

Integrated Screening, Assessment, and Brief Intervention for Co-Occurring Disorders

Participant Guide

Sponsored by:

Los Angeles County Department of Mental Health
UCLA Integrated Substance Abuse Programs
Pacific Southwest Addiction Technology Transfer Center

In collaboration with:

Matrix Institute on Addictions
Pacific Clinics
Prototypes, Centers for Innovation in Health, Mental Health and Social Services

Funding for this training event was made possible [in part] by cooperative agreement UD1 TI1359407 from the Substance Abuse and Mental Health Services Administration.

Acknowledgements

We would like to acknowledge the following people for their contributions to the development of this training curriculum:

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Jeanne Obert, LMFT, MSM
Matrix Institute on Addictions

Henry van Oudheusden, M.Div, MA, MSW, MAC
Pacific Clinics

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Prototypes, Centers for Innovation in Health, Mental Health and Social Services

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Special thanks to the Los Angeles County Department of Mental Health
who provided funding through contract # 621587 FT 20776 NG73

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Integrated Screening, Assessment, and Brief Intervention for COD



Introduction What we will cover

- Overview of the evolving field of Co-Occurring Disorders
- What is happening in the brain?
- Using motivational interviewing with this population—why and how
- Conducting effective screening and assessment for COD
- Conducting a brief intervention for clients or caregivers with COD

Co-Occurring Disorders

Co-occurring disorders

- Refers to co-occurring **substance use** (abuse or dependence) and **mental disorders**

In other words...

Clients with co-occurring disorders have:

- one or more disorders relating to the use of alcohol and/or other drugs of abuse **and** one or more mental disorders

Co-Occurring Disorders

Diagnosis of COD occurs when:

- at least **one disorder of each type** can be established independent of the other *and*
- is **not simply** a cluster of **symptoms** resulting from the one disorder

Clinicians knowledge of both **mental health** and **substance abuse** is essential, but challenging to achieve

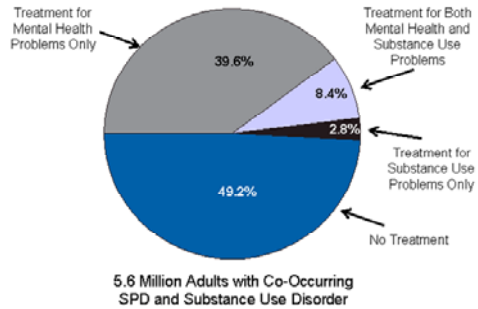
COD in Your Agency:

1. Do these definitions **describe clients** in your practice/program? (*Estimate percentage or describe prevalence*)
2. How has serving clients with COD **affected** your practice/program?
3. What **challenges** do clients with COD present to your clinical knowledge and skills?

Prevalence of COD

- In 2006, **5.6 million** adults (2.5% of persons aged 18+) met the criteria for both serious psychological distress (SPD) and substance dependence and abuse (i.e., substance use disorder, SUD)
- In 2006, **15.8 million** adults (7.2% of persons aged 18+) had at least one major depressive episode (MDE) in the past year
 - Adults with MDE in the past year were more likely than those without MDE to have used an illicit drug in the past year (27.7 vs. 12.9 percent)

Past Year Treatment of Adults with Both SPD and SUD (2006)



Prevalence and Other Data

Data now show:

- COD are **common** in general adult population.
- **Increased prevalence** of people with COD and programs for people with COD
- People with COD are **more likely to be hospitalized** and the rate may be increasing
- Rates of mental disorders increase as the number of substance use disorders increase

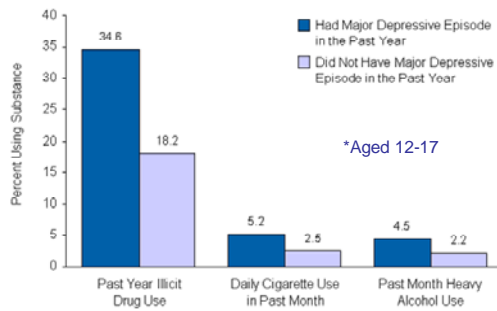
Adolescents with Substance Use Disorders...

- Are largely **undiagnosed**
- Are distributed across diverse health and social service systems
- Are more likely to be **involved in the juvenile justice** system;
- Have higher rates of **child abuse** (neglect, physical and sexual abuse);
- Have high **co-morbidity** with psychiatric conditions.

Facts About Adolescent COD

- In 2006, **3.2 million** youths (12.8% of the population aged 12 – 17) reported at least one major depressive episode (MDE) in their lifetime
- **2.0 million** youths (7.9 percent) had MDE during the past year
- Among 12 – 17 year olds who had past year MDE, **35% had used illicit drugs** during the same period

Substance Use among Youths*, by MDE in Past Year (2006)



COD and Juvenile Justice

- Nearly **two-thirds** of incarcerated youth with substance use disorders have **at least one other** mental health disorder
- As many as **50%** of substance abusing juvenile offenders have **ADHD**
- About **30%** of incarcerated youth with substance use disorders have a **mood or anxiety** disorder
- Those exposed to high levels of traumatic violence might experience **symptoms of posttraumatic stress** as well as increased rates of substance abuse

Trauma among Adolescents Presenting for Treatment for SUD

- **40-90%** have been victimized
- **20-25%** report in past 90 days, concerns about reoccurrence
- Associated with **higher rates** of
 - Substance use
 - HIV-risk behaviors
 - Co-occurring disorders

So, How Do We Treat COD?

TIP 42
Guiding Principles
and Recommendations

Six Guiding Principles (SAMHSA, TIP 42)

- Employ a **recovery perspective**
- Adopt a **multi-problem viewpoint**
- Develop a **phased approach** to treatment
- Address specific **real-life problems** early in treatment
- Plan for **cognitive** and **functional** impairments
- **Use support systems** to maintain and extend treatment effectiveness

Integrated Screening, Assessment, and Brief Intervention

Delivery of Services (SAMHSA, TIP 42)

- Provide **access**
- Complete a **full assessment**
- Provide **appropriate level** of care
- Achieve **integrated treatment**
 - Treatment Planning and Review
 - Psychopharmacology
- Provide **comprehensive services**
- Ensure **continuity of care**

Vision of Fully Integrated Treatment

- **One program** that provides treatment for **both disorders**
- Mental and substance use disorders are treated by the **same clinicians**
- The **clinicians are trained** in psychopathology, assessment, and treatment strategies for both disorders

Vision of Fully Integrated Treatment (continued)

- The focus is on **preventing anxiety** rather than breaking through denial
- Emphasis is placed on **trust, understanding, and learning**
- Treatment is characterized by a **slow pace** and a **long-term perspective**
- Providers offer **motivational counseling**

Integrated Screening, Assessment, and Brief Intervention

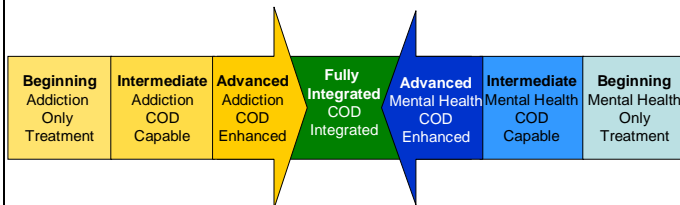
Vision of Fully Integrated Treatment (continued)

- **12-Step groups** are available to those who choose to participate and can benefit from participation
- **Pharmacotherapies** are indicated according to clients' psychiatric and other medical needs

Vision of Fully Integrated Treatment (continued)

- Supportive **clinicians** are readily available
- **Sensitivity** to culture, gender, and sexual orientation
- **Trauma sensitivity**

Quick Exercise— Levels of Program Capacity



Where on the graph would you place your agency?

Why?

We'll look at this again at the end of the day.

Integrated Screening, Assessment, and Brief Intervention

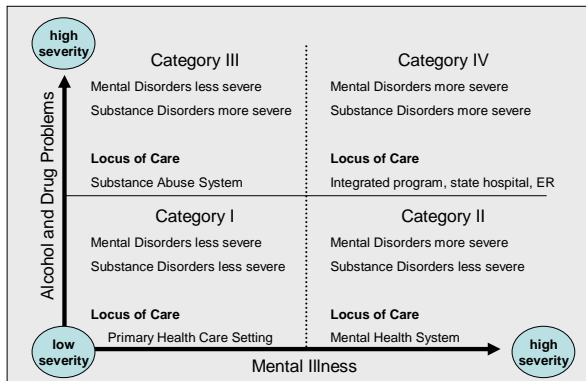
Basic Competencies Needed to Treat Persons With COD	
	+ /OK/-
Perform a basic screening to determine whether COD might exist and be able to refer the client for a formal diagnostic assessment by someone trained to do this.	
Form a preliminary impression of the nature of the disorder a client may have, which can be verified by some-one formally trained and licensed in mental health diagnosis.	
Conduct a preliminary screening of whether a client poses an immediate danger to self or others and coordinate any subsequent assessment with appropriate staff and/or consultants.	
Be able to engage the client in such a way as to enhance and facilitate future interaction.	
De-escalate the emotional state of a client who is agitated, anxious, angry, or in another vulnerable emotional state.	
Manage a crisis involving a client with COD, including a threat of suicide or harm to others. This may involve seeking out assistance by others trained to handle certain aspects of such crises; for example, processing commitment papers and related matters.	
Refer a client to the appropriate mental health or substance abuse treatment facility and follow up to ensure the client receives needed care.	
Coordinate care with a mental health counselor serving the same client to ensure that the interaction of the client's disorders is well understood and that treatment plans are coordinated	

Stop for Discussion

Examples of Ways to Avoid Burnout	
	+ /OK/-
Work within a team structure rather than in isolation.	
Build in opportunities to discuss feelings and issues with other staff who handle similar cases.	
Develop and use a healthy support network.	
Maintain the caseload at a manageable size.	
Incorporate time to rest and relax.	
Separate personal and professional time.	
Receive supervision that is supportive and provides guidance and technical knowledge.	

