Screening, Brief Intervention & Referral to Treatment (SBIRT) Training Manual

For Alcohol and Other Drug Problems
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For
Alcohol and Other Drug Problems

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I. Overview of the Manual

This manual is an adaptation of an earlier manual on Emergency Department (ED) clinician administered brief intervention for harmful and hazardous alcohol drinkers. The current manual is designed to provide the medical practitioner with the necessary skills to easily and effectively perform 1) evidence based screening, 2) a brief intervention, the Brief Negotiation Interview (BNI) and 3) a facilitated referral to treatment for alcohol and other drug problems. Special attention is given to decision-making process regarding whether to use the brief intervention to promote a reduction of use or abstinence versus a referral to a formal substance abuse treatment program. The following sections provide background information on and describe the critical components of administering screening tools for alcohol and other drugs in a variety of medical settings (e.g., ED, OB/Gyn, Pediatrics) and conducting BNIs for both use reduction and referral to treatment. Additional motivational and troubleshooting strategies, as well as other helpful resources (e.g., pros and cons of alcohol & drug use, withdrawal checklists, sample BNI dialogues) are provided. While the manual gives the reader a critical overview of SBIRT, participation in a 2-hour training course, followed by successful completion of a supervised test case is required to be fully prepared to effectively conduct SBIRT encounters with patients. Suggestions for periodic review of cases and feedback on performance, as well as booster training sessions, in order to ensure effective and consistent SBIRT implementation, are also provided.
II. Background Information

Introduction

Screening, Brief Intervention & Referral to Treatment (SBIRT) for alcohol and/or other drug problems are critical skills for the health care practitioner because the use of these substances and the myriad medical, social and legal problems they cause are highly prevalent, frequently undetected and treatable in a variety of medical settings. This introduction will cover each of these issues with an emphasis on evidence-based procedures to assist the health care practitioners in identifying and treating these problems in their day-to-day practices.

Prevalence of Alcohol & Drug Problems

Unhealthy alcohol use\(^1\) is a major preventable public health problem resulting in over 100,000 deaths each year\(^2\) and costing society over 185 billion dollars annually.\(^3\) The effects of unhealthy alcohol use have far reaching implications not only for the individual drinker, but also for the family, workplace, community, and the health care system. Based on recent survey conducted in 2007, an estimated 19.9 million Americans aged 12 or older were currently using illicit drugs, including marijuana/ hashish, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. This estimate represents 8.0 percent of the population aged 12 years or older. In that same year, 23.2 million persons needed treatment for an illicit drug or alcohol problem.

For example, opioid dependence is a major public health concern and remains primarily an untreated medical condition in the United States. In 2006 there were approximately 560,000 individuals who used heroin in 2006, and 11.4 million individuals who had non-medical use of prescription opioids.\(^4\) Economic costs of opioid dependence are estimated at greater than $21 billion/year and have far reaching implications for the individual, workplace, society and the healthcare system.\(^5\) Untreated opioid dependence is associated with HIV transmission via injection drug use and high risk sexual behaviors.\(^6\) However, treatment is associated with significant individual and society benefits,\(^7\) and opioid agonist treatment, including methadone and buprenorphine, has been demonstrated to be the most effective treatment. However, opioid dependent patients often do not seek help through specialized treatment centers, but do frequently visit Emergency Departments (ED) of hospitals, either for medical consequences of theirs addictive disorder or for comorbid medical and psychiatric conditions.\(^8\) Many of these patients, particularly young adults, have few if any other interactions with the health care system. Therefore, the medical visit may be their only contact with the treatment system and represents an ideal opportunity for screening, intervention and referral for treatment.

Lack of Detection

Of the 23.2 million people in need of treatment for substance abuse problems in 2007, only 2.4 million received treatment and 20.8 million did not receive treatment. Of the 20.8 million people who did not receive treatment, 1.3 million felt they needed treatment, 380,000 reported they made an effort to get treatment, and 955,000 reported making no effort to get treatment.\(^9\) Much of the lack of treatment engagement is due to a lack of detection of problematic use by the health care provider.\(^{1,15,39}\)
Brief Interventions Work for Alcohol, Tobacco and Other Drug Use

Brief interventions are short counseling sessions, ranging from 5-60 minutes that incorporate feedback, advice, and motivational enhancement techniques to assist the patient in reducing their alcohol consumption to low-risk guidelines thereby reducing their risk of illness/injury. The Brief Negotiation Interview (BNI) used in this grant was first developed in 1994 by Drs Edward Bernstein, Judith Bernstein and Gail D’Onofrio in consultation with Dr. Stephen Rollnick for Project ASSERT in the ED.10,11 It was later refined and tested for hazardous and harmful drinkers in the ED by our research team.12

There is compelling evidence in the literature that brief interventions for alcohol problems are effective13,14 in a variety of settings including primary care15,16 and inpatient trauma settings.17 ED-based randomized controlled trial testing the effectiveness of screening, brief intervention and referral to treatment have had mixed results. Researchers in Germany studied a computer-generated intervention in injured patients presenting to an ED and found a significant decrease in alcohol consumption in the intervention group,18 while two other studies reported a similar decrease in alcohol consumption in the intervention and control groups but demonstrated significant reductions in negative consequences after the initial brief intervention session19 or a booster session20 in the intervention group. One study detected no difference in consumption between the intervention and control groups.21 Our own study (see preliminary data section) that enrolled both injured and noninjured patients with harmful and hazardous drinking showed similar significant reductions in the control and BNI groups, without a treatment effect.22 Cohort studies without control groups have shown a significant reduction in alcohol use.23 A recently published study conducted at 14 ED sites that used a quasiexperimental comparison group design, in which we participated, revealed that screening, brief intervention and referral for treatment on patients with all degrees of unhealthy alcohol use was effective. A total of 1,132 patients were enrolled (581 control, and 551 intervention (BNI)). At 3-month follow-up, the BNI group reported consuming 3.25 fewer drinks per week than controls. Of the at risk drinkers, 37% no longer exceeded NIAAA low-risk guidelines compared with 19% in the control group, 95% CI 12% to 26% (see preliminary study section). A more recent meta-analysis of strategies targeting alcohol problems in the ED examined the extent to which interventions were effective in reducing alcohol consumption and related harm.24 Meta-analysis revealed that interventions did not significantly reduce subsequent alcohol consumption, but were associated with approximately half the odds of experiencing an alcohol-related injury (OR=0.59, CI 0.42-0.84).

Brief interventions have long been shown to be effective in treating tobacco use and dependence in all populations including adolescents, pregnant women, older adults and racial and ethnic minorities.25,26,27,28 As a result formal clinical practice guidelines have been developed for treating tobacco use by a US public Health Panel and Consortium.29

Few studies have investigated brief interventions in drug users. Bernstein and colleagues reported their experience with Project ASSERT in Boston, which used health promotion advocates to screen for alcohol and other drug use in an urban ED.30 This cohort study showed that during a one year period of time, 2,931(41%) patients screened positively for substance abuse. Of the 1,096 enrolled in a follow up program, 245 kept a referral appointment and demonstrated a significant 45% reduction in severity of drug problems and a 56% reduction in alcohol use. More recently Bernstein and colleagues tested the impact of a single, structured encounter by similar peer educators that targeted cessation of drug use in a hospital’s hospital “Walk-In” Clinics.31 Of the 1175 patients enrolled, the intervention group at 6 months was more likely to be abstinent than the control group for cocaine (22.3% versus 16.9%), heroin (40.2% versus 30.6%), and both drugs (17.4% versus 12.8%). Another study evaluated the effect of a brief alcohol intervention for injection drug users at a needle exchange facility.32 Significant reductions were observed in both treatment conditions; participants reported an
average of 12.0 drinking days at baseline and 8.3 at 6 months. Those in the brief intervention group were over two times more likely than controls to report reductions of 7 days or more, P<0.05.

These findings support further investigation of brief intervention for drug use in the ED. Given the chronic and relapsing nature of drug and alcohol dependence, the goal of these brief interventions may be to facilitate an effective referral for the patient to a formal treatment program which can have an impact on reducing drug use.

**The Medical Visit is an Opportunity for Intervention**

Given the significantly higher rate at which people see their medical doctors (versus a substance abuse specialist), the medical visit offers a potential “teachable moment” where health care practitioners have a unique opportunity to motivate change in alcohol and/or drug use behaviors. In essence, the medical practitioner has a captive audience. Given the high prevalence and frequent lack of detection of alcohol and drug problems, as well as their negative consequences and positive response to evidence-based treatment, the health care practitioner armed with competent SBIRT skills can make the difference in forestalling the progression of risky use to dependence, or effectively motivating a patient who is already on the severe end of the spectrum to engage in a treatment program.

In the following 2 sections, we will review the steps needed to effectively administer the 2 main parts of SBIRT, that is 1) Screening and 2) Brief Intervention & Referral to Treatment

**III. Screening**

The components of evidence-based screening, where we are attempting to detect the type and level of substance use in our patients, include decisions around 1) what type of substance the screening is for, 2) what type of substance problem is of interest (i.e., harmful or hazardous use, dependence, lack of treatment), 3) what questions to ask and 4) how to score the screening measure.

For the first component of screening, decide what substance is of interest, alcohol or illicit drugs (e.g., cocaine, heroin, marijuana) or both. Then, based on Table 1, select the substance problem of interest. For alcohol, the choices are harmful or hazardous (“at-risk”) drinking, dependence. For illicit substances, the choices are the same except for “at-risk” use, as there are no acceptable guidelines for non-risky use of drugs. Depending on the first two decisions, the health care provider will select the appropriate screening measure(s), and administer and score them as described below and in the “Additional Screeners” section.

**TABLE 1: Substance, Problem, Screener**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Problem</th>
<th>Screener</th>
</tr>
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</table>
| Alcohol    | On a continuum from at risk… to dependence | **NIAAA quantity frequency:** Identifies those who are over low risk amounts  
**AUDIT, TWEAK:** (for pregnant women), **CRAFFT** (for adolescents): May offer additional information regarding negative consequences  
**CAGE:** > 2 is a brief assessment for dependence |
| Illicit Drugs | On a continuum from use… to dependence | **NIAAA Screener adapted for drugs**  
**CAGE-Adapted to Include Drugs (CAGE-AID), DAST, modified CRAFFT** (for adolescents) |
The most frequently used of the above screeners will be described in detail (administration and scoring procedures) below, while information on the other measures will be offered in section VIII “Additional Screeners” of this manual.

**Screening procedures**

A) ALCOHOL

1) Harmful/Hazardous (“at-risk) drinking

The most commonly used screener for harmful/hazardous drinking is what is commonly referred to as the NIAAA (National Institute for Alcohol Abuse & Alcoholism) Quantity/Frequency screening. In order to competently administer the NIAAA screener, one first needs to know the following information (see figure below) regarding what equals a “standard drink.”

![Figure 1: WHAT IS A STANDARD DRINK?](image)

1 Standard Drink equals:

- drink made with 1.5 oz. of alcohol (whiskey, gin, etc.)
- 12 oz. Beer
- 5 oz. wine

**TABLE 2: NIAAA SCREENING for Harmful & Hazardous (“At-risk”) Alcohol Use**

1. How many days per week do you drink alcohol?
2. On a typical day when you drink, how many standard drinks do you have?
3. What is the maximum number of standard drinks you had on any given day in the past month?
TABLE 3: SCORING THE NIAAA SCREENER

*At-risk/Hazardous Drinking ALSO includes those who drink under potentially dangerous situations (e.g., while operating heavy machinery, while driving)

Harmful Drinking pertains to those who (whether or not they score above the drinking limits in Table 3) have are currently experiencing at least one problem (medical/social) related to alcohol. They do, however, also often meet the above NIAAA guidelines for at-risk drinking.

** Sometimes even 1 drink is too much! If you are:
  - driving or planning to drive
  - at work or returning to work
  - pregnant, or breast feeding
  - on medication
  - have certain medical conditions

2) Alcohol Dependence

The most common screener for more severe alcohol problems (a consistent pattern of problems related to alcohol in 1 area of a patient’s life) and dependence (a consistent pattern of problems related to alcohol in 3 areas of a patient’s life) is referred to as the “CAGE” screener.

