

# **THE ADDICTION PROFESSIONAL'S GUIDE TO SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)**

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## **LEARNER'S GUIDE DEVELOPED IN COLLABORATION WITH:**

NAADAC, the Association for Addiction Professionals

Employee Assistance Professionals Association (EAPA)

Center for Clinical Social Work (CCSW)

American Academy of Addiction Psychiatry (AAAP)

American Society of Addiction Medicine (ASAM)

Employee Assistance Society of North America (EASNA)

NORC at the University of Chicago

The BIG Initiative

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## Forward

This Learner's Guide was adapted for addiction professionals and based on the training program developed in collaboration with six national associations that represent addiction and other behavioral health professionals treating people with alcohol-related problems: NAADAC, the Association for Addiction Professionals; Employee Assistance Professionals Association (EAPA); Center for Clinical Social Work (CCSW); American Academy of Addiction Psychiatry (AAAP); American Society of Addiction Medicine (ASAM); and Employee Assistance Society of North America (EASNA). In addition, Drs. Eric Goplerud and Tracy McPherson from NORC at the University of Chicago facilitate the BIG Initiative and helped organize the six association collaborative that produced this training program.

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## Training Program Learning Objectives

Through the core components of this Learner's Guide, you will be able to use Screening, Brief Intervention and Referral to Treatment (SBIRT) to:

- Screen clients for unhealthy alcohol use with brief, valid questionnaires such as the AUDIT-C and the AUDIT;
- Deliver effective brief counseling informed by Motivational Interviewing and Cognitive-Behavioral techniques;
- Link clients to medical or specialty addiction treatment services as needed, and work with physicians and other specialists in ongoing care coordination; and
- Provide follow-up and recovery supports to help clients to reduce the negative effects of unhealthy alcohol consumption.

By reading the supplemental materials in this Learner's Guide, you will also:

- Better understand the dynamics of the alcoholic family in order to support both the family members, as well as the client, with alcohol-related issues;
- Assess and treat older adults whose use of alcohol or prescription pain medications may create health, social and/or work-related problems;
- Assess and treat young adults and adolescents whose drinking patterns are unhealthy; and
- Connect clients to mutual support groups.

# Module One

# **SBIRT for Addiction Professionals Explained**

# Why Addiction Professionals Care about SBIRT

## Addiction Professionals and SBIRT

Alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) is the leading evidence-based protocol for helping clients to reduce the impact of unhealthy alcohol use. SBIRT is widely used in outpatient medical clinics, hospital emergency departments and trauma centers, community health centers and the Veterans Administration. The therapeutic setting is a great place to establish education, prevention and brief intervention programs to impact one of the top three avoidable killers of Americans today – unhealthy and dependent alcohol use. Increasingly, addiction treatment and prevention settings are building SBIRT into practice routines and expecting that all of their clinicians be skilled in SBIRT.

Without much change to normal workflow, SBIRT can be an effective and efficient method within the total delivery system of addiction prevention and treatment. Granted, often times in an addiction treatment setting, the individual coming in for services has already self-identified his or her “drug of choice” and associated treatment needs. However, there may be other entry points within the system of care for addiction professionals to use the SBIRT protocol, such as private practice sessions, community mental health center settings, primary care clinics, emergency departments or homeless shelters. Using SBIRT, it is easy to identify clients who drink in ways that increase their risk of physical and emotional health problems, disease, injury, work, family and social problems.

## Overview from “3500 Feet”

There are three core parts of SBIRT:

### 1) ***Screening - the process of assessing risk***

Asking three simple questions about the quantity and frequency of alcohol use (the three question AUDIT-C<sup>1</sup>) takes 30 seconds to one minute. This is followed by the seven remaining questions of the AUDIT if responses to the first three questions suggest higher than average unhealthy use. Other good, brief screening instruments exist, but the AUDIT is the benchmark questionnaire that we recommend.

If you do not ask, clients will not tell you about unhealthy drinking.

### 2) ***Brief Intervention - a behavior change strategy focused on helping your client reduce or stop unhealthy drinking***

If screening indicates unhealthy alcohol use, you may choose to provide immediate feedback on how her drinking compares to others her age and gender, offer simple advice, explore the pros and cons of her drinking and ask if she is willing to change. Brief intervention can take as little as 30 seconds (when providing normative behavior information or brief advice) or can extend to 3 – 5 minutes or longer, and may take place in one or several sessions. Alcohol may be your client's primary problem and may become



the focus of your interaction, or unhealthy alcohol use may be a factor that complicates the problems that your client came to resolve. Brief intervention can help many, but certainly not all, clients to make changes. Some will not be ready to change or may need specialized addiction treatment.

### 3) ***Referral to Treatment and Follow-up – linking your client to specialized addiction treatment and staying with the client to support sustained success***

When alcohol problems are more serious or complicated, more intensive, addiction-focused treatment may be a good option. “Referral to treatment” means connecting your client to a physician for medical treatment or a specialty addiction treatment program. “Follow-up” means care management according to your organization’s protocols, as well as supporting your client during treatment and post-treatment follow-up contacts. Follow-up in the form of brief contact is appropriate for all clients.

SBIRT is simple, brief and effective. An analysis of more than 360 controlled clinical trials of treatments for alcohol use disorders found that screening and brief intervention was the most effective treatment method of more than 40 methods studied.<sup>2</sup> The U.S. Preventive Services Task Force reviewed the research literature on screening for unhealthy alcohol use and brief counseling and recommended that it be routinely provided to adolescents and adults.

For some addiction professionals, you may find this training program to be a refresher - reminding and reinforcing skills that you already know and use. Perhaps it will increase your use of skills already well honed and encourage you to use them more often. For others, the training program will fill a gap, provide new information and teach new skills. Regardless of your experience with the skills, the important first step is the same – you have to ask. Everything else flows from simply asking in a sensitive manner about your clients’ alcohol use.

#### **SBIRT and Adolescents**

It is not uncommon for addiction professionals to have clients who are under the age of 21. The *Recommend Low-Risk Drinking Guideline* for this population is complete abstinence.

The CRAFFT can be useful for clients under the age of 21 instead of the AUDIT. The CRAFFT is located in Appendix B of this Learner’s Guide.

More information regarding SBIRT and Adolescents is located in the Specialty Topics section of this Learner’s Guide.

## **Reimbursement for SBI**

The American Medical Association (AMA) has approved several billing codes that will allow you to be reimbursed for providing screening and brief intervention services.

<b>Payer</b>	<b>Code</b>	<b>Description</b>	<b>Fee Schedule</b>
--------------	-------------	--------------------	---------------------

Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min	\$33.41
Commercial Insurance	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min	\$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min	\$29.42
Medicare	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min	\$57.69
Medicaid	H0049	Alcohol and/or drug screening	\$24.00
Medicaid	H0050	Alcohol and/or drug service, brief intervention, per 15 min	\$48.00

Using these billing codes can enable reimbursement for these services and generate revenue.

## Unhealthy Alcohol Use

More than half of the U.S. population over age 12 drinks alcohol.<sup>3</sup> The majority of Americans who drink do so without negative consequences. For some, alcohol use leads to physical, emotional, family and work problems. The World Health Organization (WHO) has identified four general patterns of alcohol use:<sup>4</sup>

- **No Risk:** Those who never drink alcohol. These individuals have no risk of experiencing alcohol-related problems with their health, work or family. Approximately 40% of the population fit into this category.
- **Low Risk:** Drinkers who never exceed the recommended daily, weekly and occasion limits for alcohol consumption. These individuals have a low risk of experiencing alcohol-related problems with their health, work or family. Approximately 35% of the population fit into this category.
- **Moderate Risk:** Those who regularly exceed one of the recommended daily, weekly or occasion limits for alcohol consumption. These individuals have a moderate risk of experiencing alcohol-related problems with their health, work or family. Approximately 20% of the population fit into this category.
- **High Risk:** Those who regularly exceed 2 or more of the recommended daily, weekly or occasion limits for alcohol consumption. This population is at much higher risk of experiencing alcohol-related problems with their health, work or family. They are also at greater risk of developing the medical disease of alcohol dependence, if they have not already. Approximately 5% of the population fit into this category.



\*Approximately 75% of the population either abstain completely from alcohol or drink well within the recommended daily, weekly and occasion limits.

### Recommended Low-Risk Drinking Guidelines<sup>30</sup>

#### Men (under the age of 65): 2 - 14 - 5

No more than 2 drinks per day, 14 drinks per week, 5 drinks per occasion

#### Women (and men over the age of 65): 1 - 7 - 4








No more than 1 drink per day, 7 drinks per week, 4 drinks per occasion

There are many reliable Recommended Guidelines for Low Risk Drinking developed by government agencies and private organizations. These *Recommended Guidelines* were selected based on current research, consistency and for inclusion of alcohol-related problems to health, job or family, as opposed to only risk of alcohol dependence. A comparison summary is located in Appendix A of this Learner's Guide.

Unhealthy alcohol use can be effectively managed and addressed if the drinking pattern is identified. One of the biggest obstacles to effective screening and treatment is the failure to ask about unhealthy drinking during opportunities where asking, offering brief advice and counseling can make a huge difference. During this training program, you will learn how to introduce the topic of unhealthy alcohol use and what questions to ask. You will also learn about brief, solution-focused, motivational counseling, called brief intervention, which provides the framework and techniques for helping clients choose and act to reduce risks associated with unhealthy alcohol use.

### What is a Drink?

It may seem obvious what your client's answer means to the question: "How many drinks containing alcohol do you have on a typical day of drinking?" But, to understand how much your client actually drinks and the risks to which the client may be exposed, it can be helpful to explain what counts as a drink.<sup>5</sup>

<p><b>12 oz. of beer or cooler</b></p>	<p><b>8-9 oz. of malt liquor</b> 8.5 oz. shown in a 12-oz. glass that, if full, would hold about 1.5 standard drinks of malt liquor</p>	<p><b>5 oz. of table wine</b></p>	<p><b>3-4 oz. of fortified wine</b> (such as sherry or port) 3.5 oz. shown</p>	<p><b>2-3 oz. of cordial, liqueur, or aperitif</b> 2.5 oz. shown</p>	<p><b>1.5 oz. of brandy</b> (a single jigger)</p>	<p><b>1.5 oz. of spirits</b> (a single jigger of 80-proof gin, vodka, whiskey, etc.) Shown straight and in a highball glass with ice to show level before adding mixer*</p>
 <p><b>12 oz.</b></p>	 <p><b>8.5 oz</b></p>	 <p><b>5 oz.</b></p>	 <p><b>3.5 oz.</b></p>	 <p><b>2.5 oz.</b></p>	 <p><b>1.5 oz.</b></p>	 <p><b>1.5 oz.</b></p>

A single can or glass of alcohol can be 1, 2 or many drinks. The chart below identifies the number of standard drinks in many typical alcohol containers:

<b>Alcohol Type</b>	<b>Size of Container</b>	<b>Standard Drinks Equivalent</b>
<b>Beer</b>	12 oz.	1
	16 oz.	1.3
	22 oz.	2
	40 oz.	3.3
<b>Malt liquor</b>	12 oz.	1.5
	16 oz.	2
	22 oz.	2.5
	40 oz.	4.5
<b>Wine</b>	750 mL bottle (25 oz.)	5
<b>80-proof spirits/"hard liquor"</b>	a mixed drink	1 or more*
	a pint (16 oz.)	11
	a fifth (25 oz.)	17
	1.75 L (59 oz.)	39

Note: It can be difficult to estimate the number of standard drinks in a mixed drink. A mixed drink can contain from 1 to 3 standard drinks. Giving your client take-home material, such as NIAAA's *Rethinking Drinking*<sup>6</sup>, can be very useful when counting drinks.

## Costs of Unhealthy Drinking Patterns

The federal government estimates that 18.7 million Americans drink alcohol in ways that are potentially unhealthy. Their alcohol use puts them at risk of developing the medical illness of alcohol dependence. Sadly, only 3 million people get help.<sup>7</sup> The costs of failing to help the 15.7 million people with untreated alcohol problems are staggering. According to the Centers for Disease Control and Prevention (CDC), excessive alcohol use cost at least \$223.5 billion annually, or about \$1.90 per drink. Almost three quarters of these costs are associated with **binge drinking**. The costs largely due to losses in workplace productivity (72% of the costs), healthcare expenses (11% of total), law enforcement and other criminal justice expenses related to excessive alcohol consumption (9% of total), and motor vehicle crash costs from impaired driving (6% of total). Excessive alcohol consumption also increases dysfunction within the family system, strains social and romantic relationships, increases health-related problems, increases financial stress and potential increases the use of other substances and/or risky behaviors.

**binge**  
a short period  
of excessive  
consumption

Taking a closer look, alcohol use impacts work, even if no one actively drinks on the job. Nearly 80% of adults who have diagnosable **alcohol use disorders** are employed.<sup>8</sup> Unhealthy drinking costs American employers and employees approximately \$552 per worker per year in excess health care use. Alcohol use costs individuals in other ways too:

- lost productivity due to missed work (**absenteeism**) or reduced or impaired work functioning (**presenteeism**);
- more accidents, resulting in increased workers' compensation and medical claims;
- extra hospital, emergency and other medical costs; and
- higher rates of job turnover.<sup>9</sup>

Many more people drink in unhealthy ways than drink at dependent levels. Because there are so many more unhealthy drinkers than dependent drinkers (at least 5 to 1), the unhealthy drinkers are responsible for 60% of alcohol-related missed work, poor work quality and other work limitations. Together, unhealthy drinkers and dependent drinkers may cause up to 40% of industrial fatalities and 47% of industrial injuries. Twenty percent of employees in a recent survey reported being injured, forced to cover for a co-worker or required to work harder because of a colleague's drinking. Further, misuse of alcohol is linked to almost 50% of all trauma and injury visits to hospital emergency rooms, which drives up health insurance costs and premiums.<sup>10</sup>

While it is true that SBIRT effectively used within the workplace can detect alcohol problems early on with a proper screening and progression to treatment intervention. However, the use of SBIRT in all points of entry into the addiction and behavioral health system could provide needed data at a point early on in the person's pattern of use that enables effective intervention strategies that could prevent possible longer term problems and potential spiraling into more devastating addiction patterns. Early identification of alcohol abuse can not only save money within industry but potentially billions of dollars within the total scope of the economy through reduction in health related benefit costs, destruction to family systems and savings within the criminal justice and legal system.

# Module Two

# Screening

## Asking about Drinking with the AUDIT

Although there are several good screening questionnaires available for asking about drinking, we recommend the AUDIT and its short version, AUDIT-C. The ***Alcohol Use Disorder Identification Test (AUDIT)***, developed by the World Health Organization<sup>11</sup>, is recommended for this use because it detects hazardous and harmful use, as well as probable alcohol dependence.

***AUDIT - a screening questionnaire that gives EA professionals and clients immediate information about level of risk for alcohol-related problems by asking 10 questions related to the quantity and frequency of alcohol use, symptoms of dependence and negative consequences of drinking.***

Other alcohol screening instruments, such as the CAGE, are best at detecting alcohol dependence.<sup>12</sup> However, using the CAGE screening instrument would miss many clients with unhealthy drinking patterns. Screening instruments that identify a range of risk are preferred in order to identify the appropriate level of brief intervention based on level of alcohol use risk. Other good, brief screening instruments exist, such as the GAIN-short form, the WHO-developed ASSIST<sup>13</sup> and the MAST<sup>14</sup>, but the AUDIT is the benchmark questionnaire that we recommend.

Why we recommend the AUDIT:

- ✓ Valid
- ✓ Reliable
- ✓ Brief
- ✓ Public domain
- ✓ Free
- ✓ Multiple languages
- ✓ Widely used in the U.S. and Canada
- ✓ Identifies unhealthy and dependent drinking patterns
- ✓ Results guide treatment
- ✓ Monitors change in use
- ✓ Fits with other screeners
- ✓ Multiple ways to administer (verbally, in person or over the phone, on paper or online)

The AUDIT can be used with other screening questionnaires, such as the ***Drug Abuse Screening Test (DAST)***,<sup>15</sup> the NIAAA Single-item Drug Screen<sup>16</sup> or the ASSIST for drug and tobacco use.<sup>17</sup> Screening for unhealthy alcohol use also fits naturally with other health and mental health screeners, such as the ***Client Health Questionnaire-9 (PHQ-9)*** for depression.<sup>18</sup> The Drug Abuse Screening Test (DAST) and the Client Health Questionnaire-9 (PHQ-9) are located in Appendix C and Appendix D of this Learner's Guide, respectively.

### **DAST**

a screening instrument used to detect drug abuse

### **PHQ-9**

a screening instrument used to detect depression



The first 3 questions of the AUDIT are referred to as the **AUDIT-C**, where the “C” stands for “consumption.” These questions ask about quantity and frequency of alcohol use and generally take less than 1 minute to execute. The AUDIT-C can also be used by itself, as part of a larger set of screening questions and as an objective tool for tracking change.

**AUDIT-C**  
the first 3 questions of the AUDIT that aim to determine the quantity and frequency of a client's alcohol use

Note: Screening may be done by telephone or in-person. In some programs, the person who conducts the screening may be different from the person who conducts the brief intervention and provides referral resources.

## Asking about Drinking

Asking about alcohol use may be harder for you than for your client. Whatever the presenting problem, most clients expect that you will ask questions (some of them difficult) so they can get the help they need. Very few refuse or react negatively to being asked. Practice the following conversation until you become comfortable.

**How you raise alcohol use with your client is important.**<sup>19</sup> To start, you may say to your client:

*“In order to help you get the right services, I would like to ask you some questions that I ask all of my clients. Is that ok?”*

If your client questions asking about alcohol use, you could respond:

*“I ask everyone about alcohol use. It helps me better understand the problem you want help with and the things that may make it more difficult for me to help you.”*

After your client consents, you may say:

*“Now I am going to ask you some questions about your use of alcoholic beverages during this past year.”*

Because more than a third of adults (about 40%) in the U.S. do not drink alcohol, a single question is sufficient to screen out many clients:

*“Do you sometimes drink beer, wine or other alcoholic beverages?”*

If the response is “no,” no further alcohol screening is necessary. If the response is “yes,” proceed to the AUDIT.

## Using the AUDIT-C and AUDIT

Read the AUDIT questions aloud to the client and record the score (0-4) that corresponds to her response. Note: “Alcohol” refers to any form of alcohol, and a “drink” refers to a standard drink (explained in detail in Module One).

**Read questions as written. Record answers carefully. Begin the AUDIT by saying “I am going to ask you some questions about your use of alcoholic beverages during this past year.” Code answers in terms of “standard drinks.” Place the correct answer number in the box at the right.**

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	
3. How often do you have 5 (for men under age 65)/4 (for women and men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
<b>AUDIT-C Score (add items 1-3): Positive screen=4 for men/3 for women and men over age 65. If positive, ask the next 7 questions to administer the full AUDIT.</b>						
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	
<b>AUDIT Score (add items 1-10)</b>						

The AUDIT-C and AUDIT are located in Appendix E of this Learner’s Guide for your reference.

## Scoring and Interpreting the AUDIT

Responses to each question have a point value. Tally the points for each question to generate a total score. To score the AUDIT-C (consumption), add the points for questions 1, 2 and 3. An AUDIT-C score of 4 for men and 3 for women indicates increased risk of alcohol-related problems. An AUDIT-C score of 3 indicates increased risk for men and women over age 65. If the score indicates unhealthy use, ask the remaining seven questions.

To score the AUDIT, add up the points for all ten questions. An AUDIT score of 8 or higher indicates at-risk, harmful or hazardous drinking. Scores suggest risk ranges:

- **0 to 7 = low risk**
- **8 to 19 = moderate risk, potential harms**
- **20 to 40 = high risk, possible dependence**

The risk ranges can help guide treatment, as will be demonstrated in the next module of this Learner's Guide. They can be useful in understanding how hazardous a client's drinking is and how best to proceed. Note: A score of 10 is not necessarily better than an 11, as both scores fall within the moderate risk range. The individual AUDIT score is not as important as determining the level of risk. Further, many cases are more complex than a single screening score can capture. You are encouraged to use your clinical judgment to evaluate whether someone needs further assessment, especially when the client has an AUDIT score at the cusp of the range thresholds.

The following interaction shows how to ask about drinking using the AUDIT. A caring, non-judgmental, conversational tone when discussing alcohol, and the use of reflection and affirmation responses, help build rapport with your client:

## Sample Interaction #1: AUDIT Screening Questions

A video of this sample interaction is located at: <http://www.youtube.com/watch?v=RHcalohcunU>

*Asking AUDIT questions, interpreting results and providing brief feedback and advice*

The Addiction Professional and Client meet in person. The Addiction Professional administers the AUDIT verbally.

**Addiction Professional:** *Hello, Steve. I'm Carolyn. It's nice to meet you.*

**Client:** *Hi, nice to meet you too.*

**Addiction Professional:** *How are you doing today?*

**Client:** *Um, not that great. Or else I wouldn't be here, I guess.*

**Addiction Professional:** *It sounds like things have been better for you. **(Reflection)** You showed up here today though, and I can provide you with some support if you'd like. This could be a great step toward changing things for the better. **(Affirmation)***

**Client:** *Yeah, I guess so.*

**Addiction Professional:** *OK, well, I'd like to start out by asking you some questions about your use of alcohol during this past year. I ask all of my clients questions about alcohol and other substances in order to achieve the best outcomes for them. Because alcohol use can affect many areas of a client's life, it is important for me to know how much you usually drink and whether you have experienced any problems with your drinking. This should only take a few minutes. Would it be alright if I continue?*

**Client:** *Well, I don't really think I have a problem with alcohol, but yeah, OK, that's fine.*

**Addiction Professional:** *How often do you have a drink containing alcohol?*

**Client:** *Well, I don't drink when I'm on the job. I only drink on the weekends. Usually Friday and Saturday. Sometimes Sunday too. **(2 to 3 times a week = 3 points)***

**Addiction Professional:** *So, about two to three times a week. **(Reflection)** And how many drinks containing alcohol do you have on a typical day when you are drinking?*

**Client:** *I don't drink too much. I only have a few beers, maybe four. And then a couple of shots on top of that, so probably a total of six drinks. **(5 or 6 drinks = 2 points and 5 total)***

**Addiction Professional:** *Alright, it sounds like having six drinks is your usual routine. **(Reflection)** My next question is: How often do you have six or more drinks on one occasion? Based on what you're telling me, it sounds like this is weekly for you. **(Reflection)** Does that sound right?*

**Client:** *Yeah, weekly sounds about right. **(Weekly = 3 points and 8 total)***

**Addiction Professional:** *How often during the last year have you found that you were not able to stop drinking once you had started?*

**Client:** *Never. I can always stop when I want to. Like I said, I don't have a drinking problem. **(Never = 0)***

*points and 8 total)*

**Addiction Professional:** *OK, it sounds like you can decide how much you want to drink and stick with it. (Reflection) I just have a few more questions for you. Thanks for sharing this information with me. (Affirmation) How often during the last year have you failed to do what was normally expected from you because of your drinking?*

**Client:** *Well, I did have to call in sick one day because I was so hung-over. I guess that's considered failing to do what's expected of me. But it was just that one time. (Less than monthly = 1 point and 9 total)*

**Addiction Professional:** *Drinking interfered with your work responsibilities that one time, and it sounds as though this isn't a regular occurrence. (Reflection) How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?*

**Client:** *Never. I'm not an alcoholic. (Never = 0 points and 9 total)*

**Addiction Professional:** *Never. (Reflection) My next question is: How often during the last year have you had a feeling of guilt or regret after drinking?*

**Client:** *I only regretted drinking that one time, when I had to miss work. That just isn't me. (Less than monthly = 1 point and 10 total)*

**Addiction Professional:** *It sounds like being on top of your work responsibilities is important to you. (Affirmation) How often during the last year have you been unable to remember what happened the night before because you had been drinking?*

**Client:** *Never. I don't black out. (Never = 0 points and 10 total)*

**Addiction Professional:** *That's a good thing. (Affirmation) Have you or someone else been injured as a result of your drinking?*

**Client:** *No, never. Nothing crazy like that. I keep it under control. (Never = 0 points and 10 total)*

**Addiction Professional:** *Keeping your drinking under control seems to be important to you. You don't want it to affect your life negatively. (Reflection)*

**Client:** *Yeah, that's right.*

**Addiction Professional:** *OK, I have one last question for you. Has a friend, doctor or other health worker been concerned about your drinking or suggested you cut down?*

**Client:** *Well, my wife has bugged me about it. I think she makes too big of a deal of it though. I know when it's time to be serious and work and when it's time to let loose and have fun.*

**Addiction Professional:** *You like to keep a healthy balance of work and fun. (Reflection) And when was it that your wife last expressed concerned about your drinking? (Clarifying question)*

**Client:** *A month or so ago. That's when I called in that one time. (Yes, during the last year = 4 points and 14 total)*

*The client scored 14 on the AUDIT. When the AUDIT score is between 8 and 19, such as this one, a brief intervention focused on the reduction of hazardous drinking using simple advice and motivational enhancement techniques is most appropriate.*



**Role-play #1 for live training:**<sup>20</sup> Partner with someone to practice some of the techniques that you are learning. For this situation, one person will act as the addiction professional using the three questions of the AUDIT-C, and one person will act as the client who is seeking help for some bothersome problems. Use the blank AUDIT-C on the following page to complete the role-play.

**Client:** You are a 21-year-old woman/man who is living with her/his parents after dropping out of college three months ago. Your mom suggested that you contact someone to talk to because you have been “moody” and “unmotivated to get a job.” You are scared that they might kick you out of the house if they found out that you are taking Xanax recreationally and drinking a lot. If asked, you might say something like: *“A lot of my friends and I go out and drink on the weekends, maybe on Thursday nights too. I don’t want to stop hanging out with my friends, but my parents would kill me if they knew how much I am drinking.”*

To help with this exercise, Sample SBIRT Protocol Flowcharts and Scripting are located in Appendix F of this Learner’s Guide for your reference.

## Role Play #1 – Blank AUDIT-C and AUDIT

**Read questions as written. Record answers carefully. Begin the AUDIT by saying “I am going to ask you some questions about your use of alcoholic beverages during this past year.” Code answers in terms of “standard drinks.” Place the correct answer number in the box at the right.**

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	
3. How often do you have 5 (for men under age 65)/4 (for women and men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
<b>AUDIT-C Score (add items 1-3): Positive screen=4 for men/3 for women and men over age 65. If positive, ask the next 7 questions to administer the full AUDIT.</b>						
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	
<b>AUDIT Score (add items 1-10)</b>						





# Module Three

## **Brief Interventions**

## Brief Intervention Defined

If screening indicates unhealthy alcohol use, brief, solution-focused counseling can be very effective in helping your client to reduce or stop hazardous drinking. Usually, **brief interventions (BI)** immediately follow screening. A gap of a few days or a week does not seem to dilute the effectiveness of the brief intervention. However, a delay increases the likelihood that clients will not show to their next scheduled appointment and the immediacy of the linked screening and brief intervention (SBI) is lost.

### **brief intervention**

a behavioral change strategy that is short in length and duration that is aimed at helping a person reduce or stop a problematic behavior

### **Motivational Interviewing (MI)**

a method of communication that is focused on your client's concerns and perspectives and works to enhance your client's internal desire, willingness and ability to change by exploring and resolving his/her co-existing opposite feelings about changing

### **Cognitive-Behavioral Therapy (CBT)**

a short-term, skill-oriented, collaborative method of counseling that primarily focuses on correcting thoughts, emotions and behaviors that lead to dysfunction by simultaneously restructuring your client's automatic thoughts and learning new behaviors

Brief interventions usually include feedback about the AUDIT scoring and how the results compare to national averages. BI also includes expression of concern about the potential effects of unhealthy drinking, advice to cut back, exploration of the pros and cons of use, action planning and commitment to action.

Brief interventions take as little as 5 minutes or stretch to several full-length sessions. Use your best judgment to determine how to best integrate BI into your sessions.

The skills necessary to provide effective brief interventions for unhealthy alcohol use are not new. Some addiction professionals already know and use **Motivational Interviewing (MI)** and **Cognitive-Behavioral Therapy (CBT)** in their work. SBIRT and this training program simply organize and sharpen your existing skills to help clients with unhealthy alcohol use.

SBIRT for unhealthy alcohol and drug use is widely used in many settings. A large body of research shows the effectiveness of SBIRT in primary care and hospitals. For example, a recent randomized, control study found that risky drinkers who receive BI are twice as likely to reduce their drinking as those receiving no BI over a period of 6 to 12 months.<sup>21</sup> Additionally, a large employee assistance program (EAP) found that 64% of the people who received SBI counseling did not need further treatment to address their problem drinking.<sup>22</sup>

The U.S. Preventive Services Task Force (USPSTF) reviewed the research on screening for unhealthy alcohol use in primary care and providing brief, problem-solving counseling. It recommended SBI be a routine practice. Similarly, the research convinced the American College of Surgeons – Committee on Trauma (ACS-COT) to require Level 1 and 2 hospital trauma centers to provide SBI to remain accredited. SBI is becoming the standard of good medical care because it works. It makes sense that SBI become routine in a broad range of clinical settings, too.

The chart below shows results from several recent SBI studies and literature reviews:<sup>23</sup>

<b>Study</b>	<b>Results – conclusions</b>	<b>Reference</b>
<b>Trauma clients</b>	<ul style="list-style-type: none"> <li>• 48% fewer re-injury (18 months)</li> <li>• 50% less likely to re-hospitalize</li> </ul>	Gentilello et al, 1999
<b>Hospital ER screening</b>	<ul style="list-style-type: none"> <li>• Reduced DUI arrests</li> <li>• 1 DUI arrest prevented for 9 screens</li> </ul>	Schermer et al, 2006
<b>Physician offices</b>	<ul style="list-style-type: none"> <li>• 20% fewer motor vehicle crashes over 48 month follow-up</li> </ul>	Fleming et al, 2002
<b>Meta-analysis</b>	<ul style="list-style-type: none"> <li>• Interventions reduced mortality</li> </ul>	Cuijpers et al, 2004
<b>Meta-analysis</b>	<ul style="list-style-type: none"> <li>• Treatment reduced alcohol, drug use</li> <li>• Positive social outcomes: substance-related work or academic impairment, physical symptoms (e.g., memory loss, injuries) or legal problems (e.g., driving under the influence)</li> </ul>	Burke et al, 2003
<b>Meta-analysis</b>	<ul style="list-style-type: none"> <li>• Interventions can provide effective public health approach to reducing unhealthy use.</li> </ul>	Whitlock et al, 2004

## Feedback about Risk

The AUDIT risk ranges are helpful for you and your client to understand how alcohol use can impact health, family and work. It can also guide what to do next:<sup>24</sup>

<i>Level of Risk</i>	<i>AUDIT Score</i>	<i>Level of Intervention</i>
<b>Low</b>	<b>0 - 7</b>	<ul style="list-style-type: none"> <li>• Provide feedback</li> <li>• Inform about safe use</li> </ul>
<b>Moderate</b>	<b>8 - 19</b>	<ul style="list-style-type: none"> <li>• Provide feedback about risk</li> <li>• Compare to national norms</li> <li>• Inform about safe use</li> <li>• Advise “cutting back”</li> <li>• MI, CBT and problem-solving techniques</li> <li>• Generate change statements</li> <li>• Follow-up</li> </ul>
<b>High</b>	<b>20 - 40</b>	<ul style="list-style-type: none"> <li>• Provide feedback about elevated risk</li> <li>• Compare to national norms</li> <li>• Inform about safe use</li> <li>• Advise “cutting back”</li> <li>• MI, CBT and problem-solving techniques</li> <li>• Consider referral to addiction specialist for more intensive treatment</li> <li>• Generate change statements</li> <li>• Follow-up and continued monitoring</li> </ul>

### Feedback Using AUDIT Score

**Provide feedback to everyone**, including those who answer “no” to the question, “Do you sometimes drink beer, wine or other alcoholic beverages?”

- *AUDIT-C score below 4 (men)/3 (women and men over 65 years old) or a full AUDIT score of 7 or below:* inform your client that she is at **low risk** for alcohol-related problems and encourage her to maintain those healthy levels.