Which 2 of the are the most difficult for you?

Determine Quadrant and Locus of Responsibility



TIP Exercise— Cases & Quadrants of Care

With your partner:

- Select one case (Tony, Jessica or Kevin) below.
- Change or add information that would result in assignment of that case to a different quadrant.

(1 minute)

Case 1: Tony

Tony is a 7 year old boy who is being raised by a single mom and maternal grandmother. Tony has met all of the usual developmental milestones up to age 4. When Tony turned 5 he began to act out aggressively toward two of his siblings; Mary 2 years older, Tom 1 year younger, and other age mates. His mom thought he may be ADHD as did his 2nd grade teacher. His grandmother indicates that he is “just a sensitive boy.”

Tony’s mom is alcohol dependent and an older brother, age 16, smokes marijuana and drinks alcohol weekly with friends in the home.

What are the first 3 questions you would ask Tony regarding his experience with substance use?

If Tony indicates that his older brother has given him some alcohol and lets him “take a puff” on a joint occasionally, what are your 2 follow-up questions?

Case 2: Jessica

Jessica is a 10 year old who lives with her parents and younger brother. When Jessica was 9, her teacher reported that she often expressed sexually inappropriate behavior toward classmates and had poor impulse control.

Jessica’s father, while currently living in the home, has been in and out of jail for the past 10 years on drug-related crimes and domestic violence charges. Her father is currently unemployed and her mother works full-time as a bus driver.

Case 3: Kevin

Kevin is a 15 year old living with his Dad, older brother – age 19, and his Dad’s girlfriend. Kevin maintained good grades until starting high school last year. After repeated truancies, he was transferred to the alternative high school where he has continued to let his grades slip, and has been caught with both alcohol and marijuana in his locker. Kevin’s Dad and his girlfriend are in recovery and don’t allow drugs or alcohol in the home. His older brother regularly uses marijuana and has also experimented with heavier substances like psychedelic mushrooms, LSD and ecstasy.

Addiction: A Brain Disease

Putting Drug Use into Context with other Mental Disorders

A Work In Progress

- At four weeks gestation neurons are forming at the rate of 500,000 per minute
- At birth, the brain weighs approximately one pound
- In an area the size of a grain of rice there are ten thousand nerve cells and each one has one to ten thousand connections

Human Development by Erik Erikson

Task	Outcome	Negative
1st yr Trust/mistrust	Hope: Trust in Environment	Fear of Future Suspicion
2nd yr Autonomy/shame	Will: choice	Loss of Control
3-5 yr Initiative/guilt	Purpose/Initiative	Fear of punishment
6-puberty Industry/Inferiority	Competence	Inadequate
Adolescence Identity/role confusion	Sense of self	Confusion

When Tasks are Unfinished and Incomplete in Childhood.....

- Caregivers can only give to others what they themselves possess.
- No Trust-----Fear
- No Autonomy-----Loss of Control
- No Initiative-----Fear of Punishment
- Inferiority-----Inadequacy
- Identity-----Confusion

Onset of Mental Health Disorders

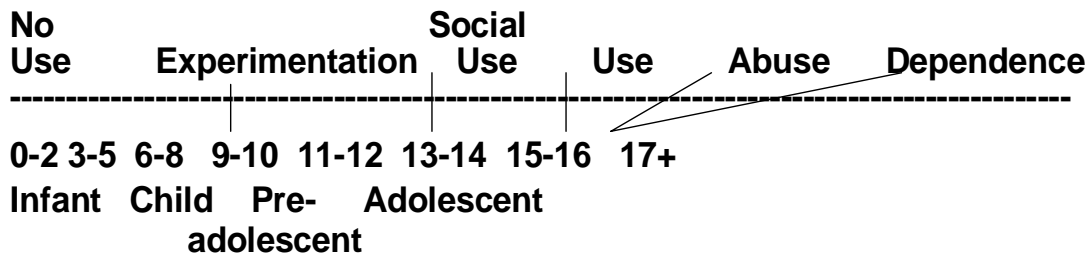
- Oppositional Defiance 5y/o
- Attention Deficit Disorder-ADHD 1.3-2.4
- Anxiety Disorders 3.8
- Conduct Disorder 5.6
- Depression 10.1
- Schizophrenia-effective disorders
 - » Teen years and mid-thirties

When Tasks are Unfinished and Incomplete in Childhood.....

- Caregivers can only give to others what they themselves possess.
- No Trust-----Fear
- No Autonomy-----Loss of Control
- No Initiative-----Fear of Punishment
- Inferiority-----Inadequacy
- Identity-----Confusion

Progression of Use

FAS---Substance use in-uterus



Mental Health Disorder's onset-----

Use: Isolation with substance-loss of relationships

Abuse: DMS IV

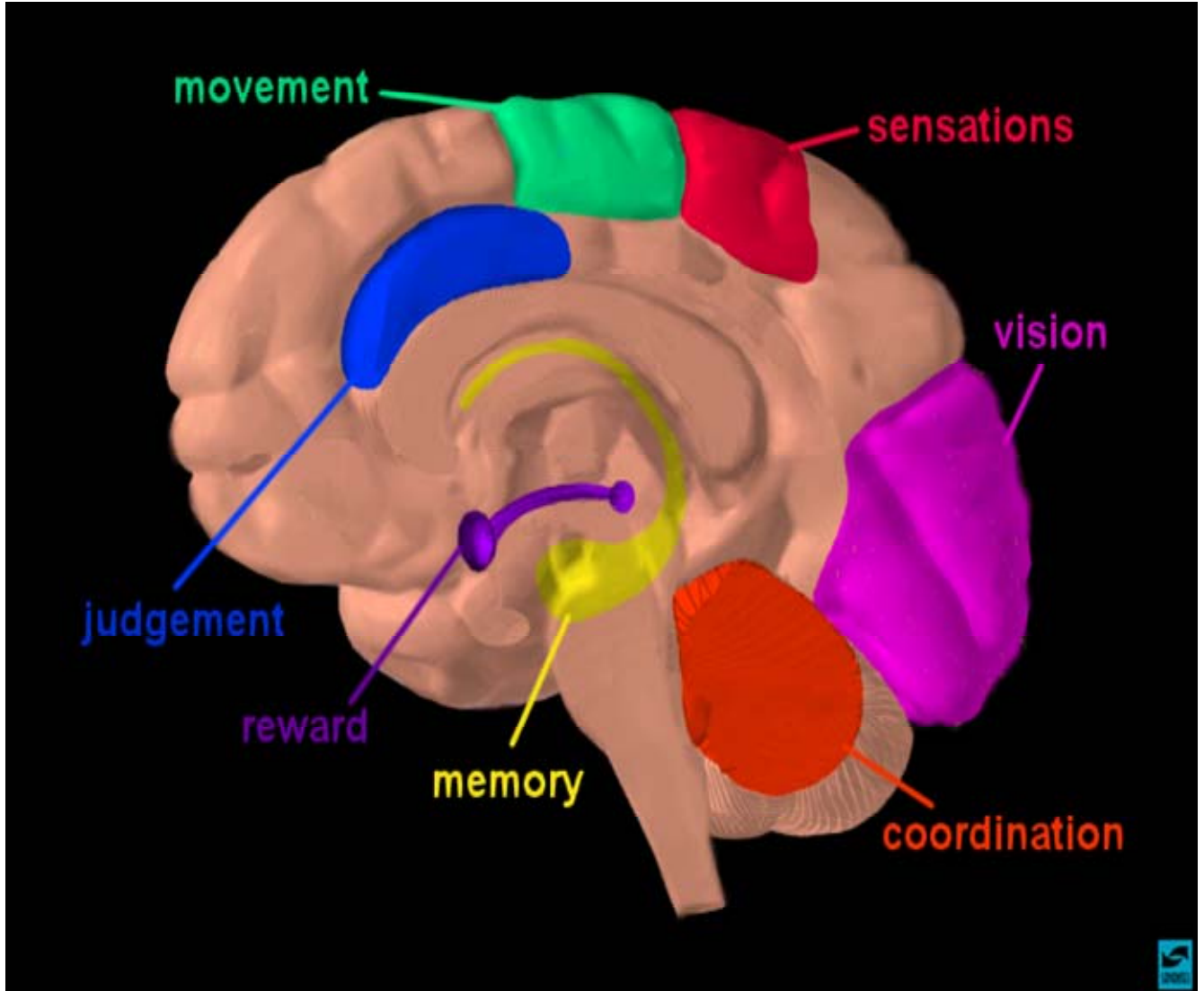
Dependence: DSM IV

Similarities of Two of These Diseases

Alcoholism/Addiction

Major Mental Disorders

- Both are diseases
- Heredity and environment play a role
- They are characterized by: chronicity and denial
- Affects the whole family
- Progression of the disease without treatment
- Shameful and stigmatized
- Leads to lack of control of behavior and emotions
- Disease is often seen as a moral issue
- Shameful and stigmatized
- Feelings of guilt and failure
- Facing the disease can lead to depression and despair
- Biological, mental, disease with social and spiritual impact



Brain Structure
The Hemispheres and Lobes

- Frontal Lobe—Self awareness, emotion
Executive functions
- Parietal--- Motor and Sensory functions
- Temporal---Language, memory, learning
- Occipital---- Vision and visual memory

Integrated Screening, Assessment, and Brief Intervention

Changes

- In the second decade of life, the brain is fully formed, but then it undergoes a last spurt of change.
- The prefrontal cortex is still very much a work in progress. **This region which governs rationality, stays underdeveloped throughout the adolescent years**

Pre-Frontal Cortex

This area of the brain is responsible for:

- Decisions for future plans
- Judgment
- Morality
- Reason
- Self discipline

Addiction: A Brain Disease

So, what do drugs do to all of this?