TABLE 4: The ALCOHOL “CAGE” Screener

<table>
<thead>
<tr>
<th></th>
<th>Per Week**</th>
<th>Per Occasion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>&gt;14</td>
<td>&gt;4</td>
</tr>
<tr>
<td>Women</td>
<td>&gt;7</td>
<td>&gt;3</td>
</tr>
<tr>
<td>All &gt; 65</td>
<td>&gt;7</td>
<td>&gt;3</td>
</tr>
</tbody>
</table>

*At-risk/Hazardous Drinking ALSO includes those who drink under potentially dangerous situations (e.g., while operating heavy machinery, while driving)
TABLE 5: SCORING THE ALCOHOL “CAGE” Screener

<table>
<thead>
<tr>
<th># CAGE Qs scored positive</th>
<th>Percent Likelihood of Dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assess further*</td>
</tr>
<tr>
<td>2</td>
<td>64</td>
</tr>
<tr>
<td>3 or 4</td>
<td>86</td>
</tr>
</tbody>
</table>

*Assess further with the MINI-SCID (see Appendices of this manual)

B) ILLICIT DRUGS

1) Screening for Use

While there are no levels of drug use that would be considered low-risk vs at-risk, the health care provider may use the aforementioned NIAAA quantity/frequency questions to assess the level of current drug use in patients. The provider, however, needs to substitute “alcohol” for whatever illicit drug is being used by the patient and number of “standard drinks” with the relevant route and form of use (e.g., “bags” of IV heroin use, e.g., “blunts” of marijuana smoked).

2) Screening for Drug Dependence

As illustrated below, the CAGE screener has been adapted to include drug use. This screener is to be used to assess drug dependence in patients.

TABLE 6: ILLICIT DRUGS “CAGE” SCREENER (CAGE-Adapted to Include Drugs)

(CAGE-AID)

C: Have you ever thought you should Cut down on your drug use?

A: Have people Annoyed you by criticizing your drug use?

G: Have you ever felt bad or Guilty about your drug use?

E: Have you ever used drugs first thing in the morning to steady your nerves or avoid withdrawal (Eye opener)
TABLE 7: SCORING THE ILLICIT DRUGS “CAGE” SCREENER
(CAGE-Adapted to Include Drugs)

<table>
<thead>
<tr>
<th># CAGE Qs scored positive</th>
<th>Percent Likelihood of Drug Dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assess further*</td>
</tr>
<tr>
<td>2</td>
<td>64</td>
</tr>
<tr>
<td>3 or 4</td>
<td>86</td>
</tr>
</tbody>
</table>

*Assess further with the MINI-SCID (see Appendix 9)

Research Findings on Screening in Medical Settings

Internal Medicine

There are many instruments available for screening and brief assessment of alcohol problems. Their effectiveness varies according to their availability, ease of administration and test characteristics.34 Our team has extensive experience evaluating the performance characteristics for screening for alcohol use in primary care.35 The NIAAA has traditionally recommended that the practitioner ask 3 quantity and frequency questions36 followed by the CAGE questionnaire.37 More recently, NIAAA has advocated for a one question screen that determines whether a patient drinks heavily (5 or more drinks in a day for men or 4 or more for women.38 The AUDIT,39 a ten item questionnaire, was developed as a screening instrument for hazardous and harmful alcohol consumption as part of a 12-country World Health Organization study of brief alcohol interventions. Alcohol consumption, drinking behavior, and alcohol-related problems are assessed over the preceding year. A cutoff score of 8 out of a possible 41 is used as a positive indicator of hazardous/harmful drinking. The CAGE questionnaire is easy to administer, and performs relatively well when preceded by the quantity and frequency questions. Saitz reported the validity of using the CAGE as a screening tool for detecting alcohol use disorders in Latinos in the primary care setting.40 While heavy drinking is as common in Latinos as in African Americans and non-Latino whites, serious consequences of heavy drinking are more common in Latinos than in other ethnic groups.41 Despite its advantages the CAGE questionnaire may be biased in relation to certain groups; one researcher reported that when applied to women, Mexican-American patients and those with annual incomes above $40,000, they were consistently less likely to endorse each CAGE question “yes” after adjusting for the alcohol use disorder and pattern of alcohol consumption.42 The Yale-SBIRT faculty has published systematic reviews on the performance characteristics of screening methods in primary care and ED setting. Our results have demonstrated, for instance, that the Alcohol Use Disorders Identification Test (AUDIT) has the best operating characteristics for detecting harmful and hazardous alcohol use in primary care, whereas the CAGE is better for detecting alcohol dependence.43 These results also demonstrate the advantage of using formal screening instruments over clinical judgment or laboratory tests. The curricula on screening will emphasize the science (e.g. sensitivity, specificity) behind the use of various screening tools

Obstetrics and Gynecology

The American College of Obstetricians and Gynecologists recommend screening all women for at-risk drinking and illicit drug use.44 Among pregnant women aged 15 to 44, 11.8% admit to drinking some alcohol during the previous month,45 which puts the fetus at risk for fetal alcohol syndrome, estimated at 1 in 100 children and the leading cause of mental retardation in the U.S.
Maternal alcoholism is also one of the leading preventable causes of fetal neurodevelopmental disorders. Children from low income ethnic minority populations are vulnerable to the long-term effects of prenatal alcohol exposure, because their mothers are less likely to receive alcohol counseling during pregnancy. Illicit drug use is associated with increased rates of sexually transmitted infections in women, including hepatitis and human immunodeficiency virus as well as depression, interpersonal violence, poverty and significant prenatal and neonatal complications. Screens such as the TWEAK, T-ACE or the NIAAA quantity and frequency questions are accurate in detecting women’s patterns of use, which may differ than men. The TWEAK was first designed to detect “at-risk” pregnant drinkers. It has been shown to have a high sensitivity & specificity in both primary care and general populations, ranging from 83%-100% and 68%-96% respectively, using a cutoff point of 3, when a weight of 2 is applied to tolerance and worry and a weight of 1 is applied to the other three.

**Pediatrics**

Knight and colleagues developed the 6-item CRAFFT questionnaire as a brief alcohol and other drug screening test and later validated its use in a general population of adolescent medical patients in comparison with a structured psychiatric diagnostic interview. More recently Knight tested the validity of CRAFFT with the AUDIT, POSIT, and CAGE questionnaire in detecting alcohol disorders in 14-18 year olds in a routine adolescent clinic. The AUDIT, POSIT and CRAFFT were found to have acceptable sensitivity for identifying alcohol problems or disorders in this age group, but the CAGE was not recommended. He also found that the CRAFFT was a reliable means of screening adolescents for other drug use.

**Emergency Medicine/Surgery**

The American College of Emergency Physicians, and the Emergency Nurses Association has adopted the preferred NIAAA quantity and frequency questions followed by the CAGE questionnaire in their toolkits for SBIRT. This is primarily due to ease of administration and acceptability by practitioners. Cherpitel studied the operating characteristics of a variety of screens in the ED setting. Although CAGE had less sensitivity compared with TWEAK 75% to 87%, the CAGE is one less question and easy to remember. More recently Cherpitel studied RAPS4 (Rapid Alcohol Problems Screen) in the ED setting compared with ICD-10 and DSM-IV criteria for alcohol dependence and for harmful drinking. A positive response to any one of the four items gave a sensitivity of 93% and specificity of 87% for alcohol dependence, and sensitivities were high across gender and ethnic subgroups. Sensitivity and specificity for harmful drinking were lower (55% and 79%).

**Screening for illicit drug use**

There are fewer rigorous evaluations or validated instruments of screening for these disorders, and screening occurs less frequently. Therefore, one of the goals will be to promote the use of validated screening instruments for drug use (e.g. CAGE-D, DAST and ASSIST) in the resident’s practices. The 10-item Drug Abuse Screening Test (DAST-10) though not lengthy requires more time to administer than quantity/frequency scales, and the individual items. Several studies have found that the 10-item DASTs is effective at screening for drug misuse with good internal reliability, validity, and temporal consistency. The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was recently developed for the World Health Organization (WHO) in an effort to screen for problem or risky use of tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, sedatives, Hallucinogens, inhalants, opioids and ‘other drugs’ that do not fall into these categories. The instrument was developed to use across a broad range of countries and cultures in primary care settings.
IV. Brief Intervention in SBIRT: An Overview of the Brief Negotiation Interview (BNI)

The Brief Negotiation Interview (BNI) described in this grant was first developed in 1994 by Drs Edward Bernstein, Judith Bernstein and Gail D’Onofrio in consultation with Dr. Stephen Rollnick for Project ASSERT in the ED. It was later refined and tested for hazardous and harmful drinkers in the ED by the current investigator group.

The BNI is a short counseling session that is done following screening and that incorporates brief feedback and advice with motivational enhancement techniques to assist the patient in changing alcohol and/or drug-related behaviors. The BNI procedure is patient-centered and the skills used are based in large part on the patient’s motivation and readiness to change. The primary outcome of the BNI procedure is the patient’s agreement to reduce alcohol/drug amounts or accept a referral to a formal specialized treatment center to decrease harm (medical problems or trauma). The interventionist and patient come to this agreement through a process of negotiation described in the following section.

The following are the 4 steps of the BNI:

1) **Raise The Subject**
   - Establish rapport
   - Raise the subject of alcohol or drug use
   - Assess comfort

2) **Provide Feedback**
   - Review patient’s alcohol/drug use and patterns
   - Make connection between alcohol/drug use and negative consequences
     - In a variety of areas of life including: medical, legal, family and employment
   - Make connection between alcohol/drug use and the medical visit
   - Discuss issues related to physical dependence, such as tolerance and withdrawal

3) **Enhance Motivation**
   - Assess readiness to change
   - Boost motivation

4) **Negotiate And Advise**
   - Negotiate goal
   - Give advice
   - Summarize and complete referral/or alcohol/drug agreement

Each step has critical components, specific objectives, actions and necessary preparations to be successful. Details of each step are provided in the following 2 sections, the first for patients who have screened positive for harmful or hazardous (“at-risk”) drinking and the second for those who have screened positive for alcohol or drug dependence.
V. The 4 Steps of the BNI

The following is a detailed description of the actions to be taken during each of the 4 steps of the BNI. In each step, specific directions are given based on whether the patient screened positive for 1) Harmful or Hazardous (“At-risk”) Drinking, in which case the BNI goal would be the patient’s agreement to reduce alcohol use to below NIAAA “at-risk” levels and/or to avoid drinking in potentially harmful situations, or 2) Alcohol and/or Drug Dependence, in which case the goal would be the patient’s agreement to follow-up with a referral to treatment or a reduction of use as the patient considers treatment options.

**STEP1: Raise the Subject**

**Critical components:**
1. Be respectful
2. Remember the patient is giving you permission to discuss his/her alcohol/drug use is an important aspect of the intervention
3. Avoid arguing or being confrontational
4. Be mindful of the patients possible physical discomfort

**PREPARATION (NOT part of screening):**
- Review medical record, Withdrawal Scale, if administered (See Appendix 9), any other additional assessments (See Section VIII. Additional Screeners)

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACTION(S)</th>
<th>QUESTIONS/COMMENTS</th>
</tr>
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<tbody>
<tr>
<td>Establish rapport</td>
<td>• Introduction and explanation of your role &lt;br&gt;• Avoid a judgmental stance &lt;br&gt;• Acknowledge the patients situation &lt;br&gt;• Set a comfortable climate</td>
<td>“Hello, I am ____ and I work here in the _______. “</td>
</tr>
<tr>
<td>Raise the subject</td>
<td>• Ask permission &lt;br&gt;• Engage the patient</td>
<td>“Would you mind if we spend a few minutes talking about your use of______(fill in with alcohol or drug(s) of abuse)?”&lt;PAUSE&gt; “I want to talk about how it’s affecting you and how we might be able to help.”</td>
</tr>
</tbody>
</table>
| Assess discomfort | • Ask about any symptoms of alcohol and/or drug withdrawal see (if applicable)(see mini-SCID & Withdrawal scales in Appendix 9)  
• Reflective listening | “Tell me about how you are feeling right now? When is the last time you drank/used any drugs?

