)

Break (10 Minutes)

Module 3 (30 Minutes)
- Remove slides 110, 105, 99-96, 91-89, 86, 84, 81, 80, 78, 73, 67

Select a Brief Intervention Option (45 minutes)

Final Sections (15 Minutes)
- Do the "Referral to Treatment" section
- Remove Module 4: "Extended BI/Brief Treatment" and Module 6:"The Business of SBIRT"

Wrap-up and GPRA (15 Minutes)

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization and the Generalitat Valenciana Conselleria De Benestar Social. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.who.org.

Excerpted from NIH Publication No. 11–7805 | www.niaaa.nih.gov/YouthGuide

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Drugs include marijuana, solvents like paint thinners, tranquilizers like Valium, barbiturates, cocaine, stimulants like speed, hallucinogens such as LSD, or narcotics like heroin. Drug use also includes using prescription or over-the-counter medications more than directed.

In the past 12 months…	YES	NO
DA1. Have you used drugs other than those required for medical reasons?	○	○
DA2. Do you abuse more than one drug at a time?	○	○
DA3. Are you unable to stop using drugs when you want to?	○	○
DA4. Have you ever had blackouts or flashbacks as a result of drug use?	○	○
DA5. Do you ever feel bad or guilty about your drug use?	○	○
DA6. Does your spouse (or parents) ever complain about your involvement with drugs?	○	○
DA7. Have you neglected your family because of your use of drugs?	○	○
DA8. Have you engaged in illegal activities in order to obtain drugs?	○	○
DA9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	○	○
DA10. Have you had medical problems as a result of your drug use (such as: memory loss, hepatitis, convulsions, or bleeding)?	○	○
Score 1 point for each question answered "Yes". **TOTAL**		

WASBIRT - PCI - Primary Care Integration, Screening and GPRA Training Manual, Department of Social and Health Services, Research and Data Analysis Division, April 2014.

TEACH BACKS

Teach backs are an essential part of any Training of Trainers and teach backs are indicated throughout the curriculum. It is a good idea to email the entire slide set to participants in advance with a note about which slides they will be responsible for presenting. Be sure to keep participants within the time limits suggested, even if they have not completed all their slides, so there will be enough time for you and the other participants to complete the Teach Back Observation Form as each teach back ends. Make sure each participant does at least one teach back. If there are teach backs left over let others volunteer to do them, as the more practice participants have with the content the more comfortable they will be when they are training others.

TRAINING OBSERVATION FORM

Trainer's Name: _____ Training Topic: _____

Place a ✓ in the appropriate box when responding to the statements and provide any comment, if applicable, in the section provided. Thank you for taking the time to provide this important feedback!

Statement	Agree	Neutral	Disagree	N/A	Additional Comment
The overall experience of the training was engaging.					
Learning Environment					
Created a friendly, safe learning environment.					
Addressed individuals by name.					
Showed respect/sensitivity to diverse learners.					
Responded to distractions effectively, yet constructively.					
Appeared relaxed.					
Used humor positively and appropriately.					
Made eye contact.					
Materials					
Explained purposes of instructional materials.					
Organized materials logically.					
Adapted materials to meet learners' needs.					
Labeled diagrams, charts and maps clearly.					
Allowed learners a sufficient amount of time to view materials.					
Trainer's Presentation Skills					
Captured learners' attention from the start.					
Articulated and enunciates words clearly.					
Projected voice.					
Spoke at an appropriate pace.					
Avoided using "filler" words (um, ah)					
Moved about while speaking.					
Avoided reading continually from notes.					
Responded to changes in learner attentiveness.					
Communicated confidence and enthusiasm about the subject.					
Described main ideas clearly.					
Described terms/concepts/theories in more than one way.					
Related information to prior knowledge.					
Checked frequently for understanding.					
Related information to future, real world application.					

Statement	Agree	Neutral	Disagree	N/A	Additional Comment
Trainer's Facilitation Skills					
Encouraged all learners to participate in discussions equally.					
Intervened when discussion gets off track.					
sked open-ended or divergent questions.					
Solicited and drew upon prior knowledge and experiences.					
Respected constructive criticism.					
Responded to nonverbal cues of confusion, boredom, or curiosity.					
Praised learner contributions.					
Managed time.					
Demonstrated a willingness to admit error and/or insufficient knowledge.					
Paused after asking questions to allow learners time to formulate answers.					
Responded constructively to learners' opinions/contributions.					
Selected training techniques appropriate for the content.					
Promoted learner-centered learning.					
Utilized a variety of training techniques.					
Took into account different learning styles.					
Circulated around the room during activities.					
Gave clear instructions.					
Set specific time limits.					
Took into account learner interests, opinions, and wishes.					
Other - Organization					
Started and ended on time.					
Appeared well-prepared for the training.					