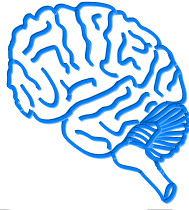
Group Activity

Let's talk about drugs and what they do.

- How is it used and what does it feel like?

- What are the benefits and consequences of use?

- What does withdrawal look like?

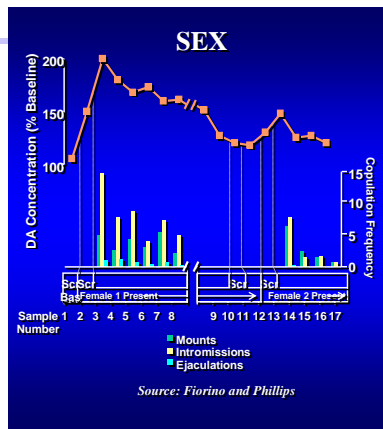
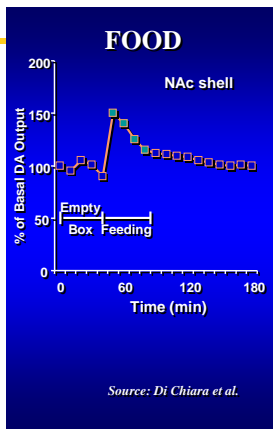


Initially, A Person Takes A Drug Hoping to Change their Mood, Perception, or Emotional State

Translation---

...Hoping to Change their Brain


Natural Rewards Elevate Dopamine Levels



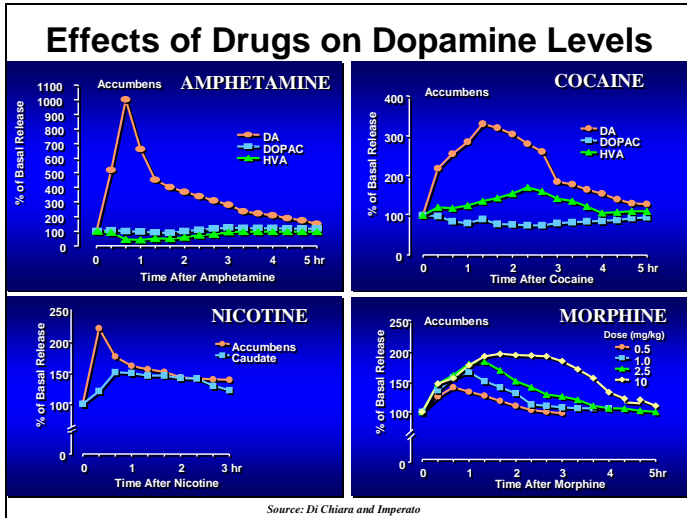
But Then...

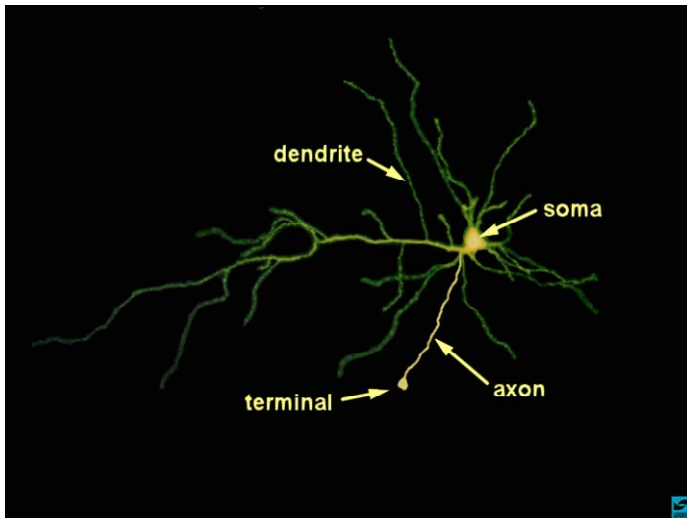
After A Person Uses Drugs For A While, Why Can't They Just Stop?

Because...
Their *Brains*

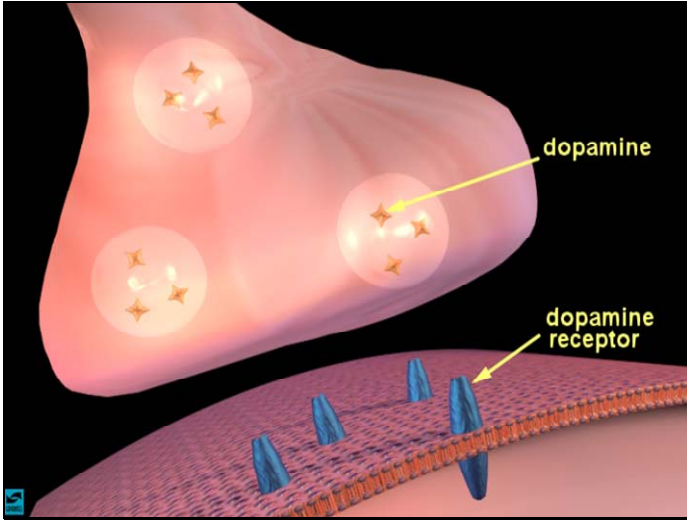


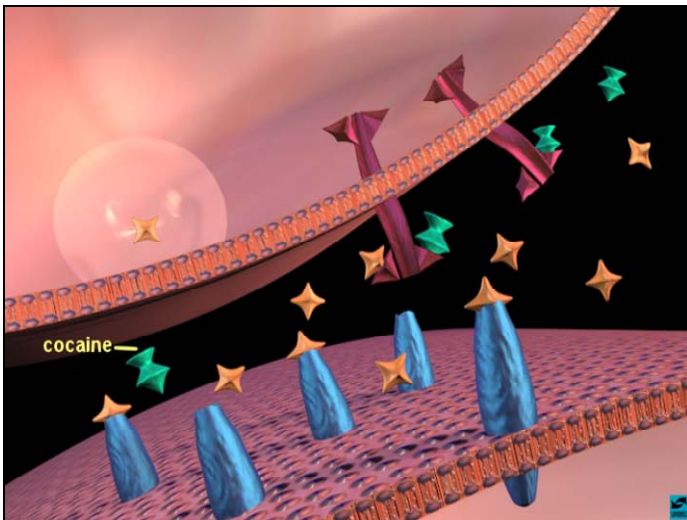
have been
Re-Wired
by *Drug Use*

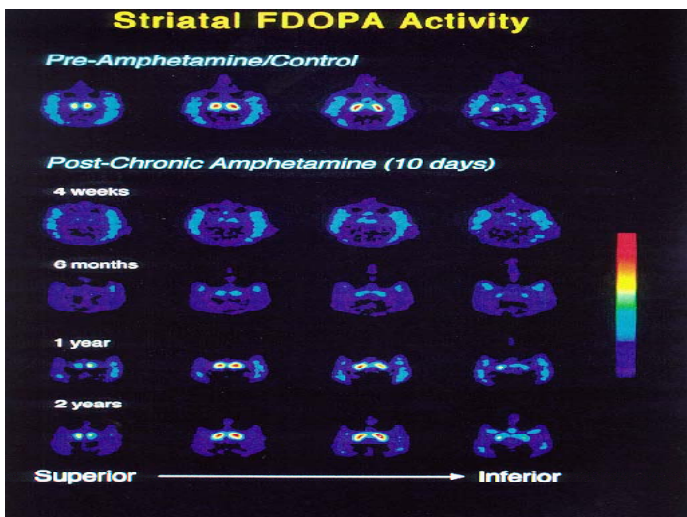




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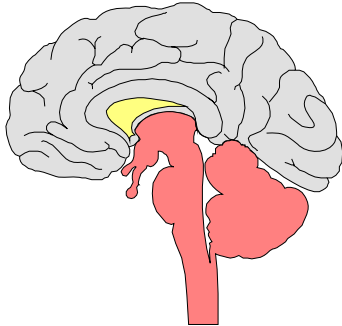






Triggers and Cravings

Human Brain



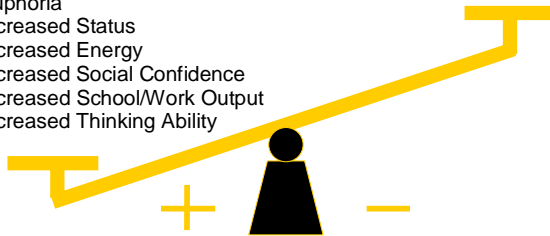
Cognitive Process During Addiction Introductory Phase

Relief From

- Depression
- Anxiety
- Loneliness
- Insomnia
- Euphoria
- Increased Status
- Increased Energy
- Increased Social Confidence
- Increased School/Work Output
- Increased Thinking Ability

} AOD

- May Be Illegal
- May Be Expensive
- Hangover/Feeling Ill
- May Miss School/Work



Conditioning Process During Addiction Introductory Phase

Strength of Conditioned Connection

Triggers

- Parties
- Special Occasions



Mild

Responses

- Pleasant Thoughts about AOD
- No Physiological Response
- Infrequent Use

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Development of Craving Response *Introductory Phase*