**REFLECT on any stated connection between pattern of alcohol and/or drug use & discomfort/withdrawal symptoms** |

**SUMMARY OF STEP1**
This first step sets the climate for a successful BNI. Asking permission to discuss the subject of alcohol/drug use formally lets the patient know that their wishes and perceptions are central to the treatment which later enhances that the patient will accept a referral to treatment if necessary. Further reflecting on patient acknowledged problems and discomfort related to their drug use (whether stated by the patient or assessed with other measures, such as the mini-SCID and/or withdrawal scales found in the “Appendices” section, motivates the patient to start considering compelling reasons for change, but without being confronted with this information in a harsh (i.e., non-motivational) manner.
**STEP 2: Provide Feedback**

---

### Critical Components:

1. Review current alcohol/drug use and patterns and dependence symptoms
2. Compare the patients drinking to national norms Discuss the role of alcohol/drug use on difficult areas of life (financial, family, employment, health, legal)
3. Make the connection between alcohol/drug use and reason for medical visit and risk of HIV/AIDS (if applicable)
4. Discuss issues related to physical dependence such as withdrawal and need to continually use alcohol/drugs (if applicable)
5. Inform patient that a variety of treatments work effectively reduce and stop drug/alcohol use, and ask for patients positive treatment experiences

---

**PREPARATION:**

- Review: Screening results, medical chart, health Insurance information, other assessments, if administered (e.g., mini-SCID, withdrawal scales [See Appendix 9])
- Handout & Explain: **FOR HARMFUL/HAZARDOUS [HH] ALCOHOL DRINKERS;** NIAAA “Standard Drink” card, NIAAA Guidelines for Low-risk vs. at-risk drinking & National Drinking Norms (see Appendices 1-4). **FOR DEPENDENT PTS:** Treatment Referral List (Appendix 10),

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### FOR HH ALCOHOL DRINKERS:

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACTION(S)</th>
<th>QUESTIONS/COMMENTS</th>
</tr>
</thead>
</table>
| Review patient’s drinking patterns | • Review screening data  
• Express concern  
• Be non-judgmental | “From what I understand you are drinking…”  
“We know that drinking above certain levels can cause problems such as … (refer to presenting medical problem/complaint if applicable, or, refer to future increased risk of illness and injury).”  
“I am concerned about your drinking.” |
| Make connection to medical visit (if applicable) | • Discussion of specific patient medical issues e.g., MVC, GI complaints, hypertension | “What connection (if any) do you see between your drinking and this ED visit?  
If patient states an accurate connection, reiterate it. If patient does not see connection where there is in fact one, then make one using facts, e.g., (MVC). Then say, “We know that our reaction time decreases even with one or two drinks. Drinking at any level may impair your ability to react quickly when driving.” |
| Compare to National norms | • Give NIAAA guidelines specific to patient sex and age | “These are what we consider high-risk, at-risk or risky drinking for your age and sex. [Show NIAAA Guidelines & National Norms] (See Table 3 &
Appendix 4). By staying BELOW this high-risk level of drinking, you would be significantly less likely to experience illness, injury or other problems related to your drinking.”

OR for a more extended explanation…

“So, in order to help you with all of this, I would like to talk with you a bit further about how your drinking might be affecting you. For example, I would encourage you to consider that drinking above certain levels (see and show NIAAA Alcohol Screener) could put you at risk for a wide range of problems, including medical, social and developing alcohol dependence. I would also like you to know that working with me to bring your drinking to at or below these levels helps you avoid those risks.”

<table>
<thead>
<tr>
<th>FOR ALCOHOL AND/OR DRUG DEPENDENT PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBJECTIVES</td>
</tr>
<tr>
<td>Review patient’s alcohol and/or drug use &amp; patterns</td>
</tr>
<tr>
<td>Make a connection with life issues</td>
</tr>
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</tr>
<tr>
<td>Make connection to medical visit (if applicable)</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>IF PATIENT DOES NOT STATE ANY ACCURATE &amp; RELEVANT CONNECTIONS, MAKE the connection based on general caution regarding alcohol and/or drug use and HIV risk</td>
</tr>
<tr>
<td>SAMPLE: Any alcohol and/or drug use compromises good judgment. Without good judgment anyone can engage in HIV-risky behavior.</td>
</tr>
<tr>
<td>• Discussion of specific patient medical issues, e.g., withdrawal, overdose, MVC or injury, infection, or any indirect consequence, treatment-seeking, etc.</td>
</tr>
<tr>
<td>IF PATIENT SEES ANY ACCURATE &amp; RELEVANT CONNECTION, reiterate what they have said.</td>
</tr>
<tr>
<td>SAMPLE: You’re right...[reiterate pt’s connection]...that’s a good connection to make.</td>
</tr>
<tr>
<td>IF PATIENT DOES NOT SEE AN ACCURATE CONNECTION, then make one using facts (if applicable)</td>
</tr>
<tr>
<td>SAMPLE: One of the things that we see as a connection is that your pattern of alcohol and/or drug use may have contributed to your fall, physical discomfort, or whatever they’re in the ED for (if relevant).</td>
</tr>
<tr>
<td>IF THERE ACTUALLY IS NO CONNECTION between today’s visit and alcohol and/or drug use, ask about any potential connections between drug use and overall health issues.</td>
</tr>
<tr>
<td>Discuss issues related to drug dependence</td>
</tr>
<tr>
<td>• Tell the patient that you will help him/her with these problems with a brief intervention</td>
</tr>
</tbody>
</table>
and referral to treatment

- Tell the patient that a variety of different treatments work and that they have a choice of treatment center.

drinking and/or drug use. For example, I wanted to encourage you to consider that there are a wide variety of treatment options available and that I am prepared to go over them with you (See and Show Treatment Referral List).”

“If you decide to accept our recommendation, you would be taking the first step towards addressing the problems connected with your drinking and/or drug use that we’ve been discussing.”

SUMMARY OF STEP 2

This step provides the opportunity to offer education related to specific patient issues. There is opportunity at four different levels that can be used towards the next step of enhancing motivation, i.e., (1) Linking the medical visit and the patient’s alcohol/drug use to the problems that they acknowledge they are feeling in their life such as financial, family, employment, health, and legal problems and; (2) Connecting the medical visit to the alcohol/drug use if possible, such as overdose, withdrawal, injury, lack of follow-up, risk of contracting HIV/AIDS, etc; and (3) discussing the cycle of tolerance, withdrawal and ongoing drug seeking behavior and ending with (4) should they decide to accept the recommendation, treatment would help.
STEP3: Enhance Motivation

Critical components:
1. Assess readiness to change
2. Boost motivation
3. Use Open-ended Questions
4. Use of Reflective Listening

PREPARATION:
- "Readiness to Change Ruler" (Appendix 2)
- Handouts: Pros/Cons of Treatment (Appendix 3)

FOR HH ALCOHOL DRINKERS

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACTION(S)</th>
<th>QUESTIONS/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess readiness to change</td>
<td>• Have patient self-identify readiness to change, on a scale of 1-10</td>
<td>(Show Readiness Ruler (See Appendix 2]) “On a scale from 1-10, how ready are you to change any aspect of your drinking?”</td>
</tr>
<tr>
<td>Develop discrepancy</td>
<td>• Identify areas to discuss</td>
<td>If patient says:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- &gt; 2, ask “Why did you choose that number and not a lower one?”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 1 or unwilling, ask “What would make this a problem for you? Or, “How important would it be for you to prevent that from happening?” Or, “Have you ever done anything you wished you hadn’t while drinking?”</td>
</tr>
<tr>
<td></td>
<td>• Use reflective listening</td>
<td>- Discuss pros and cons of drinking (See Appendix 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Restate what you think the patient meant by his or her statement. For example, in the context of discussing drinking less with friends, the statement “It’s difficult”, maybe followed by, “So it’s difficult because you’re worried about what your friends think”, delivered with downward intonation.</td>
</tr>
</tbody>
</table>
### FOR ALCOHOL AND/OR DRUG DEPENDENT PATIENTS

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACTION(S)</th>
<th>QUESTIONS/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess readiness to change</td>
<td>• Have patient self-identify readiness to change, on a scale of 1-10</td>
<td>[Show Readiness Ruler] (SEE Table 6) “On a scale from 1-10, how ready are you to enroll in an alcohol and/or drug treatment program?” “1 is not at all, 10 is right now”</td>
</tr>
</tbody>
</table>

- **Enhance motivation**
  - Ask motivational questions
  - Reflect motivational answers
  - Ask about their initial reason to get a motivating answer
  - What if the pt picks a “1”?
  - Additional motivational Strategies (ONLY if above does NOT lead to readiness to attend treatment) (OPTIONAL)

  **If patient says:**
  - **≥ 2**, ask “Why did you choose that number and not a lower one?” (i.e., “What are some reasons you would engage in treatment?” “What else?”

  **Then REFLECT** on their reasons and reinforce with clinical information (e.g., “Treatment does in fact work to help reduce and eliminate use, as well as the problems connected with it”)

  **Take the patient’s answer from the above question and ask:**

  “Why is that reason important to you?”

  - **1 or unwilling**, ask “What would it take for that “1” turn into a “2”? Or “Imagine you did go to treatment, how could that be helpful to you?”
    - Or, “What would have to happen for you to be ready? “How important would it be for you to prevent that from happening?”

  - Reflect/reiterate positive reasons for change
  - Discuss pros and cons of treatment (See Appendix 3)

  To explore more positive thoughts about treatment ask “Why might you decide to go? Have you thought about going before? What were some of the reasons why? Why is it important to have this conversation now?”

  **Would you mind If I gave you some possible reasons based on your screening?**

  If pt says, “Yes” reflect on the possible consequences of treatment (i.e., revisiting the symptoms endorsed on the SCID)
• Summarize

If pt says, “No” discuss possible benefits of treatment (e.g., reversing the negative effects of drug dependence discussed in Step 1 & 2)

Offer summary reflection of patient’s reasons for starting or considering treatment, ending with a reinforcement of the patient’s autonomy…

Ultimately, the decision to seek treatment is up to you.

SUMMARY OF STEP 3

Patients who engage in risky alcohol use or who are alcohol and/or drug dependent spend much of their time justifying their use by rehearsing reasons to continue using. However, in Step 3 of the BNI, specific motivational enhancement techniques are utilized to reverse this so that the patient begins to clarify and, through provider reflections, reinforce highly personal reasons in favor of either reducing alcohol intake to low-risk levels or engaging in treatment for their alcohol and/or drug dependence (vs. continued use). The primary tools to promote such a discussion of reasons or motives for treatment engagement are 1) the readiness ruler question (1-10), 2) asking why they did not select a lower number and other questions about positive reasons offered, and 3) selectively reflecting on reasons that promote treatment-seeking. Exploring this gap between the patient’s current situation and how their life might be if they reduced their intake or engaged in treatment, as well as stressing their autonomy and freedom to choose or not to choose these options, are the things that often tip the scale in terms of changing behavior.
STEP 4: Negotiate and Advise

Critical components:
1. Negotiate a plan on how to cut back or engage in treatment and reduce harm
2. Direct advice
3. Drinking agreement or referral agreement and provide a information handout

Preparation:
- Agreement forms
- Information handout (Appendix 6)
- Treatment Referral List (Appendix 10)

FOR HH ALCOHOL DRINKERS

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACTION(S)</th>
<th>QUESTIONS/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiate goal</td>
<td>• Assist patient to identify a goal from a menu of options</td>
<td>Reiterate what pt says in Step 3 and say, “What’s the next step?”</td>
</tr>
<tr>
<td></td>
<td>• Avoid being argumentative</td>
<td></td>
</tr>
<tr>
<td>Give advice</td>
<td>• Deliver sound medical advice/education</td>
<td>“If you can stay within these limits you will be less likely to experience (further) illness or injury related to alcohol use.”</td>
</tr>
<tr>
<td></td>
<td>• Harm reduction</td>
<td></td>
</tr>
<tr>
<td>Summarize</td>
<td>• Provide a drinking agreement</td>
<td>“This is what I have heard you say…Here is a drinking agreement I would like you to fill out, reinforcing your new drinking goals. This is really an agreement between you and yourself”</td>
</tr>
<tr>
<td></td>
<td>• Remain non-argumentative and non-judgmental</td>
<td>Agree to disagree if pt refuses to fill out agreement card or if s/he refuses to set a goal that is at or below NIAAA high-risk levels</td>
</tr>
<tr>
<td></td>
<td>• Provide health information sheet</td>
<td>Suggest Primary care f/u for drinking level/pattern.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide Health Information Sheet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do you have any questions for me?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thank patient for his/her time.</td>
</tr>
<tr>
<td>OBJECTIVES</td>
<td>ACTION(S)</td>
<td>QUESTIONS/COMMENTS</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Negotiate goal</td>
<td>• Assist patients selection of a next step goal</td>
<td>Reiterate what pt says in Step 3 and say, “What’s the next step?” [PAUSE]</td>
</tr>
<tr>
<td></td>
<td>• Avoid being argumentative</td>
<td>“Are you accepting the referral?”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IF YES TO TREATMENT, Skip to bottom “Secure Referral”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If NO, reiterate reasons patient gave above and &lt;PAUSE&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IF STILL NO, then ask if the patient might consider it and give advice below for patient to have, even if s/he does not want to consider it, and then SKIP TO “Provide Handouts”</td>
</tr>
<tr>
<td>Give advice</td>
<td>• Deliver sound medical advice/education</td>
<td>“If you enter a treatment program or referral from here you will be on the road to recovery. (see facilitated referral next page) Based on what you told me and what we know about alcohol and/or drug dependence I think you should……..”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remember what we discussed in terms of decreasing the risk of contracting HIV(or transferring HIV if already infected)</td>
</tr>
<tr>
<td>Complete Treatment Agreement &amp;</td>
<td>• Select a treatment agency with patient’s input</td>
<td>“Which of these programs might you be interested in?” [SHOW LIST]</td>
</tr>
<tr>
<td>Secure Referral</td>
<td>• Review Treatment Agreement</td>
<td>“Ok, based on your preferences, your insurance information and availability of program slots, I will make an appointment for you. I will be back to tell you about it as soon as possible.”</td>
</tr>
<tr>
<td></td>
<td>• Step out of interaction to make an appointment for the patient</td>
<td>“But, before I go, I would like you to complete this referral agreement, which will reinforce your decision to seek formal drug treatment. This is really an agreement between you and yourself”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Pt waits for provider to return with a treatment referral]</td>
</tr>
<tr>
<td>Step</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Provide a referral</td>
<td>Here is your referral. It is for...[GIVE ALL DETAILS] “How does this sound to you?” IF PATIENT UNWILLING TO ATTEND, remind them that that is up to them, but that you would like them to have the referral and additional information (see below) should they change their mind.</td>
<td></td>
</tr>
<tr>
<td>Summarize</td>
<td>Reflect on all of the patient’s previously stated reasons for entering/considering treatment</td>
<td></td>
</tr>
</tbody>
</table>
| Provide Handouts | Provide:  
- Agreement (Add Appointment Specifics, i.e., date, time, address, etc.)  
- Referral Pamphlet  
- Health Information Sheet  
- Ask the patient if s/he has any questions. <PAUSE> |
| Wrap-up | - Thank patient for his/her time. |