**Example:**

*“John, your answers to questions about your alcohol use indicate that you have low risk of developing the medical disease of alcohol dependence. Keep up these healthy patterns.”*

*“Judy, your answers to these questions about your alcohol use indicate that you are at lower risk for developing physical and emotional concerns than those who drink at higher ranges. Congratulations.”*

- *AUDIT score of 8 to 19: inform your client that she is at **moderate risk** for developing health and other problems associated with her alcohol use.*

**Example:**

*“Maria, your score on the AUDIT was a 14 out of 40. This suggests that you are at moderate risk of developing the medical disease of alcohol dependence. Your drinking greatly increases the likelihood that you will have an alcohol-related accident or begin experiencing health and/or other problems. I am concerned for you.”*

*“Mark, your score on the AUDIT was 17 out of 40 which indicates that you are at higher risk for developing physical and emotional concerns than those who drink at lower ranges. I am concerned for you and recommend you cut back.”*

- *AUDIT score of 20 to 40: inform your client that she is at **high risk** of developing the medical disease of alcohol dependence, and it is very likely that she is experiencing problems at work, at home or in her health.*

**Example:**

*“Edmund, your score on the AUDIT was 33 out of 40. This is very high. The amount that you drink and the symptoms you report place you at high risk for alcohol-related illness, including the very real medical disease of alcohol dependence. You are probably experiencing some problems due to your drinking, which may already be severe. I am very concerned for you and recommend that you cut back.”*

*“Sarah, your score on the AUDIT was 24 out of 40 which indicates that you are at higher risk for developing physical and emotional problems than those who drink in lower ranges. I am very concerned for you and recommend that you cut back.”*

## Know Your Numbers

When discussing a client's drinking patterns, it is helpful to provide clear guidance on what healthy drinking looks like. The *Recommended Guidelines for Low-Risk Drinking* can be summarized in a simple rule:<sup>25</sup>

**Men (under the age of 65): 2 - 14 - 5**  
 No more than 2 drinks per day, 14 drinks per week, 5 drinks per occasion

**Women (and men over the age of 65): 1 - 7 - 4**  
 No more than 1 drink per day, 7 drinks per week, 4 drinks per occasion

**These daily, weekly and occasion limits are recommendations for maintaining a low risk of experiencing alcohol-related problems at work, at home or with health.** Occasion guidelines are included to capture the increased risk of experiencing alcohol-related problems due to binge and heavy drinking. Whereas it may seem that the daily and occasion recommended guidelines are in conflict, they actually cover different drinking patterns – typical drinking on a daily basis and how much one drinks during an event (e.g. business dinner, party, wedding or football game). **It is recommended that pregnant women and those under 21 years of age do not drink alcohol at all.** More information on other Recommended Low-Risk Drinking Guidelines is available in Appendix A of this Learner’s Guide.

Clients at increased risk of alcohol-related problems can benefit from comparing their drinking with U.S. norms:<sup>26</sup>

<i>Drinking Patterns in U.S. Adults</i>		
<b>5%</b>	Exceed <b>2 or more</b> of the recommended per day, per week or per occasion limits (20 to 40 on the AUDIT)	<b>High Risk</b>
<b>20%</b>	Exceed <b>one</b> of the recommended per day, per week or per occasion limits (8 to 19 on the AUDIT)	<b>Moderate Risk</b>
<b>35%</b>	<b>Always</b> drink <b>within</b> low-risk limits (1 to 7 on the AUDIT)	<b>Low Risk</b>
<b>40%</b>	<b>Never</b> drink alcohol (0 on the AUDIT)	<b>No Risk</b>

**Feedback varies depending on the client's AUDIT score:**

- *AUDIT score of 0 to 7: **low risk** for alcohol-related problems. Asking permission to give feedback helps build rapport.*

**Examples:**

*"I would like to give you some feedback about how your drinking compares to other American adults. May I?"*

*"More than 1/3 of U.S. adults do not drink alcohol."*

*"Almost 3 out of 4 adults either do not drink or drink at levels that are not considered unhealthy. Those levels are below 14 drinks per week and less than 5 drinks per occasion for men, and below 7 drinks per week and less than 4 drinks per occasion for women. You are in this healthy, low risk group. Keep up these healthy patterns."*

- *AUDIT score of 8 to 19: **moderate risk** for alcohol-related problems.*

**Examples:**

*"I would like to share with you what your answers to my questions about your use of alcohol shows. May I?"*

*"Would you like to know more about how your score compares to other adults in the U.S.?"*

*"Nearly 3 out of 4 U.S. adults drink at levels below yours. If you reduce your drinking to 4 or fewer drinks per day, and 7 or fewer drinks per week (for a woman), your risk of alcohol-related health problems will drop significantly. Would you be willing to consider how to decrease your risk?"*

- *AUDIT score of 20 to 40: **high risk** of serious, potentially life-threatening alcohol dependence and other work, family and health problems.*

**Examples:**

*"Your current use of alcohol is more than that of 90% of U.S. adults. This pattern is harmful to your health and could be causing problems at work or at home."*

*"Men who drink more than 14 drinks per week or 5 or more drinks on an occasion put themselves at serious risk of problems. Would you be willing to consider how you could reduce your risk?"*

## Alcohol Education

For many people who drink at levels within the *Guidelines*, alcohol may actually be healthy. Research shows alcohol use may reduce the risk of hypertension, diabetes and other cardiovascular disorders. But, use over the *Recommended Guideline* levels increases the likelihood of developing a host of illnesses, injuries and other problems. Sustained, heavy use can be especially harmful. The chart below outlines the percentage of disease and injury occurrences that are related to alcohol use:

<b><i>Unhealthy Drinking Causes Disease and Injury<sup>27</sup></i></b>	
<b><i>Direct Primary Causes of Disease (Among People of All Ages)</i></b>	
Alcohol Poisoning	100%
Alcoholic Heart Disease (cardiomyopathy)	100%
Alcoholic Gastritis	100%
Alcoholic Liver Cirrhosis	100%
Alcoholic Nerve Disease (polyneuropathy)	100%
Alcoholic Psychoses	100%
Alcoholism	100%
<b><i>Secondary Causes of Disease (Among People Age 35 or Older)</i></b>	
<b>Cancer</b>	
Lip, Mouth and Pharynx	50% (men), 40% (women)
Esophagus	75%
Larynx	50% (men), 40% (women)
Liver and Bile Ducts	15%
Stomach	20%
Diabetes	5%
Gastrointestinal Disease	10%
<b>Heart Disease</b>	
Essential Hypertension	8%
Stroke	7%
Liver Disease	50%
<b>Pancreatitis</b>	
Acute	42%
Chronic	60%
Pneumonia/Influenza	5%



<b>Tuberculosis</b>	25%
<b><i>Injuries Attributed to Alcohol</i></b>	
<b>Motor Vehicles</b>	
<b>Fatalities</b>	41%
<b>Injuries</b>	9%
<b>Burns</b>	45%
<b>Drowning</b>	38%
<b>*Falls</b>	35%
<b>*Self-inflicted (including suicide)</b>	28%
<b>*Violence (including homicide)</b>	46%

\*Among people ages 15 and older

Educating your clients about their risks of health and other problems can help them decide to change.

- *AUDIT score of 0 to 7: **low risk.***

**Example:**

*“John, you have a low risk of experiencing problems associated with your drinking. If you continue to stay below the Guideline levels (2-14-5 [men]; 1-7-4 [women]), your alcohol use may even be healthy. Congratulations.”*

- *AUDIT score of 8 to 19: **moderate risk.***

**Examples:**

*“Fewer than 1 in 5 adults drink as much as you. The World Health Organization found that drinking at this level is hazardous. Adults who drink this much are at much higher risk of developing alcohol-related health problems (especially GI, pancreas, liver diseases and cancers), as well as having potentially dangerous accidents at work, at home and on the road. The amount that you drink also puts you at a 1 in 5 chance of developing alcohol dependence.”*

*“Your pattern of drinking places you at risk for experiencing health, emotional, social, financial, occupational and/or legal problems, and I am concerned. Would you be willing to discuss how you could reduce your risks?”*

- *AUDIT score of 20 to 40: **high risk.***

**Examples:**

*“Edmund, I am concerned that your drinking patterns put you in danger of problems with your job, your family and your health. You may be well on your way to developing the medical disease of alcohol dependence.”*

*“Roughly 50% of people who share your drinking pattern have or will develop alcohol dependence, a serious and potentially life-threatening disease. Fortunately, many people with your level of alcohol use are able to significantly reduce their risk for alcohol-related accidents and health problems by changing their use patterns or stopping drinking entirely. Would you be willing to discuss how you could reduce your risk?”*

Giving your client take-home material, such as NIAAA's *Rethinking Drinking*, can be very useful in answering questions about health risks and other common problems associated with unhealthy alcohol use. You can also recommend that your client speak with her physician for more detailed information. There are many good resources for you and your clients listed in the Resources section of this Learner's Guide.

**Concern and Advice**

For clients whose drinking puts them in the moderate or high risk categories, simple advice to reconsider their drinking patterns, cutting back or abstaining from alcohol can be powerful. Non-confrontational advice expressed with concern can motivate many people to change or rethink their use. You might say, *“Have you considered cutting back your drinking? Reducing your alcohol use could reduce your risk of problems, and cutting back could really help you concentrate on the problems that led you to come in today. I am concerned that your drinking may make things worse. I think following the recommended drinking guidelines would help make things better. If you are not ready to change, you might consider doing one or more of these things...:”*

- *keep track of how often and how much you are drinking.*
- *notice how drinking affects you.*
- *list pros and cons of changing your drinking.*
- *deal with things that may get in the way of changing.*
- *ask for support from your doctor, a friend or someone else you trust.*<sup>28</sup>

Ask your client if she can think of ways to reduce her risk of alcohol-related problems, ways that make sense to her and that she could see herself trying. Some of the options your client might suggest (or you could prompt) include:

- reducing drinking by 1 drink per day;

- setting a limit on the number of drinking days per week;
- counting drinks;
- not driving after drinking;
- avoiding triggers for excessive drinking, such as starting early at happy hours or engaging in drinking contests;
- developing activities that are alternatives to drinking;
- eating while drinking so the alcohol is absorbed more slowly;
- going for a walk when feeling stressed instead of having a drink;
- drinking only during evening meals; and
- alternating alcoholic beverages with non-alcoholic beverages.<sup>29</sup>

You can use the *Setting Goals for Change Exercise*, which is located in Appendix G of this Learner's Guide, and the *Change Plan Worksheet*, located in Appendix H, to help develop cutting back goals with your client.



**Role-play #2 for live training:**<sup>30</sup> Find a partner to practice conducting a brief intervention. One person will act as the client and the other as the addiction professional who has administered the AUDIT and determined, based on an AUDIT score of 25, that the client is at high risk of alcohol-related problems. Practice giving feedback, alcohol education and concern and advice. Refer to the completed AUDIT on the following page to learn more about the client's drinking patterns.

**Client:** You are a 42-year-old man/woman who seeks some help because you feel like you have very little energy and feel depressed and blue. If asked about alcohol use, you might say something like: *"I drink 4 or 5 drinks most days after work and a few more on the weekends. It is really the only way I relax. I have a lot of stress in my life, and it is just my release. I don't see any problem with it."*



**Role-play #3 for live training:**<sup>31</sup> Switch roles with your partner and practice conducting a brief intervention. One person will act as the client and the other as the addiction professional who has administered the AUDIT and determined, based on an AUDIT score of 12, that the client is at moderate risk of alcohol-related problems. Practice giving feedback, alcohol education and concern and advice. Refer to the completed AUDIT on the following page to learn more about the client's drinking patterns.

**Client:** You are a 56-year-old man/woman who is worrying all the time about being laid off. You have had several acute feelings of panic and doom, which also worry you a lot. You know that the company has already downsized, the economy is struggling and older workers always get cut first. Sometimes you just feel like blowing up, the pressure gets so high. You feel you have to work harder than the younger workers. If asked about your drinking, you might say something like: *"I don't think I need to stop drinking. I only have a couple of glasses of scotch or maybe a beer or 2. I have been doing this for 35 years. My health is good and besides, I don't have long to go."*

## Role Play #2 – Completed AUDIT-C and AUDIT

Read questions as written. Record answers carefully. Begin the AUDIT by saying "I am going to ask you some questions about your use of alcoholic beverages during this past year." Code answers in terms of "standard drinks." Place the correct answer number in the box at the right.

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	4
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	2
3. How often do you have 5 (for men under age 65)/4 (for women and men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	3
AUDIT-C Score (add items 1-3): <i>Positive screen=4 for men/3 for women and men over age 65.</i> If positive, ask the next 7 questions to administer the full AUDIT.						9
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	2
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	2
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	1
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	2
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	4
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	4
AUDIT Score (add items 1-10)						25

## Role Play #3 – Completed AUDIT-C and AUDIT

**Read questions as written. Record answers carefully. Begin the AUDIT by saying “I am going to ask you some questions about your use of alcoholic beverages during this past year.” Code answers in terms of “standard drinks.” Place the correct answer number in the box at the right.**

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	4
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	0
3. How often do you have 5 (for men under age 65)/4 (for women and men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	1
<b>AUDIT-C Score (add items 1-3): Positive screen=4 for men/3 for women and men over age 65. If positive, ask the next 7 questions to administer the full AUDIT.</b>						<b>5</b>
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	0
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	2
<b>AUDIT Score (add items 1-10)</b>						<b>12</b>

# Module Four

## **Referral to Treatment and Follow-up**

## Referral to Treatment

For those clients whose AUDIT score indicate need for a different level or intensity of treatment than you as an addiction professional can provide, referral is appropriate. Of course, the client must be agreeable to participating in treatment. How you broach and discuss referral with a client contributes to her likelihood of successful treatment.

Referrals, or “handoffs,” for a different level or intensity of treatment than you can provide are critically important and risky in virtually any endeavor, particularly when working with individuals with substance use problems. David Gustafson has studied the characteristics of handoffs in activities as diverse as daycare drop-off and pick-up, surgery and post-operative care, air traffic control, relay races, 911 calls, railroad dispatch, professional football and automobile racing. The findings are that all situations require a smooth handoff, and a failed handoff disrupts service delivery and introduces errors, sometimes with disastrous consequences.<sup>32</sup>

According to a 2004 Treatment Episode Data Set (TEDS) analysis, only 16% of clients discharged from detoxification programs start a new level of care. Only 30% of clients discharged from residential care start a new level of care, and only 50% of those who start outpatient care complete their regimen.<sup>33</sup> Far too many clients are lost to the system during handoffs from one level of care to another. Gustafson suggests eight principles that if followed could dramatically improve the transition of clients with substance use problems between levels of care, whether that is from a call center to an office-based addiction professional or from the addiction professional to an addiction medicine specialist or treatment program:<sup>34</sup>

- 1) **Commitment** - The addiction professional who makes referrals must believe that handoffs are essential for each client and for the organization as a whole. As an addiction professional, you play a critical role in successful handoffs, but this commitment must be felt throughout the entire process.
- 2) **Responsibility** - Clients do not always follow instructions. Many clients do not follow doctors' instructions for other types of medical treatment either. However, we do not blame a failed handoff in a relay race on the baton. Noncompliance is the reason we should devote more attention to successful handoffs, not an excuse for failing to do so. It is your responsibility to ensure that your clients with complicated chronic diseases, such as alcohol dependence, transfer to the appropriate care.
- 3) **Understanding the client** - We are not handing off an inanimate object, such as a football or an airplane. We must respect and incorporate each client's unique needs and circumstances in managing the referral.
- 4) **Designation and clearly defined roles** - For a successful handoff, responsibilities of the individual “giving” the client to the next level of care and the person “receiving” the client are clearly defined. In a smooth handoff, the receiver is fully informed of the client and demonstrates that she has understood what the client has experienced before responsibility can be passed on.



- 5) **Presence** - Clients are not “sent” but are “delivered.” Clients could be viewed in the same way as unaccompanied minors are in the airline industry - they need to be “handed off” by one supervising airline employee to another when boarding, making a connection and arriving at the final destination.
- 6) **Common language for handoffs** - A common language is crucial to activating any successful handoff process. Organizations in virtually every field have specific, unequivocal, highly clarified language that all “players” understand.
- 7) **Practice** - A smooth handoff is standardized, synchronized and practiced over and over again. Every field that performs good handoffs engages in incredible amounts of practice to make them happen. Hand offs can be hard to practice in a setting where they are done infrequently.
- 8) **Monitoring, evaluation and improvement** - In sports, team members are constantly graded on how well they are playing their roles, and they retain or lose their spots in the line-up based on performance. Grading also identifies areas where teaching can improve performance. In addiction treatment, we need to establish mechanisms for monitoring the success of our handoffs from one level of care to another and use those results to improve.

## Discussing Treatment Options

You may wish to suggest to clients who score 20 or above on the AUDIT to seriously consider more intensive treatment than the relatively brief and problem solving-focused counseling generally possible in office-based settings. As you and your client work to develop the steps of a plan, options for treatment will probably come up. After gaining permission from the client to do so, suggest and describe some treatment options that best fit her situation. One or all of the options below could form a reasonable action plan:

- **Brief treatment or more intensive outpatient counseling** – Recommend a mental health or substance abuse counselor (if this is not you), make initial contact with him/her, set-up a first appointment and follow-up to ensure the client’s problems are being addressed.
- **Specialized, intensive substance use treatment programs** – Recommend a substance abuse facility, set-up an appointment for further assessment, help reduce barriers to receiving treatment (transportation, cost, leave from work) and follow-up to ensure the client’s problems are being addressed.
- **Medical management and pharmacotherapy** - Recommend the client to discuss these options with her physician, recommend one if she does not have one and follow-up to ensure the client’s problems are being addressed. (More information is available in Module Six – Specialty Topics: Working with Physicians in Ongoing Care Coordination in this Learner’s Guide)

- **Mutual support groups** - Provide a list of relevant mutual support groups with meeting times and locations. (More information is available in Module Six – Specialty Topics: Working with Mutual Support Groups in this Learner's Guide)<sup>35</sup>

When discussing these options with your client, set the tone by displaying a non-judgmental demeanor and explain your role and concern. Also, connect the client's screening results and current visit to the need for specialized treatment:

*"Tracy, we have talked a bit about your struggles at home, at work and with your health, and I think some changes around alcohol could help with the problems you identified. Your score of 13 out of 40 on the AUDIT indicates that you might benefit from some help with cutting back on your alcohol intake. Working on this through outpatient counseling with an addiction professional like myself could be really helpful. What do you think of this idea?"*

*"I'm glad that you are wanting to make significant changes in your health by decreasing the amount you drink. You know, clients in your situation are often more successful if they are also seeing a counselor who specializes in treating clients who abuse drugs and alcohol. We have some excellent programs in our area that have helped many people in exactly your situation. Would you be willing to see one of these counselors to assist you with your plan of recovery?"*

*"Your score of 32 out of 40 on the AUDIT indicates that you are at great risk of developing alcohol dependence. I am very concerned for you and your health. I understand your desire to want to quit drinking on your own and applaud your determination. However, alcohol withdrawal at this stage can be dangerous if it is not monitored very closely. The best way to do that is to admit you to the hospital for detoxification and safely manage your withdrawal. I would be really worried if we didn't do it this way. Would you be willing to be admitted to the hospital today so that we can safely get you through this rough stage?"<sup>36</sup>*

## Effective Treatment Approaches

Just as timing is important for clients to initiate treatment, what methods are used to introduce their options is as equally important. Miller and Wilbourne conducted a massive study commonly referred to as Mesa Grande that summarizes and ranks the current evidence for various treatment approaches for alcohol use disorders. The results are below, with brief intervention ranked the highest:

**Mesa Grande Study of Effective Treatment Approaches<sup>37</sup>**

Treatment	Rank	# of Studies	Treatment	Rank	# of Studies
Brief intervention	1	31	Aversion therapy	24.5	20
Motivational enhancement	2	17	Twelve-Step facilitation	24.5	3
GABA agonist (e.g., acamprosate)	3	5	Antidepressant, SSRI	26	15
Opiate antagonist (e.g., naltrexone)	4	6	Lithium	27	7
Social skills	5	25	Marital therapy	28	8
Community reinforcement	6	4	Functional analysis	29	3
Behavior contracting	7	5	Hypnosis	30	4
Behavioral marital	8	8	Psychedelic medication	31	8
Case management	9	6	Calcium carbimide	32	3
Self-monitoring	10	6	Serotonin antagonist	33	3
Cognitive therapy	11	10	Anti-anxiety medication	34	14
Client-centered counseling	12.5	7	Relapse prevention	35	20
Disulfiram	12.5	24	Metronidazole	36	9
Aversion therapy	14.5	3	Antidepressant, non-SSRI	37	6
Covert sensitization	14.5	8	Milieu therapy	38	12
Acupuncture	16.5	3	Alcoholic anonymous	39.5	7
Aversion therapy	16.5	5	Video self-confrontation	39.5	8
Self-help	18	5	Standard treatment	41	15
Self-control training	19	35	Relaxation training	42	18
Minnesota model	20.5	3	Confrontational counseling	43	11
Exercise	20.5	3	Psychotherapy	44	18
Stress management	22	3	General alcoholism treatment	45	20
Family therapy	23	3	Educational lectures	46	23



**Self-assessment exercise:** *What are the treatment approaches most frequently used in your work environment?*

## Considerations for the Referral Process

Typically, the referral process for at-risk drinkers includes:

- 1) **Determining the specific needs of the client to determine the most appropriate referral sources.** Of course, every client is different and has varying needs when obtaining assistance. Addiction professionals consider the many multicultural factors that impact the treatment process, such as race, gender, religion/spirituality and primary language spoken, as well as geographical constraints and financial factors, such as insurance coverage and out-of-pocket expenses, when making a recommendation so the client can be matched with the most appropriate referral resource for his or her needs.
- 2) **Evaluating and, whenever possible, removing potential barriers to successful engagement with the helping resource.** Potential barriers can include lack of access to child/elder care, lack of financial resources, transportation needs, lack of family support, legal complications and/or medical needs, to name a few. Identifying and addressing these barriers can help ensure the client accesses the assistance or treatment resource available to him or her.
- 3) **Explaining to the client in clear and specific language the necessity for and process of referral to increase the likelihood of understanding and follow through with the referral.**
- 4) **Arranging referrals to other professionals, agencies, community programs, support groups or other appropriate resources to meet the client's needs.** It is preferable for the referral to be arranged immediately using a "warm transfer" where the addiction professional connects the client directly with the treatment provider by telephone while the client is still in the office. However, if impossible, the addiction professional must contact the client within 24 hours to arrange the referral. At a minimum, the client must be provided with a written referral with the treatment provider's contact information, address and date and time of the first appointment or meeting.

The speed at which you can link a client to treatment dramatically impacts their likelihood to show up, stick with treatment and experience good outcomes. Research shows that if the gap between your session and first appointment for a different level of care is more than 14 days, failure is virtually certain.<sup>38</sup> Further, up to 50% of clients with serious alcohol or drug problems will not show up for a first appointment if put on a waiting list, and the longer the wait time, the greater the attrition.<sup>39</sup> Offering a treatment appointment date immediately<sup>40</sup> and reminding clients

of their initial scheduled appointment usually improves the rate at which clients will begin treatment.<sup>41</sup> The first 24 hours after a client's initial phone contact is a critical period in initiating treatment.<sup>42</sup>

## Motivation and Referral

For a client who expresses little motivation to go into more intensive treatment, the primary task is to engage her in a discussion that allows you to get a good understanding of how she sees her substance use and explains her decision not to choose treatment. When clients hear themselves describe their thoughts and feelings about their substance use to a non-judgmental listener, they are more likely to understand their mixed feelings and increase their level of motivation for treatment. You can facilitate this process by asking open-ended questions, making empathic reflections and using summary statements. The following is an example that shows how these three strategies can be used together:

*“So you’re saying that you know that drinking is bringing you down and messing up your relationships with your family, but you are just so tired and you feel like ‘what is another round of treatment gonna do for me?’ You think it’s possible that it’s partly the drinking itself that’s got you feeling this way, but you just don’t feel ready to commit to treatment yet. Is that what you’re saying?”*

After you make reflective listening statements that express an understanding of why your client does not want to go to treatment, then you can move on to the next steps. You might ask what would need to happen to raise her level of motivation. If her initial response is something vague or noncommittal like *“I don’t know,”* try saying something like:

*“It’s hard to know what could happen that could make you feel more motivated for treatment. Sometimes people get more motivated because some things in their life get worse, like health problems or money problems. Sometimes people get more motivated to go to treatment because something good happens that makes it easier for them, like they find out that they can get transportation there or their insurance will cover it. Do you relate to any of these?”*

If your client is willing to consider treatment options at this point, you could move to discussion of barriers to treatment and linkage to treatment. If your client is not willing, you might close the discussion with a summary statement that conveys that the option is open for more intensive treatment in the future.

*“You’re saying that you know that treatment can help people, and has even been helpful to you, but you just don’t want to go back to it at this time in your life because you don’t feel ready to give up drinking yet. You feel like you’ll know when you’re ready, and you’ll get treatment then. Did I get that right?”*

For a client who expresses moderate motivation to go into more intensive treatment, the primary task is to express understanding of her ambivalence and elicit change talk that will tip the

balance in favor of your client agreeing to treatment. This can be done by exploring ambivalence, expressing empathy and reflecting:

*"Tell me about some of the reasons why you would be motivated to go to treatment."*

*"Tell me about some of the reasons why you would not be motivated for treatment."*

Use reflections to express empathy toward her responses. For example:

*"So, you're saying that you want to go to treatment because you're sick of being tired and grouchy. You really sound tired of that life."*

*"I see the way you light up when you talk about how you'd like to be a better mom to your kids."*

You will experience more success by accepting the fact that your client is ambivalent and that sometimes she will not feel like acknowledging the potential benefits of treatment. Always remain client and express empathy. Double-sided reflections that include both sides of your client's ambivalence show her that she is understood:

*"So, what I'm hearing is that you don't really feel like going to treatment now because of how much work it is, even though you think it would make things better for you and your family."*

Ask questions that invite your client to describe the potential benefits of treatment:

*"How do you think it would affect your life if you went into treatment?"*

*"It sounds like you feel that going to treatment could help your health. Tell me more about what makes you say that."*

For a client who expresses high motivation, avoid trying to convince her that she is making a good choice, because such a response could run the risk of raising pushback in someone already motivated. Instead, allow your client to explain her reasons for that motivation:

*"You indicated quite a bit of motivation to get treatment for your alcohol use right now."*

*"Tell me some of the main reasons for that... You mentioned some health concerns."*

*"Is that also related to why you want to get treatment? How so?"*

Explore possible ambivalence. This is helpful because it lets your client know it is OK to talk about her reservations. The reason to discuss ambivalence is to decrease the likelihood that these reservations will result in her not following through. You might approach discussing ambivalence in a highly motivated client by saying:

*“You’re describing a lot of reasons why it would be a good idea for you to get treatment for your alcohol dependence. Sometimes even when someone is really motivated to get treatment, they might have some negative feelings or concerns about doing that. How about you?”*

Support change talk, expressing recognition and appreciation that your client is committing to do something that a) is not easy; b) is a positive step to improve her life; and c) is taking this step willingly and openly.

*“I appreciate that you’ve been so open in looking at the ways alcohol has been complicating things for you. Now you’re planning to take back control of your life by going to intensive treatment (or taking medications, or involvement in a support group). That’s a really positive step you’re taking, and I know it’s not easy.”*

The number one reason that people who felt that they needed treatment for their substance use problem but did not get it is COST. SAMHSA found that the most often reported reason for not receiving treatment among adults and adolescents who felt a need for treatment and made an effort to receive treatment was not being able to afford it (37%). Nearly 1 in 10 individuals had health coverage that did not cover substance use treatment and 9% feared that seeking treatment would negatively impact their jobs.<sup>43</sup> When discussing treatment options, explore insurance coverage, concerns about costs and how it might impact her job.

Take care to discuss resources that are free or have a sliding fee scale. SAMHSA’s online treatment locator is available at <http://www.samhsa.gov/treatment> and National Help Line 800.662.HELP (4357) and offers confidential, free, 24-hour-a-day, 365-day-a-year, information services in English and Spanish for individuals and family members facing substance abuse and mental health issues. The Help Line service provides free referral to local treatment facilities, support groups and community-based organizations. If the client has no insurance or is underinsured, provide a referral to the local state office responsible for state-funded treatment programs, as well as offer referral to facilities that charge on a sliding fee scale or accept Medicare or Medicaid.

If your client simply is not interested in treatment at this time, rather than push her and jeopardize future opportunities, it is important for you to accept and respect her decision in a non-judgmental manner. She may be more willing to accept the notion of treatment during future sessions or at some later time. Follow-up with these clients is essential, as your initial conversation could have ignited some thoughts of change.



**Video Resource**

Boston University's BNI-ART Institute produced several excellent brief videos that might be helpful to you when discussing referral:

- Video 1 - insensitively confronting a client with an alcohol-related injury
- Video 2 - an alternate, respectful brief intervention with the same client
- Video 3 - an exceptionally sensitive video of a clinician helping an ambivalent client make his own decisions and plan to get intensive treatment

These videos are located at:

<http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/>

**Scheduling Treatment Appointments**

When a referral to another health professional, behavioral health practitioner or treatment program is appropriate, there are several steps you can take to facilitate a successful link. Consider making a 3-way call involving you, your client and the treatment program or provider immediately after the client consents to treatment. The purpose of the call is to:

- inform the treatment staff or clinician of your client's substance use, treatment barriers or ambivalence;
- agree on whether the program or some other treatment option is best;
- gain support from the program to solve or remove some of the treatment barriers (e.g., transportation, cost, insurance coverage, child care, evening appointment); and
- schedule an appointment.

Having this call within 3 days of gaining your client's consent is best; after that, no show rates climb steeply. After 14 days, about 50% of clients will not show for treatment, regardless of their motivation. Making a referral that your client does not reach wastes her time and yours. Again, as Gustafson rightly points out, we cannot blame the baton that is dropped during a relay race. We should not blame our clients if they do not show up.

**Communicating with Referral Sources**

It is essential that you and the treatment program or provider be able to share information and share responsibility for helping your client. A *Sample Release of Information* form is included in Appendix I of this Learner's Guide. These are only examples. Make sure that your release forms comply with your state and federal substance use medical record confidentiality laws and HIPAA. A *Sample Client Update Report* is also located in Appendix J of this Learner's Guide to



help facilitate quick communication between professionals so everyone involved can stay informed of the client's progress, status and additional needs.



**Application exercise:** *What treatment options would you recommend to the following clients from earlier in the training program? (Refer back to the completed AUDITs corresponding to these role-plays for more specific information.)*

**Remember Role-play #2 - Client:** You are a 42-year-old man/woman who seeks some help because you feel like you have very little energy and feel depressed and blue. If asked about alcohol use, you might say something like: *"I drink 4 or 5 drinks most days after work and a few more on the weekends. It is really the only way I relax. I have a lot of stress in my life, and it is just my release. I don't see any problem with it."*

**AUDIT score of 25**

**Remember Role-play #3 - Client:** You are a 56-year-old man/woman who is worrying all the time about being laid off. You have had several acute feelings of panic and doom, which also worry you a lot. You know that the company has already downsized, the economy is struggling and older workers always get cut first. Sometimes you just feel like blowing up, the pressure gets so high. You feel you have to work harder than the younger workers. If asked about your drinking, you might say something like: *"I don't think I need to stop drinking. I only have a couple of glasses of scotch or maybe a beer or 2. I have been doing this for 35 years. My health is good and besides, I don't have long to go."*

**AUDIT score of 12**

## Follow-Up and Support

From your first encounter with your client, discuss that you would like to **follow-up** with her, regardless of her decisions about continuing to meet with you, cutting down on unhealthy drinking or getting additional treatment. Clients generally do not know what to expect from counseling. If follow-up is presented as the standard of care and what you do for all of your clients, very few will refuse.