Additional Comments:

What were the trainer's major strengths?

What other suggestions do you have for improving the trainer's skills?

CASE STUDIES

SBIRT ROLE PLAY SCENARIOS

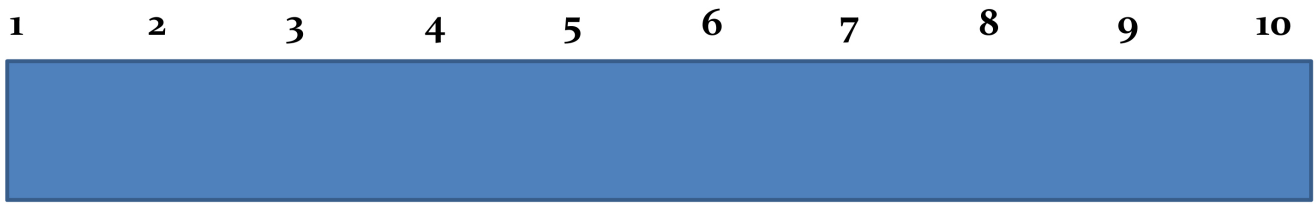
Chris Sanchez - The Man

You are a 40 year old divorced father of 2 boys, age 9 and 7. You have your own catering business, which is struggling. You have high blood pressure, feel stressed and have bouts of depression from time to time. You are mostly a beer drinker, but occasionally add hard liquor to the mix. You find that drinking is both a social activity and a stress reducer. However, it has had some negative effects on your work and your relationship with your sons and your ex-wife. You have driven after drinking on more than one occasion but have never been arrested for DUI. Your doctor is concerned about your stress and how it is affecting your blood pressure, so he recommended some counseling to address your stress and depression.

Chris Sanchez - The Woman

You are a 38 year old married mother of 3 children between the ages of 7 and 11. You have a part-time job as a waitress, working 24 hours a week. Your husband drives a bus for the local transit authority and works a variety of shifts. You have a lot of stress balancing the needs of your family with your work, and you experience occasional bouts of depression. You drink mostly wine at home to relax but enjoy a “night out with the girls” when you get the chance. You often find it difficult to get up in the morning to get your kids off to school. Your husband has sometimes complained about your drinking, which makes you angry, since he drinks too. Your doctor recently diagnosed you with early stage type 2 diabetes. He recommended that you get some counseling to help you deal better with your stress and depression.

Ruler: Readiness, Importance, Confidence



Chris Sanchez

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Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	3
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	2
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	2
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	1
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	1
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	Less than monthly	Monthly	Weekly	Daily or almost daily	1
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	2
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	1
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	0
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	0
					Total	13

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization and the Generalitat Valenciana Conselleria De Benestar Social. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.who.org.

Excerpted from NIH Publication No. 11–7805 | www.niaaa.nih.gov/YouthGuide

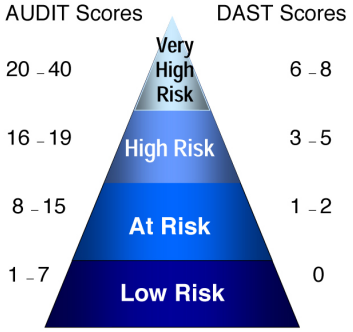
TOOLS & RESOURCES

What is a Standard Drink?

12 oz Beer	8-9 oz Malt Liquor	5 oz Wine	1.5 oz/ 1 shot liquor
			
~5%	~7 %	~12%	~40%

The percent of "pure" alcohol expressed here as alcohol/volume varies by beverage.

Your Risk Level



Lower Risk Drink Limits

	Per Day	Per Week
Healthy Men	4	14
Healthy Women	3	7
Everyone ≥ 65	3	7

No drinking/using if driving, pregnant, possibly dependent or otherwise contraindicated

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

What is a Standard Drink?

