

SBIRT Provider
Training
Handouts

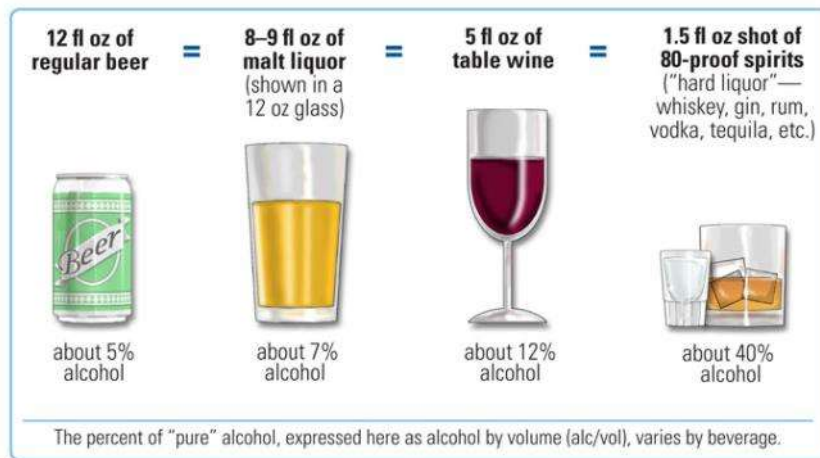
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Alcohol Use Disorders Identification Test (AUDIT)

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

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



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

PROVIDER USE ONLY				Total
I	II	III	IV	
0-7	8-15	16-19	20+	

(For the clinician or behavioralist)

Scoring and interpreting the AUDIT:

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.
2. The total score correlates with a zone of use, which can be circled on the bottom left corner.

Score*	Zone	Action
0-7	I – Low Risk	Education
8-15	II – Risky	Brief intervention
16-19	III – Harmful	Brief treatment
20+	IV – Dependent	Referral to treatment

Education: An opportunity to educate patients about low-risk consumption levels and the risks of excessive alcohol use.

Brief intervention: Patient-centered discussion that uses Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhancing his/her motivation towards behavioral change. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended behavior change is to cut back to low-risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Brief treatment

Patients with numerous or serious negative consequences from their drinking, or patients with likely dependence who cannot or will not obtain conventional specialized treatment, should receive more numerous and intensive interventions with follow up.

Referral to treatment: A proactive process that facilitates access to specialized care for individuals who have been assessed to have substance use dependence. These patients are referred to alcohol and drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

Drug Screening Questionnaire (DAST)

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

Patient name: _____

Date of birth: _____

Which of the following drugs have you used in the past year?

- methamphetamines (speed, crystal) cocaine
 cannabis (marijuana, pot) narcotics (heroin, oxycodone, methadone, etc.)
 inhalants (paint thinner, aerosol, glue) hallucinogens (LSD, mushrooms)
 tranquilizers (valium) other _____

How often have you used these drugs? Monthly or less Weekly Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes

0

1

Have you ever injected drugs? Never Yes, in the past 90 days Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? Never Currently In the past

I II III IV
 0 1-2 3-5 6+

(For the provider or behavioral health specialist)

Scoring and interpreting the DAST:

“Yes” responses are one point, “No” responses are zero points. All responses are added for a total score and correlated with a zone of use, which can be circled on the bottom right corner.

Score	Zone of use	Action
0	I – Healthy	Encouragement and Education
1 - 2, plus: <ul style="list-style-type: none"> • No daily use of any substance • No weekly use of opioids, cocaine, or methamphetamine. • No injection drug use in the past three months. • Not currently in Drug Abuse Treatment. 	<ul style="list-style-type: none"> • Offer advice on benefits and importance of remaining drug abstinent. • Monitor and reassess at next visit. • Consider providing educational materials. 	
1 - 2 (without meeting criteria above)		II - Risky
3 - 5	III - Harmful	Brief treatment
6+	IV - Dependent	Referral to treatment

Brief intervention: Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual’s awareness of his/her substance use and enhancing his/her motivation towards behavioral change. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as screening. The recommended behavior change is to abstain from illicit drug use.