**follow-up**  
contacting your  
client at a later time  
to provide additional  
support, if needed

Reconnect with your client after a couple of weeks or perhaps longer to see if she got what she needed from you, to ask how things are going and to check-in to see if any additional services are needed. There are two overlapping types of follow-ups that are distinguishable mainly by how soon they occur after your session and the amount of information that you collect:

- **Booster and linkage follow-up** – Controlled research studies have shown that a brief telephone call within a few days or weeks to a client who received a brief intervention for unhealthy alcohol use dramatically reduces alcohol intake, unhealthy drinking practices, alcohol-related negative consequences and alcohol-related injury frequency.<sup>44</sup> The booster and linkage follow-up reinforces the action plan made, demonstrates your concern for your client's health and well-being and gives you both an opportunity to resolve barriers or ambivalence through additional brief intervention. A booster follow-up also gives you an opportunity to re-administer the AUDIT-C (and other screening tools) to assess change in alcohol use consumption since the last interaction with your client.
- **Recovery management follow-up** – This type of follow-up generally occurs several months after your last interaction with your client with high risk alcohol use. These are primarily booster and linkage reconnections that give you and your client opportunities to assess whether problems have been resolved, assess need and motivation for additional services and to reinforce changes that have been made since your first contact. They also give you an opportunity to measure change and gather feedback for improving your services. These follow-ups can occur quarterly or 6 months after the initial contact with the client.<sup>45</sup>

### Making Phone Contact

Follow-ups are brief contacts, generally not more than 15 to 20 minutes and should always utilize Motivational Interviewing and Cognitive-Behavioral techniques outlined in the next module. The follow-up may begin with a brief, casual conversation as a way to get reacquainted. You could also remind your client that you had told her you planned to follow-up with her.

*“You may recall that when we spoke some time ago, I stated that I would try to check back in with you to see how you are doing. Is this OK with you? Do you have any questions?”*

Confidentiality is an essential element of any outreach to a client. If you call and get her voicemail, you might say:

*"Hello. This message is for [your client's name]. This is [your name]. I'd like to take a few minutes to speak with you. Please call me at [your work number] between the hours of [time]. If I don't hear from you, I will try back again on [date]."*

If you reach your client, you might say:

*"Hi, [name of client]. This is [your name], and I'm following up on the conversation we had on [date]. This will only take a few minutes. Is this a good time to talk?"* If yes, continue; if no: *"OK, that's not a problem. We can schedule an appointment to talk another time. I am available [day, times]. Which time would work best for you?"*

If client does not agree to a time, you might say:

*"I understand how hard it is to find a good time. Did you have any questions about why I'm calling? [pause for response] OK, I'll go ahead and leave my number with you. I look forward to talking with you soon."*

The goal of the call and of the addiction professional is to help client solve the problems for which they initially contacted you and to link people to supports and services that they may need now before they experience any major problems. The follow-up is also an opportunity to address concerns that were identified during the interaction (e.g., unhealthy alcohol use) and to measure change (e.g., reduction in alcohol consumption) since your client's last contact with you. You can ask some of the same questions (e.g., the 3-item AUDIT-C) that your client was asked when she first sought help, so that you both can see what has improved, what still might be troubling her and how you can offer additional services.



**Role-play #4 for live training:**<sup>46</sup> With a partner, practice giving feedback, alcohol education, concern and advice and referral to treatment if necessary. One person will act as the addiction professional who has administered the AUDIT. Your partner will act as a client who scored a 7 on the AUDIT and has sought help for stress and depression. Refer to the completed AUDIT on the following page to learn more about the client's drinking patterns.

**Client:** You are a 35-year-old pregnant woman, who called with concerns about feelings of stress and depression. You are concerned about the financial stresses of the new baby, your 2 other kids and childcare. If asked about your alcohol use, you might say something like: *"I stopped going out to drink with my friends as soon as I found out we were pregnant. Sometimes I will have a glass of wine, never more than 2 at night but not very often. I heard that wine is okay. I don't smoke, I don't do drugs, I wouldn't do anything that would harm the baby."*

## Role Play #4 – Completed AUDIT-C and AUDIT

**Read questions as written. Record answers carefully. Begin the AUDIT by saying “I am going to ask you some questions about your use of alcoholic beverages during this past year.” Code answers in terms of “standard drinks.” Place the correct answer number in the box at the right.**

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	3
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	0
3. How often do you have 5 (for men under age 65)/4 (for women and men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	0
AUDIT-C Score (add items 1-3): Positive screen=4 for men/3 for women and men over age 65. If positive, ask the next 7 questions to administer the full AUDIT.						3
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	0
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	0
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	0
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	0
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	0
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	4
<b>AUDIT Score (add items 1-10)</b>						<b>7</b>

# Module Five

# Counseling Techniques and Strategies

## Motivational Brief Intervention<sup>47</sup>

Change is difficult. Brief interventions are designed to help your clients take the first steps towards making healthy changes. Techniques from Motivational Interviewing (MI) and Cognitive-Behavioral Therapy (CBT) form the core of brief interventions. Your client has to choose to change and to do the work. Brief intervention techniques are used to help your clients explore the negative and positive effects of their alcohol use, their motivations to change negatives, confidence and competence to effect changes and options and plans that they generate and carry out.

You, the addiction professional, cannot provide the motivation to change by browbeating or humiliating your clients to change. A confrontational style addresses clients like they are “out of touch with reality, dishonest, incapable of responsible self-direction, deficient in knowledge and insight and pathologically defended against change.” These assumptions place the addiction professional in a role of “correcting error[s], combating delusion, taking charge, educating, breaking down defenses and being the client’s link to reality.”<sup>48</sup>

### **Examples:**

*“You are going to lose your job (kids/marriage) if you don’t stop drinking.”*

*“You are wrecking your life because of your drinking. You have to stop or it’s going to kill you.”*

*“Why don’t you stop drinking? If you really wanted to you would.”*

*“You are depressed (or stressed/anxious) and your drinking makes it worse. You aren’t going to feel better until you stop. Just do it!”*

This approach is rarely effective. In fact, “four decades of research have failed to yield a single clinical trial showing efficacy of confrontational counseling, whereas a number have documented harmful effects, particularly for more vulnerable populations.”<sup>49</sup>

Not all clients want to change their behavior. They may not feel that they have a problem with alcohol or that it’s their first priority. Even when an individual’s job is at risk if change is not made and sustained, the choice to change is the client’s. Your role with your clients is to ignite the internal motivation they have to change for their own reasons. Motivation can best be described as:

***Motivation - internal and external forces and influences that move an individual to become ready, willing and able to achieve certain goals and engage in the process of change.***

Clients at risk for alcohol-related work, health or social problems are much more likely to change their behavior if you use an empathic, client-centered, strength-based, motivationally enhancing style, focused on identifying and solving the client’s problems.

***Motivational counseling– a method of communicating that uses the perspective, ideas,***

***beliefs and strengths of an individual to evoke internal motivation to change behaviors.***

Motivational Interviewing (MI) is a collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a target behavior change by eliciting and exploring an individual's own arguments for change.

Brief motivational counseling is not a set of techniques or tricks for getting a client to do what you want. Rather, according to Drs. William R. Miller and Stephen Rollnick, the creators of Motivational Interviewing, it is "a skillful clinical style for eliciting from clients their own good motivations for making behavior changes."<sup>50</sup> The goal is for clients to arrive at the reasons for change that will be most influential to them, to create realistic plans to change and to monitor steps taken to correct or reinforce change. The aim is to help clients generate their own motivators to change their drinking.

**Examples:**

*"I don't want to lose my job because I drink too much. I like working here, but it is just so stressful. Most of the time, I drink to relax from a long day of working. I have to cut down."*

*"I know I have to stop drinking. My daughter is getting so big, and I don't want her to see me as a drunk (or as an angry/tired/overwhelmed mother)."*

*"My doctor tells me that I am hurting my liver by drinking so much. I guess I knew that was happening. I have felt my health deteriorate over the past several years."*

*"I really thought I had my drinking under control, but I can't seem to stop this depression I have been in. Maybe I will feel better if I get this drinking under control."*

MI also helps resolve **ambivalence**. Ambivalence is a hallmark of the change process. Even with wanted or positive changes, ambivalence is often present. It can impede progress if we do not address it. Addiction professionals need to pay special attention to normalizing client ambivalence through the use of empathic responses that normalize the experience.

**ambivalence**

having positive and negative considerations that have about equal weight and shift back and forth, keeping an individual from making a decision



## Ready to Change?<sup>51</sup>

People change their behaviors when:

- they become interested in or concerned about the need for change;
- they become convinced that the change is in their best interest or will benefit them more than cost them; and
- they organize a plan of action and take the actions that are necessary to make the change and sustain it.<sup>52</sup>

***“In a representative sample across more than 15 high-risk behaviors, it was found that fewer than 20% of a problem population are prepared for action at any given time. And yet, more than 90% of behavior change programs are designed with this 20% of the population in mind.”<sup>53</sup>***

Your clinical task is to help the 1 in 5 clients who are ready to make changes right now, and the 4 out of 5 clients who can move toward greater motivation and action.

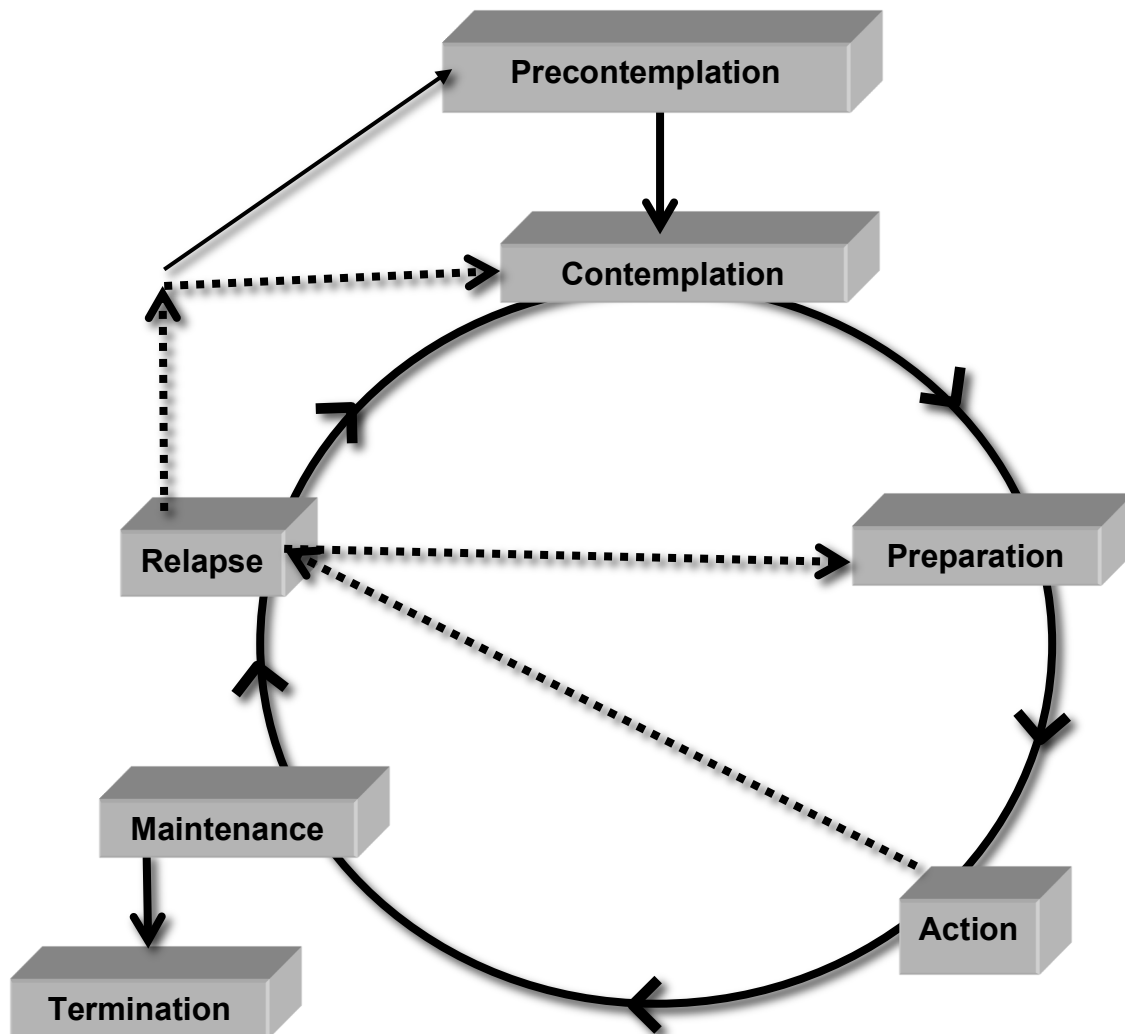
***Stages of Change model - a way to identify the important tasks needed to make change happen, better understand the treatment needs of that client and identify which treatment options are most appropriate given your client's level of motivation to change.***

Prochaska and DiClemente found five stages of change over hundreds of behavior change studies involving thoughts of clients:

- precontemplation – The client is unaware/under aware that her drinking is unhealthy, does not see a need to change, may feel hopeless, may wish others would change so she does not have to and has little or no interest in changing her drinking behavior in the foreseeable future.
- contemplation – The client is aware of her unhealthy drinking behavior, is considering possible changes in her behavior and is ambivalent about changing. Clients may feel hopeless about making a decision to change and sticking with it.
- preparation – The client makes a commitment to act and develops a plan to change (but has not made changes yet). She may test some initial steps and may feel hesitant or uncertain about success.
- action – The client takes the plunge and has started to change behaviors and thoughts to break patterns of unhealthy drinking and begins creating new behavior patterns.
- maintenance – The client is able to sustain changed behaviors and thoughts over an extended period of time, continues to make positive changes in other areas of her life and develops new coping skills to respond to stressors and changing environments.<sup>54</sup>



The practical skills of Motivational Interviewing (MI) and Cognitive-Behavioral Therapy (CBT) are used to help clients to progress through the Stages more rapidly than they would on their own. With your assistance, clients can move more quickly through the Stages. Some may regress to an earlier Stage even after progress has been made. Others may get stuck. The following chart illustrates the dynamic nature of the Stages of Change model:<sup>55</sup>



As an addiction professional, you have opportunities at whatever stage a client is in to assist her in enhancing her motivation, skills and commitment to change.

- *precontemplation* – Raise awareness of ambivalence and increase recognition of risks and negatives problems that result from your client's unhealthy drinking. The *Decisional Balance Worksheet* is located in Appendix K to help your clients assess the reasons for wanting or not wanting to change.
- *contemplation* – Tip the balance in your client's ambivalence by generating reasons for changing and risks of not changing, supporting her confidence about her ability to change unhealthy alcohol use patterns.
- *preparation* – Increase your client's commitment to discontinue her unhealthy alcohol use, develop options, choose among them and commit to a viable and acceptable plan.
- *action* – Help your client implement her plan, revise it as needed and sustain her commitment to change even when faced with difficulties and setbacks.
- *maintenance* – Turn changes in thinking and behaviors into healthy habits, resolve problems as they arise and sustain changes that make it difficult to go back to old, unhealthy patterns.<sup>56</sup>

## Motivational Interviewing Skills Used in Brief Interventions<sup>57</sup>

When addiction professionals use Motivational Interviewing (MI) techniques, many clients with substance use-related problems decrease their alcohol and drug use; reduce their risks of injury, DUI, job loss, home and social dysfunction; and engage in and complete substance use treatment.<sup>58</sup> Many addiction professionals feel that they already use MI techniques in their clinical practice. Research studying actual clinical sessions shows big gaps between theory and practice, even in highly trained MI clinicians.

Great emphasis is placed on understanding the spirit of MI. It's the combination of MI techniques and conveying the spirit of MI that makes MI effective. How you think about and understand the intervention process is vitally important in shaping it. MI holds a belief that each person possesses a powerful potential for change and understand that ambivalence to change is "normal." There are three fundamental aspects of MI:

- *collaboration* – partnerships
- *evocation* – listening and eliciting from the client
- *autonomy* – respecting the client's ability to choose

Remember, you cannot make a client change. This belongs to the client.

The following eight skills from MI can be used effectively to help clients reduce their risks of alcohol-related problems:

- 1) *Asking open-ended questions*
- 2) *Affirming the client*
- 3) *Utilizing reflective listening*
- 4) *Summarizing the client's thoughts and feelings*
- 5) *Eliciting change talk*
- 6) *Asking permission and giving advice*
- 7) *Generating a menu of options*
- 8) *Managing pushback*

Each of these MI skills is important to use right from the beginning of a brief intervention and can be used in every interaction you have with your clients.

These eight motivational counseling skills will help your clients with unhealthy and dependent alcohol use to move through the Stages of Change to reduce their risk.

- *Your primary focus of brief interventions with moderate risk clients is motivating them to reduce risk by changing their drinking patterns.*
- *Your primary focus for high risk clients also is to reduce their risk of alcohol-related problems. Often, this will involve motivating them to engage in treatment specifically addressing alcohol dependence, other substance use and mental health problems.*

Each skill is described in this module, with examples provided.



**Presenter role-play #5 for live training:**<sup>59</sup> The presenter and a volunteer from the audience will demonstrate some of the techniques that you are learning. For this situation, the presenter will act as the addiction professional who has administered the AUDIT and determined the client to be at high risk of experiencing alcohol-related problems. The volunteer from the audience will act as a client who is seeking help for some bothersome problems. The addiction professional will practice providing a motivational brief intervention to this client.

**Client:** You are a 31-year-old who has recently had an affair, and you want to get help repairing your relationship. If asked about your alcohol use, you might push back and resist a little, but say something like: *“We normally have between 5 to 6 jack and cokes maybe 3 to 4 nights a week to help us relax and enjoy time together. I am not sure why you are asking about our drinking because I’m really here because of the infidelity and all of the resulting arguments we have been having. We both work and enjoy drinking on our time off. Drinking isn’t an issue but our relationship is.”*

## Motivational Skill #1: Asking Open-Ended Questions<sup>60</sup>

The way you ask questions can powerfully affect your ability to motivate your clients to change. An efficient way to gather factual information is to ask close-ended questions.

***Close-ended questions – questions that are phrased in a way to elicit a very brief or “yes” or “no” response***

**Examples:**

“Were you told to call me?”

“Do you have a problem with alcohol?”

“Are you married?”

Your client could easily answer with a brief, factual answer or with a “yes” or “no” to each of these questions. You will have to ask more questions to understand why your client answered as she did. This could start a series of longer questions from you and short answers from your client. Although this may be an efficient way to gather intake information, it is not an effective way to engage your client in a productive working relationship. Open-ended questions are more helpful in developing rapport and creating the opportunity to support and encourage your client's existing motivation to change.

***Open-ended questions – questions that are phrased in a way that encourage your client to explore and share her feelings, experiences and perspectives***

**Examples:**

“What was it that prompted you to meet with me today?”

“How would you describe your relationship with alcohol?”

Both methods of asking questions can gain important information. The goal of asking a question in a clinical interaction is to elicit a thoughtful answer that will give you an understanding of your client's perspective and enable her to explore her problems and efforts at solutions. Open-ended questions invite your client to discuss an issue for as long as she deems necessary and allows her to identify what information she regards as most important. They also provide you with the opportunity to listen.

Open-ended questions encourage your client to include information not specifically mentioned in the question. These questions support **collaboration** because they put your client in control of the direction, pace and tone of the session and place you in a listening role. Compare the following interactions and judge for yourself which method of questioning seems more productive.

**collaboration**  
the process by which people work together to accomplish a common mission

**Conversation #1:**

Addiction professional: *"Did your friend ask you to call me for help?"*

Client: *"Yes."*

Addiction professional: *"Are you having problems at home?"*

Client: *"Yeah, sorta."*

Addiction professional: *"Has your friend suggested you call for help before today?"*

Client: *"Yes, but I didn't want to."*

Addiction professional: *"When was that?"*

Client: *"Last year."*

**Conversation #2:**

Addiction professional: *"What prompted you to meet with me today?"*

Client: *"My friend suggested it. He knows I'm going through a divorce, and I'm starting to having trouble at work."*

Addiction professional: *"Please clarify what you mean when you say, 'I'm starting to have trouble at work.'"*

Client: *"Well, my wife and I work in the same department. At first, I thought this was going to be an easy divorce because we both wanted it, but then we started arguing over custody of the kids. When things started getting nasty, it got harder and harder for us to work together, as well. It's getting to the point where I do everything I can to avoid her. Plus, I'm so worried about not being able to see the kids that I'm having trouble concentrating on my work, and I'm starting to make mistakes. I'm afraid I might lose my job."*

Although not every client will respond with as much information, the differences between these two interactions are clear. When open-ended questions were asked:

- the client is able to divulge a great deal of information that you would not have otherwise known;
- the client reveals important information about her experiences and critical incidents;

- the client talks more and you listen more, with you prompting and guiding the conversation;
- the client is more actively involved, focused on what she thinks is most relevant for you to know and has more control over the direction of conversation;
- the client shares more than just facts and reveals her emotions about the situation;
- you foster a conversation rather than an interrogation;
- the client feels supported, heard and understood; and
- you and the client have a better chance of developing a strong, therapeutic collaboration.

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### **Comparing Close-Ended and Open-Ended Questions<sup>61</sup>**

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<b>Close-Ended Questions</b>	<b>Open-Ended Questions</b>
<i>So, you are here because you are concerned about your use of alcohol, correct?</i>	<i>Tell me, what is it that brings you here today?</i>
<i>Is everything okay at work?</i>	<i>Tell me what it is like for you at work.</i>
<i>Do you agree that it would be a good idea for you to go for more intensive alcohol treatment?</i>	<i>What do you think about the possibility of going for more intensive alcohol treatment?</i>
<i>First, I'd like you to tell me about your alcohol intake. On a typical day, how much do you drink?</i>	<i>Tell me about your alcohol intake during a typical day.</i>
<i>Do you like to drink?</i>	<i>What are some of the things you like about drinking?</i>
<i>How has your alcohol intake been this week, compared to last: more, less or about the same?</i>	<i>What has your alcohol intake been like during the past week?</i>
<i>Do you think you drink alcohol too often?</i>	<i>In what ways are you concerned about your drinking?</i>
<i>How long ago did you have your last drink?</i>	<i>Tell me about the last time you had a drink.</i>
<i>Did you know there are several medications available to help you stop drinking?</i>	<i>There are several medications available to help you stop drinking. How do you feel about this idea?</i>
<i>When do you plan to quit drinking?</i>	<i>So what do you think you want to do about your drinking?</i>

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In addition to the positives of asking open-ended questions, there is also potential for serious negative effects of asking close-ended questions. Because you have to generate a list of questions from assumptions and incomplete information about your client, close-ended questions may be presumptive, invasive or leading. You can end up with partial or inaccurate information and generate defensiveness. For example, if you were to ask, *“Did either of your parents abuse you as a child?”* your client is forced to answer a question that she may not be ready to explore or may not have a clear answer. Furthermore, this question introduces the idea of abuse into your client’s consciousness and could indicate to her that you think or believe that she may have been abused. Even though you may believe that you are simply asking a standard question, your intentions may not be clear to the client. This method of questioning can damage the relationship, making your clients more passive and turning sessions into question and answer interactions. In general, open-ended questions are exploratory, not as threatening and are less leading than close-ended questions.

With close-ended questions, there is a potential to incorrectly assume facts or circumstances based on your client’s responses. For example, the question, *“Did either of your parents abuse you as a child?”* includes several assumptions. If your client responds *“no,”* you might presume that she had not been abused by her parents. However, if she does not feel comfortable using the word *“abused”* and might interpret her experience with her father as *“strict discipline,”* important information is lost. A client’s understanding of what went on in her family is revealing, and open-ended questions better allow her to express it.

Open-ended questions typically begin with words such as *“what”* and *“how”* or phrases such as *“tell me about...”* Often, open-ended questions are not technically questions but are statements that implicitly ask for a response. Open-ended questioning can be time-consuming and could elicit unnecessary information. It is your responsibility to keep the session focused, while still allowing your client to explore her emotions and thoughts.



## Motivational Skill #2: Affirming Your Client<sup>62</sup>

***Affirming – recognizing your client's strengths and accomplishments, complementing or making statements of appreciation and understanding***

Clients with substance use problems are often overwhelmed by feelings of shame and inadequacy. Affirming is a strength-based approach to support client **self-efficacy**, which is their self-confidence that change is achievable. Affirming makes it more likely that clients will recognize their own capacity to discuss difficult topics and appreciate their ability to alter them. This is done by the addiction professional demonstrating appreciation and understanding through the use of compliments and reflective listening statements that recognize your client's strengths and capacity to change. Affirming statements do not have to be complex or lengthy; they must simply be sincere, timely and positive.

**self-efficacy**  
an impression that one is capable of performing in a certain manner or attaining certain goals

### **Examples:**

*"It was wonderful talking with you today."*

*"Thank you for being on time."*

*"That is a great idea."*

Affirming is a skill that is intuitive to most addiction professionals. When affirming a client:

- **focus on strengths**

*"I have noticed that you are really good at identifying strategies which help you reduce stress."*

- **encourage your client's persistence in spite of past problems**

*"You really showed a lot of strength to talk to your girlfriend about your most recent fight. It took courage to go back to speak with her respectfully and calmly."*

- **make encouraging statements and elicit positive responses**

*"You are making great progress. Tell me how you feel in comparison to 2 weeks ago."*

- **acknowledge the positives**

*"It seems to me that work is going better for you. You are getting to work on time and are no longer getting into trouble for being late. That must feel really good."*

- **point out and celebrate steps taken so far**

*"I am very proud of your progress. You have come so far in 3 weeks."*

- **remind your client of past successes**

*"I know this appears very difficult to overcome. You have been able to do it before."*

- **compliment willingness to talk about difficult issues**

*"Thank you for taking a few minutes to talk with me about your alcohol use. I appreciate your openness and sharing your experiences and thoughts with me today."*

- **celebrate your client as a person**

*"You are a kind and warm person. I can see how this problem affects you."*

## Motivational Skill #3: Utilizing Reflective Listening<sup>63</sup>

Ideally, most of your time in a session should be spent listening. By carefully listening to your client and responding with reflective listening statements, you encourage and support your client's ability to explore and problem-solve her problems.

***Reflective listening – also known as parallel talk or paraphrasing, occurs when you carefully listen to a client's thoughts, perceptions and feelings then restate them for the purpose of clarification and further exploration***

The primary goals of reflective listening are to:

- 1) help you accurately understand not only what your client is *saying* but also what she is *meaning* by her words;
- 2) help your client clarify her thoughts; and
- 3) reassure your client that you are listening and understand her point of view.

One of your main tasks is to help your clients accurately identify their feelings, thoughts and perceptions. Clients often have difficulty accurately describing how they feel about a particular situation and often have conflicted perceptions and emotions. Reflective listening statements can help your client clarify her thoughts and emotions and help you better understand her. For example, a client may say, *"I hate my job. I should just quit."* You might assume that she does not like her job. However, by making reflective listening statements, you can encourage her to explore her feelings further, as well as clarify your understanding of the true nature of her work-related issues.

### **Example:**

Client: *"I hate my job. I should just quit."*

Addiction professional: *"You hate your job and think it would be better for you to quit."*

Client: *"Yeah! My boss is always hassling me to work faster, work harder. But it is hard to work at that pace all day. I'm under so much pressure. I go home, drink wine and watch TV to unwind. Then, the next day, I get so tired by lunchtime, my head starts pounding, and I feel nauseous. I can't keep up with everything he is asking of me."*

Addiction professional: *"Let me see if I understand you. Because your body is hung-over from the previous night's drinking, you are finding it difficult to perform at work."*

Client: *"Yeah, I guess so."*

The example above illustrates how a client may say one thing and mean something entirely different. Taken at face value, she hates her job because her boss tells her to work hard. Actually,

she is not performing at work as expected due to the physical effects related to excessive drinking. Reflective listening statements help your client feel she is being heard and allows the discussion to stay focused and truthful.

Reflective listening statements help you avoid “roadblocks,” that prevent clinical progress. Examples of roadblocks include:

- commanding
- threatening
- prematurely giving advice
- moralizing
- criticizing
- shaming<sup>64</sup>

Roadblocks tend to break-up or change the direction of your client’s thought-processes and make it more difficult for your client to explore her thoughts and feelings. Even some responses that might seem helpful or therapeutic (e.g. approving, reassuring and agreeing) can be roadblocks. These kinds of comments insert a judgment or a perspective that can shut down or redirect the conversation and the client’s free expression.

Here are several reflective listening phrases you can use to clarify and reflect back your understanding of what your client is trying to convey:

- *I understand the problem is...*
- *I’m sensing...*
- *I wonder if...*
- *I get the impression that...*
- *As I hear it, you...*
- *From your point of view...*
- *In your experience...*
- *I’m picking up that you...*
- *Where you’re coming from...*
- *You mean...*
- *Could it be that...*
- *Let me see if I understand. You...*
- *You feel...*
- *From where you stand...*
- *You think...*
- *What I think I hear you saying...*

You are not simply restating your client’s thoughts verbatim (although sometimes using the client’s own words can be very powerful). Rather, you are strategically restating your client’s words to encourage more thought and discussion.

Client: *“I don’t have a drinking problem. I just drink 4 or 5 times per week with my friends.”*

Addiction professional: *“You drink more days than not during a week, and you do not feel that you have a drinking problem.”*

Reflective listening may also include your inferences based on previous statements of your client, affect that mismatches content or other clinical cues. This is called “continuing the paragraph.” However, you need to be careful not to overreach and go too far beyond what your client is trying to convey.

Client: *“I don’t want to raise my kids like my parents. They never cared for us like they should because they were always drunk.”*

Addiction professional: *“You want a better life for your kids than what was provided to you. So you are here to ensure that alcohol does not interfere with parenting your children.”*

You can also pull out a few of your client’s words and repeat those to form a reflective listening statement.

Client: *“I got way too drunk last night and really feel it this morning.”*

Addiction professional: *“So, getting drunk last night did not feel good.”*

Most of your responses in a session should be reflective listening statements. It may feel much easier and comfortable for you to ask your client a series of questions. But, question and answer, with you asking the questions and your client answering, puts the responsibility for fixing your client’s problems on you. Your task is to help your client make her own solutions using her own resources and motivation.

Reflective listening statements work well with open-ended questions. As a general rule, you should try not ask more than 2 open-ended questions in a row and make at least 2 reflective listening statements after each open-ended question. For example:

Addiction professional: *“How do you feel about taking medication to help you stop drinking?”* (open-ended question)

Client: *“I try to avoid taking medication for any reason. They make me feel out of it.”*

Addiction professional: *“Your experiences with taking medication in the past make you uncomfortable with taking medication now for alcohol dependence.”* (reflective listening statement)

Client: *“Well, I just don’t like taking medication. I suppose I might be interested in a medication if I knew more about how they would affect me.”*

Addiction professional: *“I understand that you are uncomfortable with the idea of taking medication, and you are interested in learning more. (reflective listening statement) May I tell you more about the medications that are available to you?”*

Client: *“Sure.”*

## Motivational Skill #4: Summarizing Your Client's Thoughts and Feelings<sup>65</sup>

In a single session, your client may present a lot of overlapping bits of information about herself and the challenges she faces. Often, clients are not able to see how these bits fit together, or the similarities among the thoughts, feelings or situations that they present. Summarizing allows you to help your client see patterns, highlight similarities or inconsistencies and emphasize your client's choices and strengths.

### ***Summarizing – linking together statements or themes and presenting a condensed version***

Summarizing helps your client to change because it:

- demonstrates you are actively listening and remembering the current and previous conversations;
- reinforces information and brings into focus themes and strengths presented by your client;
- provides an opportunity for you to highlight aspects of your client's thoughts and feelings that support change;
- draws from the exact words spoken by your client that contain her own motivations for change;
- provides additional clarity to your client on her views and feelings and offers an opportunity to expand further on previously expressed thoughts and feelings;
- allows you to bridge from one topic to another; and
- allows your client to hear in your words what she has been saying and to correct misperceptions.

Summarizing is done with only a few sentences. Use it sparingly so as to not interrupt the flow of conversation. For example:

Addiction professional: *"How do you feel about taking a medication to help treat your dependence to alcohol?"*

Client: *"I don't particularly have a problem taking medication. I already take so many other pills for everything else. I just don't do well with taking a lot of pills several times a day."*

Addiction professional: *"So you feel you would respond best to a medication that is only taken perhaps once a day instead of 3 times a day."*

Client: *"Exactly. I have some meds that I take 3 times a day right now for my thyroid condition, and I forget to take it all the time. It is just too annoying to constantly have to think, "Is it time to take my medication?" every 3 minutes."*

Addiction professional: *"Ok, I hear you. You are open to the idea of medication, and you ideally would like to take one that is convenient. What else?"*

You might conclude a summary statement by asking your client an open-ended question, *"What else?"* rather than a close-ended question, *"Did I miss anything?"* This way, you are inviting her to generate as opposed to simply responding with, "yes," or "no."