12 oz Beer	8-9 oz Malt Liquor	5 oz Wine	1.5 oz/ 1 shot liquor
			
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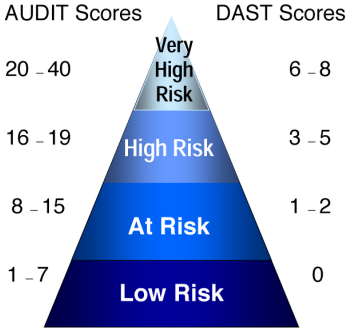
Your Risk Level



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Healthy Women	3	7
Everyone ≥ 65	3	7

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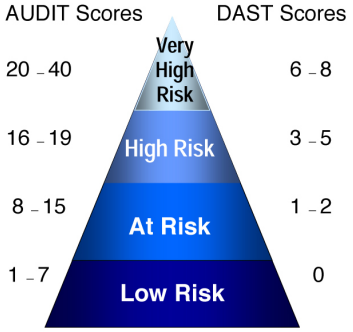

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Healthy Women	3	7
Everyone ≥ 65	3	7

No drinking/using if driving, pregnant, possibly dependent or otherwise contraindicated

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

Job of Brief Interventions:

Raise the Subject: "If it's okay with you, let's take a minute to talk about the screening questions you answered today."

Provide Feedback: "I can tell you that drinking (drug use) at this level can be harmful to your health and possibly responsible for the health problem you came in for today (and/or may interact in a harmful way with your medication)."

Enhance Motivation: "On a scale of 0—10, how ready are you to cut back on your use?"
If > 0: "Why that number and not a __ (lower number)?"
If 0: "Have you never done anything while drinking (using drugs) that you later regretted?"

Negotiate Plan: "What steps can you take to cut back on your use?"
"How would your drinking (drug use) have to impact your like in order for you to start thinking about quitting or cutting back?"

National SBIRT Addiction Technology Transfer Center

National Screening, Brief Intervention & Referral to Treatment
ATTC Addiction Technology Transfer Center Network

Adapted from SBIRT Oregon
http://www.sbirtoregon.org

Funded by:
SAMHSA

Rev. 10/2014

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Funded by:
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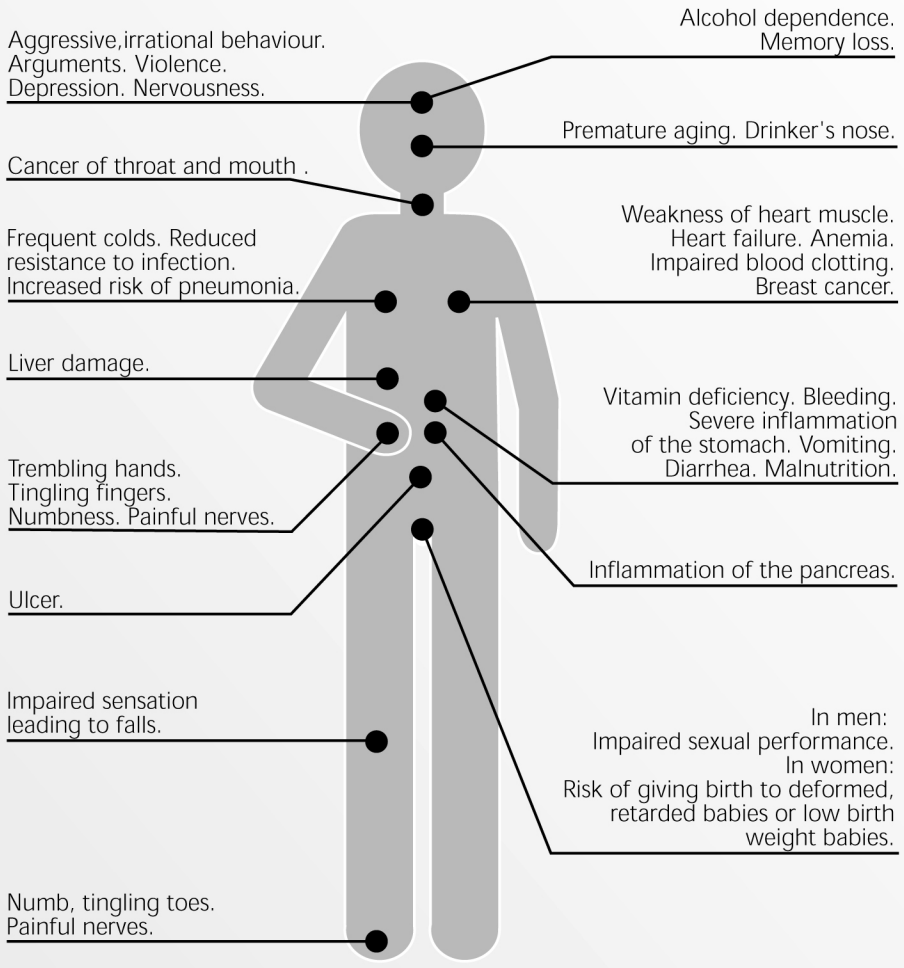
Rev. 10/2014