Brief treatment

Patients with numerous or serious negative consequences from their substance use, or patients with likely dependence who cannot or will not obtain conventional specialized treatment, should receive more numerous and intensive interventions with follow up.

Referral to treatment: A proactive process that facilitates access to specialized care for individuals who have been assessed to have substance use dependence. These patients are referred to drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

The CRAFFT Screening Interview

Begin: “I’m going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential.”

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any <u>alcohol</u> (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Smoke any <u>marijuana or hashish</u> ?	<input type="checkbox"/>	<input type="checkbox"/>
3. Use <u>anything else</u> to <u>get high</u> ? (“anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”)	<input type="checkbox"/>	<input type="checkbox"/>

For clinic use only: Did the patient answer “yes” to any questions in Part A?

No



Ask CAR question only, then stop

Yes



Ask all 6 CRAFFT questions

Part B

	No	Yes
1. Have you ever ridden in a <u>CAR</u> driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever use alcohol or drugs to <u>RELAX</u> , feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you ever use alcohol or drugs while you are by yourself, or <u>ALONE</u> ?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you ever <u>FORGET</u> things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do your <u>FAMILY</u> or <u>FRIENDS</u> ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever gotten into <u>TROUBLE</u> while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

CONFIDENTIALITY NOTICE:

The information recorded on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient for this purpose.

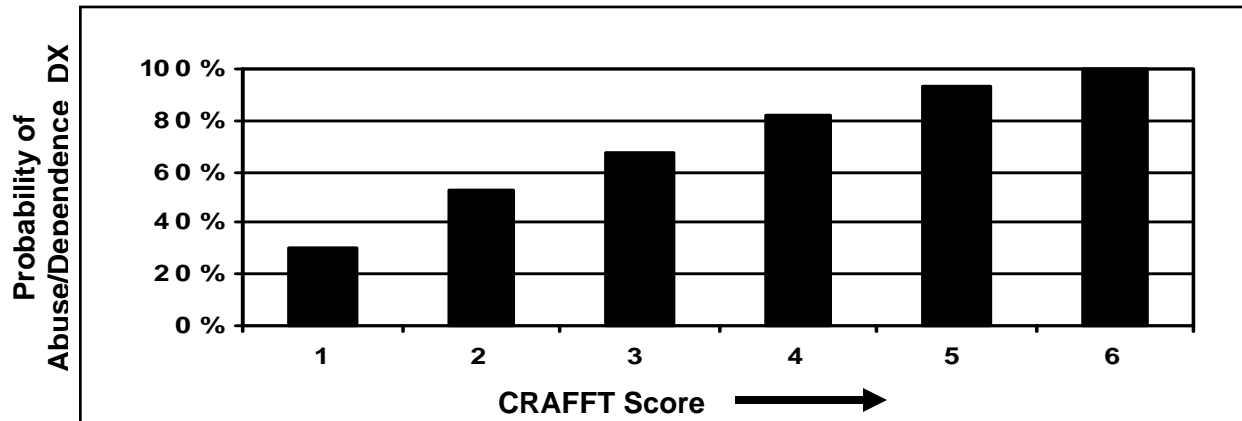
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SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY

CRAFFT Scoring: Each “yes” response in **Part B** scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score^{1,2}



DSM-IV Diagnostic Criteria³ (Abbreviated)

Substance Abuse (1 or more of the following):

- Use causes failure to fulfill obligations at work, school, or home
- Recurrent use in hazardous situations (e.g. driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):

- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

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References:

1. Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153(6):591-6.
2. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. Arch Pediatr Adolesc Med 2002;156(6):607-14.
3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision. Washington DC, American Psychiatric Association, 2000.