Entering Using Site



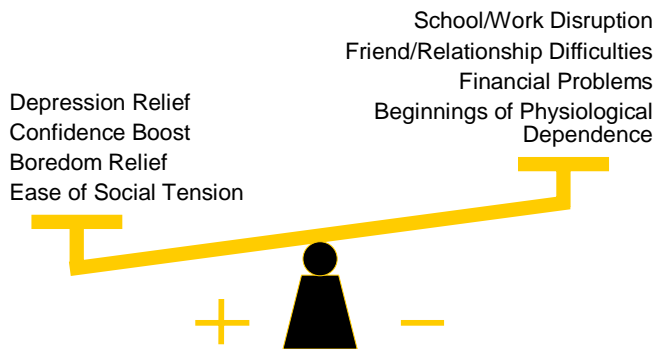
Use of AODs



AOD Effects

- ↓ Heart/Pulse Rate
- ↓ Respiration
- ↓ Adrenaline
- ↓ Energy
- ↑ Taste

Cognitive Process During Addiction *Maintenance Phase*



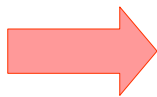
Conditioning Process During Addiction *Maintenance Phase*

Strength of Conditioned Connection

Triggers

- Parties
- Friday Nights
- Friends
- Concerts
- Alcohol
- "Good Times"
- Sexual Situations

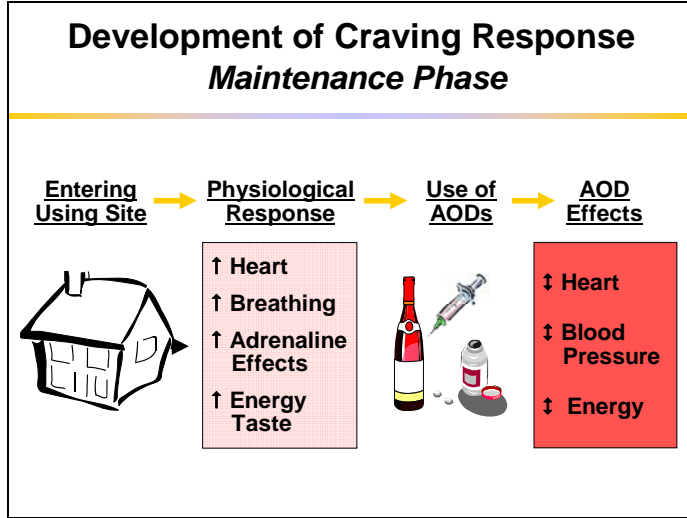
Moderate

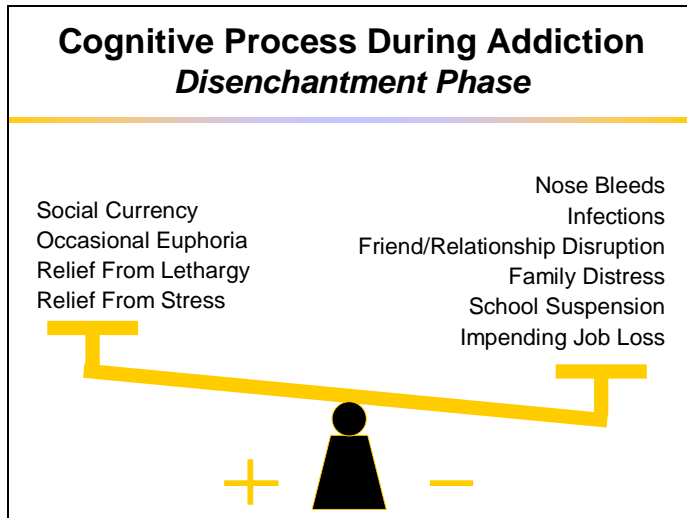


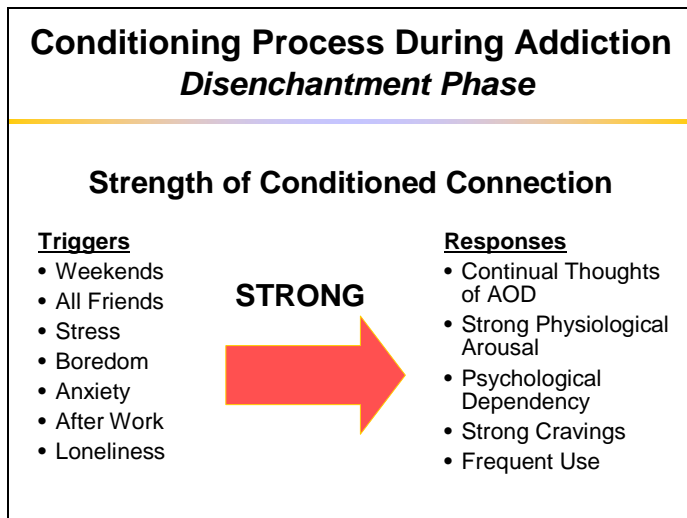
Responses

- Thoughts of AOD
- Eager Anticipation of AOD Use
- Mild Physiological Arousal
- Cravings Occur as Use Approaches
- Occasional Use

Integrated Screening, Assessment, and Brief Intervention







Integrated Screening, Assessment, and Brief Intervention

Development of Craving Response *Disenchantment Phase*

The diagram illustrates the Disenchantment Phase of craving response. On the left, a yellow head icon is shown with a thought bubble containing a house. In the center, a pink box lists physiological effects: ↑ Heart Rate, ↑ Breathing Rate, ↑ Energy, and ↑ Adrenaline Effects. To the right is a drawing of a house. Below this, a red box lists negative effects: ↓ Heart, ↓ Blood Pressure, and ↓ Energy. In the center, there are icons of a bottle, a syringe, and pills.

Cognitive Process During Addiction *Disaster Phase*

The diagram uses a seesaw to represent the cognitive process during addiction. The left side of the seesaw is higher and has a yellow '+' sign below it, representing positive effects: Relief From Fatigue, Relief From Stress, and Relief From Depression. The right side is lower and has a yellow '-' sign below it, representing negative consequences: Weight Loss, Paranoia, Loss of Family, Seizures, Severe Depression, School Expulsion, Unemployment, and Bankruptcy. A black silhouette of a person is positioned at the fulcrum in the center.

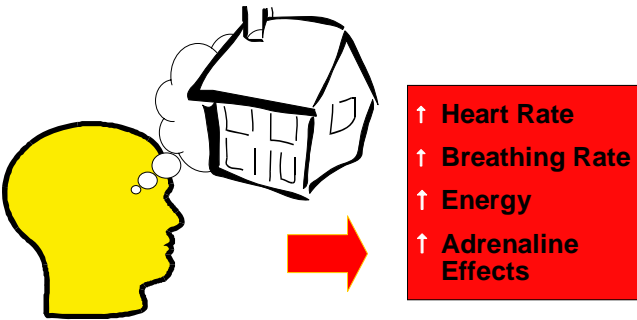
Conditioning Process During Addiction *Disaster Phase*

Strength of Conditioned Connection

OVERPOWERING

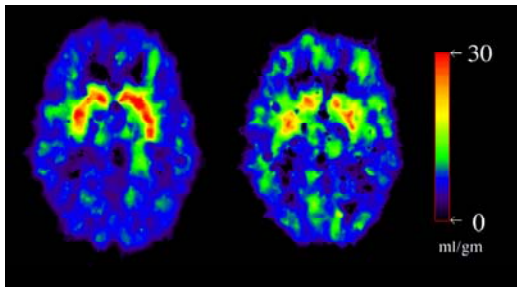
<p>Triggers</p> <ul style="list-style-type: none"> • Any Emotion • Day • Night • Work • Non-Work 		<p>Responses</p> <ul style="list-style-type: none"> • Obsessive Thoughts About AOD • Powerful Autonomic Response • Powerful Physiological Dependence • Automatic Use
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Development of Craving Response *Disaster Phase*



Prolonged Drug Use Changes the Brain In Fundamental and Long-Lasting Ways

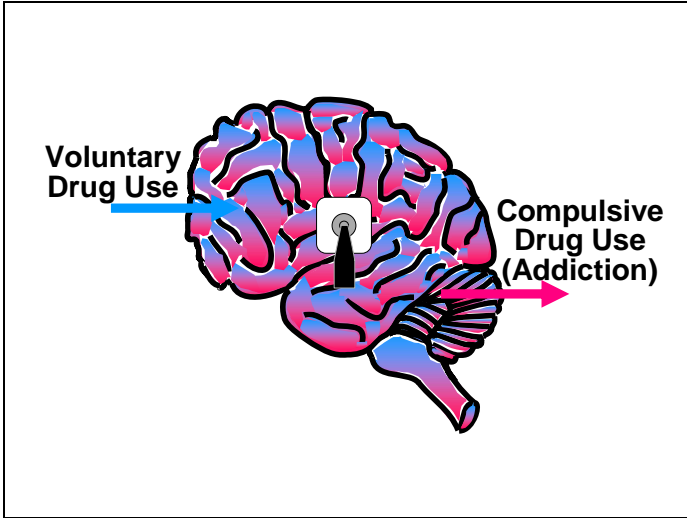
Dopamine Transporter Loss After Heavy Methamphetamine Use



Comparison
Subject

METH Abuser

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We Don't Know the Exact Switch

BUT...