Summarizing brings together thoughts and feelings your client may have presented at different points during the current session or in previous sessions. It also encourages your client to reflect on thoughts or feelings that she may not have seen as related or interconnected. For example:

Client: *"I don't understand why everyone seems to think I have a drinking problem. I only drink on weekends after a long, hard workweek. Everyone does that. I enjoy being out, watching a game, drinking and seeing friends. I'll even stay later, hanging around and drink with other friends as they come in later. It gives me a chance to be more social."*

Addiction professional: *"So, because you only drink on weekends when you feel stress from a long week at work, you feel you do not have a drinking problem any greater than the average person."*

Client: *"Right! So, I have a few beers to relax! I see the same set of guys up at the bar every weekend, watching sports and drinking just like I am. You don't see any of them sitting here right now, do you?"*

Addiction professional: *"You seem to have different perspectives on your drinking. On the one hand, you see yourself as just like your friends who are at the bar with you and, on the other hand, you see yourself as frequently drinking more than your friends and mentioned that they leave before you do."*

Linking phrases, such as, *"on one hand"* and, *"on the other hand,"* can help your client acknowledge her conflicting statements without aggressively confronting her inconsistencies. Linking summaries tend to stop the path of exploration and force your client to address only a certain topic. You can also use summarizing to correct faulty conclusions made by your client or redirect her arguments for not changing.

Summaries are most effective when used in conjunction with open-ended questions and reflective listening. This trio of strategies elicits change statements, gently encourages her to explore these statements further and reinforces your client's thoughts and feelings by repeating them aloud.

## Motivational Skill #5: Eliciting Change Talk<sup>66</sup>

Some clients walk into counseling ready to change their lives. They understand the negative consequences of their behavior and can see a potential new life ahead. Most clients are not as insightful or convinced of the need for change. For these clients, you are a guide or coach to help them figure out why they want to change and to create a plan based on their personal reasons and motivations to change.

The primary purpose of motivational counseling is to uncover and stimulate your client's internal motivations to modify unwanted behaviors or initiate new ones. An addiction professional does not have the power to "make" a client change. You probably do not control the incentives or the punishments to generate the external motivators to change. But, you can help your client verbalize the reasons for and advantages of changing behaviors that are unique to her. By eliciting change talk, you encourage your client to make their own arguments for changing unhealthy behaviors and to feel motivated to make changes they want.

***Change talk – statements said by a client that favor changing unhealthy behaviors and describe the reasons for and advantages of changing***

Change talk indicates that your client is moving forward in the process of change. When you hear change talk, this is a big, flashing sign that counseling is headed in the right direction. The more change talk from your client, the more likely she is actually going to change the problem behavior. You can highlight and encourage change talk by recognizing it when it is verbalized and appropriately responding to it to produce more of it.

There are several ways to elicit change talk:

- 1) **Ask evocative questions** – This technique is by far the simplest and most direct. These are open-ended questions geared towards 1 of the 4 categories of change talk. Examples:<sup>67</sup>

*"I can see that you are feeling stuck at the moment. What is going to have to change?"*

*"What worries you about your current situation?"*

*"What makes you think you need to do something about your drinking?"*

*"How has your drinking affected your job performance?"*

*"In what ways do you think you or other people have been harmed by your drinking?"*

*"In what ways has this been a problem for you?"*

*"If you were 100% successful and things worked out exactly as you would like with regard to your drinking, what would be different?"*

*"What are some advantages of changing your drinking habits?"*

*"How would you like for things to be different?"*

*"How would you like your life to be 5 years from now?"*



*“What encourages you that you can change if you want to?”*

*“When else in your life have you made a significant change like this? How did you do it?”*

*“What has increased your confidence that you can stop drinking?”*

*“What personal strengths do you have that will help you succeed?”*

*“Who could offer you helpful support in making this change?”*

*“What methods do you know about that you would you be willing to try to change your drinking?”*

- 2) **Use readiness rulers** – Readiness rulers, such as the importance and confidence rulers, can assist clients in determining how central or important changing is to them at present and how able or confident they feel about making the change.

The rulers give you and your client graphic feedback about progress and can stimulate reflection about your client's motivation to change. Client responses can be used to continue a conversation that hopefully elicits more change talk.

**Importance** – How important, or what is the current value, of the change to the individual? *“I want to stop drinking because it's getting harder to get up and get to work on time, and I could lose my job because of it.”* This individual is expressing her desire and reasons to change and is placing importance on changing.

**Confidence** – How confident are they in their ability to change? *“I would really like to quit drinking, but I am not sure I can. I have been drinking for so long, and I haven't been successful in the past when I have tried to stop.”* This individual is expressing a desire to change but is unsure of her ability to change.

To use the **importance ruler**, ask your client:

*“On a scale of 0 to 10, how important would you say it is for you to reduce or stop drinking, with 0 being not at all important and 10 being extremely important?”*

To use the **confidence ruler**, ask your client:

*“On a scale of 0 to 10, how confident would you say you are about being able to stop drinking, with 0 being not at all confident and 10 being extremely confident?”*

Once your client has answered either of these questions, support high scores and explore ratings by discussing her choice of numbers. You could ask:

*“What led you to pick a [6] and not a lower number like a [2]?”* (This question elicits reasons, need and/or desire to change.)

*“What would it take for you to go from a [6] to a [7]?”* (This question helps you generate options for a change plan.)

It is useful to also ask why ratings were lower. This gives your client an opportunity to explore their positive motivations to change and negative consequences of staying stuck. Asking why a low score was not higher invites your client to generate reasons not to change. Clearly, the goal is to help her to express reasons that motivate her to change and give her confidence that she can be successful.

- 3) **Explore the status quo** – Asking your client to express the advantages and disadvantages of continuing to drink in unhealthy ways, as well as the advantages and disadvantages of changing her drinking patterns can help her clarify her thinking. It allows her to verbalize the sides of her ambivalence that keep her stuck in unhealthy behaviors or thoughts. She may have never verbalized the positive benefits she gets from not changing. There are advantages and disadvantages to your client's current behavior; you can help your client to generate her own values or beliefs that can support positive change and the values or beliefs that sustain the status quo.
- 4) **Ask for elaboration** – When a client makes a change statement, you can reinforce the change talk by asking her to explore the thought in more detail. If she expresses that she drinks too much, you could ask her to say more about how much she is drinking, how often and what she considers is "too much." You might ask her to describe a specific example of when she drank too much. By describing this event, she is likely to describe negative consequences resulting from drinking and reasons she wants to change. By asking your client to elaborate on change talk, you can help her to more fully explore her motivations to change and reasons to tilt the decisional balance toward positive action.
- 5) **Ask about extremes** – Another way of eliciting change talk is by asking your client to describe the most extreme consequences that might occur if she does not change.

*"What are the worst things you could imagine happening to you if you do not stop drinking?"*

*"What scares you the most about continuing to drink?"*

On the other hand, asking your client about the most extreme positive consequences of changing her behavior can be beneficial as well.

*"What are the most wonderful things you hope to gain by stopping drinking?"*

*"Describe to me the most extreme thing you would like to do with your life if alcohol was not a part of it."*

You might also find it useful to ask your client to consider how likely she considers the extreme negatives or extreme positives to be. For example, how likely does she feel it would be, if she keeps drinking and driving after work, that she will get a DUI, lose her license,

injure someone or herself? How likely is it that, if she cut down on drinking, she would lose weight, get a promotion at work or feel healthy and positive about life?

- 6) **Look backwards** – Asking your client to describe and compare a time before she was drinking heavily and the present can highlight how much alcohol has negatively affected her life.

*“Do you remember a time in your life when your life was going well? Tell me about that time period.”*

*“Describe to me a memory you have from a time when you were not drinking heavily.”*

*“Suppose you were someone else describing you before you started drinking heavily. Tell me what she would say about you.”*

- 7) **Look forward** – Just as with looking backwards, asking your client to look into her future can elicit in her own words the likely outcome if she does not change unhealthy drinking behaviors.

*“Where do you think you will be 10 years from now if you continue to drink alcohol at this level?”*

*“What effects do you think your continuing to drink at these levels will have on your children 10 years from now?”*

On the other hand, asking your client to evaluate her future life without alcohol or drinking alcohol in a different way can plant the seeds of change by inviting her to envision herself leading a healthy life.

*“What do you think your life could look like 10 years from now if you stop drinking the way you do now?”*

*“What do you think your daughter’s life could look like 5 years from now if you stop drinking alcohol (or reduce your drinking to low risk levels)?”*

- 8) **Explore goals and values** – Asking your client to identify which goals and values she holds most important helps to highlight between what she wants and what she has now. You are helping to sharpen the positives and negatives of her current behavior from her own values and goals. Exploring your client’s values and goals gets her to reconsider her ambivalence about change from her perspective and motivation. Perhaps your client wishes to continue her education, get married, be a good parent or buy a car. All of these could be threatened by her drinking. If she places a high value on having friends and all of her friends drink heavily, then your efforts are focused on eliciting change talk involving non-drinking friends.

## Motivational Skill #6: Asking Permission and Giving Advice<sup>68</sup>

Generally, your client should be the source of ideas for changing unwanted behaviors. There are times when client are unable to explore their problems more fully or to develop appropriate course of action. You may have advice or insight that can move her forward toward change. When offering advice, ask permission and be clear that your client is in charge and is welcome to take the advice or leave it. The responsibility and strength to make healthy choices are ultimately your clients', not yours. Your role is to provide assistance, support and alternative perspectives.

Advice is a reasonable strategy in three situations:

- 1) **Your client specifically asks for your expertise** – Clients will often ask you for your opinion or recommendation. Some clients may want your technical advice, such as choice of an addiction treatment provider, medications or mutual support groups to try. Take care to evaluate the possible benefits and drawbacks before jumping in. Advice at this point is most beneficial when your client has explored all of her opinions on the topic first. At times, a request for advice is a way to divert from the hard, painful work that your client has to do to own the problem and the solution. If you feel that the timing is appropriate and your client has sufficiently engaged in exploring options, you could offer advice.
  
- 2) **Your client has granted you permission to give advice** – Many addiction professionals are very eager to offer their opinions, even when client have not asked for it. Consider holding back on unsolicited advice, unless three criteria are met:
  - You have elicited your client's own ideas and knowledge on the subject.
  - Your advice is important to your client's safety or will increase her motivation to change.
  - Your client has granted permission.

Asking permission reinforces that the strength and responsibility for change is your client's, not yours. Permission can be requested directly or indirectly:

*"I have a couple of thoughts about your plan of action. Would you mind if I shared them with you?"*

*"I don't know if this will work for you or not, but I could give you some ideas of what other people have done in your situation."*

A client could deny your request to provide advice. Your client “owns” the change process. If she is unwilling or unable to receive your advice, that is her choice.

- 3) **Your client is obviously headed in a direction that could be harmful** – Sometimes clients explore their ideas about how to change and decide on plans that are not helpful or that directly undermine their goals. In this instance, it is entirely appropriate for you to intervene and offer a different perspective. However, even at this point, your client does not have to listen or adhere to your advice. You must respect her autonomy. Regardless of the path chosen by your client, you must maintain a safe environment for her to come back and discuss her choices and the consequences resulting from them.

Client: *“I think I can still go to a bar to play pool with my friends without drinking too much.”*

Addiction professional: *“It sounds like that might be a difficult thing to do. It is clearly your choice, but can you think of some other activities to socialize with your friends that don’t put you at risk for drinking too much?”*

OR

Addiction professional: *“That seems like a risky thing to do. Tell me how that’s worked in the past for you.”*

## Motivational Skill #7: Generating Options<sup>69</sup>

***Generating options – assisting your client in developing alternative solutions to her current behavior, evaluating and choosing between options, testing that choice in practice and making necessary changes to achieve the client's goals***

Your client holds the responsibility of making changes in her life, or choosing the status quo. However, you can help her generate options and choose between them to solve her problems. By using the motivational skills of affirming, reflecting, summarizing and open-ended questioning, you can assist your clients toward changed behavior and thoughts.

- **Help your client explore her goals and create an action plan that contains achievable goals.** To help explore goals, use open-ended questions to initiate dialogue.

### **Examples:**

*“What changes are you thinking about making?”*

*“What do you think you will do? What can you do tomorrow? Or today?”*

*“What do you see as your options?”*

Developing a change plan has some similarities to developing performance management goals at work. Your client may find it helpful to use SMART goal setting guidelines. SMART stands for **S**pecific, **M**eaningful, **A**ttainable, **R**ealistic and **T**ime-bound. The following questions could be useful prompts for creating a client's change plan that is based on her strengths and capacities:

### **Examples:**

*“What will be your first (next) step?”*

*“What will you do in the next 1 or 2 days?”*

*“What goal have you set to achieve by our appointment next week?”*

*“What might get in the way?”*

*“How will you deal with those challenges?”*

For clients who are dependent on alcohol or who have significant problems with other drugs, mental illness or intimate partner violence, short-term goals might best focus on getting into intensive treatment, such as setting an appointment with an addiction professional or addiction treatment program. The *Setting Goals for Change Exercise*, which is located in Appendix G, and the *Change Plan Worksheet*, which is located in Appendix H, can help you and your client develop SMART goals. Discussing options for more intensive

treatment for addiction or other problems is no different from discussing other issues. The choice and responsibility is your client's, and you are collaborator and coach.

- **Develop a range of options.** Not all options for changing a problem behavior will be equally desirable or feasible. By developing several options and exploring the pros and cons of each, your client can choose which methods work best for her. Compare the following 2 conversations with an alcohol dependent client that further illustrates this concept:

**Example #1:**

Client: *"One of my goals is to stop drinking all together, but I honestly do not know how to do that. Do you have any suggestions?"*

Addiction professional: *"Well, you could enter into an inpatient treatment program."*

Client: *"No, I don't want to leave my daughter for that long. What would happen to my job? How would I pay my bills? I am not sure I am going to be able to do this."*

**Example #2:**

Client: *"One of my goals is to stop drinking all together, but I honestly do not know how to do that. Do you have any suggestions?"*

Addiction professional: *"Well, there are several different options available to you. You could enter into an inpatient treatment program or perhaps an outpatient program would work better for you. Some clients have had success taking a medication to help with their cravings and post-acute withdrawal symptoms. Some people benefit greatly from twelve-step and other mutual support groups. Which of these options seems the best to you, keeping in mind that you do not have to select just one option?"*

Client: *"I like the idea of getting help to reduce my cravings. That is what scares me the most about stopping drinking. Can you tell me more about medications? I also think I could do outpatient treatment for a while."*

By offering several options, your client can evaluate choices that are not appealing and ones that could work. Talking through the positive and negative aspects of options is another way to stimulate change talk and commitment to change. For example, if your client has previously tried mutual support groups, such as AA or Smart Recovery, and found they helped with heavy drinking for a while, but the feelings of craving got her back drinking, you might explore use of an oral or injectable medication for craving, periodic telephone counseling check-ups and return to the mutual support meetings.



## Motivational Skill #8: Managing Pushback<sup>70</sup>

Changing behavior is never easy. Even though clients may present as ready to change because negative consequences outweigh staying the same, it is likely that clients will exhibit some pushback to changing their problem behavior at some points in counseling.

***Pushback – responses that express opposition to an idea, observation or plan. It may be relational or in defense of continuing a behavior.***

The intensity of the pushback to change your client exhibits may be related to their previous lack of success at changing their undesirable behaviors.<sup>71</sup> Research indicates that your response to client pushback can either increase or decrease future pushback from your client.<sup>72</sup> Use the pushback as an opportunity to discuss your client's fears, concerns and ambivalence about changing.

The first step in managing pushback is to recognize it. According to Miller and Rollnick, these are four general types of resistant behaviors:<sup>73</sup>

- 1) **Arguing** – Your client contests your accuracy, expertise or integrity.
- 2) **Interrupting** – Your client breaks in and interrupts you in a defensive manner.
- 3) **Negating** – Your client expresses an unwillingness to recognize problems, cooperate, accept responsibility or take advice.
- 4) **Ignoring** – Your client shows evidence of ignoring or not following you.

Once you recognize pushback, you then can respond, taking care not to encourage more pushback. Dig through the noise of pushback and tune into what your client is actually trying to convey. An appropriate response to pushback validates your client's emotions, while decreasing the intensity of her pushback. This can be accomplished in several ways:

- **Simple reflection** – Acknowledge your client's disagreement without causing defensiveness.

Addiction professional: *"I hear what you are saying and can understand why you would feel that way."*

- **Amplified reflection** – Reflect back what your client has said in an exaggerated way. If done successfully, this encourages your client to back off a bit and will elicit the other side of her ambivalence. The tone of your voice is critical to this approach.

Client: *"My husband and friends think I have a problem with drinking. I am doing just fine."*



Addiction professional: *"So, you seem to believe you have complete control over your drinking."*

- **Double-sided reflection** – Acknowledge both sides of your client's ambivalence. This requires pulling together information she has offered throughout the session. Utilizing "and" instead of "but" can help maintain a balanced emphasis on each statement.

Client: *"I don't drink any more than any of my girlfriends."*

Addiction professional: *"On one hand, you say that you want to stop drinking because it is impacting your daughter and marriage, and on the other hand, your friends drink as much as you with no apparent negative consequences. I can see how you might be confused about this."*

- **Shifting focus** – Shift your client's attention away from the roadblock that is impeding her progress. Taking a "detour" can diffuse pushback, especially in difficult situations.

Client: *"I would not be here if it weren't for the positive result from the random alcohol test. I guess you are going to tell me to quit or lose my job."*

Addiction professional: *"Hey, I just met you. Why don't we first begin by talking about what was going on that led up to the positive alcohol test?"*

- **Reframing** – Acknowledge the validity of your client's perspective and observations but offer a new meaning or interpretation.

Client: *"I have always been able to handle my liquor. I could drink a twelve-pack of beer in one night and most people would not know that I was drunk. No matter how much I drink, I can still handle my business."*

Addiction professional: *"That is an interesting perspective, and I can see how you would view that as a benefit. Being able to drink that much without others noticing indicates a high level of tolerance and may mean you have a very great risk for developing the medical disease of alcohol dependence."*

- **Emphasizing personal control** – Communicate to your client that it is her decision whether or not to make a behavior change. This frees you of control and puts her in charge.

Addiction professional: *"It is not my place to tell you what you can or cannot do. I am simply here to help you understand your options and to assist with any elements of this process that you find troubling. How you live your life, including whether or not you choose to follow the recommendations made by the doctor, is ultimately up to you."*

- **Siding with the negative** – Agree with your client that she may not need to change. Often when you take the negative side, your clients will respond by presenting positive reasons to change.

Client: *“I don’t know if stopping drinking will really make that much difference in my life.”*

Addiction professional: *“Well, perhaps it won’t. You could keep drinking, or you could try stopping for a while and then see whether the problems in your marriage and your health improve. Then you can decide whether or not to return to drinking. If you choose to, I recommend drinking within the suggested Guidelines.”*

You can also create or intensify pushback when you behave in a way that shifts the power balance between you and your client. The following chart presents examples of six types of responses to a client’s pushback that you should avoid:<sup>74</sup>

<b>Responses to Avoid</b>	<b>Example</b>
<b>Arguing for change</b> – You directly take up the pro-change side of ambivalence on a particular issue and try to persuade your client to make a change.	<i>“You have no idea how wonderful your life can be if you were to just give up drinking. You could spend more time with your kids and husband; you would not be hung over in the morning; you would lose weight; and think of all the money you would be saving each month!”</i>
<b>Assuming the expert role</b> – You structure the conversation in a way that communicates that you “have all the answers.”	<i>“I have been doing this for a long time. I can tell you for certain that you are not going to be able to stop drinking while you are still hanging out with your friends at bars.”</i>
<b>Labeling</b> – You propose acceptance of a specific label or diagnosis to characterize or explain your client’s behavior.	<i>“I think it is important for you to acknowledge that you are an alcoholic before we can get anywhere in making you better.”</i>
<b>Claiming preeminence</b> – Your goals and perspectives override those of your client.	<i>“I’ve been in recovery a long time. You really need to listen to me. I’ve been where you are, and you need help.”</i>

## Sample Interaction #2: Brief Intervention with Moderate Risk, Non-Resistant, Contemplative Client

A video of this sample interaction is located at: <http://www.youtube.com/watch?v=uzUo3ORZC28>

### *Brief Motivational informed counseling with a non-resistant or contemplative client*

This is an example of a brief intervention with a client who is ambivalent about his drinking. He is open to discussing behavior change. The Addiction Professional focuses on amplifying his ambivalence in order to help him prepare to change his drinking behavior.

**Addiction Professional:** Alright, Steve, thank you for answering those questions for me. I appreciate your openness. (**Affirmation**) Would it be alright if I provided you some feedback? (**Asking permission to provide feedback or advice**)

**Client:** Yeah, I guess that'd be OK.

**Addiction Professional:** OK, great. Based on your answers to the questions I asked about your alcohol use, it appears that you are at moderate risk of experiencing health, social, and other problems due to your use. (**Providing feedback with permission**) What are your thoughts on this? (**Open-ended question**)

**Client:** Well, that surprises me. I don't think I have a problem with my drinking. I don't know why I scored so high.

**Addiction Professional:** It seems that the results are a bit of a surprise since you don't consider yourself to have a problem with alcohol. You're unclear about how you could be at risk. (**Reflection**) Would it be alright if I offered some feedback on this? (**Asking permission to provide feedback or advice**)

**Client:** Yeah, that'd be alright.

**Addiction Professional:** You mentioned before that you enjoy drinking on the weekends to relax and that you generally have about five or six drinks. You also mentioned that drinking has interfered with your work performance on one occasion and that your wife has expressed concern about your drinking. (**Summary**) According to the healthy drinking guidelines, it is recommended that healthy men your age drink no more than four drinks in one day and no more than 14 drinks in a week. Currently, you are drinking more than what is recommended. Drinking above the healthy drinking limit can put you at risk for health and other problems. (**Advice with permission**) So, given this information, what are your thoughts on your drinking?

**Client:** Well, I didn't know about the healthy drinking guidelines. I thought I could just handle my liquor. I don't even feel that drunk when I have six drinks.

**Addiction Professional:** So, it's new information to you that there are healthy drinking guidelines. Even though you don't feel that intoxicated having six drinks, you are still drinking more than is recommended for healthy men your age. (**Reflection**) Would it be alright if I shared some thoughts on that? (**Asking permission to provide feedback**)

**Client:** Yeah, that's OK.

**Addiction Professional:** You mentioned that you aren't feeling the effects of the alcohol even when you have six drinks. (**Reflection**) This is likely an indication that your tolerance has increased over time, meaning that it takes more alcohol to have the same effect. But drinking that much greatly increases the likelihood that you will or maybe are already experiencing some health problems. These could include hangovers, premature ageing, digestive problems, high blood pressure and inflammation of the pancreas. (**Feedback with permission**) Given this information, I'm curious to know how ready you are to stay within the healthy drinking limits. On a scale of one to ten – one being *not ready at all* and ten being *extremely ready*, how ready would you say you are? (**Open-ended question using readiness ruler**)

**Client:** Hmm, that's hard to say. I mean, I don't want to get sick or miss work due to my drinking. And I really don't want my wife mad at me. If staying within these limits meant I wouldn't have these problems, then I'd say I'm probably a seven in terms of being ready.

**Addiction Professional:** A seven is pretty high on the scale. It sounds like staying within healthy drinking guidelines is pretty important to you and that you are quite ready. (**Affirmation**) What do you think makes you a seven and not a lower number, such as a two? (**Eliciting change talk**)

**Client:** I think I'm ready to change something because I don't want those things to happen again. I don't want them to get worse. I don't want to put my job in jeopardy or upset my wife. (**Change talk**) Plus, my health is important to me. (**Change talk**)

**Addiction Professional:** Those sounds like very important reasons to change your drinking patterns. (**Affirmation**) Now, using that same one to ten scale, what would it take to move you from a seven, feeling quite ready, to a ten, feeling extremely ready, to change? (**Open-ended question using readiness ruler**)

**Client:** Well, I guess there are some reasons why I don't want to change. Like I said before, I enjoy going out with the guys. We like to watch the game and throw a few back. It's how I relax. They might wonder why I'm not letting loose as much. I don't want things to change with my buddies.

**Addiction Professional:** Your friendships sound like a great source of relaxation for you. (**Reflection**) How would it be if you explained to your friends that you are cutting back on your drinking for health reasons? (**Open-ended question**)

**Client:** Well, I guess if I made a point of it when I first started, explaining that it was due to my health, then that would be easier than explaining the other reasons. (**Change talk**) They would probably understand that better... (*Pauses.*) And they would probably hold me to it!

**Addiction Professional:** So, you see your buddies as people in your life that could help you stick to your goal. If you explained to them the importance of what you're doing, then you would feel even more ready to cut down on your drinking. (**Reflection**)

**Client:** Yes, if they see that it's something that I need to do and I can still go out and have a good time, then yeah, they will give me a hard time if they see me slipping up. Plus, they know how the wife feels. They might give me grief if they know I'm upsetting her.

**Addiction Professional:** It seems that your friends would recognize your goal as a reasonable one that would have benefits for your health and your relationship with your wife. Having such a support system may make achieving this goal even more doable. (**Reflection**)

**Client:** Yes, definitely.

**Addiction Professional:** Alright, Steve, I'd like to summarize our conversation to make sure I'm not missing anything. I really appreciate you being so open to discussing this with me. (**Affirmation**)

**Client:** No problem.

**Addiction Professional:** Today, we've assessed your current alcohol use pattern and discussed healthy drinking guidelines. Currently, you're drinking well above healthy drinking limits and have expressed that it is important to you to cut back on the number of drinks you consume. This is something that you are very ready to attempt and you believe that once you have your friends' support, you will be even more ready to commit to. (**Summary**) Do I have that right?

**Client:** Yeah, I think that pretty much covers it.

**Addiction Professional:** Great. In what ways can I support you in achieving this goal? (**Open-ended question**)

**Client:** I think just checking in about it next time would be helpful.

**Addiction Professional:** OK, then that's what we'll do. I'll be sure to check in with you about progress toward this goal in your next session. Now, let's discuss some of your other work-related concerns...

## Sample Interaction #3: Brief Intervention with Moderate Risk, Resistant Client

A video of this sample interaction is located at: <http://www.youtube.com/watch?v=25kE7p0-V0M>

### *Brief Motivational Interviewing informed counseling with a resistant or pre-contemplative client*

This is an example of a brief intervention with a client who does not yet recognize the potential negative consequences of his drinking. He is not open to discussing behavior change because he does not recognize that he has a problem. The Addiction Professional focuses on developing discrepancy between the client's values and his current drinking behavior in order to help him begin contemplating the pros and cons of his drinking.

**Addiction Professional:** Alright, Steve, thank you for answering those questions for me. I appreciate your openness. **(Affirmation)** Would it be alright if I provided you some feedback? **(Asking permission to provide feedback or advice)**

**Client:** Well, I don't know. That's not what I came here to talk about. I already answered all your questions. I'm really here to talk about my work performance. I'm not an alcoholic.

**Addiction Professional:** It sounds like addressing your work performance is important to you. And you mentioned previously that you missed work on at least one occasion because of your use of alcohol. **(Reflection)** I want to assure you that I'm not here to label you, but I would like to talk a bit about the possibility of a connection between your alcohol use and your work performance. Would that be OK, Steve? **(Asking permission to give feedback)**

**Client:** Well, I want to keep my job. If this is what I have to do, then fine, I'll do it.

**Addiction Professional:** This perhaps isn't the most comfortable conversation for you. I appreciate that you are willing to go on with it and also that you recognize the importance of working out some work-related issues. **(Affirmation)** So, on the one hand, keeping your job is a top priority for you and, on the other hand, you've noticed some things that are putting your job in jeopardy, such as not showing up for work when you're hung over. **(Double-sided reflection)** What are your thoughts about that? **(Open-ended reflection)**

**Client:** Well, I used a sick day because I was hung over. I think everyone does this once in a while. I mean, I was sick. I just partied too much. Not a big deal.

**Addiction Professional:** So, you noticed that going out drinking had an impact on your work and health. **(Reflection)**

**Client:** Yeah, but like I said, I was just hung over. It happens.

**Addiction Professional:** Being hung over seems like it's a pretty normal occurrence for you. **(Reflection)** Would it be alright if I shared some feedback with you on that?

**Client:** Here we go... OK. Yeah, go ahead if you think it's important.

**Addiction Professional:** Well, based on your answers to the questions I asked about your alcohol use, it appears that you are at increased risk of experiencing health, social, and other problems due to your use. You also mentioned that drinking has already interfered with your work performance on one occasion and that your wife has expressed concern about your drinking. **(Summary)** What are your thoughts about this?

**Client:** Well, it's like this. I don't want my wife upset with me. I obviously want to keep my job, and yeah, hangovers aren't pleasant. **(Change talk)** But I also don't think I'm doing anything wrong. I mean, I

deserve a break once in a while.

**Addiction Professional:** It seems reasonable that you deserve some free time to unwind and you find drinking with your friends to be a good outlet. You seem interested in finding a way to have the best of both worlds. (*Reflection*) I have some information that may be useful for you. Would it be alright if I shared it with you? (*Asking permission to give feedback*)

**Client:** Yeah, sure, go for it.

**Addiction Professional:** OK, great. According to the healthy drinking guidelines, it is recommended that healthy men your age drink no more than four drinks in one day and no more than fourteen drinks in a week. You mentioned before that you enjoy drinking on the weekends to relax and that you generally have about five or six drinks, which is a drink or two above the recommended limit. Drinking above the healthy drinking limit can put you at risk for work, family, health and other problems. (*Providing feedback with permission*) So, given this information, what are your thoughts on your drinking?

**Client:** Well, I don't know who came up with that, some doctor or somebody, but I really don't think having six drinks is too much. My buddies and I can put down a six-pack each and that's pretty normal. That's not going to cause us to lose our jobs or break up our marriages.

**Addiction Professional:** I'm hearing you say that you're not concerned that you are drinking above this limit and that it's pretty normal for you and your friends to consume this much alcohol. I also hear you saying that balancing work, your marriage and your friends is important to you. (*Reflection/affirmation*)

**Client:** Yeah, I mean I work hard, I have a good marriage and I deserve some time to relax. Sure, I mess up every once in a while, but it's not a big deal. Everyone does.

**Addiction Professional:** You mess up every once in a while. (*Reflection*) Tell me more about that. How does it feel when things don't go the way you'd like them to go? (*Open-ended question*)

**Client:** Well, bad, you know? That's not who I want to be. I want to keep it together, enjoy my down time but be a responsible person. (*Change talk*)

**Addiction Professional:** So, being responsible and keeping it together is a priority for you and you don't want your drinking to interfere with this. (*Affirmation*)

**Client:** Yes, I guess you could say that.

**Addiction Professional:** OK, Steve, it sounds like maintaining a healthy balance in your life is important to you. (*Affirmation*) How do you think staying within healthy drinking limits, that is, cutting back a couple of drinks to no more than four when you are out with your friends, would allow you to maintain that balance? (*Open-ended question*)

**Client:** Well, I guess I wouldn't be hung over as much. And my wife wouldn't get on my case. She might even be more agreeable when I tell her I'm going out with the guys. And missing work wouldn't be an issue. (*Change talk*)

**Addiction Professional:** Those all sound like really good reasons to stay within healthy drinking limits. I'm curious to know how ready you might be to make this change. Let me ask you this. On a scale of one to ten – one being *not ready at all* and ten being *extremely ready*, how ready would you say you are to stay within the healthy drinking limits? (*Open-ended question using readiness ruler*)

**Client:** Well, it's not something I thought about before. I didn't really think cutting back would be something that would make a difference. But, if you put it that way, I would say I'm probably a five.