SBIRT Step-by-Step

4 Phases of SBIRT


PHASE 1: ESTABLISH RAPPORT
ASSURE CONFIDENTIALITY
ADMINISTER ASSESSMENTS



PHASE 2: ELICIT THOUGHTS & PROVIDE FEEDBACK
EXPLORE PROS AND CONS
PROVIDE EDUCATION



PHASE 3: ENHANCE MOTIVATION
ASSESS READINESS TO CHANGE
RESOLVE AMBIVALENCE AND INCREASE MOTIVATION



PHASE 4: NEGOTIATE A PLAN
SUMMARIZE SESSION
INVITE THEM BACK

THE PHASES OF SBIRT

Example of a SBIRT Conversation

Phase 1

ESTABLISH RAPPORT AND ADMINISTER ASSESSMENTS

Hello Mr. /Mrs. /Ms. (*last name or other formal name*). My name is

I am part of your care team here at _____. We are now talking to each patient, no matter why they are here, about their alcohol and drug use, and about depression. We know that these things can have a significant impact on your health, and we care about your health. Is it all right if I ask you some questions?

Assure confidentiality

Everything you tell me is completely confidential and will be shared only with your health care providers here at this clinic. Do you have any questions or concerns?

Administer assessments

Phase 2

ELICIT THEIR THOUGHTS PROVIDE FEEDBACK AND EDUCATION

Discuss results

Your responses to these questions go along with what you've told me. Your scores indicate that you are (summarize the results). What are your thoughts about this?

Explore the pros and cons and develop discrepancy

What are the good things for you about X? (... is there anything else?)

What are the not-so-good things about X? (... anything else?)

So on the one hand..... and on the other hand....

What do you know about the way _____(substance) effects your body?

What concerns related to your health do you have when you think about the effects?

Sounds like you already know how _____ causes _____. (Expand their statement and perhaps add if it applies).

Would it be ok with you if I shared some information with you about how (*specific substance use*) can affect your ... (*i.e., whatever is relevant to the patient, e.g., mood, breathing, diabetes, etc*).

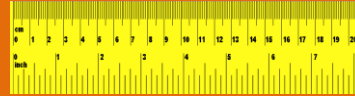
Determine how much health information/education will help motivate the person given their stage of change, e.g., for pre-contemplation or contemplation stages, patients may benefit from a more general and brief presentation of risk; use of brochures may or may not be appropriate at this point.

Any thoughts? Concerns? Any particular area that you see that relates to you or your life right now?

Phase 3

ASSESS AND ENHANCE MOTIVATION USING THE

READINESS RULER



Show the Readiness Ruler

On a scale from 0 to 10, with 0 being not at all ready to change and 10 being very ready to change, how ready are you to make any change at all (even a small one) in your substance use?

What motivates patient and what are the barriers?

Why that number and not XX (*lower number*)? (Change talk)

Why that number and not XX (*higher number*)? (Barriers for change)

So on the one hand A and on the other hand B... (E.g., “So on the one hand alcohol relaxes you at night, but on the other hand it makes it hard for you to get up on time in the morning. Do I have that right?”)

Explore patient’s ideas about implementing change

What steps, if any, might you take from here?

If patient is not interested in changing (pre-contemplator), increase perception of risk and problems with current behavior.

If I understand you correctly, you know the health risks and the problems it causes, but you’ve decided to take your chances and stick with what you are doing for now. That’s fine-- it’s your choice. I just want to be sure you have all the information you need to make decisions.

Is there anything you can think of that might come up or change in the future that would make you want to make a change?

Is there a down-side to having things stay the way they are?

Validate that patient isn’t ready to change and acknowledge their control of the decision.

I hear you saying that you are nowhere near ready to change. You are the one to decide if and when you are ready to make a change.

If patient is aware that a problem exists and is considering action, but has not yet made a commitment to change (Contemplator):

So it sounds like you are having some problems with ... and (*say negative effects of it*) and you think that if.... (you changed something) things might improve. Is that right?

Gather information about past change attempts, and frame in terms of some success rather than failure. Affirm the patient's attempt to change.

Have you ever tried to change in the past? What did you do? What was helpful? So, despite the challenges, you took action and (summarize patient's attempt and what worked).

Build on past success/effort and explore additional options for change.

What would you like to have happen now?