We Do Know that the Brain Circuitry Involved in Addiction Has Similarities to that of Other Motivational Systems

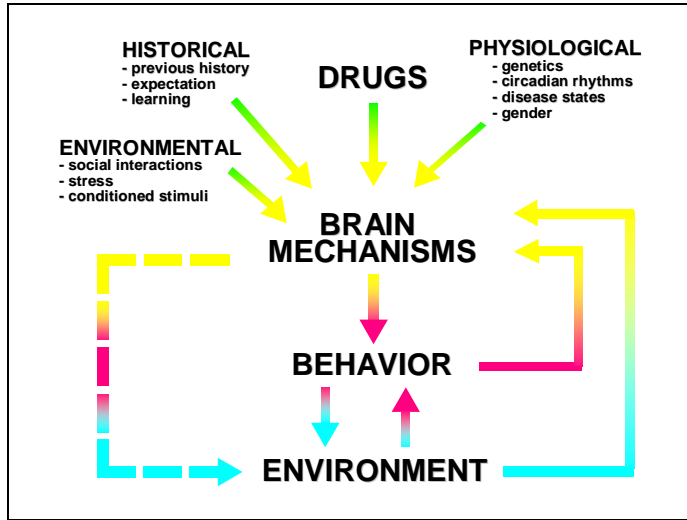


Addiction is, Fundamentally, A Brain Disease

...BUT

It's Not Just A Brain Disease

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**Addiction Is A Brain Disease
Expressed As Compulsive Behavior**

**Both Developing and
Recovering From It Depend on
Behavior and Social Context**

**That's Why Addicts Can't Just Quit
That's Why Treatment Is Essential!**

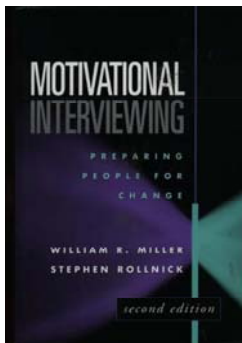
**That's Why It is Critical to
Help with Motivation for Change!**

Effecting Change through the Use of Motivational Interviewing

How can MI be helpful for us in working with our clients/patients?

- The successful MI therapist is able to inspire people to want to change
- Use of MI can help engage and retain clients in treatment
- Using MI can help increase participation and involvement in treatment (thereby improving outcomes)

What is MI?



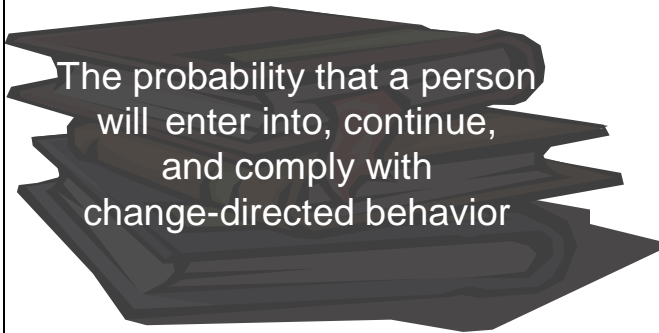
Motivational Interviewing, 2nd Edition.
Miller and Rollnick

What Causes a Person to be Judged “Motivated”

- The person agrees with us
- Is willing to comply with our recommendations and treatment prescriptions
- States desire for help
- Shows distress, acknowledges helplessness
- Has a successful outcome



Definition of Motivation



The probability that a person will enter into, continue, and comply with change-directed behavior

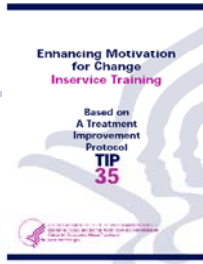
Motivational Interviewing

Elicit behavior change
Respect autonomy

A patient-centered directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

Tolerate patient ambivalence
Explore consequences

Integrated Screening, Assessment, and Brief Intervention



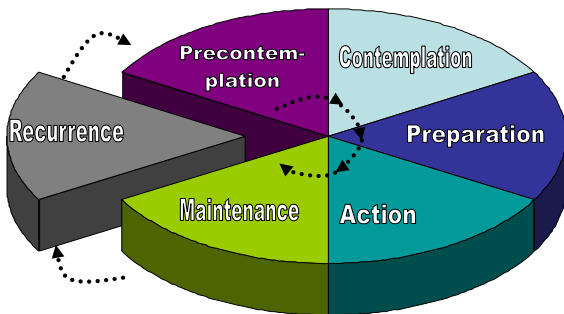
Enhancing Motivation for Change Inservice Training Based Treatment Improvement Protocol (TIP) 35

Published by the Center for Substance Abuse Treatment
www.samhsa.gov

Where do I start?

- What you **do** depends on where the client **is** in the process of changing
- The first step is to be able to identify where the client is coming from

Stages of Change Prochaska & DiClemente



Precontemplation Stage

- Definition
Not yet considering change or is unwilling or unable to change
- Primary task
Raising Awareness

Some Ways to Raise Awareness in the Precontemplation Stage

- Offer **factual** information
- Explore the **meaning of events** that brought the person in and the **results of previous efforts**
- Explore **pros and cons** of targeted behaviors

Contemplation Stage

- In this stage the client sees the possibility of change but is **ambivalent and uncertain** about beginning the process
- Primary task
Resolving ambivalence and helping the client choose to make the change

Possible Ways to Help the Client in the Contemplation Stage

- Talk about the person's **sense of self-efficacy** and **expectations** regarding what the change will entail
- **Summarize** self-motivational statements
- Continue exploration of pros and cons

Determination Stage

- In this stage the client is **committed to changing** but is still considering exactly what to do and how to do
- Primary task
Help client identify appropriate change strategies

Possible Ways to Help the Client in the Determination Stage

- Offer a **menu of options** for change or treatment
- Help client identify **pros and cons** of various treatment or change options
- Identify and **lower barriers** to change
- Help person **enlist social support**
- Encourage person to **publicly announce plans** to change

Action Stage

- In this stage the client is **taking steps toward change** but hasn't stabilized in the process
- Primary task
Help implement the change strategies and learn to limit or eliminate potential relapses

Possible Ways to Help the Client in the Action Stage

- Support a **realistic view** of change through **small steps**
- Help person **identify high-risk situations** and develop appropriate **coping strategies**
- Assist person in **finding new reinforcers** of positive change
- Help access family and social **support**

Maintenance Stage

- Definition
A stage in which the client has **achieved the goals** and is working to maintain them
- Primary task
Client needs to develop new skills for maintaining recovery

Possible Ways to Help the Client in the Maintenance Stage

- Help client identify and try **alternative behaviors** (drug-free sources of pleasure)
- Maintain **supportive contact**
- Encourage person to **develop escape plan**
- Work to **set new** short and long term **goals**

Recurrence

- Definition
Client has experienced a **recurrence of the symptoms**
- Primary task
Must cope with the consequences and determine what to do next

How to Help the Client Who Has Experienced a Recurrence

- Explore with person the meaning and reality of recurrence as a learning opportunity
- Explain Stages of Change and encourage him/her to stay in the process
- Help person find alternative coping strategies
- Maintain supportive contact

How Can I Help Clients Move through These Stages of Change?

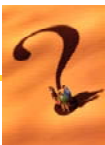
- Use the **microskills**
 - Open-ended questions
 - Affirmations
 - Reflections
 - Summaries

to elicit and reinforce **self-motivational statements** (Change Talk)

Building Motivation OARS (the microskills)

- Open-ended questioning
- Affirming
- Reflective listening
- Summarizing





Open-Ended Questions

An open-ended question is one that requires more than a yes or no response

- Solicits information in a neutral way
- Helps person elaborate own view of the problem and brainstorm possible solutions
- Helps therapist avoid prejudgments
- Keeps communication moving forward
- Allows client to do most of the talking



Affirmations

- Focused on achievements of individual
- Intended to:
 - Support person's persistence
 - Encourage continued efforts
 - Assist person in seeing positives
 - Support individual's proven strengths

Reflective Listening Key-Concepts



- Listen to both what the person says and to what the person means
- Check out assumptions
- Create an environment of empathy (nonjudgmental)
- You do not have to agree
- Be aware of intonation (statement, not question)

Summarizing



- Summaries capture both sides of the ambivalence (You say that _____ but you also mentioned that _____.)
- They demonstrate the clinician has been listening carefully.
- Summaries also prompt clarification and further elaboration from the person.
- They prepare clients to move forward.

What's the Best Way to Facilitate This Change?



- Constructive behavior change comes from connecting with something valued, cherished and important
- Intrinsic motivation for change comes out of an accepting, empowering, safe atmosphere where the painful present can be challenged

Use the Microskills of MI to:

Express Empathy

- Acceptance facilitates change
- Skillful reflective listening is fundamental
- Ambivalence is normal



Use the Microskills of MI to:

Develop Discrepancy

- Discrepancy between present behaviors and important goals or values motivates change
- Awareness of consequences is important
- Goal is to have the PERSON present reasons for change

Use the Microskills of MI to:

Avoid Argumentation

- Resistance is signal to change strategies
- Labeling is unnecessary
- Shift perceptions
- Peoples' attitudes are shaped by **their** words, not yours

Use the Microskills of MI to:

Support Self-Efficacy

- Belief that change is possible is important motivator
- Person is responsible for choosing and carrying out actions to change
- There is hope in the range of alternative approaches available

People Will Not Change Unless They Are:



READY
(The **time** is right)



WILLING
(The change is **important** to them)



ABLE
(They feel **confident** they can make the change)

You Can Help Increase:

- Importance (**Willing**) by Developing Discrepancy
- Confidence (**Able**) by Supporting Self Efficacy



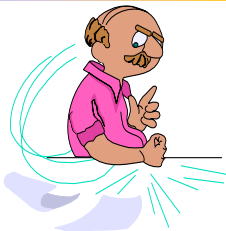
But what about **Readiness**?