**Health Professional:** A five. So, it's something you might consider, but you have a ways to go to feel ready to make this change. (*Reflection*)

**Client:** That's right.



**Addiction Professional:** OK, Steve. Why would you say you're a five and not a lower number, such as a one? (*Open-ended question; eliciting change talk*)

**Client:** Well, all the reasons we discussed. Like not missing work or upsetting my wife. (*Change talk*)

**Addiction Professional:** That's great. (*Affirmation*) And what do you think it would take to make you a higher number on the scale, such as an eight? (*Open-ended question*)

**Client:** Well, I'd have to believe that it would actually make a difference. If I was sure it would keep me from being hung over and having other problems, then I'd be more likely to do it. (*Change talk*)

**Addiction Professional:** Knowing that it will be effective is critical for you to make this change. (*Reflection*) What would it look like if you gave it a try to see if it's something that you would want to continue doing? (*Open-ended question*)

**Client:** I mean, I guess I could give it a go, just for kicks. It couldn't hurt. (*Change talk*)

**Addiction Professional:** Ok, good. It sounds like you're willing to commit to trying this at least once. (*Affirmation*) If you find that it is something that is beneficial for you, it might be something you can continue to incorporate into your life long-term. (*Reflection*) Would it be alright if I followed up with you on this during our next session?

**Client:** Yeah, that would be OK.

**Addiction Professional:** Excellent. Thank you for being willing to have this conversation with me and being open to some new ideas. (*Affirmation*) Now, what else would you like to discuss?

*It is implied that the brief intervention is part of a longer session that continues.*



**Role-play #5 for live training:**<sup>75</sup> Partner with two other participants to practice some of the techniques that you are learning. For this situation, one person will act as the addiction professional who has administered the AUDIT and determined, based on an AUDIT score of 19, that the client is at high risk of experiencing alcohol-related problems. One person will act as a client who is seeking help for some bothersome problems. Another will be the addiction professional who practices providing a motivational brief intervention and referral to this client. The third person will act as an observer and rate the addiction professional on the MI skills used. Refer to the completed AUDIT on the following page to learn more about the client's drinking patterns.

Refer to the Quick Reference Guides in Appendix L of this Learner's Guide to help facilitate the conversation.

**Client:** You are a 52-year-old x-ray technician whose partner was diagnosed with cancer 3 months ago. You are seeking help because you feel "unhappy" inside. If asked to talk about your life, you might say, *"I don't really feel like talking about it. I've had a hard life, and I've had to fight hard for everything. But everything keeps being taken away from me."* You are reluctant and do not think you drink a lot since you only drink to excess on the weekends.

**If Asked About Pros & Cons:**

**PROS:** It helps you escape and numbs the pain that you have to keep inside all week. Then when you get home after work on Friday, *"I open up the cabinet and I feel the sadness lift as I pour my first glass and then another."*

**CONS:** *"I cannot lose my job."* Lately, you have been calling in sick to work on Mondays because of your alcohol intake on Sunday. **If pressed for more cons:** You know that alcohol has caused you some problems in the past, and you don't want them repeated.

**When Asked About Your Readiness:** You think that your readiness is about 3 out of 10. It's not a 1 or a 2 because you don't want to lose your job while your partner is not working, but you feel unmotivated to change a problem that only occasionally gets out of control.

**If the Addiction Professional Suggests Plan/Next Steps:** You feel like you can cut back whenever you want. However, you feel stressed and sad at the moment, and you're not sure stopping drinking at this point in time will help. **If pressed:** You agree that you are drinking to not feel as sad on the weekends, but it does start to "turn super sad at a certain point in the bottle."



## Role Play #5 – Completed AUDIT-C and AUDIT

Read questions as written. Record answers carefully. Begin the AUDIT by saying "I am going to ask you some questions about your use of alcoholic beverages during this past year." Code answers in terms of "standard drinks." Place the correct answer number in the box at the right.

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	4
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	0
3. How often do you have 5 (for men under age 65)/4 (for women and men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	3
AUDIT-C Score (add items 1-3): Positive screen=4 for men/3 for women and men over age 65. If positive, ask the next 7 questions to administer the full AUDIT.						7
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	3
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	0
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	3
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	3
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	2
AUDIT Score (add items 1-10)						19

**Brief Intervention Observer Sheet**

Listen for examples of the helper's use of each of the MI Brief Intervention skills. As you hear them, place a hash mark (/) in the appropriate row. Make notes of good examples of each type so you can give helpful feedback.

Listener Response	Count (Hash Mark)	Good Examples
Open Questions		
Closed Questions		
Affirmations		
Reflective Listening		
Summaries		
Advice with Permission		
Eliciting Change Talk (includes rulers)		

## Cognitive-Behavioral Therapy and Coping Skills<sup>76</sup>

**Cognitive-Behavioral Therapy (CBT)** is based on the idea that distorted thoughts, not realistic ones, lead to unhealthy, negative emotions and behaviors. CBT is active and change-oriented. In order for your clients to master skills that help them change their unhealthy drinking and other undesirable thoughts or behaviors, they must first identify high risk situations, thoughts and cognitive distortions that increase the likelihood of negative outcomes and practice alternative behaviors and thoughts that result in positive outcomes. They must learn new ways of thinking and acting and practice the new skills in order to achieve a change in their thought processes.

Perfection is not the goal. Everyone makes mistakes, especially when learning new behaviors. By actively practicing new skills and cognitive strategies, clients will replace maladaptive habits with adaptive ones. Role-plays, constructive feedback, practice exercises ("homework" may have negative connotations) and more practice are fundamental to helping clients change learned, maladaptive thinking and drinking. It takes continuous practice to change the patterns etched in a person's brain.

Cognitive Behavioral Therapy (CBT) is a framework and set of tools to help your clients learn to think about their problems, whether with alcohol or other negative experiences and feelings, in a more realistic and positive way that will produce changes in the way that they feel and act. CBT is not a "feel good all the time" approach. For example, in the instance of your client's husband criticizing her in front of other people, the sudden death of a friend or family member or a poor performance appraisal at work, it is natural and healthy to be distressed and upset. However, anger, depression, drinking to excess, overeating or similar responses ("Consequences") can be unhealthy and destructive. Obsessing on these feelings and the resulting behaviors are what CBT techniques are designed to change.

Researchers have pointed out that many people who are alcohol dependent or use alcohol in highly unhealthy ways have common cognitive distortions:

- 1) They deny that they cannot control their drinking;
- 2) They believe they drink abnormally because of pain and that drinking relieves pain;
- 3) They do not see that drinking becomes the source of pain; and
- 4) They are ignorant and hopeless about solving this problem.<sup>77</sup>

"Stinking thinking," an Alcoholics Anonymous (AA) slogan, leads to "drinking thinking," then, usually, to drinking without thinking. From a CBT perspective, it is not the drinking itself that creates the problem but how people deal with their thoughts about drinking. Mutual support meetings encourage individuals to confront distorted thinking and to substitute thoughts incompatible with the negative consequences of heavy drinking and/or drug use. Slogans of AA

that specifically target “stinking thinking,” such as “Let go and let God;” “Live and let live;” “Easy does it;” “Keep it simple;” and “One day at a time,” are repeated frequently to change an individual’s perspective. AA’s *Big Book* points to the importance of restructuring thinking: “Some of us have tried to hold onto our old ideas and the result was nil until we let go absolutely.”<sup>78</sup>

In order to help your client identify thought patterns that are unhealthy and to relearn more adaptive cognitions and behaviors, ask questions such as:

- *How long have you been feeling this way? How much longer do you want to feel miserable about this? What pay-off do you receive from feeling so badly?*
- *Are you doing something to change the problem, or are you doing behaviors that make it worse? Do you know methods or ways to move away from unhealthy or unproductive thoughts and feelings? Are you feeling stuck? May I give you with some suggestions?*
- *Are your feelings or reactions to the events in your life proportional to the events that they seem to cause? Could you be avoiding a problem and denying that you are really upset about it?*
- *Are you making yourself unhappy or acting in an unhealthy or destructive way in a situation that is beyond your control?*
- *Are your expectations for the world and of yourself realistic?*

## Changing Beliefs

David Burns<sup>79</sup> developed several techniques to examine and change the “B” beliefs associated with depression. These techniques can be fruitfully used with clients who have other unhealthy and destructive feelings and behaviors, such as high risk alcohol or drug use.

### 1) Identify the distortions:

Have your clients write down a brief description of the actual situation or problem that is bothering her. Next, identify and rate each of her negative emotions and behaviors on a scale from 1 to 100. The third step is to write down and number each of her thoughts that come between the actual situation and negative emotions and behaviors (see gray text box above). She does not have to be overly precise in identifying specific distortions, as there may be overlap. The important thing is to find at least 1 cognitive distortion for every “Belief.”

As an example, suppose your client’s supervisor criticizes her work performance in front of others in her work unit. She might get upset and think, “I am a loser. I never get a break around here. I hate him and everything about this stinking job!” In response to these thoughts, she feels angry, depressed and has an urge to go home and drink heavily in order to forget her embarrassment and anger. What are the distortions in these thoughts?

2) *Examine the evidence:*

After your client writes down a negative thought and identifies the distortions in her thinking, ask her: *“What is the evidence for this thought?”* Because she feels so badly, and those feelings come immediately after being criticized, she believes that things are bad without checking the facts.

In the previous example, how could she examine the evidence to “talk back” to her automatic thought that *“I’m a loser! I never get a break around here”*? Is it really true that she never does anything right and she is never treated fairly? Examining the evidence helps focus on the specific problem rather than applying an absolute label.

3) *The double-standard:*

When she has a distorted thought (“Belief”), suggest that she ask herself: *“Would you say this to a close friend who was very much like you and had a similar problem?”* People are frequently much harder on themselves than on others. If your client makes a mistake, for example, she might rip into herself and think, *“I am such a worthless worm. I always mess up.”* However, if a friend made the same mistake, she probably would be supportive. Why not be equally encouraging to herself? Harsh messages to oneself usually do not help one do better; they are more likely to make one feel like giving up.

4) *Experiment:*

When your client identifies a distorted thought, have her ask herself if there is some way to test it to find out if it is really true, to do an experiment. For example, she might believe, *“I can’t have a good time unless I drink.”* or *“I can’t unwind from stress at work without drinking.”* or *“I can’t deal with my husband and the demands from my kids unless I get away with my friends for a bunch of drinks.”* Is this always the case? Can she set up situations where she could test this? It does not mean that there is no truth to her beliefs that using alcohol (or other unhealthy thoughts or behaviors) does not relax her or cope with stress. The belief that this is the only way that she can relax or cope is simply not true, and it is helpful for her to make a change in her thought processes.

For example, to develop a role-play during a session, you could ask your client to recall a situation in the recent past where it would have been desirable to use a new skill (e.g., a client wanted to start a conversation but could not; another wanted to express negative feelings towards her spouse but could not without drinking first). Alternatively, you could ask her to describe a difficult situation that may arise in the near future that calls for use of the skill (e.g., She is going to a retirement party one night this week and will be offered alcoholic drinks).

## Triggers

Your client can be aware of her urges or desires to use alcohol or to participate in other behaviors that have a risk of negative outcomes or they have been hidden from her awareness, showing up in thoughts, feelings or behaviors that may seem automatic. Urges to use alcohol in

risky situations or to use in such quantities and frequency that your client's health, work performance or family is jeopardized may be triggered by something external (people, places, events, experiences or objects) or internal (feelings or thoughts). When your client experiences cravings or urges to use alcohol in an unhealthy manner, her thoughts and feelings determine how she will cope.

**Triggers** are thoughts, feelings, events, people, places that stimulate or increase your client's desire to use. **External triggers** may be people, places, events, situations, objects or even smells or sounds that directly or indirectly increase your client's sense of urgency to use alcohol or other substances. Drinking buddies or co-workers may trigger an intense desire, as can places where she has previously been drinking (home, office, bar, package store, friend's house, TV room, sporting event) trigger a desire to drink. Some situations can be triggers, such as after-work "happy hour" or work travel. Sights, smells, sounds (e.g., music, sight of beer) related to alcohol could increase risk. Desire to use may be linked with certain times or days, such as early evenings, Thursday night happy hour after work or weekend sports games.

Sometimes cravings are caused by **internal triggers**, such as thoughts, feelings, memories or physical sensations. Intense feelings such as stress, anxiety, depression, tiredness or anger can trigger desires to use. Negative emotional states are common triggers of unhealthy use, as are positive thoughts and memories. For example, internal triggers can be thoughts like: *"I don't really have a problem," "I can handle my drinking," "I worked hard and need to relax," "I need to change, but it's not worth the effort" or "I can't stand not drinking (or using drugs or tobacco), so why fight it?"*

## Assessing High Risk Situations

Recording triggers, the intensity of the urge to use that is associated with them and strategies used for coping can be a powerful exercise. If drinking changes the way a person acts, thinks and feels, it could be useful for your client to figure out what situations she is most likely to drink in and what she is thinking and feeling about these situations. She will try to find out what kinds of things are triggering or maintaining her drinking. Then, she will develop other ways to deal with high risk situations without drinking or drinking to excess.

To help your client identify high risk situations, you might ask:

- *In what kinds of situations do you drink? What are your triggers for your drinking?*
- *Can you give a specific example?*
- *Can you remember your thoughts and feelings at the time?*
- *What were the positive consequences of your drinking?*
- *What were the negative consequences of your drinking?*



Below are 2 practical exercises you might suggest your client do between sessions:

- 1) **Make a list of craving or risk triggers.** Circle the triggers that she can avoid or to which she can reduce her exposure (e.g. not having alcohol in her home or not going to a bar at happy hour).
- 2) **Keep a trigger self-monitoring diary.** Use whatever words your client feels most comfortable with to describe her thoughts or feelings associated with desire to use. It also helps if she can be aware of the physical and emotional feelings that are associated with the urge to use in excess or in an unhealthy way. These might include anxiety, tension, sweaty palms, irritability, tiredness, thirst or scratchy throat. Suggest that she take a few minutes at the end of the day to review how strong her urge to drink was. If she was exposed to a triggering situation but did not drink, what did she do or think to reduce the urge to drink? There will probably be days during which she experiences a temporary increase in her urge to drink. Those days are particularly useful to review what may have been triggering external situations or internal feelings or thoughts (e.g. menstrual period, stress overload, excessive working). It is very helpful to pay close attention to the coping strategies that she uses to avoid using, especially in the days of increased urge to use. *Sample Triggering Self-Monitoring Diaries* are located in Appendix M of this Learner's Guide.

Perhaps the most logical way to deal with triggers is to avoid them in the first place. Getting rid of alcohol in the house, not going to parties or bars or reducing contact with friends who drink can be helpful. However, sometimes triggers cannot be avoided, and it is necessary to find a way to cope with them. There are many different strategies for coping with triggers. You might suggest that your client generate a list of alternative behaviors, thoughts or coping strategies to use with her triggers. Examples might include:

- 1) **Get involved in some alternative activity.** Reading, a hobby, going to a movie and exercising (jogging, biking) are good examples of alternative activities. Another alternative behavior could include eating, as most people do not feel like drinking after eating something sweet.
- 2) **Talk it through.** Talk to friends or family members. Talking about urges can be very helpful in relieving the feeling or thoughts around drinking alcohol.
- 3) **Challenge and change thoughts.** Many people have a tendency to remember only the positive effects of alcohol and often forget the negative consequences of drinking. It can be helpful to remind oneself of the benefits of not drinking and the negative consequences of drinking. She may not really feel better if she just has 1 drink, and she can remind herself that she may stand to lose a lot by drinking. Sometimes it is helpful to have these benefits and consequences listed on a small card that your client can keep with her. What she tells herself about her urges to drink will affect how she experiences and handles them. Her self-talk can be put to use to strengthen or weaken her urges.

The process of making self-statements becomes so automatic that your client may not notice that she does it. Hidden or automatic self-statements about urges to use (triggered situations, emotions) can make it harder for your client to handle an urge. For example, *"Now I want a drink. I won't be able to stand this. The urge is going to keep getting stronger and stronger until I blow up or drink."* Other types of self-statements can make the urge easier to handle, such as, *"Even though my mind is made up to stay away from drinking for now, my body will take a while to learn this too. This urge is uncomfortable, but in 15 minutes or so, I'll be feeling like myself again."* Below are 2 basic steps to using self-talk constructively:

- 1) Pinpoint what you tell yourself about an urge that makes it harder to cope with it. One way to tell if you are on the right track is when you hit upon a self-statement that increases your discomfort. That discomfort-raising self-statement is a leading suspect to challenge, since it pushes your buttons.
- 2) Use self-talks constructively to challenge that statement. An effective challenge will make you feel better (less tense, anxious, panicky) even though it may not make the feelings disappear entirely. The most effective challenges are ones that are tailored to your specific upsetting self-statements.

Here are some challenges to self-talk that your clients may find useful:

- *What is the evidence? If I do not have a drink in the next 10 minutes, will I die? Has anyone (who has been detoxed) ever died from not drinking?*
- *What is the evidence that people who are recovering from an alcohol problem do not experience the feelings that I have? What is the evidence that there is something the matter with me or that I will never improve?*
- *What is so awful about that? What is so awful about feeling bad? Of course, I can survive it. Who said that stopping drinking (changing other undesirable behaviors or thoughts) would be easy? What is so terrible about experiencing an urge to drink? If I hang in there, I will feel fine. These urges are not like being hungry, thirsty or needing to relieve myself. They are more like a craving for food or an urge to talk to a particular person. They pass, in time.*
- *I am a regular human being and have a right to make mistakes. Maybe I worry about being irritable, preoccupied or hard to get along with. What is so bad about that? We all make mistakes, and in a situation that is complicated, there is no right or perfect way to get along. My most memorable lessons, invariably, are learned in the "school of hard knocks." It's a school that every single one attends throughout life.*

Here are some exercises for your clients to do between sessions:

- 1) **Make up a craving/risk plan.** Pick 2 or 3 of the general strategies discussed above and make up a plan about how you will put them into practice when you experience an urge to drink or engage in similar risky behaviors. Triggers and urges to use can come when you



least expect them. Some of the substitute thoughts or self-statements will only be necessary or helpful initially, as ways of distracting yourself from persistent urges. You will have an easier time if you replace the uncomfortable thoughts with other activities. After a while, it will feel less unnatural. Many of the urges will diminish and drop out, and you will not need constant replacements.

2) **Answering.**<sup>80</sup> Once your client recognizes her negative thoughts, she can begin answering them. The secret to answering negative thoughts is to realize there are different interpretations of any event and some are closer to reality than others. When answering her thoughts, try to consider a wide range of possible interpretations, not just the negative ones. Answering negative thoughts is important, but she will also have to act differently. By practicing different self-talks, she can replace old thinking habits and strengthen the new ones. A good way to answer negative self-talks is to ask questions of yourself and your automatic thoughts:

- **What is the evidence?** Ask yourself: *"Would this thought hold up in a court of law or is it circumstantial?"* Just because you had a stressful day at work, it does not mean that every day is stressful or that it is so stressful that you have to drink. Give yourself a fair trial before you convict yourself.
- **Am I making a mistake in assuming what causes what?** Causes are rarely simple. Many people think that they drink too much (or eat too much, etc.) because they have no willpower. Scientists have been studying alcohol dependence for years, and they don't know what causes it. They know that there is a big genetic component and that there are cultural, psychological, familial and economic factors that contribute. Saying lack of willpower causes alcoholism or unhealthy drinking is an oversimplification. Specifics are difficult to pinpoint.
- **Am I confusing a thought with a fact?** This can lead to trouble, especially if your client calls herself names and then believes them. There is an old story that makes this point: *"How many legs would a dog have if you called the tail a leg? Five? Wrong. The answer is four. Calling a tail a leg doesn't make it so."* Do not be dogmatic about thoughts. Look for the facts.
- **All-or-none terms?** Does your client see the world in either/or or black and white terms (*"I'm ugly and everyone else is beautiful"*)? Just about everything is in degrees and on a continuum.
- **Is she using ultimatum words in her thinking?** (*"I always should be nice or no one will like me."* *"If I don't stop drinking forever, I'm a total loser."*) If she places ultimatums on herself with these thoughts, is she holding herself to an unmatchable and inhuman standard? These thoughts relate directly to how she feels and acts.

- **What is the source of her information?** Consider her sources. People have their own reasons for what they tell you. Is she depending on unreliable sources and spreaders of gloom to tell her how it is? Why let other people define reality or define my feelings of worth?
- **Is she confusing a low probability (a rare occurrence) with a high probability?** What is the likelihood that a catastrophe would actually occur? Do awful things happen every time?
- **Is she overlooking her strengths?** When people feel locked in negative emotions or self-defeating behavior patterns, they overlook or discount the problems they have solved in the past. Your client might ask herself: *"How have I handled situations like these in the past? What tools have I used in other situations that have been successful?"*
- **What does she want?** What are her goals? Does she want to be happy and get the most out of life? Is this negative thought getting her what she wants? How can she change this thought to be positive and get what she wants out of life?
- **How would she look at this if she were not drinking?** How would others (nonpartisan viewers) interpret this situation? Imagine how she will react to it once she is not drinking (or engaging in other negative behaviors or feelings).
- **What can she do to solve the problem?** Are her thoughts leading to problem solving (generating solutions) or to problem blockage? If her kids are fighting and her job is at risk, thinking about the "unfairness of it all" doesn't lead to any solutions.
- **Is she asking herself questions that have no answers?** (*"How can I redo the past?" "How can I be someone different?" "How can a relationship that's ended not be over?"*) Questions like these often can only be answered with questions. *"Why should this happen to me?"* Answer: *"Why shouldn't it?"* *"What if something terrible happens?"* Answer: *"So what if it does?"* Asking yourself unanswerable questions is another way of demanding that the world be different than it is. That exempts your client from changing – and the result is staying stuck.
- **What are the distortions in her thinking?** Once she pinpoints the errors, she can correct them. Examine the list of cognitive distortions at the beginning of this section for examples.
- **What are the advantages and disadvantages of thinking this way?** Ask if there are advantages in thinking, *"I hate this house, I hate this neighborhood, I hate this city and everything in it."* Probably few. The disadvantage is that this type of thinking can stop her from feeling pleasure from what she has.

- **What difference will this make in a week, a year or 10 years?** Will anyone remember (let alone care) in 10 years that she made a stupid remark at a party or had dandruff on her sweater? People often believe that their mistakes will be frozen forever in others' minds.

It may be useful to suggest that your client focus on the 3 A's of overcoming negative moods and behaviors:

- ✓ Be **AWARE** of your alcohol use.
  - Be aware of your moods and the situations that influence them.
  - Be aware of your automatic negative thoughts.
- ✓ **ANSWER** these thoughts.
  - Ask questions, challenge the assumptions behind these thoughts.
  - Replace the negative thoughts with positive ones.
- ✓ **ACT** differently.
  - Use your problem-solving skills to deal with issues that previously resulted in unhealthy drinking and other negative behaviors and moods.
  - Increase your positive activities.
  - Decrease your involvement in unpleasant activities.
  - Reward yourself for the positive steps you are making.

Below is a useful checklist of cognitive distortions ("Beliefs") that can be uncovered and countered to reduce clients' risk of unhealthy alcohol use:<sup>81</sup>

- 1) **All or nothing thinking:** You look at things in absolute, black-and-white categories.
- 2) **Overgeneralization:** You view a negative event as a never-ending pattern of defeat. *"I always fail."* or *"I fail at everything I ever try."*
- 3) **Mental filter:** You dwell on the negatives and ignore the positives.
- 4) **Discounting the positives:** You insist that your accomplishments or positive qualities *"don't count."*

- 5) **Jumping to conclusions:** (A) *Mind reading* – you assume that people are reacting negatively to you when there is no definite evidence for this. *“Everyone there thought I was fat and ugly.”* (B) *Fortune-telling* – you arbitrarily predict that things will turn out badly.
- 6) **Magnification or minimization:** You blow things out of proportion or you shrink their importance inappropriately. Blowing negative events out of proportion, overlooking the fact that *“nothing really bad happened.”* Glossing over saving and positive factors.
- 7) **Emotional reasoning:** You reason from how you feel: *“I feel like an idiot, so I really must be one.”* or *“I don’t feel like doing this, so I’ll put it off.”*
- 8) **“Should statements”:** You criticize yourself or other people with *“should”* or *“shouldn’t.”* *“Musts,” “oughts,” “coulds”* and *“have tos”* are similar offenders.
- 9) **Labeling:** You identify with your shortcomings. Instead of saying, *“I made a mistake,”* you tell yourself, *“I’m a jerk,”* or *“a drunk,”* or *“a loser.”*
- 10) **Personalization and blame:** You blame yourself for something you were not entirely responsible for, or you blame other people and overlook ways that your own attitudes and behaviors might contribute to a problem. This pattern of thinking leads you to believe that all situations and events revolve around you. Thinking all situations and event revolve around you. *“Everyone was looking at me and wondering why I was there.”*
- 11) **Either/or thinking:** *“Either I’m a loser or a winner.”* Not taking into account the full continuum.
- 12) **Taking events out of context:** Focusing on 1 or 2 less than favorable aspects of an event to shape your opinion of the entire event. *“I completely blew the interview.”*
- 13) **Jumping to conclusions:** *“I have a swollen gland. This must be cancer.”*
- 14) **Self-blame:** Blaming total self rather than specific behaviors that can be changed. *“I’m no good.”*
- 15) **Magical thinking:** *“Everything is awful because of my bad past deeds.”*
- 16) **Comparing:** Comparing yourself with someone else and ignoring all of the basic differences. *“Cher has a better figure than me.”*
- 17) **Catastrophizing:** Putting the worst possible construction on events. *“I know something terrible happened.”*



**Role-play #6 for live training:**<sup>82</sup> Partner with two other participants to practice some of the techniques that you are learning. For this situation, one person will act as the addiction professional who has administered the AUDIT and determined, based on an AUDIT score of 16, that the client is at moderate risk of experiencing alcohol-related problems. One person will act as a client who is seeking help for some bothersome problems. The addiction professional will practice providing a motivational brief intervention and referral to this client. The third person will act as an observer and rate the addiction professional on the MI skills used. Refer to the completed AUDIT on the following page to learn more about the client's drinking patterns.

Refer to the Quick Reference Guides in Appendix L of this Learner's Guide to help facilitate the conversation.

**Client:** You are a 26-year-old who is concerned because you recently injured your wrist in a fight, have been missing work and arguing more with your family. You were living with your significant other, but caught him/her cheating on you. So, you moved in with your mother and father, who are not too happy about you being there. You were blowing off some steam with friends a few nights ago when a fight broke out. When you returned home, your parents insisted you go to the hospital to get your wrist checked out. You drink 1 to 2 beers during the week and 4 to 6 drinks on most weekend nights. You also sometimes smoke pot on the weekends but only if a friend has some. You think this kind of drinking is the "norm" for most people your age.

**If Provider Asks About Pros & Cons:**

**PROS:** Everyone you know drinks like you do; it is a part of your social life. You enjoy the slight buzz you get when you drink, and it especially feels good after a long week of work. It helps you to have fun and forget about all your work.

**CONS:** At first, nothing you can think of. **If provider prompts you about regrets:** You admit that you blacked out when you injured your arm and are not quite sure what happened. You are lucky you did not hit your head. Although your wrist still hurts, the bruising is gone and it is not swollen anymore. You concede that it was probably the alcohol that made you black out.

**When Asked About Your Readiness:** You identify yourself as a 2 on the Readiness Scale and feel that there is not really a need to change your behavior. **If provider asks "why not 1?":** You do not want to black out again. You are pretty confident that if you want to change in the future, you will be able to do it on your own.

**If the Addiction professional suggests Plan/Next Steps:** You do not really feel that drinking is a problem, but you agree that maybe drinking so much that you black out is not a good thing. So you agree to try to drink less, drink slower and make sure there is a friend to watch out for you.

## Role Play #6 – Completed AUDIT-C and AUDIT

Read questions as written. Record answers carefully. Begin the AUDIT by saying "I am going to ask you some questions about your use of alcoholic beverages during this past year." Code answers in terms of "standard drinks." Place the correct answer number in the box at the right.

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	3
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	0
3. How often do you have 5 (for men under age 65)/4 (for women and men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	2
AUDIT-C Score (add items 1-3): Positive screen=4 for men/3 for women and men over age 65. If positive, ask the next 7 questions to administer the full AUDIT.						5
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	0
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	2
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	0
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	0
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	4
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	4
AUDIT Score (add items 1-10)						16

**Brief Intervention Observer Sheet**

Listen for examples of the helper's use of each of the MI Brief Intervention skills. As you hear them, place a hash mark (/) in the appropriate row. Make notes of good examples of each type so you can give helpful feedback.

Listener Response	Count (Hash Mark)	Good Examples
Open Questions		
Closed Questions		
Affirmations		
Reflective Listening		
Summaries		
Advice with Permission		
Eliciting Change Talk (includes rulers)		





# Module Six

# Specialty Topics

## Working with Physicians in Ongoing Care Coordination<sup>83</sup>

Clients who are identified as having unhealthy drinking patterns may need to be referred to a physician for additional services. Medical services for a client that are identified during the SBIRT protocol could be related to:

- alcohol-related physical illnesses or impairments;
- detoxification necessity;
- psychiatric conditions; and/or
- pharmacotherapy options.

## Maintaining Communication with the Physician<sup>84</sup>

It is imperative for you to coordinate these services with the physician, follow-up with your client to ensure services are being received and share information so that you and the physician are working together (with a signed Release of Information, of course - A *Sample Release of Information* form is included in Appendix I of this Learner's Guide). Below are some tips for you when referring to a physician to ensure that needed care is effective and consistent:

- **Locate a knowledgeable prescriber.** It is not uncommon for a client to not have a primary physician. If your client does not already have a relationship with a qualified physician who is knowledgeable about addiction medicine, you can recommend one. The American Academy of Addiction Psychiatry (AAAP) and the American Society of Addiction Medicine (ASAM) are organizations of medical professionals who have been specially educated and trained in the field of addiction medicine. You and your client can contact either of these organizations to locate a physician in your client's area.

**The American Academy of Addiction Psychiatry's (AAAP) physician locator program is located at <http://www2.aaap.org/client-referral-program>.**

**The American Society of Addiction Medicine's (ASAM) physician locator system is at <http://www.asam.org/>.**

**The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a searchable directory of drug and alcohol treatment programs.** It shows the location of specialty substance use treatment programs around the country that treat alcohol use disorders and drug use disorders. The SAMHSA Locator includes more than 11,000 addiction treatment programs, including residential treatment centers, outpatient treatment programs and hospital inpatient programs for drug addiction and alcoholism. The SAMHSA Locator does not list individual physicians, advance practice nurses, psychologists, social

workers or other addictions specialists who do not practice within licensed treatment programs. **This service is located at:** <http://findtreatment.samhsa.gov/>.

It is a good idea to develop a list of addiction physician specialists in your area, especially if your clientele lives in a small community or rural area where knowledgeable physicians are scarce. The more familiar that you are with these physicians and with their practices, the more smoothly your handoffs will be and the better the treatment will be for your clients.

- **Send a written report.** Maintain consistent communication with your client's physician so any concerns that arise during a session with you can be addressed by the physician (or vice versa). Significant clinical issues encountered or addressed by either you or the physician need to be included in your client's medical record. When information is in a medical record, it is more likely to be acted on. The most efficient way to update a physician on the status of your client or significant changes potentially impacting care is to submit a written report to the physician's office. This report can be submitted via fax, mail or email, depending on the communication preferences of the prescriber and must be in accordance with 42 C.F.R. § 2.
- **Make it look like a report - and be brief.** Since physicians maintain caseloads of hundreds of clients at a time, it is important that your written report be brief, concise and official. A report should include the date, client's name and date of birth, your contact information and any relevant information that needs to be conveyed to the physician so he/she may remain informed of your client's progress and current status. Client update reports should not be longer than 1 page. Reports that include lots of details and are longer than 1 page will probably not be read.
- **Keep the tone neutral.** You can provide details about your client's use or abuse of alcohol, prescription medications or illicit drugs. Avoid making direct recommendations about prescribing medications, as doing so could be practicing beyond the scope of your license. The physician will use his/her clinical judgment draw his/her own conclusions. Providing "just the facts" will enhance your alliance with your client's physician and make it more likely that he/she will act on your input.

## Alcohol-Related Illnesses or Impairment

While some clients will benefit from a brief intervention advising them to cut back in their unhealthy levels of drinking, some health conditions will warrant advising a client to abstain totally from drinking rather than reduce drinking. These conditions can range from chest pain or liver damage to frequent falling and blackouts. In this event, you are advised to direct the client to her physician for a full physical examination and recommendation for treatment. There are numerous other medical illnesses that are caused or complicated by heavy alcohol use. (A full list

of diseases and injuries resulting from unhealthy drinking is located in Module Three of this Learner's Guide.) GI distress, depression, several types of cancer, diabetes and hypertension are just some of the illnesses associated with heavy alcohol use. Medical treatment and collaboration with your client's physician is essential to good care.