What might you do differently now?

Phase 4

NEGOTIATE A PLAN, SUMMARIZE AND END ON A POSITIVE NOTE

If patient is ready to make a change (Preparation), praise the decision to change behavior! Assist patient in building an action plan. Examine barriers and elicit solutions. Build coping behaviors

Is there one thing you might be willing to change right now?

How do you plan to do that?

TIPS for Setting Goals

Can you think of one thing you could do to make a change in the next month?

Never mind the "how" for right now. What would you like to achieve?

So what do you intend to do?

What strengths do you have that will help you succeed?

Who could offer you helpful support in making this change?

How confident are you that you can make this change?

Do you see any barriers to making this change? What are they? What can you do to overcome them?

What will happen if you slip up?

Can you write it down here in your own words? (Hand them an informational brochure-- on the back is a space to write a goal/plan)

For patients whose AUDIT and/or DAST results indicate a BT or RT:

BT

We offer counseling services here at our clinic that may help you achieve the changes you want to make. You can meet with me at no cost, or with one of our clinic counselors. What do you think?

RT

Given everything we've discussed, I think it would be helpful for you to take advantage of a program that specializes in What do you think?

Emphasize door is always open

Thank you for talking with me today. I appreciate your time, and your honesty in talking with me. Please let me know if there is anything I can do in the future to help you in any way. The door is always open to talk with me or your health care staff.







Low Risk Drinking Limits



WE ASK EVERYONE.

Women 	In a Single Day  No more than drinks per day 3	Per Week  No more than drinks per week 7
Men 	In a Single Day  No more than drinks per day 4	Per Week  No more than drinks per week 14

One Standard Drink

-  12 fl. oz. regular beer
-  8-9 fl. oz. malt liquor (shown in 12 oz. glass)
-  5 fl. oz. table wine
-  1.5 fl. oz. shot of 80-proof spirits (liquor)

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Thinking About Change

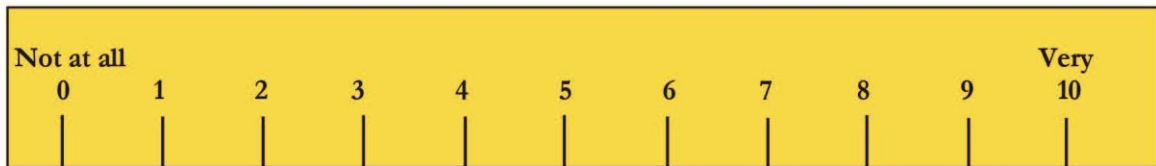
What change(s) are you considering?

How important is it that you make this change?

How confident are you that you are able to make this change?

How ready are you to make this change?

Readiness Ruler



SBIRT Scenarios

This section offers 7 patient/client scenarios that are intended for practicing SBIRT conversations. Each scenario includes a description of the patient/client, along with completed pre-screen questions and full screenings.

Scenario 1: Low Risk Alcohol Use

Scenario 2: Moderate Risk Alcohol Use

Scenario 3: High Risk Alcohol Use

Scenario 4: High Risk Alcohol Use

Scenario 5: Moderate Risk Alcohol Use- Adolescent

Scenario 6: Moderate Risk Drug Use

Scenario 7: High Risk Drug Use

Scenario 1

Ben is a 34 year-old male who has a steady job. He enjoys spending time with his two young children and his wife. They often go to family-friendly locations, such as the park or arcades. Every Sunday during football season, their friends come by to watch their favorite team play. This is usually the only time during the week when Ben will drink, so he doesn't worry about drinking too much. If his team isn't doing well or the game goes into overtime, it is not unusual for him to have five or six beers in one sitting. When Ben's team loses, he tends to have a headache the next morning, but he still follows his normal routine. After taking the AUDIT, Ben scored a 5.