Readiness

- The client will change if he/she believes it's possible (able), thinks it's important (willing) and thinks the change has a high priority (ready).
- Low priority does not = pathology; rather, low readiness

Providing Feedback

- Elicit (ask for permission)
- Give feedback or advice
- Elicit again (the person's view of how the advice will work for him/her)



How Do I Know When I've Succeeded?



One measure of success is the amount of **Change Talk** coming from the client.

Change Talk Is Happening When the Client Makes Statements That Indicate:

Recognition of a problem

A concern about the problem

Statements indicating an intention to change

Expressions of optimism about change

Signs of Readiness to Change

- Less resistance
- Fewer questions about the problems
- More questions about change
- Self-motivational statements
- Resolve
- Looking ahead
- Experimenting with change



Drumming for Change Talk



- Listen to the following statements
- If the statement is **change talk**
 - Drum roll
- If it is **NOT** change talk
 - Remain silent

Change Talk – Commitment

- The precursor to commitment is DARN
 - **D**esire
 - **A**bility
 - **R**eason
 - **N**eed
- **Commitment Talk** is:
 - Intention
 - Obligation
 - or
 - Agreements to change

Commitment Talk – Massaging the Pearl

- Listen to the following statements
- If the statement is **DARN change talk**:
 - Drum roll
- If it is **commitment talk**:
 - Massage the Pearl
- If it is **NEITHER**:
 - Remain Silent

Integrated Screening, Assessment, and Brief Intervention

How Do I Finish?

- Develop a Change Plan with the client by:
 - Offering a menu of change options
 - Developing a behavior contract
 - Lowering barriers to action
 - Enlisting social support
 - Educating the client about treatment

You Are Using MI If You:

- Talk less than your client does
- On average, reflect twice for each question
- Reflect with complex reflections more than half the time
- Ask mostly open ended questions
- Avoid getting ahead of your client's stage of readiness (warning, confronting, giving unwelcome advice, taking "good" side of the argument)

Screening and Assessing Children and Youth for COD

What can be determined through the screening and assessment process?

- The interplay between the substance use and the mental health problem
- The degree to which each disorder interferes functioning and is situational or social
- The frequency, intensity and duration of use and associated diagnosis (i.e., substance abuse or dependence)

THESE DETERMINATIONS TAKE TIME

Substance Use that Interferes with Childhood Development

- There are clear criterion to diagnose the disorders ordinarily found in childhood. None require a substance use rule out
- Frequency, intensity and duration and age of onset of symptoms are linked with specific disorders
- There is no **clear frequency, intensity and duration** of child substance use that interferes with childhood development according to the DSM IVR
- The Criterion for substance abuse and dependence were developed with an adult, not child, bias

Collision of Symptomology

- Differential Diagnosis is essential for accurate assessment. Is the presenting problem affected by a medical condition or substance?
 - Is it depression/dysthymic disorder **or** alcohol, marijuana, inhalants use?
 - Is it ADHD **or** is it methamphetamine/crack/cocaine use?
 - Is it oppositional defiant/conduct disorder **or** substance use?
 - Is it a disruptive behavior disorder **or** methamphetamine use?

'The Secret in the Pocket'



- Please write down one personal experience, that you have determined to keep to yourself. This can be an experience or character flaw that you are NOT proud of. YOUR SECRET.
- A word or phrase that will help identify this experience to you and you alone.

YOU WILL NOT BE ASKED TO SHARE THIS OR SHOW THIS TO ANYONE.

Appreciating the 'difficult to tell....'

Before we begin to ask questions, we need to:

- understand and appreciate the DIFFICULT process of sharing what is considered personal and private
- understand the processes whereby individuals communicate 'family secrets' and information to strangers

We need to review what we see as healthy, intrapersonal **non-disclosure** versus unhealthy, self destructive **secret-keeping**



Tasks of Mental Health Clinician:

- Our responsibility is to provide the best, most **comprehensive assessment and treatment** for clients
- This requires a **complete** and **thorough** assessment
- **Balance timeframes** between completing necessary forms and County paperwork and providing Evidence Based Practice
- Families who struggle with children and/or youth **need an ally** who has a complete understanding of the problem
- Services must move at the **pace set by the youth and their family**

When do I bring up ‘the topic’

- Meet with the family and review the limits of confidentiality
- Ensure that sufficient rapport has been established with the child and family
- Embed questions about substance use into the overall assessment
- Completing paperwork and broaching specific topics may be two different events
- Using the Substance Use Screeners ensures that the topic will be raised during intake

Integrating the Assessment and Screening Tools with Intake Documentation

- Using the DMH Intake Assessment Form we obtain information regarding:
 - Presenting Problem—Symptoms
 - History of substance use
 - Family History—prenatal exposure
 - Current or past use and treatment history

Integrated Screening, Assessment, and Brief Intervention

In a non-judgmental atmosphere people are more apt to be truthful.

- Building rapport is extremely important.
- How does the family, youth present?
- Have you done enough today?

The COJAC* Screening Tool

- **Simple** tool to determine if a problem might exist in each of the key areas:
 - Mental Health
 - Addiction
 - Trauma

* Co-Occurring Joint Action Policy Council (COJAC) Workgroup

See COJAC form on Next Page

Co-Occurring Disorders Screening Instrument

Step 1 – Ask the Primary Screening Questions

3 Questions for Mental Health:

- Have you ever been worried about how you are thinking, feeling, or acting?
- Has anyone ever expressed concerns about how you were thinking, feeling, or acting?
- Have you ever harmed yourself or thought about harming yourself?

3 Questions for Alcohol & Drug Use (Health Canada Best Practice Report):

- Have you ever had any problem related to your use of alcohol or other drugs?
- Has a relative, friend, doctor, or other health worker been concerned about your drinking or other drug use or suggested cutting down?
- Have you ever said to another person, “No, I don’t have (an alcohol or a drug) problem,” when around the same time you questioned yourself and felt, maybe I do have a problem?

3 Questions for Trauma/Domestic Violence:

- Have you ever been in a relationship where your partner has pushed or slapped you?
- Before you were 13, was there any time when you were punched, kicked, choked, or received a more serious physical punishment from a parent or other adult?
- Before you were 13, did anyone ever touch you in a sexual way or make you touch them when you did not want to?

Step 2 – If participant answers two questions Yes (1 mental health and 1 substance abuse or 1 substance abuse and 1 trauma), complete:

- Complete appropriate DMH Screening forms for COD

Adapted from Collaborative Care Project, Canada and Co-Morbidity Screen, Boston Consortium.

Integrated Screening, Assessment, and Brief Intervention

LADMH Tools to assist in the screening and assessment process

- There are two DMH screening tools:
 - Parent/Caregiver Questionnaire (MH 552): given to all parents and caregivers to complete.
 - The Child/adolescent Substance Use Self Assessment (MH 554): self report by youth 11 and above and by discretion of the therapist, verbally administered to youth under 11 or to those who cannot read.

THESE ASSESSMENT INSTRUMENTS MUST BE GIVEN AS PART OF THE INTAKE PROCESS AND AN INITIAL 'X' and 'U' CODE IS NEEDED FOR THE FACE SHEET

Parent/Caregiver Questionnaire (MH 552):

- Screening for substance use risk factors
- Asks directly about substance use
- Given to all parents and caregivers to complete

The Child/Adolescent Substance Use Self Assessment (MH 554)

- Any 'Yes' answer will lead to the need for a further assessment.

Integrated Screening, Assessment, and Brief Intervention

MH552
Revised 3/03

PARENT/CAREGIVER QUESTIONNAIRE

Child/Adolescent Drug and Alcohol Use (To be completed by parent/caregiver)

Date Completed: _____

Parent/Caregiver Name: _____ Relationship to Child: _____

Please include tobacco as a drug.

1. Have you ever spoken to your child about the use of alcohol or drugs? YES NO
2. Have you ever suspected that your child may use alcohol or drugs? YES NO
3. Would you recognize the symptoms of drug/alcohol use? YES NO
4. Have you ever caught your child using or under the influence of alcohol or drugs (cigarettes included)? YES NO
5. Has your child ever left school to use alcohol or drugs? YES NO
6. Does your child hang out with a group of friends who use drugs or alcohol? YES NO
7. Has your child ever stayed out all night without calling? YES NO
8. Does your child ever miss classes or days of school without permission? YES NO
9. Does your child make frequent references or jokes about alcohol or drugs? YES NO
10. Does your child wear t-shirts or other clothes that have logos with references to alcohol or drug use? YES NO
11. Has your child's school performance declined recently? YES NO
12. Has your child's weight or eating habits changed recently? YES NO
13. Has your child become more irritable, depressed, or withdrawn recently? YES NO
14. What substances has your child tried?
15. What drugs/alcohol does your child use most often? (List and describe frequency of use.)
16. Have you ever wondered if your child might have problems with alcohol and/or other drugs?
WHY or WHY NOT?

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Name: _____ MIS #: _____
Agency: _____ Prov.#: _____

Los Angeles County - Department of Mental Health

PARENT/CAREGIVER QUESTIONNAIRE

Integrated Screening, Assessment, and Brief Intervention

MH554
Revised 3/03

CHILD/ADOLESCENT SUBSTANCE USE SELF EVALUATION

Administer to all children 11 years or older. Clinician's judgment as to whether or not it is clinically appropriate to administer when child is less than 11 years old. May be administered verbally by clinician or completed in writing by the child.