## Detoxification Necessity

Clients who are unable to stop drinking on their own or who become physically ill when they try to stop drinking will need to be referred to a physician or a medical facility, such as a hospital, to assist with medical withdrawal. These clients report symptoms such as nausea, vomiting, anxiety, sweating, shakiness and heart racing several hours after the last consumption of alcohol. Untreated alcohol withdrawal can be life threatening for some; therefore, it is imperative that your client seeks medical care immediately. Clients who report these symptoms or who have experienced these symptoms in the past when they stopped drinking need medical monitoring and should never be encouraged to try to detoxify without it.

Detoxification is not substance use treatment. Only about 1 in 4 people who receive medically supervised detoxification follow-up to receive treatment for their addiction. This is the reason to remain closely involved in your client's care, so that the medical crisis of detoxification is followed closely by treatment for the addiction.

## Psychiatric Conditions

Untreated psychiatric conditions can seriously interfere with a client's ability to comply with pharmacotherapy and psychosocial treatment for alcohol dependence and can cause your client preventable suffering. Research shows that psychiatric conditions, such as major depression, generalized anxiety disorder, posttraumatic stress disorder, schizophrenia and personality disorders frequently co-occur with heavy alcohol consumption.<sup>85</sup> Some psychiatric symptoms resolve with abstinence and others lessen. Therefore, the physician should assess your client for these disorders and suicidal ideation or intent (or refer your client for assessment) and continuously monitor the progress of these disorders and their subsequent treatment. If your client drinks heavily and is seriously depressed, medical treatment of both is effective.

## Pharmacotherapy

Research has demonstrated that the combination of medication and psychosocial therapy combination is much more effective than either alone. When appropriately used, medical treatment with medications, combined with Motivational Enhancement or Cognitive-Behavioral "talk therapies" can:

- Reduce withdrawal symptoms that can lead to a return to drinking (e.g., acamprosate's hypothesized mechanisms of action);
- Lessen craving and urges to drink or use drugs (e.g., naltrexone's effects); and/or

- Decrease impulsive or situational use of alcohol (e.g., disulfiram).

None of the pharmacotherapies approved by the Food and Drug Administration (FDA) for alcohol dependence (naltrexone, disulfiram or acamprosate) have any mood-altering effects or abuse liability. The use of these medications is not “replacing a drug with a drug” but rather treating a medical illness with a medication. While you can recommend the use of medication-assisted treatment to a client and her physician, this decision is left to the medical judgment of the physician.

You can help your client who is prescribed medications to treat her addiction by monitoring adherence and reporting to the physician any relapses or noticeable changes that might be related to the medication or your client's physical health. You and your client's physician work together to maximize the effect of medical treatments by:

- Including discussions of pharmacotherapy in your sessions, using Motivational Enhancement and Cognitive-Behavioral techniques to surface and address any barriers or concerns your client is experiencing;
- Monitoring and reinforcing your client's action plan;
- Checking-up on adherence to the prescribed medication regimen;
- Witnessing your client's ingestion of the medication (if not beyond your scope of practice);
- Having your client use blister card packs or pill boxes as a reminder; or
- Involving family members in the medication adherence process (only with written consent from your client first).

You and your client's physician can work together to support attending mutual support groups,<sup>86</sup> and involving family members or significant others in treatment and action planning. Several websites list physicians who are specially trained to prescribe medications to treat addictions.<sup>87</sup> Research has shown that better outcomes are achieved the longer a person with a significant substance use problem remains in treatment, taking medications and attending complementary activities, such as mutual support groups.<sup>88</sup> As abstinence lengthens, other issues related to alcohol use become clearer and more amenable to treatment. Mutual support groups, such as Alcoholics Anonymous, Smart Recovery or Women in Sobriety, are not treatments but can be incredibly helpful supports.

Management of your client with an alcohol use disorder may be seen as a series of stages. The first stage is the physician assessing your client's suitability for treatment with a medication and determining *which* medication best fits the needs of your client. The next stage is providing and/or referring your client for psychosocial services. Finally, the physician continually re-assesses your client's response to medication, including both efficacy (*Is it working?*) and side effects (*Are there problems?*).

Because alcohol use disorders are chronic disorders, clients may need long-term use of medication or more than one episode of pharmacotherapy. Alternatively, other clients may benefit from using a medication over shorter periods of time to help them through a particularly stressful period or a situation that has typically elicited cravings for alcohol (e.g., a client may want to take disulfiram or naltrexone while visiting family members who drink excessively or at a class reunion). Your client and physician will decide together to begin and to subsequently discontinue pharmacotherapy when it is appropriate to meet their needs, such as when your client has maintained stable abstinence over a sustained period and is engaged in ongoing recovery, including community supports.

## Clients and Their Family Members<sup>89</sup>

Addiction affects families, as well as the individual. Addiction is not only about unhealthy substance use; it's about emotional and psychological trauma, as well. Living with addiction often results in cumulative trauma that deeply affects family members from the earliest stages of life throughout the life cycle.

Addiction develops in the individual and is maintained via family functioning. Family members often unwittingly engage in behaviors that maintain the addiction and sustain the addicted-distorted family system. Their attempts to control the chaos and confusion can result in experiencing a “loss of self,” shame, emotional numbing, low self-esteem, depression, anxiety, rage and interpersonal problems. The disease manifests itself in other family members in the form of enabling and often times use and abuse of substances, as well.

Growing up with alcohol abuse and/or illicit drug use in the home facilitates a spectrum of damaging childhood experiences that can create an environment of chronic emotional stress. These childhood traumas can lead to a wide array of negative health and social consequences that affect adult relationships at home and often in the workplace. Growing up in an environment of chronic emotional stress then sets the stage not only for an increased risk of developing substance use and/or mental health problems, it also increases the incidence of the leading causes of death – heart disease, chronic lung disease, liver disease, suicide, cancer, stroke and injuries over the life span.

An addictive family system is harmful to all members of the family and particularly damaging to children.<sup>90</sup> While it has long been known that alcohol and drug use are among the fuels that feed child abuse and other forms of family violence; what is less discussed is that the addicted family environment is unpredictable, sometimes dangerous, often filled with chronic emotional stress, and it can facilitate the development of depression and anxiety disorders that can have lifetime consequences. There are many traumatic consequences and learned behaviors that are often associated with exposure to addiction in the family. It is not uncommon for these symptoms to surface in adulthood as a post-traumatic stress reaction. For example:<sup>91</sup>

- 1) **Learned Helplessness:** A person loses the feeling that they can affect or change what's happening to them. They give up and become “helpless” which can also affect other areas of life.
- 2) **Depression:** Unexpressed and unacknowledged emotion can lead to flat internal world – or an agitated/anxious defense against feeling internal pain. Also, anger, rage and sadness that remain unexpressed or not understood leads to a lack of resolution and can be turned inward toward the self.
- 3) **Anxiety:** Free floating anxiety, worries and anxieties that are not identified or acknowledged may manifest as phobias, sleep disturbances or hyper-vigilance.

- 4) **Emotional Constriction:** Numbness and shutdown as a defense against overwhelming pain may lead to a restricted range of affect or lack of authentic expression of emotion.
- 5) **Distorted Reasoning:** Convoluted attempts to make sense and meaning out of chaotic, confusing, frightening or painful experience that feels senseless. Children may attach variously distorted meanings to chaotic behavior depending on their developmental level.
- 6) **Loss of Trust and Faith:** Deep ruptures in primary, dependency relationships and breakdown of an orderly world can create significant problems in all relationships.
- 7) **Hyper-vigilance:** This is the anxiety created by “waiting for the other shoe to drop” – constantly scanning environment and relationships for signs of potential danger or repeated rupture.
- 8) **Traumatic Bonding:** Unhealthy bonding style resulting from power imbalance in relationships and lack of other sources of support.
- 9) **Problems with Self-Regulation:** The deregulated limbic system can manifest problems with the regulation of many areas affecting the self-system; such as thinking, feeling and behavior. The tendency to go from “0 – 10” and “10 – 0” without intermediate stages, black and white thinking, feeling and behavior with no shades of gray, are examples of trauma’s numbing vs. hi-affect.
- 10) **Easily Triggered; hyper-reactive:** Stimuli reminiscent of trauma, e.g., yelling, loud noises, criticism or gunfire, triggers a person into shutting down, acting out or intense emotional states. Other subtle stimuli, such as changes in eye expression, physical position or feeling humiliated, can be observed.
- 11) **High Risk Behaviors:** Speeding, sexual acting out, spending, fighting or other behaviors that puts one at risk. Misguided attempts to jump-start the numbing of inner world or acting out pain from an intense pain filled inner world.
- 12) **Disorganized Inner World:** Disorganized object constancy and/or sense of relatedness. Internal emotional disconnects or fused feelings (e.g., anger & sex, intimacy and danger, need and humiliation)
- 13) **Survival Guilt:** From witnessing abuse and trauma and surviving, or from “getting out” of an unhealthy family system while others remain mired within it.



- 14) **Development of Rigid Psychological Defenses:** Over-reliance on dissociation, denial, splitting, repression, minimization, intellectualization, projection or developing rather impenetrable “character armor.”
- 15) **Cycles of Reenactment:** Unconscious repetition of pain-filled dynamics, the continual recreation of dysfunctional dynamics from the past.
- 16) **Relationship Issues:** Difficulty in being present in a balanced manner; a tendency to over or under engage, explode or withdraw or be emotionally hot and cold. Problems with trusting, staying engaged, or taking in love and caring from others.
- 17) **Desire to Self-Medicate:** Attempts to quiet and control turbulent, troubled inner world through the use of drugs and alcohol or behavioral addictions.

When unhealthy drinking patterns are present within a household or family system, the client's ability to cope or perform well on the job is often compromised. By utilizing SBIRT, the addiction professional is significantly more likely to identify unhealthy drinking, provide appropriate brief intervention and/or referral to appropriate educational or treatment resources. Harmful or hazardous drinking can have a profoundly negative impact on a family. Reduction in drinking to a low-risk pattern can positively affect the entire family.

## A Family in Recovery

Families can recover from addiction; however, the process is complex and progressive. When working with clients and their family members it is important to “...challenge the prevailing expectation that families can rapidly move toward health with the initiation of alcoholism recovery... Research [shows] that the emotional turbulence within the family produced by addiction continues well into the first three to five years of recovery. Family recovery begins with what are, in essence, individual recoveries of its members. Without ‘holding environments’ to sustain these individual recoveries until couple and family relationships can be reconstructed, the risk of collapse and disintegration of the family is quite high.”<sup>92</sup> An addiction professional can act as one of these “holding environments” to help support the family while it heals.

The Substance Abuse and Mental Health Services Administration (SAMHSA) categorized a family's progress in recovery regarding attainment of, adjustment to and long-term maintenance of sobriety. The levels of family recovery are:<sup>93</sup>

- Attainment of Sobriety - The family system is unbalanced but healthy change is possible.
- Adjustment to Sobriety - The family works on developing and stabilizing a new system.
- Long-term Maintenance of Sobriety - The family must rebalance and stabilize a new and healthier lifestyle.

As both the individual and the family begin to change, both have to adjust to a change in lifestyle that supports sobriety or abstinence, the changes needed to maintain sobriety (or abstinence) and a stable family system. The addiction professional is in the position to support early whole family recovery programs and to encourage their implementation and inclusion in the treatment programs to which they refer. While recovering individuals can and do become more dependable, competent, contributing and honest people, the recovery process for the individual and family needs support to proceed effectively.

Children are particularly vulnerable to the negative consequences of addiction in the family. Life for children of alcoholics does not automatically improve when the unhealthy family member stops drinking. As the member begins to devote time and energy on recovery, children may be somewhat neglected and left without guidance. The effects on the child can be long lasting.

## **Help is Available**

Addiction professionals can help improve the family system in the following ways:

- 1) Educate the client and her family about recommended low-risk drinking guidelines, potential effects of unhealthy drinking on the individual and family system and the concept of how unhealthy alcohol use affects the entire family system.
- 2) Encourage family members to seek recovery support for themselves to ameliorate the effects of the family disease on them.
- 3) Suggest referrals for outpatient individualized or group therapy for each family member, as well as mutual support group attendance such as Al-Anon or Alateen (for adolescents). A referral for further assessment may also be appropriate.
- 4) Communicate to the family that healthy clients are a priority, early identification and support are important for the whole family and that there is help available.

For more information regarding substance abuse treatment and the family, download The Substance Abuse and Mental Health Services Administration (SAMHSA) *Treatment Improvement Protocol 39: Substance Abuse Treatment and Family Therapy*, which is located at: [www.ncbi.nlm.nih.gov/books/NBK14505/](http://www.ncbi.nlm.nih.gov/books/NBK14505/)

## SBIRT and Older Adults<sup>94</sup>

Age is a factor to be considered when using SBIRT. Excessive alcohol use among older adults represent major but often neglected public health problems, even among those who regularly receive health care from a physician.<sup>95</sup> These problems can include drinking and driving, medication interactions, depressive symptoms, health problems, impaired cognitive functioning and loss of balance leading to falls, which is the most common cause of fractures and accidental death in this age group.<sup>96</sup>

Only a small proportion of older men and women meet diagnostic criteria of alcohol use disorders (1.5% for men, 0.3% for women).<sup>97</sup> However, over 2 million men (approximately 27.3%) and almost 700,000 women (10.4%) 65 years and older report drinking 5 or more drinks on at least one occasion within the previous 30 days.<sup>98</sup> Further, one older adult in 15 (6.6%) report heavy alcohol use on two or more occasions in the previous month.<sup>99</sup> Identifying this population of older Americans who use alcohol at unhealthy levels is the primary objective of the SBIRT protocol.

Unfortunately, many physicians mistakenly believe that substance use problems are largely confined to the young. In fact, physicians are significantly less likely to recognize an alcohol problem in an older client than in a younger one.<sup>100</sup> As a result, these problems usually go undetected, resulting in harmful, expensive and sometimes even catastrophic consequences.

The Substance Abuse and Mental Health Services Administration (SAMHSA) projects that future alcohol and drug use disorders among elderly clients will rise by 44% by 2020.<sup>101</sup> Thus, it is timely and critical to introduce routine screening and brief intervention for alcohol and harmful prescription drug use problems as a routine component of clinical care for this fastest growing segment of society.<sup>102,103</sup>

### Medication Interaction

Perhaps the largest concern with unhealthy drinking with this population is the risk of medication interaction. Granted, few older adults use street drugs; however, as many as one in four older adults take psychoactive medications, such as sedative-hypnotics, anxiolytics and narcotic-analgesics, that have high abuse potential and that interact dangerously with alcohol and other prescription drugs.<sup>104</sup> One study found that among current drinkers aged 65 and older, nearly half (46%) were taking 1 to 3 medications with substantial interaction potential, 32% were taking 4 to 6 medications and 9% were taking 7 or more such medications.<sup>105</sup>

In one study examining drug adverse events reported to the FDA, just three medications accounted for 41% of the cases where alcohol was a suspect:<sup>106</sup>

- 1) oxycodone
- 2) acetaminophen

3) diazepam (Valium)

Other medications that dangerously interact with alcohol use include:

- ketoconazole (Nizoral), an anti-fungal drug can cause vomiting, nausea and other effects from consumption of even a small amount of alcohol;
- methotrexate (Rheumatrex), a commonly prescribed drug for rheumatoid arthritis that may cause severe injury to the liver if a client drinks;
- warfarin (Coumadin), a widely used to prevent blood clots, but a small overdose can cause severe bleeding and too little is ineffective.

### **Tips for the Addiction Professional**

- 1) Ask older clients about their current medications and compare against the list above to better detect any potential adverse medication interactions with alcohol.
- 2) Ask about recent falls or dizzy spells that indicate physical instability.
- 3) Since this population is susceptible to depression, include in your screening process questions to detect these symptoms.
- 4) With permission, maintain communication with the client's physician.
- 5) Educate these clients on the risks of drinking above the *Recommended Low-Risk Drinking Guidelines* and suggest ways to cut back if currently above these limits.

### **The BRITE Program**

Once a client reaches the age of 55, certain protocols, procedures and requirements need to change to better assess, treat and prevent older adult's problems pertaining to alcohol use, as well as other age-related issues, such as medication abuse or misuse, dependence and depression.

An adaptation of SBIRT for older adults is the BRITE program, or Brief Intervention and Treatment for Elders. The BRITE program is evidenced-based and proven to identify, refer and treat substance use disorders in adults aged 55 or older.

Like SBIRT, the BRITE program identifies unhealthy patterns by asking a series of screening questions. Based on your client's answers and score during the screening, a brief intervention is conducted and a possible referral to treatment is made. The BRITE program utilizes alternative screening instruments to determine your client's risk, but the brief intervention and referral process is identical to that presented in this training program. Research on the BRITE program has

demonstrated its effectiveness at significantly reducing the number of substance usage days from the initial interview to the follow-up interview in adults aged 55 and older.<sup>107</sup>

## Screening

Similar to AUDIT screenings, BRITE begins with seven pre-screening questions that determine if your client is at risk for alcohol, medication drug use and/or depression problems. The first 3 questions ask for quantity and frequency of alcohol use (much like the AUDIT-C), the next 2 are related to substance use disorders and the final 2 questions pertain to depression. These seven pre-screening questions are as follows:

- 1) *On average, how many days a week do you drink alcohol?*
- 2) *On a typical day when you drink, how many drinks do you have?*
- 3) *What is the maximum number of drinks you had on any given day in the past month?*

If the responses to the first three questions reveal that your client drinks more than the *Recommended Guidelines for Low-Risk Drinking*, the Alcohol, Smoking and Substance Involvement Screening Tests (ASSIST) is then administered, after the reminder of the BRITE, to determine the level of risk and the type of brief interventions to be implemented (see below for more information about the ASSIST).

### **Recommended Low-Risk Drinking Guidelines<sup>30</sup>**

#### **Men (under the age of 65): 2 - 14 - 5**

No more than 2 drinks per day, 14 drinks per week, 5 drinks per occasion

#### **Women (and men over the age of 65): 1 - 7 - 4**

No more than 1 drink per day, 7 drinks per week, 4 drinks per occasion

- 4) *In the last year, have you tried to cut down on the drugs (including tobacco) or medication that you use? (yes or no)*
- 5) *In the last year have you used prescription or other drugs more than you meant to? (yes or no)*

If your client answers “yes” to either of these questions related to substance use disorders, the ASSIST is administered, after the remainder of the BRITE, to determine the level of risk and the type of brief interventions to be implemented (see below for more information about the ASSIST).

- 6) *During the past month, have you often been bothered by feeling down, depressed or hopeless? (yes or no)*
- 7) *During the past month, have you ever been bothered by little interest or pleasure in doing things? (yes or no)*

If your client answers “yes” to either of these questions related to depression, the Short Version Geriatric Depression Scale (S-GDS) is administered to determine the level of risk and the type of

brief interventions to be implemented. The S-GDS is located in Appendix N of this Learner's Guide for your reference.

## Administering the ASSIST

If an ASSIST is necessary, you simply read the ASSIST questions to your client and carefully record the corresponding number answer and score. Each question on the ASSIST has a set of responses to choose from, and each response has a numerical score. At the end of the interview, these scores are added together to produce an ASSIST score. The ASSIST is available for free download in both English and Spanish here:

[http://www.who.int/substance\\_abuse/activities/assist\\_v3\\_english.pdf](http://www.who.int/substance_abuse/activities/assist_v3_english.pdf).

## Brief Intervention

Determining the level of brief intervention with the BRITE program and older adults is similar to that with SBIRT. The only difference is that the ASSIST score determines the level of intervention instead of the AUDIT.

- *With ASSIST scores of 10 or less for alcohol, or 3 or less for all other substances:* These clients are at low risk of experiencing health and other problems from their current pattern of use. Just like with SBIRT, these clients are informed of their score and provided normative feedback and substance-related education.
- *With ASSIST scores of 11 to 26 or less for alcohol, or 4 to 26 for all other substances:* These clients are at moderate risk of experiencing health and other problems from their current pattern of use. These clients are informed of their score and provided a motivationally-inclined brief intervention, along with substance-related education and simple advice. Follow-up with moderate risk client is very important to ensure that any desired help is being received.
- *With ASSIST scores of 27 or higher for any substance:* These clients are at high risk of experiencing severe health and other problems (health, social, financial, legal, relationship) from their current pattern of use and are likely to be dependent. In addition to being informed of their score and receiving a motivationally-inclined brief intervention with substance-related education and simple advice, it is recommended that these clients be provided with a referral to a specialist for diagnostic evaluation and treatment. Follow-up and continued monitoring is essential for these clients, due to the intensity of their risk of experiencing further complications if the harmful pattern is continued.

For more specific information about using the ASSIST to provide brief interventions, brief treatments or referrals, please see The Guidelines for Use Training Manual located at: [http://www.who.int/substance\\_abuse/activities/en/Draft\\_The\\_ASSIST\\_Guidelines.pdf](http://www.who.int/substance_abuse/activities/en/Draft_The_ASSIST_Guidelines.pdf).

## SBIRT and Young Adults<sup>108</sup>

The majority of adolescents have used alcohol or another drug by the time they have reached 12th grade. Alcohol is the most commonly used drug among adolescents<sup>109</sup> and is responsible for more mortality and morbidity in this age group than all other drugs combined.<sup>110</sup> Use typically begins during early adolescence, with peak initiation during grades 7 through 9. By the 12th grade, 80% of high school seniors report having used alcohol, 62% report having gotten drunk and 31% report heavy episodic use.<sup>111</sup>

Among adolescents who drink alcohol, 38% to 62% report having had problems related to their drinking,<sup>112</sup> such as interference with work, emotional and psychological health problems, the development of tolerance and the inability to reduce the frequency and quantity of use.

Asking about alcohol use is fundamental. Asking an adult client: *“Are you concerned about the alcohol or drug use of someone in your family or who is close to you?”* opens a discussion. A client who does not drink or who is at low risk of alcohol-related problems may use feedback about drinking norms and educational materials such as the *Rethinking Drinking* booklet to share with their children.

For a teen or young adult client, the CRAFFT<sup>113</sup> (a mnemonic acronym of first letters of key words in the six screening questions) can be useful to ask age-appropriate questions about risky alcohol and drug use.

- C** – Have you every ridden in a **CAR** driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- R** – Do you ever use alcohol or drugs to **RELAX**, feel better about yourself or fit in?
- A** – Do you every use alcohol or drugs while you are by yourself or **ALONE**?
- F** – Do you ever **FORGET** things you did while using alcohol or drugs?
- F** – Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
- T** – Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

The CRAFFT is located in Appendix B of this Learner's Guide for your reference.

The CRAFFT is a brief questionnaire about risky alcohol use that is an effective screener for teens and young adults. It is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents. It is reliable and valid.<sup>114</sup> Its ability to identify young people with alcohol and drug problems is as good as the longer AUDIT and much greater than the CAGE (which is not recommended for use with adolescents).<sup>115</sup> The CRAFFT works equally well for alcohol and drugs, for boys and girls, for younger and older adolescents and for youth from diverse racial/ethnic backgrounds.



To begin, you might ask an adolescent or young adult client: *"I would like to next ask you some questions that I ask all of my clients. Please answer these next questions honestly:*

*During the past 12 months, did you:*

- 1) Drink any alcohol (more than a few sips)?*
- 2) Smoke any marijuana or hashish?*
- 3) Use anything else to get high"*

(Note: "Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff".)

If your adolescent or young adult client answers "no" to all three questions, you only need to ask the CAR question: *"Have you every ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?"*

If the adolescent answers "yes" to any 1 or more of the 3 opening questions, consider proceeding with the 6 CRAFFT questions.

## **Brief Intervention**

Each "yes" response to the 6 CRAFFT questions is scored 1 point. Adolescents who report no use of alcohol or drugs and have a CRAFFT score of 0 receive praise and encouragement. Those who report any use of alcohol or drugs and have a CRAFFT score of 0 or 1 are encouraged to stop and receive brief advice regarding the adverse health effects of substance use. A score of 2 or greater is a "positive" screen and indicates that the adolescent is at high-risk for having an alcohol or drug-related disorder and requires further assessment.

Adolescents who have developed substance dependence will need specific treatment for substance use disorders and ongoing support, and in most cases will need a referral to specialty care. However, in these cases, a brief intervention may be helpful in order to motivate the adolescent to get the help that she needs.



## Working with Mutual Support Groups<sup>116</sup>

For more than 250 years, Americans with alcohol and other drug problems have banded together for mutual support in recovery.<sup>117</sup> Modern, organized mutual support groups provide a common space for individuals who are struggling in similar ways to get support.

***Mutual support groups – adjuncts to or alternatives to professional counseling services where ordinary citizens meet to discuss similar struggles***

Mutual support groups, also known as self-help, mutual aid or mutual help groups, are based on the assumption that change can result from a group of people sharing their common problems, experiences and feelings. Participants are encouraged to identify with the emotions of the other members and use this commonality to motivate them to change their behavior. Mutual support groups hold scheduled meetings and provide online services free to the public. They generally do not have limitations on who can attend a meeting, just that one must have a genuine desire to rid their life of the problematic behavior.

Mutual support groups are particularly beneficial for clients identified as drinking in unhealthy ranges through the SBIRT protocol because they:<sup>118</sup>

- *Contain members who have transformed their lives using the group's key ideas and methods.* Learning from one another regarding successes and tips can often result in increased motivation to change and emulate others.
- *Provide the opportunity to enhance self-esteem.*
- *Provide daily prescriptions for recovery maintenance.* Some mutual support groups provide a series of steps, others groups provide tools, but all mutual support groups encourage and provide daily information to their participants to help them maintain their sobriety.
- *Create a social "linkage."* Participation in a mutual support group enmeshes each individual in a sanctuary of shared "experience, strength and hope." Exposure to the personal stories and lives of people in recovery can serve as a catalyst of personal transformation for people suffering from severe alcohol or other drug problems.<sup>119</sup>

Mutual support groups have an extensive body of research that supports their effectiveness. Studies have found that participation in recovery mutual support groups during and following addiction treatment enhances long-term recovery outcomes, reduces continuing care costs and post-treatment health care costs. In fact, mutual support groups are so integral to the recovery process it is advantageous to link individuals to recovery support groups prior to linkage to treatment.<sup>120</sup>

## Mutual Support Group Options

Alcoholics Anonymous (AA), the original 12-Step group is currently the most well-known mutual support groups in the world. However, a variety of other mutual support groups exist, some of which operate in ways radically different than AA. The diversity of available groups now increases the chances that someone seeking recovery can find a good “match” for their beliefs and problems. Knowing the differences between these groups will help determine which group is most appropriate for a specific at-risk client. Note: Clients do not have to choose only one mutual support group. There is more than one pathway to recovery, and for many clients, attendance at multiple groups may provide benefits that could not be achieved with one group alone.

- **Alcoholics Anonymous (AA):** Established in 1935. Alcoholics Anonymous® is a fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; the organization is self-supported via contributions. AA's primary purpose is to stay sober and help other alcoholics to achieve sobriety. The program follows 12 steps, which are:
  - 1) We admitted we were powerless over alcohol - that our lives had become unmanageable.
  - 2) Came to believe that a Power greater than ourselves could restore us to sanity.
  - 3) Made a decision to turn our will and our lives over to the care of God as we understood Him.
  - 4) Made a searching and fearless moral inventory of ourselves.
  - 5) Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
  - 6) Were entirely ready to have God remove all these defects of character.
  - 7) Humbly asked Him to remove our shortcomings.
  - 8) Made a list of all persons we had harmed, and became willing to make amends to them all.
  - 9) Made direct amends to such people wherever possible, except when to do so would injure them or others.
  - 10) Continued to take personal inventory and when we were wrong promptly admitted it.
  - 11) Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
  - 12) Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

AA has a listing in any U.S. phone book and typically has multiple meetings in any locality. AA attendance has been the “standard” in the U.S. addiction recovery and treatment community for several decades. Many other fellowships have branched off from AA to address other problems, such as drugs (Narcotics Anonymous) or compulsive eating (Overeater Anonymous).

- **LifeRing:** Established in 1999. LifeRing offers sober, secular self-help to abstain from alcohol and non-medically-indicated drugs by “relying on our own power and the support of others.” LifeRing operates according to the “3S” Philosophy. “3S” is short for the fundamental principles of LifeRing: Sobriety, Secularity and Self-Help.
  - *Sobriety* in LifeRing means continuous abstinence from alcohol and other non-medically indicated drugs. Its basic membership requirement is a desire to remain abstinent from alcohol and other drugs. LifeRing welcomes people regardless of their “drug of choice.”
  - *Secularity* in LifeRing welcomes people of all faiths and those of with no religious affiliation. Participants’ spiritual or religious beliefs or lack thereof remain private. There is no religious or anti-religious content in the meeting process.
  - *Self-Help* in LifeRing means that the key to recovery is the individual’s own motivation or effort. The main purpose of the group process is to reinforce each participant’s desire to remain clean and sober. Other than “Don’t Drink or Use,” LifeRing does not believe in a prescribed set of steps that everyone needs to follow. The *Recovery By Choice Workbook* may provide a framework for structuring your personal recovery “program.”

LifeRing brings people together via face-to-face and online support groups and provides sobriety tools through original books, publications and interactive online resources. LifeRing meetings are friendly, confidential, non-judgmental gatherings of peers. The atmosphere is relaxed, practical and positive. Members of other recovery programs are welcome in LifeRing meetings. LifeRing is a free-standing, self-supporting, democratically run organization. All directors and officers are unpaid volunteers.

- **Moderation Management (MM):** Established in 1993. MM is an international mutual aid support group which offers education, behavioral change techniques and peer support for problem drinkers seeking to decrease their drinking, whether to moderate levels or to total abstinence. MM is particularly appropriate for problem drinkers whose drinking would not be categorized as dependent. It is a good first step for those unwilling or unable to “just say no” or to join an abstinence program. MM supports both abstinence and moderation as approaches to resolving alcohol problems. Whether your client can afford the further consequences of additional failed attempts at moderation is a question the professional might do well to press. However, a client who attends any support group is likely to be better off than a client who does not attend any, and may hasten the decision to abstain, if moderation is not achieved. Not all clients who wish to pursue moderation are successful at achieving it, but Moderation Management may nevertheless be a support group they are willing to attend (vs. an abstinence-only group). Its concrete guidelines, limits and techniques give experiential

information for each participant to discover whether moderate drinking can be a viable solution.

MM offers a variety of behavioral methods for change, guidelines for responsible drinking and tools to measure progress. The MM approach encourages reading and discussion and assumes personal responsibility. Group support and shared experiences enhance the belief that moderate drinking is within personal control. MM follows 9 Steps Toward Moderation and Positive Lifestyle Changes, specifically:

- 1) Attend meetings or on-line groups and learn about the program of Moderation Management.
- 2) Abstain from alcoholic beverages for 30 days and complete steps 3 through 6 during this time.
- 3) Examine how drinking has affected your life.
- 4) Write down your life priorities.
- 5) Take a look at how much, how often, and under what circumstances you had been drinking.
- 6) Learn the MM guidelines and limits for moderate drinking.
- 7) Set moderate drinking limits and start weekly "small steps" toward balance and moderation in other areas of your life.
- 8) Review your progress and update your goals.
- 9) Continue to make positive lifestyle changes and attend meetings whenever you need ongoing support or would like to help newcomers.

MM is available in face-to-face meetings in the U.S. and other countries and in an online program. The online program features a member listserv, forum, chat rooms, online meetings, an abstinence group, listings of moderation-friendly therapists and Abstar, the online drink counter.

- **SMART Recovery®:** Established in 1994. SMART Recovery is an abstinence-based program open to those who have chosen to abstain or are considering abstinence from any substance or activity addiction. (SMART = **S**elf **M**anagement **A**nd **R**ecovery **T**raining.) SMART Recovery participants learn tools for recovery based on the latest scientific research and participate in a worldwide community, which includes free, self-empowering, science-based mutual help groups. SMART Recovery's Purposes and Methods are:
  - 1) We help individuals gain independence from addictive behavior.
  - 2) We help people learn how to:

- enhance and maintain motivation to abstain
  - cope with urges
  - manage thoughts, feelings and behavior
  - balance momentary and enduring satisfactions
- 3) Our efforts are based on scientific knowledge, and evolve as scientific knowledge evolves.
- 4) Individuals who have gained independence from addictive behavior are invited to stay involved with us, to enhance their gains and help others.