SBIRT INTAKE AND PRE-ASSESSMENT QUESTIONNAIRE

PRESCREENING	Question #1: ALCOHOL USE
	MEN: How many times in the PAST 12 MONTHS have you had 5 or more drinks in a day? <u>5</u> (Write # of days of 5 or more drinks)
	WOMEN: How many times in the PAST 12 MONTHS have you had 4 or more drinks in a day? _____ (Write # of days of 4 or more drinks)
	Question #2: SUBSTANCE USE
	How many times in the PAST 12 MONTHS have you used an illegal drug or used a prescription drug for nonmedical reasons? <u>0</u> (Write # of times)


- Zone I- Low Risk
- Education, Raise Awareness, and Affirm Positive Behaviors

Alcohol screening questionnaire (AUDIT)


Drinking alcohol can affect your health and some medications you may take.

Please help us provide you with the best medical care by answering the questions below.


One drink equals:



12 oz.
beer



5 oz.
wine



1.5 oz.
liquor
(one shot)

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

0 1 2 3 4

I II III IV
0-7 8-15 16-19 20+

Scenario 2

Lilly is a 45 year-old woman who is recently divorced. She doesn't have any children, so most weekends, she goes out with her girlfriends to their favorite bar. While there, Lilly will usually have two or three mixed drinks. During the weeknights, Lilly will sometimes go out after work as well to try to meet new people, since it is lonely for her at her empty house. The next day, she sometimes has to come in late to work and regrets having that much to drink. On her AUDIT, Lilly scored a 10.

SBIRT INTAKE AND PRE-ASSESSMENT QUESTIONNAIRE

PRESCREENING	Question #1: ALCOHOL USE
	MEN: How many times in the PAST 12 MONTHS have you had 5 or more drinks in a day? _____ (Write # of days of 5 or more drinks)
	WOMEN: How many times in the PAST 12 MONTHS have you had 4 or more drinks in a day? <u>7</u> (Write # of days of 4 or more drinks)
	Question #2: SUBSTANCE USE
	How many times in the PAST 12 MONTHS have you used an illegal drug or used a prescription drug for nonmedical reasons? <u>0</u> (Write # of times)


- Zone II- Moderate Risk
- Brief Intervention

Alcohol screening questionnaire (AUDIT)


Drinking alcohol can affect your health and some medications you may take.

Please help us provide you with the best medical care by answering the questions below.


One drink equals:



12 oz.
beer



5 oz.
wine



1.5 oz.
liquor
(one shot)

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

I II III IV
 0-7 8-15 16-19 20+

Scenario 3

Carmen is a newly 21 year-old woman who really wants to enjoy her time in college. She is a Marketing major and is actively involved with many clubs on campus. Carmen and her friends go bar hopping several times per week and commonly stay out until 3 a.m. on Thursday and Friday nights. They typically start out with mixed drinks, but quickly switch to shots. Sometimes, Carmen doesn't remember what happened the next day, and she often ends up skipping her Friday morning class. On Saturday nights, Carmen always finds a good party to go to. Once there, she finds it difficult to stop drinking because there is so much alcohol available. After taking the AUDIT, Carmen scored a 16.

SBIRT INTAKE AND PRE-ASSESSMENT QUESTIONNAIRE

PRESCREENING	Question #1: ALCOHOL USE
	MEN: How many times in the PAST 12 MONTHS have you had 5 or more drinks in a day? _____ (Write # of days of 5 or more drinks)
	WOMEN: How many times in the PAST 12 MONTHS have you had 4 or more drinks in a day? <i>10</i> (Write # of days of 4 or more drinks)
	Question #2: SUBSTANCE USE
	How many times in the PAST 12 MONTHS have you used an illegal drug or used a prescription drug for nonmedical reasons? <i>0</i> (Write # of times)

- Zone III- High Risk
- Brief Treatment or Referral to Treatment

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take.

Please help us provide you with the best medical care by answering the questions below.