**SUMMARY OF STEP 4**

In Step 4 of the BNI, the provider assists the patient in exploring a menu of options regarding reducing their alcohol intake (for HH Drinkers) or engaging in treatment (for alcohol and/or drug Dependent Patients). The provider also attempts to negotiate a formal agreement around one of these goals (i.e., alcohol reduction or a referral to a formal specialized alcohol/drug treatment program), where the patient ultimately complete and signs an agreement form. If the patient is not ready to make an agreement, then additional advice is given and options discussed in another attempt to negotiate and motivate the patient. However, the patient is the decision-maker and should ultimately be responsible for his/her plan. Step 4 is ended by asking if the patient if s/he has any questions about the information or instructions and by thanking them for their time.
VI. Additional Motivational Strategies

➢ Refrain From Directly Countering Resistance Statements

For example, the patient may say “How can I have an alcohol and/or drug problem when I drink/use less than all my buddies?” You can reply noting that drug dependence can vary between patients and that it is worthy of further assessment and discussion, within the context of this brief interview and advice from treatment professionals.

➢ Focus On The Less Resistant Aspects Of The Statement

For example, the above patient may be wondering about how much their alcohol and/or drug use is a problem. The response might be to restate his concern and ask about his level of drug use, which is the less resistant part of the statement. “It sounds like you’re confused about how you could have an issue with your alcohol/drug use if you use less than all your friends. I’d like to explain this to you.” (And remember, this is a statement NOT a question, so the intonation should turn down at the end of the remark).

➢ Restate Positive or Motivational Statements

For example, if a patient says: “You know, now that you mention it, I feel like I have been drinking/using more than I wanted to lately,” the medical practitioner could say, “It sounds like you realize that your drinking/use is out of your control.” This serves to reinforce the patient’s motivation—even if the motivational statement is a relatively weak one. If the patient says, “I guess I might have to change my drinking/drug use” this could be restated as “It sounds like you’ve been thinking about changing your drinking or stopping your use”.

➢ Other Helpful Hints

Encourage patients to think about previous times they have cut back or been abstinent, even for a few days.

Praise patients for their willingness to discuss such a sensitive topic, their willingness to consider change, and their courage for considering treatment. Acknowledge how hard it is to find treatment options.

View the patient as an active participant in the intervention.
VII. Common Problems

Certain problems may occur during the course of the intervention steps.

- **Refusal To Engage In The Discussion Of The Topic Of Alcohol or Drug Use**

  Most patients will agree to discuss the topic, but in the unlikely event that someone outright refuses to discuss it at all, tell the patient that you will respect their wishes and that all you will be doing is giving him/her 3 pieces of information:

  **ALCOHOL:**
  1. His/her drinking exceeds low-risk drinking limits (or is harmful);
  2. Low-risk drinking limits recommended for patient’s age and sex; and,
  3. You are concerned and that s/he should cut down to low-risk drinking limits to avoid future harm (Steps 2 and 4 only).

  **DRUGS:**
  1. His/her drug use meets criteria for dependence, which requires treatment
  2. There is no safe level of drug use
  3. You are concerned and that s/he should cut down and stop to avoid future harm (Steps 2 and 4 only).

- **Refusal To Self-Identify Along The Readiness Ruler**

  When this happens, it is usually a problem with understanding the numbers. There are several ways of dealing with this:

  1. Anchor the numbers with descriptors, such as “1” means not ready at all or 0 per cent ready, and 10 means completely ready or 100% ready to change.
  2. Ask “What would make this a problem for you?” Or, “How important is it for you to change any aspect of your alcohol/drug use?”
  3. Discussion of Pros and Cons (See Appendix 3).

- **Unwilling To Associate Visit With Alcohol or Drug Use**

  Don’t force the patient to make the connection, but be sure that he/she hears that in your medical opinion there is a connection. However, this connection may not be the thing that ultimately motivates the patient to change. If this happens try to find some other negative consequence of alcohol/drug use that the patient can agree bothersome enough to consider decreasing or stopping their alcohol/drug use.

- **Not Ready To Bring Drinking Patterns Down to Low-Risk Limits**

  Tell the patient that the best recommendation is to cut back to low-risk drinking limits, but that any step in that direction is a good start. The patient’s goal is then written on the drinking agreement. Regardless of the individual goal, the patient also receives the practitioner’s advice for low-risk drinking on the patient health information handout.
**VIII. Additional Screeners**

**AUDIT (ALCOHOL USE DISORDERS IDENTIFICATION TEST)**

**AUDIT**

_for the following questions about drinking, please keep in mind that for our purposes, one drink equals:_ one 12 oz. beer, or one 5 oz. glass of wine, or one 12 oz. wine cooler, or one 1 ½ oz. shot of liquor or one mixed drink containing 1 shot of liquor

1. How often do you have a drink containing alcohol?
   - Never [0]
   - Monthly or less [1]
   - Two to four times a month [2]
   - Two to three times a week [3]
   - Four or more times a week [4]

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   [Code number of standard drinks]
   - 1 or 2 [0]
   - 3 or 4 [1]
   - 5 or 6 [2]
   - 7 to 9 [3]
   - 10 or more [4]

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

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

SUBTOTAL pg1
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   - Never [0]
   - Less than monthly [1]
   - Monthly [2]
   - Weekly [3]
   - Daily or almost daily [4]

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   - Never [0]
   - Less than monthly [1]
   - Monthly [2]
   - Weekly [3]
   - Daily or almost daily [4]

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

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

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

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

TOTAL

AUDIT TOTAL SCORE INTERPRETATION:
A score of 8 or more is associated with harmful or hazardous drinking. 
A score of 13 or more in women, and 15 or more in men, is likely to indicate Alcohol dependence.
Drug Abuse Screening Test (DAST)

Substance Abuse Screening Instrument (O4/05)

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has “exhibited valid psychometric properties” and has been found to be “a sensitive screening instrument for the abuse of drugs other than alcohol.”

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or “over-the-counter” drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

1. Have you used drugs other than those required for medical reasons?  
2. Have you abused prescription drugs?  
3. Do you abuse more than one drug at a time?  
4. Can you get through the week without using drugs (other than those required for medical reasons)?  
5. Are you always able to stop using drugs when you want to?  
6. Do you abuse drugs on a continuous basis?  
7. Do you try to limit your drug use to certain situations?  
8. Have you had “blackouts” or “flashbacks” as a result of drug use?  
9. Do you ever feel bad about your drug abuse?  
10. Does your spouse (or parents) ever complain about your involvement with drugs?  
11. Do your friends or relatives know or suspect you abuse drugs?  
12. Has drug abuse ever created problems between you and your spouse?  
13. Has any family member ever sought help for problems related to your drug use?  
14. Have you ever lost friends because of your use of drugs?  
15. Have you ever neglected your family or missed work because of your use of drugs?  
16. Have you ever been in trouble at work because of drug abuse?  
17. Have you ever lost a job because of drug abuse?  
18. Have you gotten into fights when under the influence of drugs?  
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?  
20. Have you ever been arrested for driving while under the influence of drugs?  
21. Have you engaged in illegal activities in order to obtain drug?  
22. Have you ever been arrested for possession of illegal drugs?  
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?  
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?  
25. Have you ever gone to anyone for help for a drug problem?  
26. Have you ever been in a hospital for medical problems related to your drug use?  
27. Have you ever been involved in a treatment program specifically related to drug use?  
28. Have you been treated as an outpatient for problems related to drug abuse?

Scoring and interpretation: A score of “1” is given for each YES response, except for items 4, 5, and 7, for which a NO response is given a score of “0.” Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for scoring for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4, 7, 16, 20, and 22.
**CRAFFT** (used for screening for adolescents for alcohol and/or drug dependence)

C: Have you ever 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 ever use alcohol or drugs while you are by yourself (Alone)

F: Do your family or Friends ever tell you that you should cut down on your drinking or drug use?

F: Do you ever Forget things you did while using alcohol or drugs?

T: Have you gotten in Trouble while you were using alcohol or drugs?

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**TWEAK** (used for screening pregnant and non-pregnant women for alcohol dependence)

T: How many drinks does it take before you begin to feel the effects of the alcohol? (>2 indicates Tolerance.)

W: Have close friends or relatives Worried about or complained about your drinking in the past year?

E: Have you ever taken a drink to steady your nerves or to get over a hangover? (Eye-opener)

A: has a close friend or relative ever told you about things you said or did while you were drinking that you could not remember? (Amnesia)

K: Have you ever felt the need to cut (Kut) down on your use of alcohol?
Appendix 1: THE SPECTRUM OF ALCOHOL USE

TYPES OF DRINKERS:

Abstainers
Drink no alcohol.

Low-risk
Drink within NIAAA guidelines (TABLE 1). Alcohol use does not affect health or result in problems.

Hazardous (At Risk)
Exceed NIAAA consumption guidelines. Alcohol use puts them at risk for injury/illness or social problems.

Harmful (Problem)
Currently experiencing problems (medical/social) related to alcohol; often exceed NIAAA guidelines for low-risk drinking. (TABLE 2)

Dependent
Physically dependent on alcohol (experience withdrawal symptoms); meet criteria for dependence based upon assessment criteria such as DSM-IV-TR
Appendix 2: The “READINESS RULER”
(Referred to in Step 3 of the BNI)

<table>
<thead>
<tr>
<th></th>
<th>Not ready at all</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Completely ready</th>
</tr>
</thead>
</table>
### Reasons to Quit or Cut Down on Drinking

- To live longer, and feel better
- To consume fewer empty calories (alcohol has no nutritional value)
- To sleep better
- To be less likely to have a stroke
- To improve blood pressure control
- To reduce the possibility of death from liver disease
- To prevent problems with medications
- To decrease the likelihood of falls or other injuries
- To prevent memory loss that may lead to loss of independence
- To be able to care for myself longer
- To be a better parent or grandparent
- To reduce the possibility that I will die in a car crash
- Other reasons: ____________________

---

### Reasons for Drinking

- I enjoy the taste
- It enhances meals
- For pleasure in social situations
- To more easily socialize
- Other people expect that I will drink with them
- To relax or relieve stress
- To cope with feelings of anger
- To cope with feelings of boredom
- To deal with momentary feelings of depression
- To deal with momentary feelings of loneliness
- To deal with feelings of frustration
- To relieve the stress of arguments with family members or friends
- It’s something I do when I’m smoking
- It’s something I do when I’m watching TV.
- It’s something I do with certain friends or relatives
- To help me sleep
- To relieve pain
Reasons to enter drug treatment

To spend less money
To avoid constantly seeking drugs
To do a better job at home
To do a better job at work
To live longer, and feel better
To sleep better
To be able to care for myself longer
To be able to care for my children better
To be a better son/daughter, wife/husband, parent or grandparent
To reduce the possibility that I will die
Other reasons:___________________________