Date Completed: _____ Date of Birth: _____ Sex: F M

Please mark YES or NO to the following questions:

1. Do you smoke cigarettes? YES NO
2. a. Do you currently use alcohol, marijuana, inhalants or other drugs? YES NO
b. Have you ever used alcohol, marijuana, inhalants or other drugs? YES NO
3. Do you use alcohol or drugs on weekends with friends? YES NO
4. Do you use alcohol or drugs when you are alone? YES NO
5. Have your parents ever caught you using alcohol or drugs? YES NO
6. Have you ever left school to use alcohol or drugs? YES NO
7. Have you ever been under the influence of alcohol or drugs while at school or work? YES NO
8. Have you ever woken up and not remembered any of or only a portion of the previous night's events after using drugs or alcohol? YES NO
9. Have you ever driven a car or motorcycle while under the influence of drugs or alcohol? YES NO
10. Have you ever had more alcohol or drugs than planned? YES NO
11. Have you ever felt the need to cut down or stop completely your use of drugs or alcohol? YES NO
12. Have friends ever suggested you might have an alcohol or drug problem? YES NO
13. Has anyone ever sought professional help for you due to your use of drugs or alcohol? YES NO
14. Have you ever lost a boyfriend / girlfriend / close friend because of your alcohol or drug use? YES NO
15. Are you using more alcohol or drugs than you used to? YES NO

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Name: _____ MIS #: _____
Agency: _____ Prov.#: _____

Los Angeles County - Department of Mental Health

CHILD/ADOLESCENT SUBSTANCE USE SELF EVALUATION

When the Screen Indicates the Need for Assessment

- The assessment does not need to be completed until:
 - the **clinician has met with the family**
 - **rapport** has been built
 - the clinician has reasonable assurance that **accurate information** will be obtained

Prior to an Assessment, how do I raise the questions of substance use with children?

- Discussion of school and social functioning often provide openings to INTRODUCE the issue of substance use.
- Many children and adolescents will provide more information if interviewed alone.
- Begin by asking the child/adolescent general, open ended questions, questions regarding attitudes towards drug and alcohol use at school, among peers, and within the family.
- Then proceed to more specific questions about the individual's use.

Considerations when working with Young Children

- **Do not assume** that a child has no experience or knowledge of substances based on age.
- For school aged children under 11 years of age, initial questions might focus on their **knowledge base** or **exposure** and then proceed to questions regarding their own use.

Integrated Screening, Assessment, and Brief Intervention

Exercise 1: Interviewing a 7 year old

- Look at Case 1 (Tony) below.
- Please form pairs with one person playing the part of the child and the other, the therapist.
- The therapist is to interview the child to assess if there is any substance use and to what extent the use interferes with functioning.

Case 1: Tony

Tony is a 7 year old boy who is being raised by a single mom and maternal grandmother. Tony has met all of the usual developmental milestones up to age 4. When Tony turned 5 he began to act out aggressively toward two of his siblings; Mary 2 years older, Tom 1 year younger, and other age mates. His mom thought he may be ADHD as did his 2nd grade teacher. His grandmother indicates that he is “just a sensitive boy.”

Tony’s mom is alcohol dependent and an older brother, age 16, smokes marijuana and drinks alcohol weekly with friends in the home.

What are the first 3 questions you would ask Tony regarding his experience with substance use?

If Tony indicates that his older brother has given him some alcohol and lets him “take a puff” on a joint occasionally, what are your 2 follow-up questions?

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Integrated Screening, Assessment, and Brief Intervention

Exercise 2: Interviewing a 10 year old

- Look at Case 2 (Jessica) below.
- Please form pairs with one person playing the part of the child and the other, the therapist.
- The therapist is to interview the child (using form 554 and your best MI skills) to assess if there is any substance use and to what extent the use interferes with functioning.
- Be sure to introduce the topic before diving into the form

Case 2: Jessica

Jessica is a 10 year old who lives with her parents and younger brother. When Jessica was 9, her teacher reported that she often expressed sexually inappropriate behavior toward classmates and had poor impulse control.

Jessica's father, while currently living in the home, has been in and out of jail for the past 10 years on drug-related crimes and domestic violence charges. Her father is currently unemployed and her mother works full-time as a bus driver.

Integrated Screening, Assessment, and Brief Intervention

Sample questions for discussion with child under 11 years old:

1. Has anyone ever talked to you about alcohol and drugs? Who?
2. What did they say?
3. What do you think about it - about what they said?
4. Do kids at school ever talk about smoking, drinking, drugs, using inhalants (may have to describe inhalant use specifically)?
5. Have you ever seen kids at school or older kids smoking, drinking, or using drugs?

Sample questions for discussion with child under 11 years old:

6. What do you think about kids who smoke? Drink? Use drugs?
7. Does anyone in your family use alcohol or drugs? Brothers or sisters?
8. Has anyone ever let you try cigarettes or alcohol?
9. What have you tried?
10. Has anyone ever told you not to talk about it – to keep it a secret – that you used or that they used?

Introducing the Topic of Substance Use to Pre-Adolescents and Adolescents (age 11 +)

- Initial questions may be focused on their **exposure and experiences at school and with peers**
- Wording and pacing of the **questions** should be **tailored** to fit the responses of the child/adolescent and not read verbatim or in a rote manner

Integrated Screening, Assessment, and Brief Intervention

Introducing the Topic of Substance Use to Pre-Adolescents and Adolescents (age 11 +)

- After rapport has been established, the screening can proceed on to more specific questions regarding **personal use history**
- Meet with the adolescent or **child alone**, with **caretaker(s) alone**, as well as with the **family together**
- Proceed slowly, matter-of-factly, and do not focus too quickly on substance use
 - Match the **adolescent's pace**; do not ask too many questions

What are Positive Indications at Intake or on the Screening Tools...

- If a child/adolescent indicates any substance use, or answers 'yes' to any screening questions...
- If the parent/caregiver indicates child's substance use...
- If school or legal system indicates knowledge of child/adolescent substance use...

A Substance Use Assessment is Indicated and Must be Completed in a 'Timely Manner'

Sample questions for discussion with young adolescent (11+ y.o.)

1. Tell me about drinking and drugs at your school (do not ask about the drug "problem" at the school as doing so may convey a judgmental attitude)
2. What do most teenagers at your school think about smoking cigarettes? Marijuana? Inhalants? Alcohol? Other Drugs?
3. How common is smoking cigarettes, drinking alcohol, inhalant use, or other drug use? OR How many students at school smoke, use alcohol, or drugs?

Integrated Screening, Assessment, and Brief Intervention

Sample questions for discussion with young adolescent (11+ y.o.)

4. How easy is it to buy or get marijuana and other drugs at school or in your neighborhood?
5. How easy is it to get alcohol and cigarettes?
6. How common is drug/alcohol use at parties or raves?
7. At home, what are your parents' attitudes regarding smoking, drinking, and drug use?

Exercise 3: Interviewing a Young Adolescent

- Look at Case 3 (Kevin) below.
- Please form pairs with one person playing the part of the child and the other, the therapist.
- The therapist is to interview the child (using form 554 and your best MI skills) to assess if there is any substance use and to what extent the use interferes with functioning.
- Be sure to introduce the topic before diving into the form

Case 3: Kevin

Kevin is a 15 year old living with his Dad, older brother (age 19), and his Dad's girlfriend.

Kevin maintained good grades until starting high school last year. After repeated truancies, he was transferred to the alternative high school where he has continued to let his grades slip, and has been caught with both alcohol and marijuana in his locker.

Kevin's Dad and his girlfriend are in recovery and don't allow drugs or alcohol in the home. His older brother regularly uses marijuana and has also experimented with heavier substances like psychedelic mushrooms, LSD and ecstasy.

Getting Information in a Timely Manner

- Most adolescents will acknowledge some level of knowledge of substance use at their school or among their peers
- If an adolescent denies any knowledge of substance use at school or among peers in response to general inquiries, the clinician should recognize that such denials typically signal a lack of comfort or trust in the assessment process
 - Delay further inquiry until greater rapport has been established and return to topic at a later session

When Screening leads to Assessment

- If substance use is reported proceed to the formal assessment of substance abuse.
-
- If client denies documented use—**STOP**...Gain a greater understanding of the lack of comfort or trust and return to screening and assessment when rapport is better.
- **Pacing is critical** as too many questions may result in the adolescent withdrawing.
- Conduct the assessment in a **matter-of-fact, non-judgmental** manner.

Child/Adolescent Substance Use Assessment (MH553)

- Remember that maintaining rapport is critical to getting good information
- Use your best MI interviewing Skills to assess the following

Integrated Screening, Assessment, and Brief Intervention

Completing the Assessment Form

Context of Use
When
With whom
How obtained

Perceived Benefits of Use

Negative Consequences of Use
School/work
Legal
Family/peer relationships

Attempts To Control Use
Personal Limits
Treatment (specify)

Response to Treatment

Clinician may not be able to assess this at time of Intake.
That's OK.

The Supplemental COD Assessment Checklist

Use this checklist:

- After substance use has been acknowledged and the child/youth is comfortable...
- After a connection between the presenting problem and substance use has been agreed upon
- To develop treatment goals and objectives

Integrated Screening, Assessment, and Brief Intervention

MH553
Revised 3/03

CHILD/ADOLESCENT SUBSTANCE USE ASSESSMENT

Clinician to verbally administer to child when drug use is reported by child, parent or other.