One drink equals:



12 oz.
beer



5 oz.
wine



1.5 oz.
liquor
(one shot)

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

0

1

2

3

4

I II III IV
0-7 8-15 16-19 20+

Scenario 4

Keith is a 29 year-old college drop-out who is working part-time until he can figure out a more permanent career. Keith is under a significant amount of pressure from his parents to get his act together. Keith's friends noticed that his parents ask him about his future and drinking habits a lot, so they invented a game: every time Keith's family refers to his future, they take a shot of vodka. His parents call almost every night, and he often can't stop drinking once he starts. Keith makes sure he isn't scheduled until the late morning or afternoon for work because he knows he will be hungover most mornings. Keith's recent AUDIT score was a 23.

SBIRT INTAKE AND PRE-ASSESSMENT QUESTIONNAIRE

PRESCREENING	Question #1: ALCOHOL USE
	MEN: How many times in the PAST 12 MONTHS have you had 5 or more drinks in a day? <u>50+</u> (Write # of days of 5 or more drinks)
	WOMEN: How many times in the PAST 12 MONTHS have you had 4 or more drinks in a day? _____ (Write # of days of 4 or more drinks)
	Question #2: SUBSTANCE USE
	How many times in the PAST 12 MONTHS have you used an illegal drug or used a prescription drug for nonmedical reasons? <u>0</u> (Write # of times)

- Zone IV- High Risk
- Referral to Treatment

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take.

Please help us provide you with the best medical care by answering the questions below.

One drink equals:



12 oz.
beer



5 oz.
wine



1.5 oz.
liquor
(one shot)

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

0

1

2

3

4

I II III IV

0-7 8-15 16-19 20+

Scenario 5

Alicia is a 16 year-old high school junior who is involved in several clubs and organizations at school, volunteers at her church, and takes several Advanced Placement classes. Her parents view her as the perfect daughter. However, Alicia is under a lot of stress to maintain her high GPA to get into a good college. A few months ago, her friends convinced her to go to a party, so she could have some fun for a change. While there, she had some beer and found that it helped her relax and minimize the pressure she was feeling. After that night, Alicia has been going out to parties much more frequently and has begun to consume larger amounts of alcohol.

- Score: 2
- Moderate Risk
- Brief Intervention

**Pre-screen questions are on the next page*

CRAFFT

We ask all our adolescent patients to complete this form at least once a year, because substance use and mood can affect your health. Please ask your doctor if you have any questions.

Your answers on this form will remain confidential.

Substance use:

In the last 12 months, did you:

	No		Yes	
Drink any alcohol (more than a few sips)?	<input type="checkbox"/>	}	<input checked="" type="checkbox"/>	}
Smoke, vape or eat any kind of marijuana?	<input checked="" type="checkbox"/>		<input type="checkbox"/>	
Use anything else to get high?	<input checked="" type="checkbox"/>		<input type="checkbox"/>	

If you answered No to all three questions, answer #1

If you answered Yes to any questions, answer questions

	No	Yes	
1. Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	←
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	←
3. Do you ever use alcohol or drugs while you are by yourself, or alone?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	←
4. Do you ever forget things you did while using alcohol or drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	←
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	←
6. Have you ever gotten into trouble while you were using alcohol or drugs?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	←

Scenario 6

Ruben is a 68 year-old grandfather who is on medication for his anxiety and high blood pressure. His wife recently passed away from a heart attack, and he is having trouble coping with the loss. They were married for 45 years and had two kids. Ruben loves it when his children and grandchildren can come and visit him, but it is sometimes difficult to be alone in his house once they leave. He occasionally takes an extra dose of his anxiety medication, Xanax (alprazolam), because it helps him feel better. Ruben knows that he should not take more medication than is prescribed and feels guilty after doing so. His DAST score was a 2.

SBIRT INTAKE AND PRE-ASSESSMENT QUESTIONNAIRE

PRESCREENING	Question #1: ALCOHOL USE
	<p>MEN: How many times in the PAST 12 MONTHS have you had 5 or more drinks in a day? <u> 0 </u> (Write # of days of 5 or more drinks)</p> <p>WOMEN: How many times in the PAST 12 MONTHS have you had 4 or more drinks in a day? <u> </u> (Write # of days of 4 or more drinks)</p>
	<p>Question #2: SUBSTANCE USE</p> <p>How many times in the PAST 12 MONTHS have you used an illegal drug or used a prescription drug for nonmedical reasons? <u> 12 </u> (Write # of times)</p>

- Zone II- Moderate Risk
- Brief Intervention

Drug Screening Questionnaire (DAST)

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

Which of the following drugs have you used in the past year?