Reasons for ongoing drug use

Boredom
Habit
I enjoy the taste or the way that it feels
For pleasure in social situations
To more easily socialize
Other people expect that I will use when I am with them
To relax or relieve stress
To cope with feelings of anger
To cope with feelings of anxiety
To cope with feelings of boredom
To deal with momentary feelings of depression
To deal with momentary feelings of loneliness
To deal with feelings of frustration
To relieve the stress of arguments with family members or friends
It’s something I do when I’m watching T.V.
It’s something I do with certain friends or relatives
To help me sleep
To relieve pain
To make me feel better
Other reasons:
## Appendix 4: NATIONAL NORMS FOR ALCOHOL USE
(Referred to in Step 2 of the BNI)

### Alcohol Consumption Norms for U.S. Adults

<table>
<thead>
<tr>
<th>Drinks per week</th>
<th>Total %</th>
<th>% Men</th>
<th>% Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>35</td>
<td>29</td>
<td>41</td>
</tr>
<tr>
<td>1</td>
<td>58</td>
<td>46</td>
<td>68</td>
</tr>
<tr>
<td>2</td>
<td>66</td>
<td>54</td>
<td>77</td>
</tr>
<tr>
<td>3</td>
<td>68</td>
<td>57</td>
<td>78</td>
</tr>
<tr>
<td>4</td>
<td>71</td>
<td>61</td>
<td>82</td>
</tr>
<tr>
<td>5</td>
<td>77</td>
<td>67</td>
<td>86</td>
</tr>
<tr>
<td>6</td>
<td>78</td>
<td>68</td>
<td>87</td>
</tr>
<tr>
<td>7</td>
<td>80</td>
<td>70</td>
<td>89</td>
</tr>
<tr>
<td>8</td>
<td>81</td>
<td>71</td>
<td>89</td>
</tr>
<tr>
<td>9</td>
<td>82</td>
<td>73</td>
<td>90</td>
</tr>
<tr>
<td>10</td>
<td>83</td>
<td>75</td>
<td>91</td>
</tr>
<tr>
<td>11</td>
<td>84</td>
<td>75</td>
<td>91</td>
</tr>
<tr>
<td>12</td>
<td>85</td>
<td>77</td>
<td>92</td>
</tr>
<tr>
<td>13</td>
<td>86</td>
<td>77</td>
<td>93</td>
</tr>
<tr>
<td>14</td>
<td>87</td>
<td>79</td>
<td>94</td>
</tr>
<tr>
<td>15</td>
<td>87</td>
<td>80</td>
<td>94</td>
</tr>
<tr>
<td>16</td>
<td>88</td>
<td>81</td>
<td>94</td>
</tr>
<tr>
<td>17</td>
<td>89</td>
<td>82</td>
<td>95</td>
</tr>
<tr>
<td>18</td>
<td>90</td>
<td>84</td>
<td>96</td>
</tr>
<tr>
<td>19</td>
<td>91</td>
<td>85</td>
<td>96</td>
</tr>
<tr>
<td>20</td>
<td>91</td>
<td>86</td>
<td>96</td>
</tr>
<tr>
<td>21</td>
<td>92</td>
<td>88</td>
<td>96</td>
</tr>
<tr>
<td>22</td>
<td>92</td>
<td>88</td>
<td>97</td>
</tr>
<tr>
<td>23-24</td>
<td>93</td>
<td>88</td>
<td>97</td>
</tr>
<tr>
<td>25</td>
<td>93</td>
<td>89</td>
<td>98</td>
</tr>
</tbody>
</table>

Source: 1990 National Alcohol Survey, Alcohol Research Group, Berkeley, Courtesy of Dr. Robin Room
Appendix 5: DRINKING/DRUG USE AGREEMENT & REFERRAL AGREEMENT
(Referred to in Step 4)

DRINKING/DRUG USE AGREEMENT

Date: ______________

I, __________________, agree to the following goals:

Alcohol
___ I will not drink at all
    Or
___ Number of drinks week: ____________________________
    Number of drinks per occasion: ______________________

Drugs
___ I will not use ________________________ at all.
    (list drugs)
___ I will use my prescription medications only as prescribed

Follow-up__________________ With ______________________ MD/APRN

Patient Signature: ____________________________________

REFERRAL ACCEPTANCE

Date: ______________

I, ________________________________ agree to accept the following treatment referral to (name of referral location):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Patient signature: ____________________________________
Please read the following important information, about reducing risky health behaviors, which may apply to you.

<table>
<thead>
<tr>
<th>Health Risk</th>
<th>What we know…</th>
<th>What you can do…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>• It’s not healthy to smoke.</td>
<td>We recommend that you speak with your primary care physician for his or her advice.</td>
</tr>
<tr>
<td></td>
<td>• There are many options available to help you stop.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Or you may call: (203) 688-9999 [8-5; M-F]</td>
</tr>
<tr>
<td>Exercise</td>
<td>• It’s healthy to exercise on a regular basis.</td>
<td>We recommend that you speak with your primary care physician for his or her advice.</td>
</tr>
<tr>
<td></td>
<td>• The amount of exercise recommended on a daily basis is 30 minutes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Or you may call: (203) 688-9999 [8-5; M-F]</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>• Drinking above low risk limits will increase your risk for illness and/or injury.</td>
<td>We recommend that you speak with your primary care physician for his or her advice.</td>
</tr>
<tr>
<td></td>
<td>• Please see the drinking information for your sex and age, on the back of this paper.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• It’s never good to drink and drive.</td>
<td>➢ Or you may call: (203) 688-9999 [8-5; M-F]</td>
</tr>
<tr>
<td>Safety Issues</td>
<td>• It is always healthy to take safety precautions.</td>
<td>We recommend that you speak with your primary care physician for his or her advice.</td>
</tr>
<tr>
<td></td>
<td>• Always use a seatbelt when in a car.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Always wear a helmet while biking, riding a motorcycle or rollerblading.</td>
<td>➢ Or you may call: (203) 688-9999 [8-5; M-F]</td>
</tr>
</tbody>
</table>
WHAT IS A STANDARD DRINK?

1 Standard Drink equals:

- Mixed drink made with 1.5 oz. of alcohol (whiskey, gin, etc.)
- 12 oz. Beer
- 5 oz. wine

HOW MUCH IS TOO MUCH?

If you drink more than this you can put yourself at risk for illness and/or injury:

<table>
<thead>
<tr>
<th># Drinks*</th>
<th>Week</th>
<th>Occasion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Women</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>All age &gt;65</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>

** Sometimes even 1 drink is too much! If you are:**
- driving or planning to drive
- at work or returning to work
- pregnant, or breast feeding
- on medication
- have certain medical conditions
### Appendix 7: CASE EXAMPLE OF BNI DIALOGUE FOR ALCOHOL USE REDUCTION

<table>
<thead>
<tr>
<th>SPEAKER</th>
<th>DIALOGUE</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>Hello, I am Dr. Jones. Would you mind spending a few minutes talking about your use of alcohol?</td>
<td>RAISE THE SUBJECT</td>
</tr>
<tr>
<td>Patient</td>
<td>Ok, like what?</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>From what I understand you were drinking tonight and were involved in a car crash. You told the nurse that you drink 2-3 days a week and usually have 6-8 beers per occasion. I am concerned because that level of drinking can put you at risk for illness or injuries, such as why you are here today. What connection do you see between your drinking and this ED visit?</td>
<td>PROVIDE FEEDBACK</td>
</tr>
<tr>
<td>Patient</td>
<td>None really. I mean, I really had the right of way. I had a few beers. What is the problem with that? I can hold my alcohol well. He ran into me. You know that intersection between Grand and College Ave. I was going south on College and he just smacked right into me. I didn't see him at all. I am in kind of a rush. I need to get out of here, but it wasn't my fault</td>
<td>Make Connection</td>
</tr>
<tr>
<td>Physician</td>
<td>I believe that is was not your fault. I know that busy intersection. However we know that drinking even small amounts such as 1 or 2 drinks can reduce your reaction time. As you know, we avoid crashes almost every day. Drivers run stop signs, backup without looking etc. At that very intersection there are near-misses everyday. Do you think that you might have seen that other car approaching and avoided the crash if you had not been drinking? I don't know for sure, I was not there, but it is one thing I would like you to consider.</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Well, I said that I didn’t see him at all. I didn’t see him until the crash</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>So one thing, you might have seen him if you weren’t drinking any amount. It is clear that legally you had the right of way. I am also concerned about the amount you drink. Based on a large amount of research and national information we know that if you drink above certain levels puts you at risk for injuries and illness. For your age and sex that means the upper limits of low risk drinking are no more than 14 drinks per week, and no more than 4 drinks on any occasion. A standard drink is one 12 ounce can of beer, 5 ounces of wine or 1 ½ ounces of distilled spirits.</td>
<td>Show NIAAA guidelines</td>
</tr>
<tr>
<td>Patient</td>
<td>Yeah, I guess I am over that.</td>
<td></td>
</tr>
<tr>
<td>SPEAKER</td>
<td>DIALOGUE</td>
<td>PROCEDURE</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Physician</td>
<td>Well now that we have discussed the risks of further injury when drinking over the recommended amounts, how ready are you to change any aspect of your drinking?</td>
<td>ENHANCE MOTIVATION</td>
</tr>
<tr>
<td></td>
<td>Readiness to change</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>I don’t know, maybe a 5</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>OK, so that is good, you are halfway or 50% there. Why not less? In other words why did you not pick a 1 or 2? What are some reasons why you think some changes need to be made?</td>
<td>Develop discrepancy</td>
</tr>
<tr>
<td>Patient</td>
<td>Well, I am here I guess, and I can tell that my neck and back are really going to hurt tomorrow. But I really do like to drink with my friends. Normally I do not drink and drive, but I needed to be somewhere after, so I drove myself.</td>
<td>Reflection</td>
</tr>
<tr>
<td>Physician</td>
<td>So you already know that drinking and driving is not a good idea and that was a rare event for you. But rare events can sometimes lead to consequences, like today. So I guess you are ready because you don’t think that it’s a good idea to drink and drive. On the other hand you enjoy drinking with your friends. Any disadvantages to that?</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>We normally go out on Friday and Saturdays. Sometimes on Thursdays and then I’m a little late to work on Friday. It takes the morning and lots of coffee to clear my head.</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>So what I hear your saying is that there are two reasons why you are dissatisfied with your drinking. First is that you ended up in the ED and will probably have some muscles aches and pains for a few days, and second that sometimes you are slow at work. That could cause you trouble I suspect with your boss. In addition I have given you some information regarding the risks of drinking over the recommended limits. So, where does that leave you now? (or what is the next step?) What agreement could you make between you and yourself regarding your drinking levels?</td>
<td>NEGOTIATE &amp; ADVISE</td>
</tr>
<tr>
<td></td>
<td>Summarize</td>
<td>Negotiate goal</td>
</tr>
<tr>
<td>Patient</td>
<td>We normally go out on Friday and Saturdays. Sometimes on Thursdays and then I’m a little late to work on Friday. It takes the morning and lots of coffee to clear my head.</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>So what I hear your saying is that there are two reasons why you are dissatisfied with your drinking. First is that you ended up in the ED and will probably have some muscles aches and pains for a few days, and second that sometimes you are slow at work. That could cause you trouble I suspect with your boss. In addition I have given you some information regarding the risks of drinking over the recommended limits. So, where does that leave you now? (or what is the next step?) What agreement could you make between you and yourself regarding your drinking levels?</td>
<td>NEGOTIATE &amp; ADVISE</td>
</tr>
<tr>
<td></td>
<td>Summarize</td>
<td>Negotiate goal</td>
</tr>
<tr>
<td>Patient</td>
<td>Well, I’m definitely not going to drink and drive. That is a big deal because even though I thought I could, I probably can’t. I don’t know about the limits. I can stay within 14 a week, but I don’t know about the 4 at a time. I will try but it is often a long game we are watching.</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>So no more drinking and driving, and you are going to try to keep it to 4 beers per occasion, knowing that it’s tough at times but you are willing to try.</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>OK</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>Good luck. I would also recommend that you follow-up with your primary care doctor and discuss how you are doing with the agreement. Thanks for your time</td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td>Thank patient</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 8: CASE EXAMPLE OF BNI DIALOGUE FOR REFERRAL TO A DRUG TREATMENT PROGRAM