AUDIT Scores and Zones

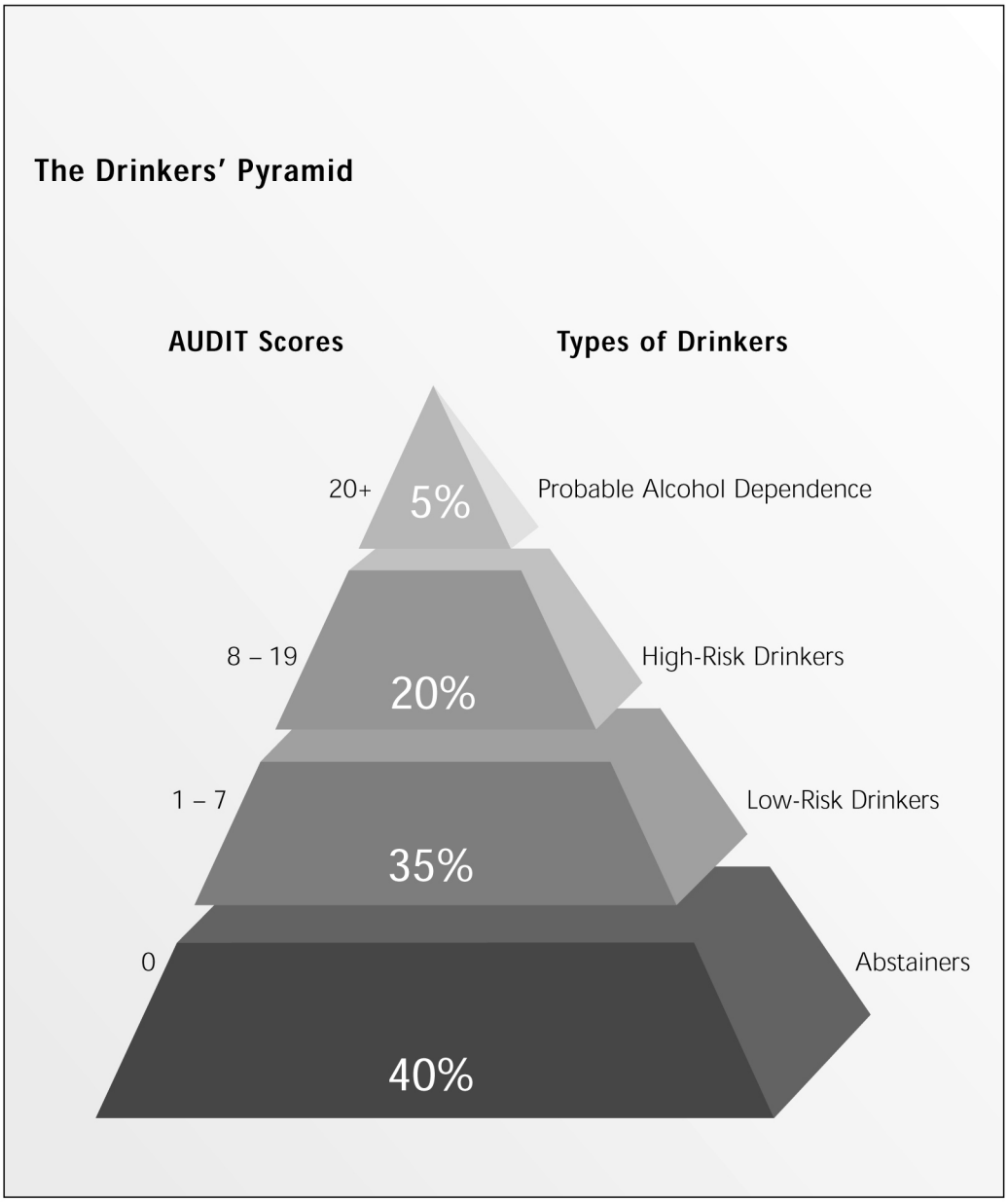
Score	Risk Level	Intervention
0-7	Zone 1: Low Risk Use	Alcohol education to support low-risk use – provide brief advice
8-15	Zone 2: At Risk Use	Brief Intervention (BI), provide advice focused on reducing hazardous drinking
16-19	Zone 3: High Risk Use	**BI/EBI** – Brief Intervention and/or Extended Brief Intervention with possible referral to treatment
20-40	Zone 4: Very High Risk, Probable Substance Use Disorder	Refer to specialist for diagnostic evaluation and treatment