The SMART Recovery 4-Point Program<sup>®</sup> (drawn from statement #2 above) is comprised of:

- Point #1: Enhancing and maintaining motivation to abstain;
- Point #2: Coping with Urges;
- Point #3: Managing thoughts, feelings and behavior (more effectively problem-solving); and
- Point #4: Balancing momentary and enduring satisfactions (lifestyle balance).

Specific tools used in the program include: Stages of Change; Change Plan Worksheet; Cost-Benefit Analysis, Hierarchy of Values, ABCs of REBT for Urge Coping, DISARM (Destructive Irrational Self-talk Awareness & Refusal Method); Role-playing and Rehearsing; Brainstorming; ABCs of REBT for Emotional Upsets, USA (Unconditional Self-Acceptance) and VACI (Vital Absorbing Creative Interests). "ABC" refers to Albert Ellis's approach (in REBT, Rational Emotive Behavior Therapy) to changing dysfunctional feelings and behaviors by analyzing the Activating event, the Belief elicited by this event, and the behavioral or emotional Consequence of that Belief. By "doing an ABC," the participant gains insight into how emotions and behaviors can be changed by developing a new interpretation of events. SMART Recovery sponsors face-to-face meetings around the world, and daily online meetings. In addition, they provide an online message board and 24/7 chat room.

- **Secular Organizations for Sobriety/Save Our Selves (SOS):** Established in 1985. SOS is international in scope with meetings held around the world. SOS takes a self-empowerment approach to recovery and maintains that sobriety is a separate issue from all else. SOS addresses sobriety (abstinence) as "Priority One, no matter what!" SOS credits the individual for achieving and maintaining her own sobriety. SOS respects recovery in any form, regardless of the path by which it is achieved. It is not opposed to or in competition with any other recovery program. SOS supports healthy skepticism and encourages the use of the scientific method to understand the addictive disorders. Suggested guidelines for sobriety include:
  - To break the cycle of denial and achieve sobriety, we first acknowledge that we are alcoholics or addicts.

- We reaffirm this truth daily and acknowledge without reservation that, as clean and sober individuals, we cannot and do not drink or use no matter what.
- Since drinking or using is not an option for us, we take whatever steps are necessary to continue our Sobriety Priority lifelong.
- A quality of life – “the good life” – can be achieved. However, life is also filled with uncertainties. Therefore, we do not drink or use regardless of feelings, circumstances or conflicts.
- We share in confidence with each other our thoughts and feelings as sober, clean individuals.
- Sobriety is our Priority, and we are each responsible for our lives and our sobriety.
- **Women for Sobriety® (WFS):** Established in 1976. WFS is a self-help program for women with problems of addiction, both alcohol and chemical dependency. It is the first and only self-help program for women only and its precepts take into account the very special problems women have in recovery: the need for feelings of self-value and self-worth, and the need to expiate feelings of guilt and humiliation. WFS is an organization whose purpose is to help all women recover from problem drinking and drug addiction through the discovery of self, gained by sharing experiences, hopes and encouragement with other women in similar circumstances. WFS is unique in that it is an organization of women for women. It recognizes women's necessity for self-esteem and self-discovery and by offering face-to-face and online meetings/message boards in a non-judgmental atmosphere as well as coping tools using original WFS literature and the monthly *Sobering Thoughts* newsletter. The focus is on emotional and spiritual growth; therefore, each woman's personal spiritual journey is welcome. The “New Life” Acceptance Program includes:
  - 1) I have a life-threatening problem that once had me. - *I now take charge of my life and my disease. I accept the responsibility.*
  - 2) Negative thoughts destroy only myself. - *My first conscious sober act must be to remove negativity from my life.*
  - 3) Happiness is a habit I will develop. - *Happiness is created, not waited for.*
  - 4) Problems bother me only to the degree I permit them to. - *I now better understand my problems and do not permit problems to overwhelm me.*
  - 5) I am what I think. - *I am a capable, competent, caring, compassionate woman.*
  - 6) Life can be ordinary or it can be great. - *Greatness is mine by a conscious effort.*
  - 7) Love can change the course of my world. - *Caring becomes all important.*



- 8) The fundamental object of life is emotional and spiritual growth. - *Daily I put my life into a proper order, knowing which are the priorities.*
- 9) The past is gone forever. - *No longer will I be victimized by the past, I am a new person.*
- 10) All love given returns. - *I will learn to know that others love me.*
- 11) Enthusiasm is my daily exercise. - *I treasure all moments of my new life.*
- 12) I am a competent woman and have much to give life. - *This is what I am and I shall know it always.*
- 13) I am responsible for myself and for my actions. - *I am in charge of my mind, my thoughts and my life.*

A *Mutual Support Groups Comparison Chart* is located in Appendix O of this Learner's Guide for your quick reference. For more information regarding any of the mutual support groups outlined above, please contact the organization directly. Contact information for each mutual support group is listed in the Resources section of this Learner's Guide. A flyer for your clients describing the various mutual support groups is also available for download at [www.smartrecovery.org/professionals/EAPflyer.pdf](http://www.smartrecovery.org/professionals/EAPflyer.pdf).

## Selecting Mutual Support Groups

When considering referring a client to a mutual support group, your job is to create an informed and assertive client. There is insufficient guidance from the scientific literature for a professional to make a firm recommendation about which support group a given individual should attend. Therefore, whether or not to attend a mutual support group and which one to attend is the sole decision of your client. You can help your client make a good decision regarding her referral by:

- affirming your client's right to choose;
- distributing and reviewing consumer guides on treatment and recovery support services published by recovery advocacy organizations;
- encouraging consumers to visit service options before making a decision (versus taking whatever is offered them); and
- defining the criteria by which your client will know if participation in a particular group is or is not working.<sup>121</sup>

In addition, the following tips can increase the chances of clients making good, informed decisions for a mutual support group that meets their needs:

- Ask your client what is most important to her in selecting a mutual support group. A *Sample Checklist of Mutual Support Group Considerations* is located for your reference in Appendix P of this Learner's Guide.
- Ask your client about her spiritual/religious beliefs and preferences. There are a growing number of Christian-oriented groups sprouting up, such as Christians in Recovery and Alcoholics Victorious, as well as Jewish and Buddhist recovery groups, including Jewish Alcoholics, Chemically Dependent Persons and Significant Others (JACS) and Buddhist Recovery Network. There is some evidence to suggest that individuals with strong religious beliefs may prefer the 12-step approach (if their beliefs are compatible with the 12-step spiritual orientation). Individuals with external locus of control (the expectation that one's future life will be largely determined by "what happens to me") may prefer a 12-step approach, as well. Atheists, agnostics and others may prefer a secular group. Individuals with more internal locus of control expect the future to arise from their own proactive efforts and their reactions to what occurs to them and therefore may prefer a self-empowering support group. However, other aspects of particular groups may over-ride these variables.
- If a mutual support group of choice is not available in her area, encourage your client to utilize online activities available for each organization or to start a meeting of her choice in the community.
- Remain personally knowledgeable and up-to-date on established and new recovery support groups. It is recommended to maintain a library of recovery support group literature and contact information that can be shared with your clients, such as providing all local recovery support meeting schedules or giving each client a wallet card with the central contact numbers of local recovery support groups.
- Represent the diversity of pathways and styles of recovery by informing your client of the variety of mutual support group options and not only information of one favorite group.
- Encourage clients with computer resources and capabilities to explore the websites of various recovery support groups and to explore the world of Internet recovery support meetings.
- When helpful, orient your client to the particular recovery support group he/she has chosen to explore and provide a direct, human connection between your client and either a representative of a recovery support organization or her first exposure to meetings of that organization.



# Appendices

## Appendix A: Recommended U.S. Adult Drinking Guidelines and Definitions of Drinking Patterns Comparison

Many different terms are used to describe drinking behavior, and there is no absolute consensus on which ones to use. "Abstaining" usually means drinking no alcohol at all. However, in some studies, it can mean drinking 12 or fewer drinks per year and not drinking over daily or weekly maximum limits. "Low risk" use usually refers to drinking within recommended guidelines and is not likely to cause problems. The terms "risky use" and "harmful drinking" refer to drinking amounts that **increase the risk of causing** serious problems and amounts that **actually cause** serious problems. These problems include motor vehicle crashes, physical health and/or mental health problems, violence, injuries, unsafe sex and serious issues in areas of life such as work, school, family, social relationships and finances. Some literature also uses the term "hazardous drinking" for drinking that runs the risk of causing serious problems.<sup>122</sup> The developers of this Training Program decided to combine several recommendations to be more inclusive increased risk of experiencing alcohol-related problems, in addition to risk of alcohol dependence. Below is a comparison of the various previously developed Recommended Low-Risk Drinking Guidelines by organization or government agency.

### U.S. Department of Health and Human Services (this includes SAMHSA) and U.S. Department of Agriculture<sup>123</sup>

#### *"Moderate Drinking"*

- Men – no more than 2 drinks a day for most men
- Women and persons older than 65 – no more than 1 drink a day for most women

These guidelines exclude the following persons, who should not consume alcoholic beverages: women who are pregnant or trying to conceive; people who plan to drive or engage in other activities that require attention or skill; people taking medication, including over-the-counter medications; recovering alcoholics; and persons under the age of 21.

#### *"Binge Drinking"*

5 or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) at least once in the past 30 days.

#### *"Heavy Drinking"*

5 or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 5 different days in the past 30 days.

**CDC**<sup>124</sup>*“Moderate Drinking”*

There is no one definition of moderate drinking, but generally the term is used to describe a lower-risk pattern of drinking. CDC cites the *Dietary Guidelines for Americans* as having drinking in moderation defined as having no more than 1 drink per day for women and no more than 2 drinks per day for men. This definition is referring to the amount consumed on any single day and is not intended as an average over several days.

*“Binge Drinking”*

Cites two definitions, including NIAAA's and the one they use in their BRFSS epidemiological study, i.e.,

- Men - 5 or more drinks during a single occasion during the past 30 days.
- Women – 4 or more drinks during a single occasion during the past 30 days.

*“Heavy Drinking”*

- Men – drinking more than 2 drinks per day on average (or more than 60 drinks) during the past 30 days.
- Women – drinking more than 1 drink per day on average (or more than 30 drinks) during the past 30 days.

**NIAAA**<sup>125</sup>*“Maximum Drinking Limits”*

- Healthy Men up to age 65 - no more than 4 drinks per day AND no more than 14 drinks per week
- Healthy Women and Healthy Men over age 65 - no more than 3 drink per day AND no more than 7 drinks per week
- Recommend lower limits or abstinence as medically indicated, e.g., clients who take medications that interact with alcohol, have a health condition exacerbated by alcohol.
- Pregnant or breast feeding women - 0 drinks per day

*“Heavy Drinking”*

- Men - 5 or more drinks in a day
- Women – 4 or more drinks in a day

*“Binge Drinking”*

A form of heavy drinking, drinking that brings blood alcohol concentration (BAC) to 0.08 grams percent or above, for the typical adult this pattern corresponds to:

- Men - 5 or more drinks in about 2 hours

- Women - or 4 or more drinks in about 2 hours

*"Moderate Drinking Levels" also called "Safe Drinking Levels"*

- Men – up to 2 drinks per day
- Women – up to 1 drink per day

### **U.S. Preventive Services Task Force<sup>126</sup>**

USPSTF uses the terms moderate drinking and alcohol misuse. "Alcohol Misuse" is "risky/hazardous" and "harmful" drinking that places individuals at risk for future problems.

*"Moderate Drinking Levels"*

- Men - 2 standard drinks or less per day
- Women and persons older than 65 - 1 standard drink or less per day

*"Risky" or "Hazardous" Drinking*

- Men – more than 14 drinks per week or more than 4 drinks per occasion.
- Women – more than 7 drinks per week or more than 3 drinks per occasion.

*"Harmful Drinking"*

Describes persons who are currently experiencing physical, social, or psychological harm from alcohol use but do not meet criteria for dependence.

Alcohol abuse and dependence is associated with repeated negative physical, psychological and social effects from alcohol.

### **WHO<sup>127</sup>**

An AUDIT score of 1 or more on Question 2 or Question 3 indicates consumption at a hazardous level. In the AUDIT, Questions 2 and 3 assume that a standard drink equivalent is 10 grams of alcohol (in the U.S. 1 drink is 14 grams). The recommended low-risk drinking level set in the WHO brief intervention manual and used in the WHO study on brief interventions is no more than 20 grams of alcohol per day, 5 days a week (recommending 2 non-drinking days).

- Men - no more than 2 drinks per day or 14 per week
- Women - no more than 1 drink per day or 7 per week
- Older adults (men and women over age 65) – no more than 1 drink per day or 7 per week
- Drinking on no more than 5 days a week (2 non-drinking days)

WHO also recommends that persons not use any alcohol when:

- Pregnant or breast feeding women
- Driving or operating machinery
- Taking medications that react with alcohol
- Have medical conditions made worse by alcohol
- Cannot stop or control your drinking

Note: The existence of separate guidelines for men and women reflects research findings that women become more intoxicated than men at an equivalent dose of alcohol.<sup>128</sup> This results, in part, from the significant difference in activity of an enzyme in stomach tissue of males and females that breaks down alcohol before it reaches the bloodstream. The enzyme is four times more active in males than in females.<sup>129</sup> Moreover, women have proportionately more fat and less body water than men. Because alcohol is more soluble in water than in fat, a given dose becomes more highly concentrated in a female's body water than in a male's.<sup>130</sup> Since the proportion of body fat increases with age, Dufour and colleagues recommend a limit of one drink per day for the elderly.<sup>131</sup>

## Appendix B: CRAFFT<sup>132</sup>

Please answer all questions honestly. Your answers will be kept confidential.

<b>PART A:</b>	<b>NO</b>	<b>YES</b>
<b>During the past 12 months, did you:</b>		
4) Drink any alcohol (more than a few sips)?		
5) Smoke any marijuana or hashish?		
6) Use anything else to get high?		
<b>PART B:</b>	<b>NO</b>	<b>YES</b>
<b>C</b> – Have you every ridden in a <b>CAR</b> driven by someone (including yourself) who was “high” or had been using alcohol or drugs?		
<b>R</b> – Do you ever use alcohol or drugs to <b>RELAX</b> , feel better about yourself or fit in?		
<b>A</b> – Do you every use alcohol or drugs while you are by yourself or <b>ALONE</b> ?		
<b>F</b> – Do you ever <b>FORGET</b> things you did while using alcohol or drugs?		
<b>F</b> – Do your family or <b>FRIENDS</b> ever tell you that you should cut down on your drinking or drug use?		
<b>T</b> – Have you ever gotten into <b>TROUBLE</b> while you were using alcohol or drugs?		
<b>Total “yes” responses in Part B</b>		

## Appendix C: Drug Abuse Screening Test (DAST)<sup>133</sup>

- 1) Have you used drugs other than those required for medical reasons?  Yes  No
- 2) Have you abused prescription drugs?  Yes  No
- 3) Do you abuse more than one drug at a time?  Yes  No
- 4) Can you get through the week without using drugs (other than those required for medical reasons)?  Yes  No
- 5) Are you always able to stop using drugs when you want to?  Yes  No
- 6) Do you abuse drugs on a continuous basis?  Yes  No
- 7) Do you try to limit your drug use to certain situations?  Yes  No
- 8) Have you had "blackouts" or "flashbacks" as a result of drug use?  Yes  No
- 9) Do you ever feel bad about your drug abuse?  Yes  No
- 10) Does your spouse (or parents) ever complain about your involvement with drugs?  
 Yes  No
- 11) Do your friends or relatives know or suspect you abuse drugs?  Yes  No
- 12) Has drug abuse ever created problems between you and your spouse?  Yes  No
- 13) Has any family member ever sought help for problems related to your drug use?  Yes  No
- 14) Have you ever lost friends because of your use of drugs?  Yes  No
- 15) Have you ever neglected your family or missed work because of your use of drugs?  
 Yes  No
- 16) Have you ever been in trouble at work because of drug abuse?  Yes  No
- 17) Have you ever lost a job because of drug abuse?  Yes  No
- 18) Have you gotten into fights when under the influence of drugs?  Yes  No

- 19) Have you ever been arrested because of unusual behavior while under the influence of drugs?  
 Yes  No
- 20) Have you ever been arrested for driving while under the influence of drugs?  Yes  No
- 21) Have you engaged in illegal activities to obtain drugs?  Yes  No
- 22) Have you ever been arrested for possession of illegal drugs?  Yes  No
- 23) Have you ever experienced withdrawal symptoms as a result of heavy drug intake?  
 Yes  No
- 24) Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)?  Yes  No
- 25) Have you ever gone to anyone for help for a drug problem?  Yes  No
- 26) Have you ever been in hospital for medical problems related to your drug use?  Yes  No
- 27) Have you ever been involved in a treatment program specifically related to drug use?  
 Yes  No
- 28) Have you been treated as an outpatient for problems related to drug abuse?  
 Yes  No

**Scoring:** Each item in bold = 1 point; 6 or more points = substance use problem (abuse or dependence)



## Appendix D: Client Health Questionnaire-9 (PHQ-9)<sup>134</sup>

Name \_\_\_\_\_ Date \_\_\_\_\_

<i>Over the last 2 weeks, how often have you been bothered by any of the following problems?</i>	<i>Not at all</i>	<i>Several days</i>	<i>More than half the days</i>	<i>Nearly every day</i>
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
<i>Tally each column to determine <b>Total Score</b> _____ = _____ + _____ + _____</i>				

If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all    
  Somewhat difficult    
  Very difficult    
  Extremely difficult

### Instructions for Scoring PHQ-9

A depression diagnosis that warrants treatment or treatment change, needs at least one of the first two questions endorsed as positive (*little pleasure, feeling depressed*) indicating the symptom has been present more than half the time in the past two weeks.

In addition, the tenth question about difficulty at work or home or getting along with others should be answered at least "somewhat difficult."

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation
5-9	Minimal symptoms*	Support, educate to call if worse; return in 1 month
10-14	Minor depression	Support, watchful waiting
	Dysthymia*	Antidepressant or psychotherapy
	Major depression, <i>mild</i>	Antidepressant or psychotherapy
15-19	Major depression, <i>moderately severe</i>	Antidepressant or psychotherapy
≥ 20	Major depression, <i>severe</i>	Antidepressant and psychotherapy (especially if not improved on monotherapy)

## Appendix E: AUDIT-C and AUDIT

**Read questions as written. Record answers carefully. Begin the AUDIT by saying "I am going to ask you some questions about your use of alcoholic beverages during this past year." Code answers in terms of "standard drinks." Place the correct answer number in the box at the right.**

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	
3. How often do you have 5 (for men under age 65)/4 (for women and men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
<b>AUDIT-C Score (add items 1-3): Positive screen=4 for men/3 for women and men over age 65. If positive, ask the next 7 questions to administer the full AUDIT.</b>						
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	
<b>AUDIT Score (add items 1-10)</b>						

## Appendix E: Additional Blank AUDIT-C and AUDIT

**Read questions as written. Record answers carefully. Begin the AUDIT by saying "I am going to ask you some questions about your use of alcoholic beverages during this past year." Code answers in terms of "standard drinks." Place the correct answer number in the box at the right.**

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	
3. How often do you have 5 (for men under age 65)/4 (for women and men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
<b>AUDIT-C Score (add items 1-3): Positive screen=4 for men/3 for women and men over age 65. If positive, ask the next 7 questions to administer the full AUDIT.</b>						
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	
<b>AUDIT Score (add items 1-10)</b>						

# Appendix F: Sample SBIRT Protocol Flowcharts and Scripting

**Open by saying:** “How can I help you today?...proceed with Intake

**Introduce screening by saying:** “We ask all our clients intake questions to help us better understand who you are and what your needs might be. As part of our holistic approach and as a preventive measure, we also ask some screening questions of all our members. Your answers will remain confidential”...proceed with screening [embed alcohol questions, e.g., start with depression, go to alcohol, drug use, then close with stress]

## **Conduct AUDIT-C Hazardous Use Prescreen (3 questions)**

Q1: Frequency of drinking

Q2: Quantity in a typical day

Q3: Frequency of heavy use

Record responses and add Q1+Q2+Q3, then Enter AUDIT-C score.

If client refuses at any point, indicate “Refused AUDIT-C”

### **If AUDIT-C = <4 for men, <3 for women and adults over age 65**

#### **Follow NEGATIVE PRESCREEN Procedures:**

- AUDIT-C score feedback
- Alcohol education
- Normative feedback

#### **Brief Intervention RESPONSE**

- “From your responses, your drinking is in a healthy range, which means that you are at lower risk for many health and emotional concerns than those who drink at higher ranges. The U.S. recommended guidelines for low-risk drinking for women and adults over 65 is no more than 1 drink per day or 7 drinks per week, and for men no more than 2 drinks per day or 14 drinks per week. Most people, about 72% of adults in the U.S. never exceed these daily or weekly limits. Would you like me to send you some more information on healthy drinking patterns?”

If yes, offer to email booklet and links

- “[Tips for Cutting Down on Drinking](http://pubs.niaaa.nih.gov/publications/Tips/tips.pdf)” booklet  
<http://pubs.niaaa.nih.gov/publications/Tips/tips.pdf>
- EAP website

Document “BI provided” or “BI refused”

Document “alcohol education materials provided”

Close alcohol SBI:

- “Thank you for taking a few minutes to talk with me.”

**STOP alcohol BI, continue EAP intake**

### **If AUDIT-C = 4+ for men, 3+ for women and adults over age 65**

#### **Follow POSITIVE PRESCREEN Procedures:**

- AUDIT-C score feedback
- Alcohol Education
- Normative Feedback
- Simple Advice

#### **Brief Intervention RESPONSE**

##### **AUDIT-C Score Feedback**

- “From your responses, your drinking may put you at higher risk for health and emotional concerns than those who drink at lower ranges. These questions have been given to thousands of people, so you can compare your drinking to others. Normal scores are 0-4 for men and 0-3 for women and anyone over age 65, which is low-risk drinking. Your score was [#] ...on a scale of 0-12 which places you in the category for higher risk of harm.”

##### **Alcohol Education**

- “Unhealthy alcohol use can put you at risk for injury, accidents, and health problems such as diabetes, cancer, insomnia, high blood pressure, stroke, heart and gastrointestinal problem, depression and other conditions.”
- “The U.S. recommended guidelines for low-risk drinking for women and adults over the age of 65 is no more than 1 drink per day (or 7 drinks per week) and for men no more than 2 drinks per day (or 14 drinks per week).”

##### **Normative Feedback**

- “Most people, about 72% of adults in the U.S. never exceed these daily or weekly limits.”

##### **Simple Advice**

- “Reducing your alcohol consumption to safer drinking levels can decrease your risk.”

##### **Provide Alcohol Educational Materials**

- “Could I send you some information about healthy drinking?”

If yes, offer to email booklets and links to websites:

- [Rethinking Drinking](http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking_Drinking.pdf) booklet  
[http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking\\_Drinking.pdf](http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking_Drinking.pdf)
- [Rethinking Drinking: Alcohol and Your Health](http://rethinkingdrinking.niaaa.nih.gov/) website <http://rethinkingdrinking.niaaa.nih.gov/>
- “[Tips for Cutting Down on Drinking](http://pubs.niaaa.nih.gov/publications/Tips/tips.pdf)” booklet  
<http://pubs.niaaa.nih.gov/publications/Tips/tips.pdf>
- EAP/BH website and other materials as appropriate: (e.g., [Mixing Alcohol and Medication](#); [Alcohol and Women](#); [Young Teens and Drinking](#); [Alcohol and Older Adults](#); [Prevention for Children](#))

Document “BI provided” or “BI refused”, “alcohol education materials provided”

Close alcohol SBI:

- “Thank you for taking a few minutes to talk with me.”

**STOP alcohol BI, continue EAP intake**

**Why screen for alcohol and drug use?**

Brief motivational conversations with patients can promote significant, lasting reductions in risky use of alcohol and other drugs. Nearly 30% of adult Americans engage in risky, problematic use of alcohol and/or other drugs, yet very few are identified or participate in a conversation that could prevent injury, disease, or more severe use disorders.

Brief Screening - Ask		
Substance	Questions	Positive Screen
Alcohol*	When was the last time you had more than 3 (for women/men >65 yrs.)/4 (for men) drinks in one day? How many drinks do you have per week?  *Any alcohol use is a positive screen for patients under 21 years or pregnant women. A standard drink in the U.S. is any drink that contains about 14 grams of pure alcohol. One drink = 12 oz. beer, 5 oz. wine, 1.5 oz. liquor	In the past 3 months More than 14 (men) More than 7 (women, men >65 yrs.)
Drugs	In the past 12 months, have you used drugs other than those required for medical reasons?	Yes
Tobacco	Do you currently smoke or use any form of tobacco?	Yes

**(+) Positive on Brief Screen**

**Assess**

- Use a **brief assessment instrument** (see table below) to determine level of risk or assess risk with interview based on DSM criteria for substance abuse and dependence.
- For patients who screen positive for drug use, ask further questions to determine which drug(s) and how often they use.
- Advise tobacco users to quit. Refer to Colorado Quitline 1-800-784-8669 or [www.coquitline.org](http://www.coquitline.org). Go to [www.coloradoguidelines.org/tobacco](http://www.coloradoguidelines.org/tobacco) for specific recommendations.
- Consider co-occurring conditions such as depression, other mood disorders, ADHD, anxiety, pain, and sleep disorders. Go to [www.coloradoguidelines.org/guidelines/depression.asp](http://www.coloradoguidelines.org/guidelines/depression.asp) for information about managing depression.

**Brief Assessment Instruments**  
Available at [www.coloradoguidelines.org/guidelines/sbirt.asp](http://www.coloradoguidelines.org/guidelines/sbirt.asp)

	AUDIT <i>(adult alcohol use)</i>	DAST-10 <sup>®</sup> <i>(adult drug use)</i>	CRAFFT <i>(adolescent alcohol &amp; drug use)</i>
<b>Hazardous use (risky use)</b>	Score 8-15 for men Score 7-15 for women	Score 3-5	Score of 2 or more positive items indicates need for further assessment
<b>Harmful use (use plus consequences)</b>	Score 16-19	Score 6-8	
<b>Possible dependence (compulsive use)</b>	Score ≥ 20	Score 9-10	

**(continue on back for hazardous/harmful use and possible dependence)**

**(-) Negative on Brief Screen**

**Reinforcement and Continued Screening**

- Reinforce positive decisions.
- Rescreen at least yearly.
- Consider more frequent screening for:
  - women who are pregnant or contemplating becoming pregnant
  - adolescents (transition to middle school, high school, college)
  - significant increase in psychosocial stressors (e.g., major change in finances, primary relationship/support system)
  - people with substance use problems who have recently changed their behavior

This guideline (approved 07/15/08) is designed to assist clinicians in alcohol and substance use screening and management. It is not intended to replace a clinician's judgment or establish a protocol for all patients with a particular condition. For references, important updates and copies of the guideline go to [www.coloradoguidelines.org](http://www.coloradoguidelines.org) or call 720-297-1681 or 1-866-401-2092.

**Why screen for alcohol and drug use?**

Brief motivational conversations with patients can promote significant, lasting reductions in risky use of alcohol and other drugs. Nearly 30% of adult Americans engage in risky, problematic use of alcohol and/or other drugs, yet very few are identified or participate in a conversation that could prevent injury, disease, or more severe use disorders.

**Brief Screening - Ask**

Substance	Questions	Positive Screen
Alcohol*	When was the last time you had more than 3 (for women/men >65 yrs.)/4 (for men) drinks in one day? How many drinks do you have per week?  *Any alcohol use is a positive screen for patients under 21 years or pregnant women. A standard drink in the U.S. is any drink that contains about 14 grams of pure alcohol. One drink = 12 oz. beer, 5 oz. wine, 1.5 oz. liquor	In the past 3 months More than 14 (men) More than 7 (women, men >65 yrs.)
Drugs	In the past 12 months, have you used drugs other than those required for medical reasons?	Yes
Tobacco	Do you currently smoke or use any form of tobacco?	Yes

**(+) Positive on Brief Screen**

**Assess**

- Use a **brief assessment instrument** (see table below) to determine level of risk or assess risk with interview based on DSM criteria for substance abuse and dependence.
- For patients who screen positive for drug use, ask further questions to determine which drug(s) and how often they use.
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- Consider co-occurring conditions such as depression, other mood disorders, ADHD, anxiety, pain, and sleep disorders. Go to [www.coloradoguidelines.org/guidelines/depression.asp](http://www.coloradoguidelines.org/guidelines/depression.asp) for information about managing depression.

**Brief Assessment Instruments**

Available at [www.coloradoguidelines.org/guidelines/sbirt.asp](http://www.coloradoguidelines.org/guidelines/sbirt.asp)

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<b>Possible dependence (compulsive use)</b>	Score ≥ 20	Score 9-10	

**(-) Negative on Brief Screen**

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- Consider more frequent screening for:
  - women who are pregnant or contemplating becoming pregnant
  - adolescents (transition to middle school, high school, college)
  - significant increase in psychosocial stressors (e.g., major change in finances, primary relationship/support system)
  - people with substance use problems who have recently changed their behavior

**(continue on back for hazardous/harmful use and possible dependence)**

This guideline (approved 07/15/08) is designed to assist clinicians in alcohol and substance use screening and management. It is not intended to replace a clinician's judgment or establish a protocol for all patients with a particular condition. For references, important updates and copies of the guideline go to [www.coloradoguidelines.org](http://www.coloradoguidelines.org) or call 720-297-1681 or 1-866-401-2092.



## Appendix G: Setting Goals for Change Exercise<sup>135</sup>

The following exercise can be used to help a person set one or more behavior change goals. The goal(s) must be SMART (specific, measurable, attainable, realistic and timely). Although long-term goals may be stated, short-term immediate goals and specific actions and steps to be taken should be clearly stated. Clients only need to set 1 or 2 goals during the session, as setting numerous goals may be overwhelming. At subsequent sessions, previously stated goals and progress made toward them can be revisited and new goals can be stated as goals are achieved. Setting and achieving smaller, fewer goals can build self-efficacy over time.

One goal might be to either cut down or stop drinking. Another goal may have to do with behaviors related to drinking (e.g., *"I won't drive after I've been drinking."*) The following exercise can be done verbally or written to assist a client with deciding on what the goals will be.

### WILL I CUT DOWN – OR WILL I STOP MY ALCOHOL USE?

Now that you have decided to make a change to your alcohol use, your next decision is whether you will drink less or stop drinking altogether.

To help you make up your mind, think about these questions:

- Do you have any health or psychological problems that might be made worse by your alcohol use? - Your doctor can advise you.
- Do you experience withdrawal symptoms when you stop drinking? If so, stopping drinking entirely is probably the best goal for you. - Your doctor can help you manage the withdrawal symptoms.
- Do your employer have policies related to alcohol or drug use?
- Do you have any legal or financial problems as a result of your alcohol use?
- Do you have any relationship or family problems because of your alcohol use?
- Have you solved alcohol use problems before by stopping completely? – Then, this might be your best way now.



## Appendix H: Change Plan Worksheet<sup>136</sup>

The goal setting exercise below is useful for helping a client articulate specifically what they want to change and develop a plan for change.

**The changes I want to make are:**

**The most important reasons why I want to make this change are:**

**My main goals for myself in making this change are:**

**I plan to do these things in order to accomplish my goals:**

*Specific action:*

*When:*

**Other people could help me with change in these ways:**

*Person:*

*Possible ways to help:*

**These are some possible obstacles to change, and how I could handle them:**

*Possible obstacle to change:*

*How to respond:*

**I will know that my plan is working when I see these results:**

You can provide (verbally or written) the following considerations to assist the person in completing the Change Plan Worksheet.