<table>
<thead>
<tr>
<th>SPEAKER</th>
<th>DIALOGUE</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td><strong>Physician</strong> Hello, I am Dr. Jones. Would you mind spending a few minutes talking about your use of opioids?</td>
<td>RAISE THE SUBJECT</td>
</tr>
<tr>
<td>Patient</td>
<td>Ok, like what?</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>“I would like to take some time to talk with you about the issues related to your use and then to explore how we might be able to help with that.” How are you feeling right now?</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Not great at all. I like it; it makes me feel good, but it would be great to slow down a little or take a break on some days without getting sick. I’m feeling really bad right now.</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>Sounds like you’re in a lot of physical discomfort and that using less would really be something you’d like to do. We’d be happy to help you with that.</td>
<td>PROVIDE FEEDBACK</td>
</tr>
<tr>
<td>Patient</td>
<td>Alright…well…</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>From what I understand you use heroin intravenously everyday, about 4-5 bags a day throughout the day, and that it’s caused you some problems. Tell me more about those problems.</td>
<td>Make Connection</td>
</tr>
<tr>
<td>Patient</td>
<td>Well, I mean…nothing I can’t handle, but life does seem to suck right now. People can’t take my crap anymore, especially my boss.</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>So, it sounds like heroin has caused some relationship and work problems for you. Although you are able to keep your job it’s getting tougher.</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Yes, I spend more and more time trying to get heroin and it’s hard to find clean needles. Sometimes I have to share needles.</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>So sharing needles can lead to real health problems and spending more time trying to find the drug certainly takes you away from your work. How does it affect other parts of your life?</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Well I had to drop out of my adult ed classes. And I lost my friends and girlfriend because I have no time to hang with them.</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>This must be a very hard time for you. So you’re telling me that both your work and personal life are in a mess and the fact that you’re sharing needles is putting your health at even greater risk. What connection do you see between your drug use and this medical visit?</td>
<td></td>
</tr>
<tr>
<td>SPEAKER</td>
<td>DIALOGUE</td>
<td>PROCEDURE</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Patient</td>
<td>I’m dope sick and I don’t know what to do anymore. I thought you could help me out. Look, at least I’m being straight with you and not giving you a whole story about fake pain.</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>We can help you with this by getting you a referral to a drug treatment center right now. Treatment works – it can help you reduce and stop your heroin use, which is escalating to a point where you’re always in some degree of withdrawal. So, let’s next talk about how ready you might be to do engage in treatment. On a scale from 1-10, how ready are you to go to the appointment we arrange for you, where 1 means not ready at all and 10 means totally ready?</td>
<td>ENHANCE MOTIVATION Readiness to change</td>
</tr>
<tr>
<td>Patient</td>
<td>I don’t know, maybe a 5</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>OK, so that is good, you are halfway or 50% there. Why not less? In other words why did you not pick a 1 or 2? What are some reasons why you think starting this treatment would be good for you?</td>
<td>Evoke “Change Talk”</td>
</tr>
<tr>
<td>Patient</td>
<td>Well, I am here because I have no place left to get my stuff and I’ll just get more and more sick. I’m also tired of this pattern and miss my girlfriend.</td>
<td>Beginning “Change Talk”</td>
</tr>
<tr>
<td>Physician</td>
<td>Those are 2 good reasons, anything else?</td>
<td>Open Question to elicit more “Change Talk”</td>
</tr>
<tr>
<td>Patient</td>
<td>My girlfriend did say that she’d consider taking me back if I ever got into treatment.</td>
<td>More “Change Talk”</td>
</tr>
<tr>
<td>Physician</td>
<td>So, even though the answer to this question should be obvious, tell me in your own words why it would be important to you to start treatment and get your girlfriend back?</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Because she’s the only person that has ever gotten me and really understood why I am this way. And she’s totally drug-free – she’s never even touched the stuff. I know I can get her back.</td>
<td>Deeper “Change Talk”</td>
</tr>
<tr>
<td>Physician</td>
<td>So it sounds like starting treatment would give you a number of things that are very important to you. In the short-run, it would make you much more physically comfortable and you wouldn’t have to be running around anymore. It could also help things between you and your boss, because you wouldn’t have to be running around anymore and you might even re-connect with your friends. But most importantly, it would help you get back together with your girlfriend. Now, if you don’t mind, I’d like to add one more thing to the list (wait for permission). You would also reduce the risk of contracting HIV/AIDS.</td>
<td>Reflection of “Change Talk”</td>
</tr>
<tr>
<td>SPEAKER</td>
<td>DIALOGUE</td>
<td>PROCEDURE</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Patient</td>
<td>I’ve always thought about all the bad stuff heroin was doing to me, which only made me want to use more. Now, you make it sound like I could get a lot of good stuff from doing this treatment.</td>
<td>Commitment Talk</td>
</tr>
<tr>
<td>Physician</td>
<td>So, what’s the next step, if any?</td>
<td>NEGOTIATE &amp; ADVISE</td>
</tr>
<tr>
<td>Patient</td>
<td>I want to try it. How do I start?</td>
<td>Summarize</td>
</tr>
<tr>
<td>Physician</td>
<td>Well I’m going to review this list with you so we can identify the best place for you to get help and I will call to try to get an appointment with you today. Because it is sometimes helpful to write down our goals and plans, I’m going to ask you to fill out this agreement sheet. It is an agreement between you and your self and is not a part of your medical records. I think you’ve made an excellent decision and I wish you all the best. Thank you for your time.</td>
<td>Negotiate goal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thank patient</td>
</tr>
</tbody>
</table>
**Appendix 9: OTHER RESOURCES FOR ASSESSING ALCOHOL AND DRUG DEPENDENCE**

**Mini-SCID Symptoms for Alcohol & Other Drugs** *(Referred to in Steps 1 and 2 of the BNI)*

| a. | Needing to use more *(name the drug/drug class selected)* to get the same effect that you did when you first started taking it |
| b. | When you reduced or stopped using *(name the drug/drug class selected)*, having withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feel agitated, anxious, irritable, or depressed), or using any drug(s) to keep yourself from getting sick (withdrawal symptoms) or so that you would feel better. |
| c. | Finding that when you used *(name the drug selected)*, you end up taking more than you thought you would. |
| d. | Trying to reduce or stop taking *(name the drug selected)* but failed. |
| e. | On the days that you used *(name the drug/drug class selected)*, spending substantial time (>2 hours) obtaining, using, or in recovering from the drug, or thinking about the drug. |
| f. | Spending less time working, enjoying hobbies, or being with others because of your drug use. |
| g. | Continuing to use *(name the drug selected)*, even though you knew that the drug caused you health or mental problems. |
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient’s signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score...

<table>
<thead>
<tr>
<th>Project #:  1</th>
<th>Date:</th>
<th>RA:</th>
<th>Time (military)</th>
<th>RA:</th>
</tr>
</thead>
</table>

Reason for this assessment: ____________________________________________________________

**Resting Pulse Rate:**
- Measured after patient is sitting or lying for 1 minute
- □ 0… pulse rate 80 or below
- □ 1… pulse rate 81-100
- □ 2… pulse rate 101-120
- □ 4… pulse rate greater than 120

**GI Upset:**
- Over last ½ hour
- □ 0… no GI symptoms
- □ 1… stomach cramps
- □ 2… nausea or loose stool
- □ 3… vomiting or diarrhea
- □ 5… multiple episodes of diarrhea or vomiting

**Sweating:**
- Over past ½ hour not accounted for by room temperature or patient activity.
- □ 0… no report of chills or flushing
- □ 1… subjective report of chills or flushing
- □ 2… flushed or observable moistness on face
- □ 3… beads of sweat on brow or face
- □ 4… sweat streaming off face

**Tremor:**
- Observation of outstretched hands
- □ 0… No tremor
- □ 1… tremor can be felt, but not observed
- □ 2… slight tremor observable
- □ 4… gross tremor or muscle twitching

**Restlessness:**
- Observation during assessment
- □ 0… able to sit still
- □ 1… reports difficulty sitting still, but is able to do so
- □ 3… frequent shifting or extraneous movements of legs/arms
- □ 5… Unable to sit still for more than a few seconds

**Yawning:**
- Observation during assessment
- □ 0… no yawning
- □ 1… yawning once or twice during assessment
- □ 2… yawning three or more times during assessment
- □ 4… yawning several times/minute

**Pupil size:**
- □ 0… pupils pinned or normal size for room light
- □ 1… pupils possibly larger than normal for room light
- □ 2… pupils moderately dilated
- □ 5… pupils so dilated that only the rim of the iris is visible

**Anxiety or Irritability:**
- □ 0… none
- □ 1… patient reports increasing irritability or anxiousness
- □ 2… patient obviously irritable anxious
- □ 4… patient so irritable or anxious that participation in the assessment is difficult

**Bone or Joint aches:**
- If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored
- □ 0… not present
- □ 1… mild diffuse discomfort
- □ 2… patient reports severe diffuse aching of joints/muscles
- □ 4… patient is rubbing joints or muscles and is unable to sit still because of discomfort

**Gooseflesh skin:**
- □ 0… skin is smooth
- □ 3… piloerrection of skin can be felt or hairs standing up on arms
- □ 5… prominent piloerrection

**Runny nose or tearing:**
- Not accounted for by cold symptoms or allergies
- □ 0… not present
- □ 1… nasal stuffiness or unusually moist eyes
- □ 2… nose running or tearing
- □ 4… nose constantly running or tears streaming down cheeks

The total score is the sum of all 11 items...

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal
OBJECTIVE OPIOID WITHDRAWAL SCALE (OOWS)

Observe the patient during a 5 minute observation period then indicate a score for each of the opioid withdrawal signs listed below (items 1-13). Add the scores for each item to obtain the total score.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yawning</td>
<td>0 = no yawns, 1 = ≥ 1 yawn</td>
</tr>
<tr>
<td>2</td>
<td>Rhinorrhea</td>
<td>0 = &lt; 3 sniffs, 1 = ≥ 3 sniffs</td>
</tr>
<tr>
<td>3</td>
<td>Piloerection (observe arm)</td>
<td>0 = absent, 1 = present</td>
</tr>
<tr>
<td>4</td>
<td>Perspiration</td>
<td>0 = absent, 1 = present</td>
</tr>
<tr>
<td>5</td>
<td>Lacrimation</td>
<td>0 = absent, 1 = present</td>
</tr>
<tr>
<td>6</td>
<td>Tremor (hands)</td>
<td>0 = absent, 1 = present</td>
</tr>
<tr>
<td>7</td>
<td>Mydriasis</td>
<td>0 = absent, 1 = ≥ 3 mm</td>
</tr>
<tr>
<td>8</td>
<td>Hot and cold flushes</td>
<td>0 = absent, 1 = shivering / huddling for warmth</td>
</tr>
<tr>
<td>9</td>
<td>Restlessness</td>
<td>0 = absent, 1 = frequent shifts of position</td>
</tr>
<tr>
<td>10</td>
<td>Vomiting</td>
<td>0 = absent, 1 = present</td>
</tr>
<tr>
<td>11</td>
<td>Muscle twitches</td>
<td>0 = absent, 1 = present</td>
</tr>
<tr>
<td>12</td>
<td>Abdominal cramps</td>
<td>0 = absent, 1 = Holding stomach</td>
</tr>
<tr>
<td>13</td>
<td>Anxiety</td>
<td>0 = absent, 1 = mild – severe</td>
</tr>
</tbody>
</table>