SUBSTANCE	AGE AT FIRST USE	NEVER	PAST USE 1 YR AGO OR MORE	# OF TIMES IN PAST YR.	# OF TIMES IN PAST MO.	# OF TIMES IN PAST WK.	DAILY	AMOUNT USED PER OCCASION
Caffeine, coffee								
Nicotine, cigarettes, chewing tobacco								
Alcohol, beer, wine								
Marijuana								
Cocaine or crack								
Inhalants (glue, paint, etc.)								
Amphetamines (crack, crystal, meth, ice, etc.)								
Ecstasy, MDMA, GHB, others								
Hallucinogens (LSD, mushrooms, peyote, etc.)								
Tranquilizers (Xanax, Valium, Ativan, etc.)								
PCP								
Over the counter medications								
Opiates (i.e., heroin/pain meds)								
Prescription								
Other								

<p>Context of Use When With whom How obtained</p> <p>Perceived Benefits of Use</p> <p>Negative Consequences of Use School/work Legal Family/peer relationships</p> <p>Attempts To Control Use Personal Limits Treatment (specify)</p> <p>Response to Treatment</p>	
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Describe interaction of substance use with mental health DSM diagnostic condition.

Was mental health DSM condition present prior to regular drug/alcohol use? Yes No Unknown

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CHILD/ADOLESCENT SUBSTANCE USE ASSESSMENT

Assessing Risk Factors

Factors affecting risk for involvement with substance use

Assessing Family Risk Factors

- Parental substance abuse
- Favorable parent beliefs and attitudes regarding use
- Lack of closeness or bonding with the parents
- Lack of parental involvement
- Lack of appropriate supervision and limits

Assessing Peer Risk Factors

- Friends who use
- Positive peer attitudes regarding substance use
- Peer involvement in delinquent or antisocial behavior
- An orientation toward peer values over parent values

Assessing Individual Risk Factors

- Favorable attitudes towards the use of substances
- Emotional/behavioral problems, especially early disruptive or risk-taking behaviors
- Early age of onset of substance use
- Gender: Males more likely to abuse substances than females
- Genetics: Family history of substance abuse
- History of sexual/physical abuse
- Trauma/displacement

Assessing Socio-Cultural Risk Factors

- Prevailing norms and laws
- Extreme economic deprivation
- Deterioration of the neighborhood
- High crime rate/ "culture of violence"
- Degree of acculturation

Assessing School Risk Factors

- Poor school performance and school failure
- Lack of connectedness to school
- Truancy
- Placement in a special education class
- Dropping out of school

Exercise 4: Roberto

- Roberto answered yes to 4 Screening questions: Numbers 1, 4, 5, and 14
- His mother answered yes to all questions on the Parent Questionnaire

**With your exercise partner
please indicate the first 2 things
you are going to do**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Really Brief Intervention Basics



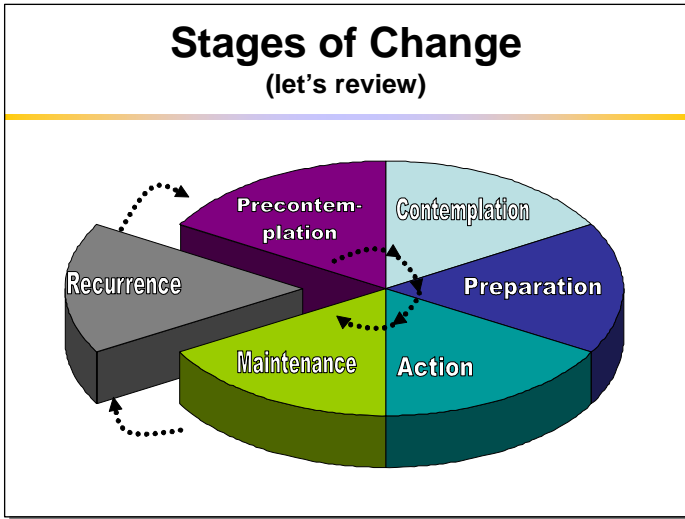
Rationale for Brief Intervention

- When working with young children, parental involvement is critical to the treatment
- Parents who have COD require help to
 - Identify the nature of the problems that they face
 - Participate in interventions to help themselves and their family (collateral interventions)
 - Accept referral for more intensive treatment of these problems

Brief Intervention

- What are the ingredients of successful brief interventions?
 - Include **feedback** of personal risk and advice to change
 - Offer a **menu** of change options
 - Place the **responsibility** to change on the patient
 - Based on a **Motivational Interviewing**, or counseling style, and typically incorporate the **Stages of Change Model**

Integrated Screening, Assessment, and Brief Intervention



Stages of Change

- Recognizing the need to change and understanding how to change doesn't usually happen all at once. It takes time and patience.
- People go through a series of "stages" as they begin to recognize that they have a problem.

Helping People Change

Helping people change involves:

- increasing their awareness of their need to change
- helping them begin to move through the stages of change
 - Start "where the client is"
 - Positive approaches are more effective than confrontation

Helping People Change

- Motivational Interviewing is the process of helping people move through the stages of change



An Important MI Skill When Conducting Brief Interventions

Forming Reflections

Adapted from Exercise
By
Bill Miller

Forming Reflections Purpose

To help participants learn how to form effective reflective-listening statements

Forming Reflections Instructions

- Listener is making a guess at what the speaker means and offers it for a response.
- Reflection has to be in the form of a *statement* rather than a question. (Voice turns down, not up at the end of the reflection)
- Discuss why statements work better than questions as reflections.

Forming Reflections Divide into groups of three

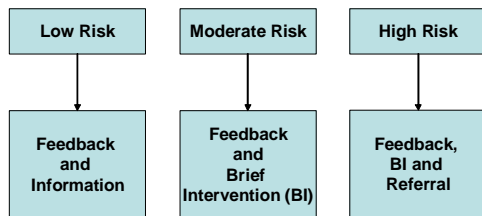
- Participants in each triad take turns being the speaker. The other two people listen and offer reflections.
 - Some helpful stems to making reflections are:
 - So you feel
 - It sounds like you
 - You're wondering if
- The speaker responds to each statement with elaboration.

Forming Reflections Debriefing

- How did the speakers feel in this exercise?
- How easy was it to generate reflections?
- What problems did you have?
(Reminder: No MI interview will ever consist of only reflections. A good ratio to aim for is at least one reflection for every 3 questions.)

Learning to Conduct the Brief Intervention

Link Screening/Assessment Results to the Appropriate Intervention



How is the BI conducted?

- **FEEDBACK:** use screening/assessment forms
- **ADVICE**
- **RESPONSIBILITY**
- **CONCERN** (level of substance use/mental health sx's)
- **GOOD THINGS ABOUT USING**
- **NOT-SO-GOOD THINGS ABOUT USING**
- **SUMMARIZE**
- **CONCERN** (about not-so-good things)
- **TAKE-HOME INFORMATION**

Source: Humeniuk, 2005

Provide Feedback

- Use the screening/assessment forms to provide patient feedback

“I’d like to share with you the results of the questionnaire you just completed. Your answers to these questions about alcohol and drug use indicate that your risk of having problems related to your use are low/moderate/high.”

(Show the client their forms to demonstrate the results)

Offer Advice

- *“The best way to reduce your risk of alcohol related harm is to cut back on your use, that is reduce the behavior that is putting you at risk.”*
- Educate patient about sensible drinking limits based on NIAAA recommendations
 - no more than 14 drinks/week for men (2/day)
 - no more than 7 drinks/week for women and people 65+ yrs (1/day)

Source: McGree, 2005

Place Responsibility for Change on Patient

- *“What you do with the information is up to you. I’m here to assist you if you’d like help cutting back on your use. I can help you explore strategies to change how much you are using or refer you for additional assistance if you have problems meeting your goals”*

Elicit Patient Concern

- *“What are your thoughts about your screening results, particularly the one for alcohol?”*

(Take note of patient’s **“change talk”**)

Source: McGree, 2005

Coax Patient to Weigh the Benefits and Costs of At-Risk Use

- *“What are some of the good things about using for you personally?”*
- *“What are some of the not-so-good things?”*
- *“What are some of your concerns about these not-so-good things?”*

Source: McGree, 2005

Summarize

- Summarize by developing a discrepancy:
“OK, so on the one hand, you’ve mentioned a lot of good things about getting drunk – you have a great time at parties, you’re not so inhibited around your friends – everyone thinks you’re the life of the party. But on the other hand, you’ve missed a lot of class time, your grades are suffering, and school is very important to you.”

Source: McGree, 2005

Offer Self-Help Information/Brochures and Assistance in Cutting Back

"I can give you some information about cutting back on your drinking. If you'd like to make a plan for cutting back or stopping, I'm here to help you."

(If patient seems interested, discuss self-help strategies with him/her)

Source: McGree, 2005

Making Referrals

- Be prepared to make referrals for further assessment and treatment
 - Giving a phone number isn't enough
 - Become familiar with local community resources
 - Take proactive role in learning about the availability of appointments or treatment slots, costs, transportation, and get names of contacts at the agencies

Source: SAMHSA, 1994

Making Referrals

- Making contact with an assessment/treatment agency to set up an appointment may constitute a "client-identifying disclosure"
 - Need to be aware of laws and regulations about communicating client information
 - Need written consent from clients
 - Need to be aware of laws regarding minors

Source: SAMHSA, 1994

Encourage Follow-Up Visits

At follow-up visit:

- Inquire about use
- Review goals and progress
- Reinforce and motivate
- Review tips for progress

Source: "Cutting Back" 1998 Univ. of Connecticut Health Center

Activity: Role-Play with Brief Intervention

- Practice BI with a partner
- One person be the clinician
- The other person play the client
- Group Discussion



20 minutes

Next Steps

- Implementation
 - Practice skills with your clients
 - Use COD Project resources for consultation and assistance
- More Training
 - Treating trauma in clients with COD
 - Schedule for June and July 2008
- Continued implementation of old and new skills with help from COD Project Resources

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