- methamphetamines (speed, crystal) cocaine
 cannabis (marijuana, pot) narcotics (heroin, oxycodone, methadone, etc.)
 inhalants (paint thinner, aerosol, glue) hallucinogens (LSD, mushrooms)
 tranquilizers (valium) other _____

How often have you used these drugs? Monthly or less Weekly Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes

0

1

Have you ever injected drugs? Never Yes, in the past 90 days Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? Never Currently In the past

I II III IV
0 1-2 3-5 6+

Scenario 7

Beth is a 37 year-old single mom of a five-year-old son who works two part-time jobs to pay the bills. About six months ago at her day job in a factory, she strained her back. She was prescribed a muscle relaxer to help relieve the pain. Beth's back pain subsided a few months ago, but she keeps going back to the doctor to get more medication because she can't stop using and often has tremors if tries to stop. She also recently got prescribed an anti-anxiety medication since she is so worried about making ends meet. When Beth gets back from her night job, she immediately takes a muscle relaxer and some of her anti-anxiety medication; this sometimes causes her to be late for work the next day. Recently, there was an accident where her son hit his head and was bleeding for a couple of hours while Beth was asleep after taking the medication. Beth's parents threatened to fight for custody of him if she doesn't start taking care of him. Beth scored an 8 on the DAST.

SBIRT INTAKE AND PRE-ASSESSMENT QUESTIONNAIRE

PRESCREENING	Question #1: ALCOHOL USE
	MEN: How many times in the PAST 12 MONTHS have you had 5 or more drinks in a day? _____ (Write # of days of 5 or more drinks)
	WOMEN: How many times in the PAST 12 MONTHS have you had 4 or more drinks in a day? <u>0</u> (Write # of days of 4 or more drinks)
	Question #2: SUBSTANCE USE
	How many times in the PAST 12 MONTHS have you used an illegal drug or used a prescription drug for nonmedical reasons? <u>? Not sure</u> (Write # of times)

- Zone IV- High Risk
- Referral to Treatment

Drug Screening Questionnaire (DAST)

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

Which of the following drugs have you used in the past year?

- methamphetamines (speed, crystal) cocaine
 cannabis (marijuana, pot) narcotics (heroin, oxycodone, methadone, etc.)
 inhalants (paint thinner, aerosol, glue) hallucinogens (LSD, mushrooms)
 tranquilizers (valium) other Muscle Relaxers

How often have you used these drugs? Monthly or less Weekly Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes

0

1

Have you ever injected drugs? Never Yes, in the past 90 days Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? Never Currently In the past

I II III IV

0 1-2 3-5 6+

Did you know?

Mixing prescriptions with alcohol or over-the-counter drugs can be dangerous!

- It can cause a drop in heart rate and breathing
- It can increase risk of overdose and death

What to expect when cutting back or quitting your drinking:

- Your doctor or Behavioral Health Specialist can help you set up a plan.
- Change takes time.
- You will need support.
- You may have some withdrawal symptoms.
- Contact your doctor if you are having any medical concerns.

Where can I learn more?

www.drugabuse.org
www.nida.nih.gov

Something to try:

1. _____

 2. _____

Community Resources:

1. _____

 2. _____

Behavioral Health Specialist:

Phone number:



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Alcohol

IPRC Indiana Prevention Resource Center

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What is considered one drink?

One drink, or a standard drink, is the same as a beer, a shot of liquor, or a glass of wine if the amount poured is 12 ounces of beer, 1.5 ounces of liquor or 5 ounces of wine.