**TOTAL SCORE**
**Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)**

<table>
<thead>
<tr>
<th>Nausea/Vomiting - Rate on scale 0 - 7</th>
<th>Tremors - have patient extend arms &amp; spread fingers. Rate on scale 0 - 7.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - None</td>
<td>0 - No tremor</td>
</tr>
<tr>
<td>1 - Mild nausea with no vomiting</td>
<td>1 - Not visible, but can be felt finger tip to finger tip</td>
</tr>
<tr>
<td>2</td>
<td>2 - Moderate, with patient’s arms extended</td>
</tr>
<tr>
<td>3 - Intermittent nausea</td>
<td>3 - Severe, even w/ arms not extended</td>
</tr>
<tr>
<td>4 - Constant nausea and frequent dry</td>
<td>5 -</td>
</tr>
<tr>
<td>5 - eyes and vomiting</td>
<td>6 -</td>
</tr>
<tr>
<td>6 - equivalent to acute panic states</td>
<td>7 -</td>
</tr>
<tr>
<td>seen in severe delirium or acute</td>
<td></td>
</tr>
<tr>
<td>schizophrenia reactions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anxiety - Rate on scale 0 - 7</th>
<th>Activation - Rate on scale 0 - 7.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0- no anxiety, patient at ease</td>
<td>0 - normal activity</td>
</tr>
<tr>
<td>1 - mildly anxious</td>
<td>1 - somewhat normal activity</td>
</tr>
<tr>
<td>2</td>
<td>2 - moderately anxious</td>
</tr>
<tr>
<td>3</td>
<td>3 - moderatelyqd anxious or guarded, so anxiety is inferred</td>
</tr>
<tr>
<td>4</td>
<td>4 - moderately anxious or guarded, so anxiety is inferred</td>
</tr>
<tr>
<td>5</td>
<td>5 - very anxious</td>
</tr>
<tr>
<td>6</td>
<td>6 - extremely anxious</td>
</tr>
<tr>
<td>7 - equivalent to acute panic states</td>
<td>7 - paces back and forth, or constantly thrashes about</td>
</tr>
<tr>
<td>seen in severe delirium or acute</td>
<td></td>
</tr>
<tr>
<td>schizophrenia reactions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tanky disturbances - Ask: “Have you experienced any itching, pins &amp; needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?”</th>
<th>Auditory disturbances - Ask: “Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn’t there?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - None</td>
<td>0 - not present</td>
</tr>
<tr>
<td>1 - very mild itching, pins &amp; needles, burning, or numbness</td>
<td>1 - very mild hardness or ability to startle</td>
</tr>
<tr>
<td>2 - mild itching, pins &amp; needles, burning, or numbness</td>
<td>2 - mild hardness or ability to startle</td>
</tr>
<tr>
<td>3 - moderate itching, pins &amp; needles, burning, or numbness</td>
<td>3 - moderate hardness or ability to startle</td>
</tr>
<tr>
<td>4 - severe hallucinations</td>
<td>4 - severe hallucinations</td>
</tr>
<tr>
<td>5 - extremely severe hallucinations</td>
<td>5 - extremely severe hallucinations</td>
</tr>
<tr>
<td>6 - continuous hallucinations</td>
<td>6 - continuous hallucinations</td>
</tr>
<tr>
<td>7 - continuous hallucinations</td>
<td>7 - continuous hallucinations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visual disturbances - Ask: “Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn’t there?”</th>
<th>Headache - Ask: “Does your head feel different than usual? Does it feel like there is a band around your head?” Do not rate dizziness or lightheadedness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - not present</td>
<td>0 - not present</td>
</tr>
<tr>
<td>1 - very mild sensitivity</td>
<td>1 - very mild</td>
</tr>
<tr>
<td>2 - mild sensitivity</td>
<td>2 - mild</td>
</tr>
<tr>
<td>3 - moderate sensitivity</td>
<td>3 - moderate</td>
</tr>
<tr>
<td>4 - severe hallucinations</td>
<td>4 - severe</td>
</tr>
<tr>
<td>5 - extremely severe hallucinations</td>
<td>5 - very severe</td>
</tr>
<tr>
<td>6 - continuous hallucinations</td>
<td>6 - extremely severe hallucinations</td>
</tr>
</tbody>
</table>

**Procedure:**
1. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for “Orientation and clouding of sensorium” which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.
### Assessment Protocol

- **Vital Signs**
- **Assessment Note**
- **Date**
- **Time**
- **Pulse**
- **RR**
- **O2 sat**
- **BP**

Assess and rate each of the following (CIWA-Ar Scale):

#### Nausea/Vomiting (0 - 7)
- 0: score; 1: mild nausea, no vomiting; 2: intermittent nausea;
- 3: constant nausea, no vomiting;
- 4: moderate w/ some vomiting;
- 5: severe w/ some vomiting;
- 6: very severe w/ frequent vomiting;
- 7: hyperemesis

#### Tremors (0 - 7)
- 0: no tremor; 1: not visible but can be felt;
- 2: moderate w/ some postural changes;
- 3: marked w/ significant postural changes;
- 4: severe w/ marked postural changes;
- 5: hyperactivity;
- 6: hyperactivity plus
- 7: hyperactivity plus

#### Anxiety (0 - 7)
- 0: calm, at ease;
- 1: mildly anxious;
- 2: moderately anxious;
- 3: moderately distressed;
- 4: severely distressed;
- 5: extremely distressed;

#### Agitation (0 - 7)
- 0: normal activity;
- 1: slightly increased;
- 2: slightly disorganized;
- 3: severely disorganized;
- 4: extremely disorganized;

#### Paroxysmal Sweats (0 - 7)
- 0: no sweats;
- 1: barely perceptible sweating, palms moist;
- 2: sweat on armpits;
- 3: sweat on chest;
- 4: profuse sweating

#### Orientation (0 - 4)
- 0: oriented;
- 1: orientation disturbed by time;
- 2: orientation disturbed by place;
- 3: orientation disturbed by person;
- 4: disoriented

#### Tactile Disturbances (0 - 7)
- 0: no tactile phenomena;
- 1: mild touch sensations;
- 2: moderate touch sensations;
- 3: severe touch sensations;
- 4: extremely severe touch sensations;

#### Auditory Disturbances (0 - 7)
- 0: no auditory phenomena;
- 1: mild auditory phenomena;
- 2: moderate auditory phenomena;
- 3: severe auditory phenomena;
- 4: extremely severe auditory phenomena;

#### Visual Disturbances (0 - 7)
- 0: no visual phenomena;
- 1: mild visual phenomena;
- 2: moderate visual phenomena;
- 3: severe visual phenomena;
- 4: extremely severe visual phenomena;

#### Headache (0 - 7)
- 0: no headache;
- 1: mild headache;
- 2: moderate headache;
- 3: severe headache;
- 4: extremely severe headache;

#### Total CIWA-Ar score:

<table>
<thead>
<tr>
<th>PRN Med. (circle one)</th>
<th>Dose given (mg):</th>
<th>Time of PRN medication administration:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diazepam</td>
<td>Lorazepam</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assessment of response (CIWA-Ar score 30-60 minutes after medication administered)

RN Initials

### Scale for Scoring:

- **Total Score**
  - 0 - 4: absent or minimal withdrawal
  - 5 - 9: mild to moderate withdrawal
  - 10 - 19: severe withdrawal

### Indications for PRN medication:

- a. Total CIWA-Ar score 5 or higher if ordered PRN only (Symptom-triggered method).
- b. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + PRN method)

Consider transfer to RN for any of the following. Total scores above 35, q1h assess, x more than 4hrs required, more than 4 mg/hr lorazepam x 3hrs or 20 mg/hr diazepam x 3hrs required, or resp. distress.

### Signature / Title

<table>
<thead>
<tr>
<th>Signature / Title</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cannabis Withdrawal Assessment Scale

Drug & Alcohol Services Council, SA, 2002

Note: Total Score is indicative of increasing or decreasing severity of withdrawal. Scores are not directly linked to pharmacological management as occurs with alcohol scores based on the CIWA-Ar.

Surname: ___________________________Given name: ___________________________

Date of birth: ___________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Temperature</th>
<th>Pulse</th>
<th>Respiration rate</th>
<th>Blood pressure</th>
<th>Pupil size</th>
<th>Reaction</th>
<th>Weight</th>
</tr>
</thead>
</table>

Score range = 0-7

<table>
<thead>
<tr>
<th>Restlessness/Agitation</th>
<th>Racing thoughts</th>
<th>Mood changes</th>
<th>Feelings of unreality</th>
<th>Fear</th>
<th>Drowsiness</th>
<th>Hunger</th>
<th>Appetite</th>
<th>TOTAL</th>
</tr>
</thead>
</table>

Sleep (0800 obs only)

Other symptoms
These questions refer to how the person is feeling **right now**, at the present moment.

|   | **Restlessness/Agitation—Observation**<br>Ask ‘Do you feel more restless than you are normally?’ |   | **Fear**<br>Ask ‘Do you feel fearful?’ |   | **Racing thoughts**<br>Ask ‘Are your thoughts racing?’ |   | **Drowsiness—Observation**<br>Ask ‘Do you feel sleepy or drowsy?’ |   | **Mood changes—Observation**<br>Ask ‘Are your moods changing over a short period (hours)?’ |   | **Hunger**<br>Ask ‘Do you feel hungry?’ |   | **Feelings of unreality**<br>Ask ‘Do you feel that things around you are not real or change in shape?’ |   | **Appetite**<br>Ask ‘Have you noticed any change in your appetite?’ |   | **Sleep**<br>Ask ‘How did you sleep last night?’ |   |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | Normal activity | 0 | No fear | 0 | No racing thoughts | 0 | No drowsiness | 0 | No mood changes, feels stable | 0 | No hunger | 0 | No | 0 | Sufficient sleep |
| 1 | Somewhat more than normal activity | 1 | Mildly fearful | 1 | Mild | 1 | Mild | 1 | Mild | 1 | Slight loss | 1 | Slight loss | 1 | Some sleep |
| 4 | Moderately fidgety or restless | 4 | Moderately fearful | 4 | Moderate | 4 | Moderate | 4 | Moderate | 4 | Complete loss of appetite, unable to eat at all | 4 | Complete loss of appetite, unable to eat at all | 4 | Moderate/restless sleep |
| 7 | Unable to sit or stand still | 7 | Extremely fearful | 7 | Severe, unable to stay awake | 7 | Severe | 7 | Severe and constant feelings of hunger | 7 | Severe and constant feelings of hunger | 7 | Severe and constant feelings of hunger | 7 | No sleep |


---

51
Cocaine

Guidelines for Administration of the CSSA

The CSSA is a simple scale that reliably and validly measures cocaine withdrawal signs and symptoms. The scale is designed to be administered at each detoxification visit and measures withdrawal over the past 24 hours. It takes only a few minutes to administer and requires no special equipment. Almost any member of a clinical staff can be trained to administer the scale. The accuracy of the scale depends on the consistency of administration. For this reason, we have put together this set of guidelines for administration of the CSSA. We found that administering the scale according to these guidelines significantly improved scale reliability and validity.

When ascertaining the date of last use, pay close attention to the time of last use. For example, if someone states that his/her last cocaine use was last night, determine if the last use was after midnight. If the last cocaine use was after midnight, then record days since last use as zero.

To complete items one and two, it is important to limit the individual to the previous 24 hours. Ask the individual "How has your appetite been in the past 24 hours?" Compare this response with his/her usual food intake for a typical 24-hour period. Score appetite according to the guidelines provided within items one and two on the CSSA. If a person is hyperphagic, then he/she cannot be hypophagic and vice versa. Thus, an individual can have a response of zero for both questions or can have a response greater than zero for item one or item two but not both.

To complete item three ask "Do you have, or have you had any cravings for cookies, candy or sweets in the past 24 hours?" Score his/her carbohydrate craving utilizing the guidelines provided on the CSSA to quantify his/her response.

To complete items four and five, cocaine craving and craving frequency, have the individual mark a vertical line at the appropriate spot representing his/her cocaine craving and another mark corresponding to his/her cocaine craving frequency on the appropriate scale. When scoring his/her mark, you should assess which position on the scale is closest to the new mark and assign an appropriate value. You cannot score his/her mark as fraction. It must be a whole number. Any mark between zero and one is scored as one. If the individual displays confusion in trying to distinguish the difference between cocaine craving and craving frequency, explain that cocaine craving is how much he/she wanted to use cocaine in the last 24 hours and the craving frequency is how often he/she wanted to use cocaine. Individuals who report some craving intensity on item four must report some craving frequency on item five, and likewise, patients who report some craving frequency on item five must also report some craving intensity on item four.

To complete item six, take the individual's radial pulse and assign the value defined by the given parameters representing his/her head rate.

To complete items seven and eight ask "How has your sleep been for the last 24 hours?" Compare the response with his/her usual sleep for a typical 24 hour period, and score his/her sleep according to the guidelines provided within items seven and eight on the
CSSA. Total sleep time, including naps is taken into account. Individuals cannot have both hyper and hypsomnias. Thus, an individual can have a response of zero for both items seven and eight, or can have a response greater than zero for item seven or eight but not both.

To complete items nine through thirteen, it is important not to lead the individual with your questioning. For example, begin inquiring about anxiety in item nine by asking "Have you felt anxious in the past 24 hours?" If the patient reports feeling some anxiety then inquire further about how anxious he/she has felt using the guidelines on the scale to help quantify his/her response. Complete the other four items following the same method.

To complete item fourteen begin by asking "Do you have difficulty trusting people?" If the individual reports suspicion, then probe further to determine how unrealistic and specific the suspicion is. Vague feelings of distrust are scored lower than articulated feelings of being harassed. True paranoid delusions are given the maximum score. This item requires the highest degree of interviewing skill and requires the interviewer to determine the validity of an individual's suspicion. Consequently, in recent test-reset reliability testing, this item received the lowest reliability rating and may eventually be eliminated from the revised scale.

To complete items fifteen through eighteen, it is important not to lead the individual with your questioning. For example to complete item fifteen ask "Have you been able to enjoy yourself over the last 24 hours?" To complete item seventeen ask "Have you had any thoughts about death in the past 24 hours?" Follow up positive responses with more specific inquiries using the guidelines in the scale to help quantitate responses.