- *The changes I want to make are...* Be specific. Include goals that are positive (wanting to increase, improve and do more of something) and not just negative goals (stop, avoid or decrease a behavior).
- *My main goals for myself in making these changes are...* What are the likely consequences of action or inaction? Which motivations for change are most compelling?
- *The first steps I plan to take in changing are...* How can the desired change be accomplished? What are some specific, concrete first steps? When, where, and how will the steps be taken?
- *Some things that could interfere with my plan are...* What specific events or problems could undermine the plan? What could go wrong? How will the person stick with the plan despite these particular problems or setbacks?
- *Other people could help me in changing in these ways...* What specific things can another person do to help them take the steps to change? How will the person arrange for such support?
- *I will know that my plan is working if...* What will happen as a result of taking the different steps in the plan? What benefits can be expected?

# Appendix I: Sample Release of Information

I, \_\_\_\_\_, authorize \_\_\_\_\_  
(Client Name) (Clinic, Counselor or Doctor's Name)  
to disclose to \_\_\_\_\_  
(Name and Location of Person(s)/Organization to Receive Information)

the copies of any and all records and information which you may have in your possession. This includes all the transmission of information and data via verbal and electronic contact.

These records and information include, but may not be limited to:

- Hospital records, including that of attending nurses, physicians, health care personnel and technicians
- Laboratory test results
- Medical examination results
- Medical opinions, diagnosis, progress notes and recommendations
- Treatment plans and progress
- Description of treatment and prescriptions
- Notes of conversations, phone calls, memoranda or any type of communication concerning the overall treatment

I understand that the purpose of this disclosure is: \_\_\_\_\_

This authorization expires on: \_\_\_\_\_, or when \_\_\_\_\_ is no longer providing me with services.

I understand that my records are protected under Federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Print Client Name \_\_\_\_\_ Date \_\_\_\_\_

Signature of Client \_\_\_\_\_

Date of Birth \_\_\_\_\_

Print Witness Name \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_

### ATTENTION RECIPIENT – Notice Prohibiting Redisclosure

This information has been disclosed to you from the records protected by Federal confidentiality rules 42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug client.

## Appendix J: Sample Client Update Report

Today's Date:	Service Provider's Name:	Service Provider's Address:
---------------	--------------------------	-----------------------------

**SECTION 1: CLIENT IDENTIFICATION**

Last Name:	First Name:	Middle Name:	Date of Birth:
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**SECTION 2: CLIENT STATUS**

**Admission Date:** \_\_\_\_\_  active  discharged

**SECTION 3: CLIENT COMPLIANCE**

*Other information: (check all that apply)*

- referred to \_\_\_\_\_
- inpatient
- outpatient program (multiple sessions/wk)
- counseling (weekly or less often)
- withdrew against program advice

- medically compliant
- not medically compliant
- clinically compliant
- not clinically compliant
- no contact/abort
- relapsed
- incarcerated
- deceased

**SECTION 4: CLINICAL SUMMARY**

Notes:

---

Service Provider's Signature:

---

Service Provider's Phone Number:

**Please return this form to:**

---

## Appendix K: Decisional Balance Worksheet<sup>137</sup>

You can use the exercise below to help a client make a clear decision on whether he/she wants to change. This exercise asks a client to articulate the pros and cons of changing, as well as continuing their current behavior.

One of the first steps toward successfully changing your substance use is reaching a clear decision that you want to change.

In this exercise, you will think about and record some of the important advantages and disadvantages of changing or continuing your drinking. You will stack up what you have to lose against what you have to gain.

Fill in the table below. When you are finished, review your answers and weigh your reasons for change. Which way does your decisional balance tip?

### Changing Your Current Drinking

What's good about it?

What's not so good about it?

### Continuing Your Current Drinking

What's good about it?

What's not so good about it?

# Appendix L: Quick Reference Guide

Funded by SAMHSA • Administered by Colorado Division of Behavioral Health  
Managed by Peer Assistance Services, Inc. • Initiative of Colorado Office of the Governor

### YOUR SCREENING RESULT

**HIGH RISK**

**MODERATE RISK**

**LOW RISK**

### A STANDARD DRINK

ANY DRINK CONTAINING ABOUT 14 GRAMS OF ALCOHOL\*

\*NIAAA (www.rethinkingdrinking.niaaa.nih.gov)

**12 oz beer**      **5 oz wine**      **1.5 oz liquor**

### LOWER RISK DRINK LIMITS

	DAILY	WEEKLY	OCCASION
<b>WOMEN</b>	1	7	4
<b>MEN</b>	2	14	5
<b>OVER 65</b>	1	7	4

**LESS IS BETTER**

**IT'S SAFEST TO AVOID ALCOHOL IF YOU ARE**

- taking medications that interact with alcohol
- have a health condition made worse by drinking
- underage
- planning to drive a vehicle or operate machinery
- pregnant or trying to become pregnant

**HOW READY ARE YOU?    HOW CONFIDENT ARE YOU?    HOW IMPORTANT IS IT TO YOU?**

NOT AT ALL    1    2    3    4    5    6    7    8    9    10    EXTREMELY

SOMEWHAT

Funded by SAMHSA • Administered by Colorado Division of Behavioral Health  
Managed by Peer Assistance Services, Inc. • Initiative of Colorado Office of the Governor

### YOUR SCREENING RESULT

**HIGH RISK**

**MODERATE RISK**

**LOW RISK**

### A STANDARD DRINK

ANY DRINK CONTAINING ABOUT 14 GRAMS OF ALCOHOL\*

\*NIAAA (www.rethinkingdrinking.niaaa.nih.gov)

**12 oz beer**      **5 oz wine**      **1.5 oz liquor**

### LOWER RISK DRINK LIMITS

	DAILY	WEEKLY	OCCASION
<b>WOMEN</b>	1	7	4
<b>MEN</b>	2	14	5
<b>OVER 65</b>	1	7	4

**LESS IS BETTER**

**IT'S SAFEST TO AVOID ALCOHOL IF YOU ARE**

- taking medications that interact with alcohol
- have a health condition made worse by drinking
- underage
- planning to drive a vehicle or operate machinery
- pregnant or trying to become pregnant

**HOW READY ARE YOU?    HOW CONFIDENT ARE YOU?    HOW IMPORTANT IS IT TO YOU?**

NOT AT ALL    1    2    3    4    5    6    7    8    9    10    EXTREMELY

SOMEWHAT







## Appendix N: Short Geriatric Depression Scale (S-GDS)<sup>139</sup>

*Please choose the answer that best describes how you have felt over the past week.*

- 1) Are you basically satisfied with your life?  Yes  No
- 2) Have you dropped many of your activities and interests?  Yes  No
- 3) Do you feel that your life is empty?  Yes  No
- 4) Do you often get bored?  Yes  No
- 5) Are you in good spirits most of the time?  Yes  No
- 6) Are you afraid that something bad is going to happen to you?  Yes  No
- 7) Do you feel happy most of the time?  Yes  No
- 8) Do you often feel helpless?  Yes  No
- 9) Do you prefer to stay at home, rather than going out and doing new things?  Yes  No
- 10) Do you feel you have more problems with memory than most?  Yes  No
- 11) Do you feel it is wonderful to be alive now?  Yes  No
- 12) Do you feel pretty worthless the way you are now?  Yes  No
- 13) Do you feel full of energy?  Yes  No
- 14) Do you feel your situation is hopeless?  Yes  No
- 15) Do you think that most people are better off than you?  Yes  No

## Appendix O: Mutual Support Groups Comparison Chart

Element	AA, NA & other 12-step programs	LifeRing	Moderation Management	Secular Organization for Sobriety	SMART Recovery	Women for Sobriety
<b>Goal</b>	Abstinence from alcohol & other drugs (AOD)	Abstinence from AOD	Moderate alcohol consumption, or abstinence	Abstinence from any addictive behavior or substance	Abstinence from any addictive behavior or substance	Abstinence from AOD
<b>Main Technique</b>	The 12-Steps and the 12-Traditions	Peer Support and Self Empowerment/Responsibility	Self-monitoring & lifestyle balance with online support	"Priority one" - not drinking or using as a separate issue from everything else	4-Point Program <sup>®</sup> ; Self-Management	Empowering statements & spiritual growth
<b>Habit or Disease?</b>	Disease (but could be a spiritual disease)	No opinion	Habit	Determined by each individual member	No opinion	Disease
<b>Optimal Length of Program</b>	A lifetime or as needed	6 – 24 months and then as needed	6-18 months	Determined by each individual member	Until skills are mastered; move on or volunteer	As needed
<b>Emphasis on Social Support</b>	Strong	Strong	Moderate	Moderate – Self Management encouraged	Moderate – Self Management encouraged	Strong
<b>Sponsorship</b>	Yes	No	No	No	No	No
<b>Spiritual/Religious Emphasis</b>	Essential	Optional	Optional	One's personal quest	Optional	Emphasis on spiritual growth, not religion
<b>Optimal # of meetings to attend per week</b>	Daily at first	1 - 3	1 - 2	2 - 3	1 - 3	1 - 3
<b>Group size</b>	5 - 100's	5 - 15	5 - 15	5 - 15	5 - 15	5 - 15
<b>Cost</b>	Donations	Donations	Donations	Donations	Donations	Donations
<b>Current availability</b>	Widely available	Depends on locality; online support available	Depends on locality; online support available	Depends on locality; online support available	Depends on locality; online support available	Depends on locality; online support available
<b>Randomized clinical trial supporting efficacy?</b>	Yes (Project MATCH) <sup>140</sup>	No	No	No	No	No

## Appendix P: Sample Checklist of Mutual Support Group Considerations<sup>141</sup>

Which of the following are important to you in selecting a recovery mutual support group?

People who: (check all that apply)

- have experience with my primary drug
- are the same gender
- are close to my age
- share my ethnic/cultural background
- share my views on religion, spirituality or secularity
- share my sexual orientation
- smoke tobacco
- do not smoke tobacco
- are very available socially outside the meeting, by telephone or for coffee
- have tolerant attitudes toward mental illness
- have tolerant attitudes toward medications prescribed for addiction or mental illness
- have prior experience in the criminal justice system
- do not have prior experience in the criminal justice system
- have approximately the same income level
- have had very severe alcohol/drug problems
- have had mild to moderate alcohol/drug problems
- share my goal of complete abstinence
- share my goal of moderated use



# Resources

## Addiction and Alcohol Dependency Resources

American Public Health Association (APHA) *Alcohol Screening and Brief Intervention: A Guide for Public Health Practitioners*  
[http://www.apha.org/NR/rdonlyres/B03B4514-CCBA-47B9-82B0-5FEB4D2DC983/0/SBImanualfinal4\\_16.pdf](http://www.apha.org/NR/rdonlyres/B03B4514-CCBA-47B9-82B0-5FEB4D2DC983/0/SBImanualfinal4_16.pdf)

*Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care*  
[http://whqlibdoc.who.int/hq/2001/WHO\\_MSD\\_MSB\\_01.6b.pdf](http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf)

Centers for Disease Control (CDC) *Screening and Brief Intervention for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide for Trauma Centers*  
<http://www.cdc.gov/InjuryResponse/alcohol-screening/pdf/SBI-Implementation-Guide-a.pdf>

Faces & Voices of Recovery (FaVoR) website  
<http://www.facesandvoicesofrecovery.org>

Fishman, Marc J. (2010). *ASAM Client Placement Criteria: Supplement on Pharmacotherapies for Alcohol Use Disorders*. Philadelphia: Lippincott Williams & Wilkins.

Fletcher, Anne M. (2001). *Sober for Good: New Solutions for Drinking Problems – Advice from Those Who Have Succeeded*. New York: Houghton Mifflin Co.

George Washington University's *Workplace SBI Toolkit*  
[http://www.ensuringsolutions.org/solutions/solutions\\_show.htm?doc\\_id=450551](http://www.ensuringsolutions.org/solutions/solutions_show.htm?doc_id=450551)

George Washington University's *Workplace Screening and Brief Intervention: What Employers Can and Should Do About Excessive Alcohol Use*  
[http://www.ensuringsolutions.org/usr\\_doc/Workplace\\_SBI\\_Report\\_Final.pdf](http://www.ensuringsolutions.org/usr_doc/Workplace_SBI_Report_Final.pdf)

George Washington University's EAP and Workplace SBI Resources websites  
[http://www.ensuringsolutions.org/resources/resources\\_show.htm?doc\\_id=335841&cat\\_id=988](http://www.ensuringsolutions.org/resources/resources_show.htm?doc_id=335841&cat_id=988)  
[http://www.ensuringsolutions.org/resources/resources\\_list.htm?cat\\_id=964](http://www.ensuringsolutions.org/resources/resources_list.htm?cat_id=964)

Institute for Research, Education and Training in Addictions (IRETA) SBIRT website  
<http://www.ireta.org/sbirt/links.htm>

Join Together's *Screening and Brief Intervention: Making a Public Health Difference*  
<http://www.jointogether.org/aboutus/ourpublications/pdf/sbi-report.pdf>

Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches by William White and Ernest Kurtz  
[http://store.ireta.org/merchant2/merchant.mvc?Screen=PROD&Store\\_Code=I&Product\\_Code=mng995-DLD1.zip&Category\\_Code=mng](http://store.ireta.org/merchant2/merchant.mvc?Screen=PROD&Store_Code=I&Product_Code=mng995-DLD1.zip&Category_Code=mng)

Motivational Interviewing Video Series  
<http://www.motivationalinterview.org/training/miorderform.pdf>

MotivationalInterview.org Training Resources

<http://motivationalinterview.org/training/index.html>

MotivationalInterviewing.org Library

<http://www.motivationalinterview.org/library/index.html>

National Highway Traffic Safety Administration (NHTSA) *Screening and Brief Intervention Tool Kit for College and University Campuses*

[http://www.friendsdrivesober.org/documents/SBI\\_College.pdf](http://www.friendsdrivesober.org/documents/SBI_College.pdf)

National Institute on Alcohol Abuse and Alcoholism (NIAAA) *Cocktail Calculator*

<http://rethinkingdrinking.niaaa.nih.gov/ToolsResources/CocktailCalculator.asp>

National Institute on Alcohol Abuse and Alcoholism (NIAAA) *Helping Clients Who Drink Too Much: A Clinician's Guide*

[http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking\\_Drinking.pdf](http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking_Drinking.pdf)

Peer-based Addiction Recovery Support: History, Theory, Practice & Scientific Evaluation by William White

<http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=510&rcID=3>

Prochaska, J.O., Norcross, J., and DiClemente, C. (1994). *Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward*. New York: Harper Paperbacks.

Richard Saitz and Boston Medical Center's *Alcohol Clinical Training (ACT)*

<http://www.bu.edu/act/mdalcoholtraining/index.html>

Substance Abuse and Mental Health Services Administration (SAMHSA) *Talking With Your Adult Clients about Alcohol, Drug, and/or Mental Health Problems: A Discussion Guide for Primary Health Care Providers*

[http://www.kap.samhsa.gov/products/brochures/pdfs/Talking\\_with\\_Your\\_Clients.pdf](http://www.kap.samhsa.gov/products/brochures/pdfs/Talking_with_Your_Clients.pdf)

Veterans Affairs HCRC *Teaching Guide for Health Care Providers: Reducing Alcohol Use with Brief Intervention*

<http://www.hepatitis.va.gov/vahep?page=prtop03-wp-01-res>

William Miller's *Treatment Improvement Protocol (TIPS): Enhancing Motivation for Change in Substance Abuse*

<http://ncadi.samhsa.gov/govpubs/BKD342/>

World Health Organization's *AUDIT: Guidelines for Use in Primary Care*

[http://whqlibdoc.who.int/hq/2001/WHO\\_MSD\\_MSB\\_01.6a.pdf](http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf)

## Addiction and Alcohol Dependency Organizations

### ***American Academy of Addiction Psychiatry***

#### **(AAAP)**

400 Massasoit Avenue, Suite 307  
East Providence, RI 02914  
Phone: 401.524.3076  
Fax: 401.272.0922  
Email: [information@aaap.org](mailto:information@aaap.org)  
Web: [www.aaap.org](http://www.aaap.org)

### ***American Society of Addiction Medicine***

#### **(ASAM)**

4601 N. Park Avenue, Upper Arcade #101  
Chevy Chase, MD 20815  
Phone: 888.362.6784  
Fax: 301.656.3815  
Email: [email@asam.org](mailto:email@asam.org)  
Web: [www.asam.org](http://www.asam.org)

### ***Employee Assistance Professionals Association***

#### **(EAPA)**

4350 North Fairfax Drive, Suite 740  
Arlington, VA 22203  
Phone: 703.387.1000  
Email: [j.price@eapassn.org](mailto:j.price@eapassn.org)  
Web: [www.eapassn.org](http://www.eapassn.org)

### ***Employee Assistance Society of North America***

#### **(EASNA)**

2001 Jefferson Davis Highway, Suite 1004  
Arlington, VA 22202-3617  
Phone: 703.416.0060  
Web: [www.easna.org](http://www.easna.org)

### ***NAADAC - The Association for Addiction Professionals***

1001 N. Fairfax Street, Suite 201  
Alexandria, VA 22314  
Phone: 703.741.7686  
Fax: 703.741.7698  
Email: [naadac@naadac.org](mailto:naadac@naadac.org)  
Web: [www.naadac.org](http://www.naadac.org)

### ***National Addiction Technology Transfer***

#### ***Center (NATTC)***

5100 Rockhill Road  
Kansas City, MO 64110  
Phone: 816.482.1200  
Email: [no@nattc.org](mailto:no@nattc.org)  
Web: [www.nattc.org](http://www.nattc.org)

### ***National Clearinghouse for Alcohol and Drug Information (NCADI)***

Phone: 800.729.6686  
Español: 877.767.8432  
TDD: 800.487.4889  
Web: [www.ncadi.samhsa.gov](http://www.ncadi.samhsa.gov)

### ***National Council on Alcoholism and Drug Dependence, Inc. (NCADD)***

22 Cortlandt Street, Suite 801  
New York, NY 10007-3128  
Phone: 212.269.7797  
Email: [national@ncadd.org](mailto:national@ncadd.org)  
Web: [www.ncadd.org](http://www.ncadd.org)

### ***National Institute on Alcohol Abuse and Alcoholism (NIAAA)***

5635 Fishers Lane, MSC 9304  
Bethesda, MD 20892-9304  
Phone: 301.443.3860  
Web: [www.niaaa.nih.gov](http://www.niaaa.nih.gov)

### ***National Institute on Drug Abuse (NIDA)***

6001 Executive Boulevard, Room 5213  
Bethesda, MD 20892-9561  
Phone: 301.443.1124  
Web: [www.nida.nih.gov](http://www.nida.nih.gov)

### ***Substance Abuse and Mental Health Services Administration (SAMHSA)***

1 Choke Cherry Road, Room 8-1054  
Rockville, MD 20857  
Phone: 240.276.2130 (Office of Communications)  
Web: [www.samhsa.gov](http://www.samhsa.gov)



## Mutual Support Groups

### ***Alcoholics Anonymous (AA) World Services***

P.O. Box 459  
New York, NY 10163  
Phone: 212.870.3400  
Web: [www.aa.org](http://www.aa.org)

### ***LifeRing***

1440 Broadway Suite 312  
Oakland, CA 94612-2023  
Phone: 510.763.0779  
Toll-Free: 800.811.4142  
Email: [service@lifering.org](mailto:service@lifering.org)  
Web: [www.lifering.org](http://www.lifering.org)

### ***Moderation Management (MM)***

2795 East Bidwell Street  
Suite 100-244  
Folsom, CA 95630-6480  
Phone: 212.871.0974  
Email: [mm@moderation.org](mailto:mm@moderation.org)  
Web: [www.moderation.org](http://www.moderation.org)

### ***Narcotics Anonymous (NA)***

P.O. Box 9999  
Van Nuys, CA 91409  
Phone: 818.773.9999  
Email: [fsmail@na.org](mailto:fsmail@na.org)  
Web: [www.na.org](http://www.na.org)

### ***Secular Organizations for Sobriety/Save Our Selves (SOS)***

4773 Hollywood Blvd.  
Hollywood, CA 90027  
Phone: 323.666.4295  
Email: [sos@cfiwest.org](mailto:sos@cfiwest.org)  
Web: [www.sossobriety.org](http://www.sossobriety.org)

### ***SMART Recovery***

7304 Mentor Avenue, Suite F  
Mentor, OH 44060  
Phone: 440.951.5357  
Fax: 866.951.5357  
Email: [information@smartrecovery.org](mailto:information@smartrecovery.org)  
Web: [www.smartrecovery.org](http://www.smartrecovery.org)

### ***Women for Sobriety (WFS)***

P.O. Box 618  
Quakertown, PA 18951-0618  
Phone: 215.536.8026  
Email: [newlife@nni.com](mailto:newlife@nni.com)  
Web: [www.womenforsobriety.org](http://www.womenforsobriety.org)

## Project Collaborators

**Dr. Eric Goplerud** and **Dr. Tracy L. McPherson**. For 9 years, Dr. Goplerud, Dr. McPherson and staff at the Center for Integrated Behavioral Health Policy and Ensuring Solutions to Alcohol Problems at George Washington University and at NORC at the University of Chicago have been among the most visible leaders in the country. They work with employers, health insurers, accrediting bodies and government agencies on policy, training and quality improvement initiatives that are transforming employers' and health insurers' approaches to detecting and treating alcohol, prescription opiate and illicit drug use.

Web: [www.norc.uchicago.edu](http://www.norc.uchicago.edu)

**NAADAC - The Association for Addiction Professionals** is the largest membership organization serving addiction counselors, educators and other addiction-focused health care professionals, who specialize in addiction prevention, treatment, recovery support and education. With 8,000 members and 43 state affiliates, NAADAC's network of addiction services professionals spans the United States and the world. NAADAC's members work to create healthier individuals, families and communities through prevention, intervention, quality treatment and recovery support.

Web: [www.naadac.org](http://www.naadac.org)

**Employee Assistance Professionals Association (EAPA)** is the world's largest, oldest and most respected membership organization for employee assistance professionals. With members in over 35 countries around the globe, EAPA is the world's most relied upon source of information and support for and about the employee assistance profession. EAPA publishes the *Journal of Employee Assistance*, hosts professional conferences and offers training and other resources to fulfill its mission. EAPA's mission is to promote the highest standards of EA practice and the continuing development of employee assistance professionals, programs and services.

Web: [www.eapassn.org](http://www.eapassn.org)

**Center for Clinical Social Work (CCSW)** promotes clinical social work as a profession that is highly respected and clearly defined in terms of the rights of its members, the standards to which they adhere and the unique abilities they bring to the challenge of helping others.

Web: [www.centercsw.org](http://www.centercsw.org)

**American Academy of Addiction Psychiatry (AAAP)** is an international academic society that was founded in 1985 with approximately 1,000 members. AAAP's mission is to promote accessibility to the highest quality treatment for all who need it; promote excellence in clinical practice in addiction psychiatry; educate the public and influence public policy regarding addictive illness; provide continuing education for addiction professionals; disseminate new information in the field

of addiction psychiatry; encourage research on the etiology, prevention, identification and treatment of the addictions.

Web: [www.aaap.org](http://www.aaap.org)

**American Society of Addiction Medicine (ASAM)** is a professional society founded in 1954 that represents close to 3,000 physicians with chapters nationwide. ASAM's mission is to increase access to and improve the quality of addiction treatment; to educate physicians, other health care providers and the public; to support research and prevention; to promote the appropriate role of the physician in the care of clients with addiction; and to establish addiction medicine as a recognized medical specialty.

Web: [www.asam.org](http://www.asam.org)

**Employee Assistance Society of North America (EASNA)** is a tri-national professional association (Canada, United States, and Mexico) with membership who are individuals, organizations, employers and students interested in advancing knowledge, research and best practices toward achieving healthy and productive workplaces.

Web: [www.easna.org](http://www.easna.org)

**NORC at the University of Chicago** creates unique value for its clients by developing effective, innovative solutions that combine state-of-the-art technology with high quality social science research in the public interest.

Web: [www.norc.org](http://www.norc.org) and [www.norc.uchicago.edu](http://www.norc.uchicago.edu)

## Additional Project Contributors

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Web: [www.centercsw.org](http://www.centercsw.org)

**Kathryn Cates-Wessel** is the Executive Director of the American Academy of Addiction Psychiatry.

Web: [www.aaap.org](http://www.aaap.org)

**Denise Ernst, PhD**, is a nationally and internationally recognized expert in Motivational Interviewing and has extensive experience teaching EAP clinicians to use MI approaches that work with alcohol and drug problems.

Web: [www.deniseernst.com](http://www.deniseernst.com)

**Abdel Fahmy, MD, CPHIMS**, is board certified in Internal Medicine, Palliative Medicine and Addiction Medicine. Prior to his current position with the DuPage Medical Group, he served as the Regional Medical Director and Medical Director for Substance Abuse at ACCESS Community Health, the US's largest community health organization serving the Chicago metropolitan area. Dr. Fahmy has served as the Principal Investigator for multiple SAMHSA grants including an SBIRT grant for medical residents targeting three Chicago-area teaching hospitals.

**Denise Hall, MS, NCC, ASE**, is a licensed professional counselor (LPC) and adjunct faculty member in the Department of Rehabilitation Counseling at Virginia Commonwealth University. She is a member of the Motivational Interviewing Network of Trainers with extensive experience training and implementing motivational interviewing and other evidence-based practices within organizations.

Email: [drhall@vcu.edu](mailto:drhall@vcu.edu)

**Hanley Center Inc.'s** mission is to advance the prevention, diagnosis and treatment of alcoholism, chemical dependency and addictive behavior, including support for related research and education, with a special emphasis on treating the substance use problems of older adults.

Web: [www.hanleycenter.org](http://www.hanleycenter.org)

**Cynthia Moreno Tuohy** is the Executive Director of NAADAC, The Association for Addiction Professionals. She has previously served as President of NAADAC, Certification Board Commissioner, International Chair, Treasurer and Legislative Chair for NAADAC.

Web: [www.naadac.org](http://www.naadac.org)

**National Association for Children of Alcoholics' (NACoA)** mission is to eliminate the adverse impact of alcohol and drug use on children and families by working to raise public awareness, providing leadership in public policy, advocating for effective education and prevention services and facilitating and advancing professional knowledge and understanding.

Web: [www.nacoa.org](http://www.nacoa.org)

**Michele A. Packard, PhD**, is a licensed psychologist and licensed addictions counselor. She is the Executive Director of Sage Training & Consulting, providing continuing education training to the field since 1983. She is a contributing author in the Motivational Interviewing text.

Web: [www.sagetraining.com/Contact.htm](http://www.sagetraining.com/Contact.htm)

**Peer Assistance, Colorado State Employee Assistance Program and SBIRT Colorado** provides clinical service and training organizations that delivers EAP and substance use screening, brief intervention, and treatment throughout the state of Colorado.

Web: [www.codrugfreeworkplace.org](http://www.codrugfreeworkplace.org)

**Jan Price** is the Manager of Professional Learning Resources for the Employee Assistance Professionals Association (EAPA). Price was former President (2007 & 2008) and Vice President (1997 & 1998) of the North Georgia chapter of EAPA.

Web: [www.eapassn.org](http://www.eapassn.org)

**Brie Reimann, MPA**, is the Program Director for the screening, brief intervention, referral to treatment program in Colorado. She is employed by Peer Assistance Services, Inc., a non-profit organization in Denver dedicated to providing quality, accessible prevention and intervention services in workplaces and communities, focusing on substance use and related issues.

Web: [www.peerassistanceservices.org](http://www.peerassistanceservices.org)

**Gerard J. Schmidt, MA, LPC, MAC**, the Chief Operations Officer at Valley HealthCare System in Morgantown, WV since September 1980, has been in the mental health and addictions treatment profession for over forty years.

Web: [www.valleyhealthcare.org](http://www.valleyhealthcare.org)

**SMART Recovery** is the leading self-empowering addiction recovery support group. Participants learn tools for addiction recovery based on the latest scientific research and participate in a world-wide community, which includes free, self-empowering, secular and science-based, mutual-help support groups.

Web: [www.smartrecovery.org](http://www.smartrecovery.org)

**Misti Storie, MS**, is the Director of Training and Professional Development for NAADAC, The Association for Addiction Professionals. She develops webinars, online courses, training manuals and other educational products for addiction professionals.

Web: [www.naadac.org](http://www.naadac.org)

## Glossary

### A

**absenteeism** – not being at the worksite or at work; an "objective" number typically measured in hours absent from work

**affirming** - recognizing your client's strengths and accomplishments, complementing or making statements of appreciation and understanding

**alcohol use disorder** – a medical disease characterized by the excessive consumption of alcoholic beverages, leading to physical and psychological harm and impaired social and/or vocational functioning

**ambivalence** – having positive and negative considerations that have about equal weight and shift back and forth, keeping an individual from making a decision

**AUDIT** - a screening questionnaire that gives EA professionals and clients immediate information about level of risk for alcohol-related problems by asking 10 questions related to the quantity and frequency of alcohol use, symptoms of dependence and negative consequences of drinking

**AUDIT-C** - the first three questions of the AUDIT that aim to determine the quantity and frequency of a client's alcohol use

### B

**binge** - a short period of excessive consumption

**brief intervention** - a behavior change strategy focused on helping your client reduce or stop unhealthy drinking

### C

**change talk** - statements said by a client that favor changing unhealthy behaviors and describe the reasons for and advantages of changing

**close-ended questions** - questions that are phrased in a way to elicit a very brief or "yes" or "no" response

**Cognitive-Behavioral Therapy (CBT)** - a short-term, skill-oriented, collaborative method of counseling that primarily focuses on correcting thoughts, emotions and behaviors that lead to dysfunction by simultaneously restructuring your client's automatic thoughts and learning new behaviors

**collaboration** - the process by which people work together to accomplish a common mission

### D

**DAST** - a screening instrument used to detect drug abuse

### F

**follow-up** - contacting your client at a later time to provide additional support, if needed

### G

**generating options** – assisting your client in developing alternative solutions to her current behavior, evaluating and

choosing between options, testing that choice in practice and making necessary changes to achieve the client's goals

## M

**motivation** - internal and external forces and influences that move an individual to become ready, willing and able to achieve certain goals and engage in the process of change

**Motivational Interviewing (MI)** – a method of communication that is focused on your client's concerns and perspectives and works to enhance your client's internal desire, willingness and ability to change by exploring and resolving his/her co-existing opposite feelings about changing

**motivational counseling**– a method of communicating uses the perspective, ideas, beliefs and strengths of an individual to evoke internal motivation to change behaviors

**mutual support groups** – adjuncts to or alternatives to professional counseling services where ordinary citizens meet to discuss similar struggles

## O

**open-ended questions** - questions that are phrased in a way that encourage your client to explore and share his/her feelings, experiences and perspectives

## P

**PHQ-9** - a screening instrument used to detect depression

**presenteeism** - being at work but with diminished performance due to personal distractions

**pushback** - responses that express opposition to an idea, observation or plan

## R

**Referral to Treatment** - the process of recommending a particular treatment resource to assist a client with an issue that is beyond the scope of practice of the referring professional

**reflective listening** - also known as parallel talk or paraphrasing, occurs when an EA professional listens to a client's thoughts, perceptions and feelings then restates them for the purpose of clarification and further exploration

## S

**Screening** - the process of assessing risk

**Screening, Brief Intervention and Referral to Treatment (SBIRT)** - an evidence-based procedure aimed at identifying and treating unhealthy, problem or hazardous alcohol use, including binge drinking and other forms of heavy drinking

**self-efficacy** – an impression that one is capable of performing in a certain manner or attaining certain goals

**Stages of Change model** – a behavioral model that identifies five independent stages of behavior and thinking in clients that are experienced during the treatment process

**summarizing** - linking together statements or themes and presenting back a condensed version



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- <sup>2</sup> Miller, WR and Willbourne, PL. (2002). Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. *Addiction*, 97, 265–277.
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- <sup>4</sup> Babor, T, and Higgins-Biddle, J. (2001). Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care. WHO/MSD/MSB01.6, World Health Organization, Geneva. Retrieved on July 18, 2011 from [http://www.afcrossroads.com/websites/corc\\_docs/SG\\_Toolkit/Bucket1/AUDIT\\_Feedback.pdf](http://www.afcrossroads.com/websites/corc_docs/SG_Toolkit/Bucket1/AUDIT_Feedback.pdf)
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- <sup>7</sup> Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4856Findings). Rockville, MD.
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- <sup>14</sup> Selzer, M.L. (1971). The Michigan Alcoholism Screening Test (MAST): The quest for a new diagnostic instrument. *American Journal of Psychiatry*, 127, 1653-1658.
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