Effects of High-Risk Drinking



High-risk drinking may lead to social, legal, medical, domestic, job and financial problems. It may also cut your lifespan and lead to accidents and death from drunken driving.

https://www.healthpartners.com/files/29898.pdf

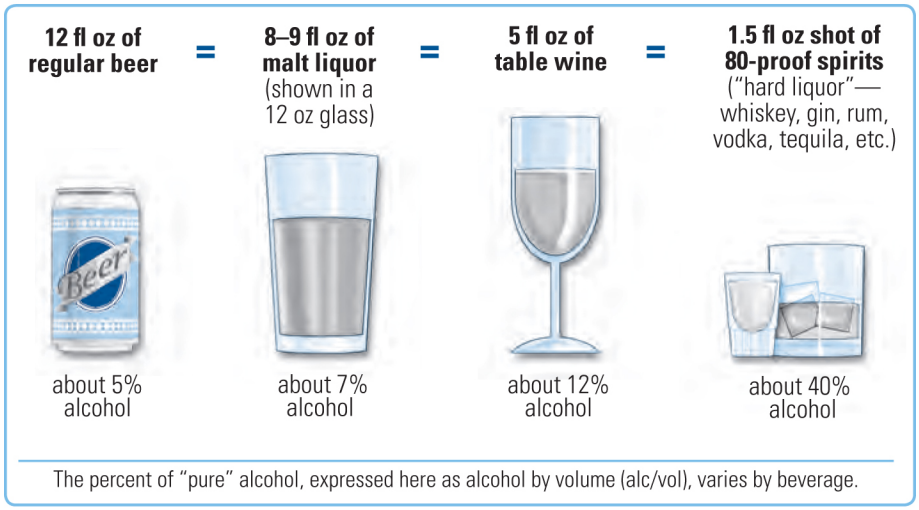


BRIEF INTERVENTION FOR HAZARDOUS AND HARMFUL DRINKING

HOW MUCH IS TOO MUCH?

What counts as a drink?

Many people are surprised to learn what counts as a drink. In the United States, a "standard" drink is any drink that contains about 0.6 fluid ounces or 14 grams of "pure" alcohol. Although the drinks pictured below are different sizes, each contains approximately the same amount of alcohol and counts as a single drink.



The percent of "pure" alcohol, expressed here as alcohol by volume (alc/vol), varies by beverage.

How many drinks are in common containers?

Below is the approximate number of standard drinks in different sized containers of

regular beer	malt liquor	table wine	80-proof spirits or "hard liquor"
12 fl oz = **1** 16 fl oz = **1⅓** 22 fl oz = **2** 40 fl oz = **3⅓**	12 fl oz = **1½** 16 fl oz = **2** 22 fl oz = **2½** 40 fl oz = **4½**	750 ml (a regular wine bottle) = **5**	a shot (1.5 oz glass/50 ml bottle) = **1** a mixed drink or cocktail = **1 or more** 200 ml (a "half pint") = **4½** 375 ml (a "pint" or "half bottle") = **8½** 750 ml (a "fifth") = **17**

The examples shown on this page serve as a starting point for comparison. For different types of beer, wine, or malt liquor, the alcohol content can vary greatly. Some differences are smaller than you might expect, however. Many light beers, for example, have almost as much alcohol as regular beer—about 85% as much, or 4.2% versus 5.0% alcohol by volume (alc/vol), on average.

Although the standard drink sizes are helpful for following health guidelines, they may not reflect customary serving sizes. A mixed drink, for example, can contain one, two, or more standard drinks, depending on the type of spirits and the recipe.

INSIDE BACK COVER