**COCAINE SELECTIVE SEVERITY ASSESSMENT**

1. **HYPERPHAGIA**: .................................................................
   0 = normal appetite
   3-4 = eats a lot more than usual
   7 = eats more than twice usual amount of food

2. **HYPOPHAGIA**: .................................................................
   0 = normal appetite
   3-4 = eats less than normal amount
   7 = no appetite at all

3. **CARBOHYDRATE CRAVING**: .................................................................
   0 = no craving
   3-4 = strong craving for sweets half the time
   7 = strong craving for sweets all the time

4. **COCAINE CRAVING**: (Please have subject rate intensity on pg. 3) 0-7 ............

5. **CRAVING FREQUENCY**: (Please have subject rate intensity on pg. 3) 0-7 ......

6. **BRADYCARDIA**

<table>
<thead>
<tr>
<th>Apical Pulse</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&gt;64</td>
<td>64-63</td>
<td>62-61</td>
<td>60-59</td>
<td>58-57</td>
<td>56-55</td>
<td>54-53</td>
<td>&lt;53</td>
</tr>
</tbody>
</table>
7. **SLEEP I:**
   - 0 = normal amount of sleep
   - 3-4 = half of normal amount
   - 7 = no sleep at all

8. **SLEEP II:**
   - 0 = normal amount of sleep
   - 3-4 = could sleep or do sleep half the day
   - 7 = sleep or could sleep all the time

9. **ANXIETY:**
   - 0 = usually does not feel anxious
   - 3-4 = feels anxious half the time
   - 7 = feels anxious all the time

10. **ENERGY LEVEL:**
    - 0 = feels alert and has usual amount of energy
    - 3-4 = feels tired half the time
    - 7 = feels tired all the time

11. **ACTIVITY LEVEL:**
    - 0 = no change in usual activities
    - 3-4 = participates in half of usual activities
    - 7 = no participation in usual activities

12. **TENSION:**
    - 0 = rarely feel tense
    - 3-4 = feels tense half the time
    - 7 = feels tense most of the time

13. **ATTENTION:**
    - 0 = able to concentrate on reading, conversation, tasks, and make plans without difficulty
    - 3-4 = has difficulty with the above half the time
    - 7 = has difficulty with the above all the time

14. **PARANOID IDEATION**
    - 0 = no evidence of paranoid thoughts
    - 3-4 = unable to trust anyone
    - 7 = feels people are out to get him/her
    - 8 = feels a specific person/group is plotting against him/her

15. **ANHEDONIA**
    - 0 = ability to enjoy themselves remains unchanged
    - 3-4 = able to enjoy themselves half the time
    - 7 = unable to enjoy themselves at all
16. DEPRESSION
0 = no feelings related to sadness or depression
3-4 = feels sad or depressed half the time
7 = feels depressed all of the time

17. SUICIDALITY
0 = does not think about being dead
3-4 = feels like life is not worth living
7 = feels like actually ending life

18. IRRITABILITY
0 = feels that most things are not irritating
3-4 = feels that many things are irritating
7 = feels that mostly everything is irritating and upsetting

Interviewer Initials: ____________

Please rate the highest intensity of the desire for cocaine you have felt in the last 24 hours:

| No desire at all | Unable to resist |

Please identify on the line below, how often you have felt the urge to use cocaine in the last 24 hours:

| Never | All the time |
## WITHDRAWAL ASSESSMENT TOOL – 1 (WAT – 1)

**Patient Identifier**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
</table>

**Information from patient record, previous 12 hours**

| Any loose/watery stools | No = 0  
|                         | Yes = 1 |
| Any vomiting/wretching/gagging | No = 0  
|                             | Yes = 1 |
| Temperature > 37.5°C | No = 0  
|                      | Yes = 1 |

**2 minute pre-stimulus observation**

| State | SBS ≤ 0 or asleap/awake/calm = 0  
|       | SBS > 1 or awake/distressed = 1  |
| Tremor | None/mild = 0  
|        | Moderate/severe = 1  |
| Any sweating | No = 0  
|               | Yes = 1  |
| Uncordinated/repetitive movement | None/mild = 0  
|                                   | Moderate/severe = 1  |
| Yawning or sneezing | None or 1 = 0  
|                     | > 2 = 1  |

**1 minute stimulus observation**

| Startle to touch | None/mild = 0  
|                  | Moderate/severe = 1  |
| Muscle tone      | Normal = 0  
|                  | Increased = 1  |

**Post-stimulus recovery**

| Time to gain calm state (SBS ≤ 0) | < 2 min = 0  
|                                    | 2 - 5 min = 1  
|                                    | > 5 min = 2  |

**Total Score (0-12)**

### WITHDRAWAL ASSESSMENT TOOL (WAT – 1) INSTRUCTIONS

- Start WAT-1 scoring from the **first day of weaning** in patients who have received opioids or benzdiazepines by infusion or regular dosing for prolonged periods (e.g., ≥ 5 days). Continue twice daily scoring until 72 hours after the last dose.
- The Withdrawal Assessment Tool (WAT-1) should be completed with the SBS1 at least once per 12 hour shift (e.g., at 06:00 and 20:00 ± 2 hours). The progressive stimulus used in the SBS1 assessment provides a standard stimulus for observing signs of withdrawal.

**Obtain information from patient record (this can be done before or after the stimulus):**

- Loose/watery stools: Score 1 if any loose or watery stools were documented in the past 12 hours; score 0 if none were noted.
- Vomiting/wretching/gagging: Score 1 if any vomiting or spontaneous wretching or gagging were documented in the past 12 hours; score 0 if none were noted.
- Temperature > 37.5°C: Score 1 if the model (most frequently occurring) temperature documented was greater than 37.5°C in the past 12 hours; score 0 if this was not the case.

**2 minute pre-stimulus observation:**

- **State:** Score 1 if awake and distress (SBS ≥ +1) observed during the 2 minutes prior to the stimulus; score 0 if asleap or awake and calm/ Cooperative (SBS ≤ 0).
- **Tremor:** Score 1 if moderate to severe tremor observed during the 2 minutes prior to the stimulus; score 0 if no tremor (or only minor, intermittent tremor).
- **Sweating:** Score 1 if any sweating during the 2 minutes prior to the stimulus; score 0 if no sweating noted.
- **Uncordinated/repetitive movements:** Score 1 if moderate to severe uncoordinated or repetitive movements such as head turning, leg or arm flailing or torso arching observed during the 2 minutes prior to the stimulus; score 0 if no or (only mild) uncoordinated or repetitive movements.
- **Yawning or sneezing ≥ 1:** Score 1 if more than 1 yawn or sneeze observed during the 2 minutes prior to the stimulus; score 0 if 0 to 1 yawn or sneeze.

**1 minute stimulus observation:**

- **Startle to touch:** Score 1 if moderate to severe startle occurs when touched during the stimulus; score 0 if none (or mild).
- **Muscle tone:** Score 1 if tone increased during the stimulus; score 0 if normal.

**Post-stimulus recovery:**

- Time to gain calm state (SBS ≤ 0): Score 2 if it takes greater than 5 minutes following stimulus; score 1 if achieved within 2 to 5 minutes; score 0 if achieved in less than 2 minutes.

**Sum the 11 numbers in the column for the total WAT-1 score (0-12).**

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### Appendix 11: Summary of Screening & Brief Intervention Studies

<table>
<thead>
<tr>
<th>PI(s) / Location</th>
<th>Title</th>
<th>Purpose</th>
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</thead>
<tbody>
<tr>
<td>D’Onofrio/Fiellin Yale University</td>
<td>Models of SBIRT for Opioid Dependent Patients in the Emergency Department</td>
<td>RCT, ED Based SC, SBIRT, SBI+Bup 1, 2, 6, 12m follow-up N=360, opioid dependent</td>
</tr>
<tr>
<td>Roy-Byrne University of Washington</td>
<td>Brief Intervention in Primary Care for Problem Drug Use and Abuse</td>
<td>RCT, hospital PC BI Problem drug users</td>
</tr>
<tr>
<td>Field/Velasquez University of Texas</td>
<td>Multidisciplinary Approach to Reduce Injury and Substance Abuse</td>
<td>RCT, Trauma Center BA, BMI, BMI+B 3, 6, 12m follow-up Injured pts w/drug probls</td>
</tr>
<tr>
<td>Svikis Virginia Commonwealth University</td>
<td>Computer vs Therapist-Delivered Brief Intervention for Drug Abuse in Primary Care</td>
<td>RCT, General Med outpt SC, CA, CACI, CATI 1, 3, 6m follow-up N=680, heavy/problem SA</td>
</tr>
<tr>
<td>Study</td>
<td>Study Design and Setting</td>
<td>Patient Population and Admission Criteria</td>
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| Monti et al. 1999            | Design: Randomized controlled trial (RCT)  
Setting: Emergency Department (ED) | 94 patients ages 18–19, admitted to an Emergency Department (ED) after an alcohol-related event  
- Positive blood alcohol concentration (BAC) or  
- Report of drinking prior to the event that precipitated treatment |  
- Standard care  
- One 35- to 40-minute brief intervention (BI) (motivational interview)  
Interventions performed by 12 experienced research assistants (bachelor’s and master’s level)  
No followup sessions |  
- 3 months (phone): 93%  
- 6 months (in person): 89% |  
- Decrease in alcohol consumption in both groups  
- Greater reduction alcohol-related injuries during the followup period in the BI group  
- Greater reduction other alcohol-related problems (e.g., drinking and driving, social and legal problems) in the BI Group | Positive effect with the BI |
| Gentilello et al. 1999       | Design: RCT  
Setting: Inpatient Trauma Center | 762 patients ages ≥18 admitted to a trauma center  
- BAC ≥100 mg/dL or  
- SMAST score ≥3 or  
- BAC 1–99 mg/dL and SMAST score of 1 or 2 or  
- BAC 1–99 mg/dL and elevated GGT or  
- SMAST score of 1 or 2 and elevated GGT |  
- Standard care  
- One 30-minute BI (motivational interview)  
Interventions performed by one Ph.D.-level psychologist  
Followup letter sent after 1 month |  
- 6 months: 75%  
- 12 months: 54% |  
- Greater reduction in alcohol-related injuries during the followup period in the BI group  
- Greater decrease in alcohol consumption in the BI group  
- Greater reduction in ED visits and hospitalizations in the BI group | Positive effect with the BI |
<table>
<thead>
<tr>
<th>Study</th>
<th>Study Design and Setting</th>
<th>Patient Population and Admission Criteria</th>
<th>Intervention</th>
<th>Followup Rate</th>
<th>Outcome</th>
<th>Effect</th>
</tr>
</thead>
</table>
| Longbaugh     | Design: RCT Setting: ED   | 539 patients ages 3-18 with evidence of harmful or hazardous drinking, whose injury did not require hospitalization  
• Breath BAC ≥ 0.03 mg/dL or  
• Report of alcohol use 6 hours prior to injury or  
• AUDIT score ≥ 8 | Standard care  
• One 40- to 60-minute BI  
• One 40- to 60-minute BI followed by scheduled return visit (booster) 7-10 days later (BIB)  
Interventions performed by 5 clinically experienced research assistants (Ph.D., master’s or bachelor’s level) | 1 year (phone, mail, in person): 85% | Greater reduction in alcohol-related injuries during the follow-up period in the BIB group  
• Decreases in alcohol consumption in all groups  
• Greater reduction in alcohol-related negative consequences in the BIB group | Positive effect with the BIB |
| Spirito et al. | Design: RCT Setting: ED in an urban level-1 trauma center | Adolescents treated in an ED after an alcohol-related event  
• Positive for alcohol in breath, saliva, or blood or  
• Self-reported alcohol use 6 hours prior to injury  
Note: 47% of adolescents asked to participate refused | Standard care (5 minutes)  
• One 35- to 45-minute BI (motivational interview)  
Interventions performed by 12 clinically experienced research assistants (bachelor’s and master’s level)  
No followup sessions | 3 months (phone): 93.4%  
6 months (in person): 89.5%  
12 months (in person): 89.5% | Greater reduction in frequency of drinking and binge drinking for patients with pre-existing problematic alcohol use in the BI group | Positive effect with the BI for problem drinkers |
X. References

1 Saitz, R. Clinical Practice. Unhealthy Alcohol Use. New England Journal of Medicine


3 Harwood HJ. Updating Estimates of the Economic Costs of Alcohol Abuse in the United States:
Estimates, Update Methods and Data. Report prepared by the Lewin Group for the National Institute
on Alcohol Abuse and Alcoholism, 2000.

4 Substance Abuse and Mental Health Services Administration, Results from the 2006 National Survey on Drug Use and Health: National Findings, September 2007.


9 Substance Abuse and Mental Health Services Administration, Results from the 2007 National Survey on Drug Use and Health: National Findings, September 2008.


27 Glynn TJ, Manley MW, Pechacek TF. Physician-initiated smoking cessation program: the National Cancer Institute trials. Prog Cin Biol Res. 1990;339:11-25