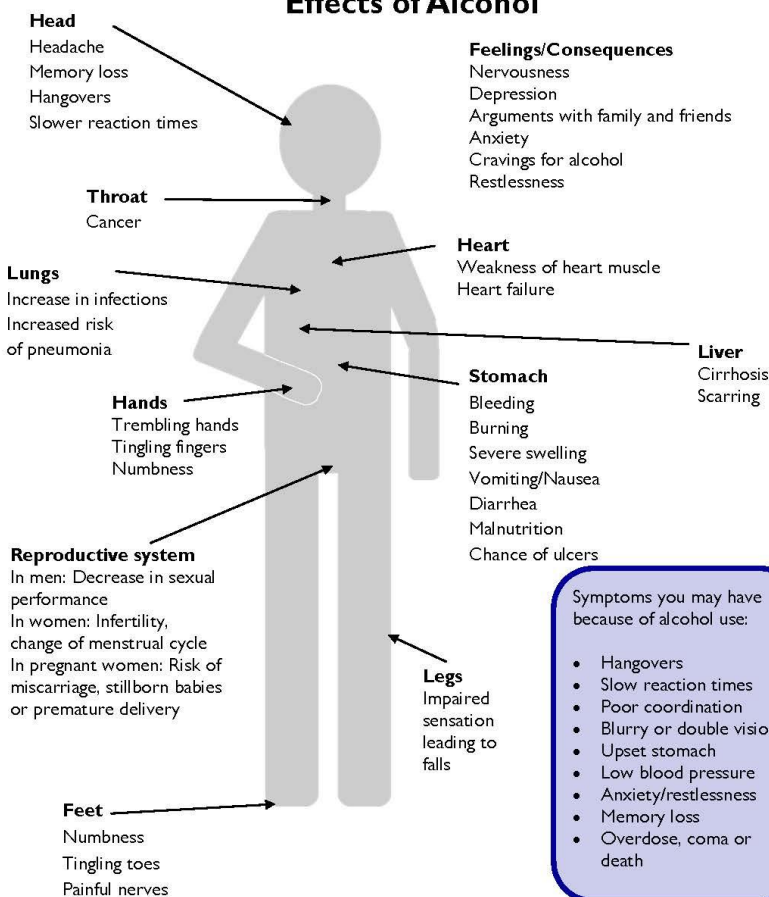
Follow this chart to keep drinking at low risk. If you drink more than these amounts, you are at risk for developing problems due to alcohol use.

Men	Women
No more than 4 drinks on any day	No more than 3 drinks on any day
No more than 14 drinks per week	No more than 7 drinks per week

Some people should not drink at all:

- Women who are pregnant
- People who plan to drive or engage in activities that require alertness and skill
- People taking certain medications
- People with medical conditions
- Recovering alcoholics
- Anyone under the age of 21

Effects of Alcohol



- Symptoms you may have because of alcohol use:
- Hangovers
 - Slow reaction times
 - Poor coordination
 - Blurry or double vision
 - Upset stomach
 - Low blood pressure
 - Anxiety/restlessness
 - Memory loss
 - Overdose, coma or death

Did you know?

- Bath Salts can cause a state of “excited delirium” in which the user hallucinates and becomes disoriented, violent, aggressive, and impossible to restrain.
- Excited delirium can last for days or even longer.
- *Excited delirium can cause permanent damage to the brain, and can be deadly.*

What to expect when cutting back or quitting:

- Your doctor or Behavioral Health Specialist can help you set up a plan.
- Change takes time.
- You will need support.
- You may have some withdrawal symptoms.
- Contact your doctor if you are having any medical concerns.

Where can I learn more?

- www.drugabuse.org
- www.nida.nih.gov

Something to try:

1. _____

2. _____

Community Resources:

1. _____

2. _____

Behavioral Health Specialist:

Phone number:



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Bath Salts

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Bath Salts

“Bath Salts” is the street name for a designer drug that *looks* similar to real bath salts, but is actually a chemical made in a lab. Some common chemicals in Bath Salts are: mephedrone, methylone, and methylenedioxypyrovalerone (MDPV).

Are Bath Salts Illegal?

2 of the 3 most common chemicals in Bath Salts are banned by the Food and Drug Administration (FDA).

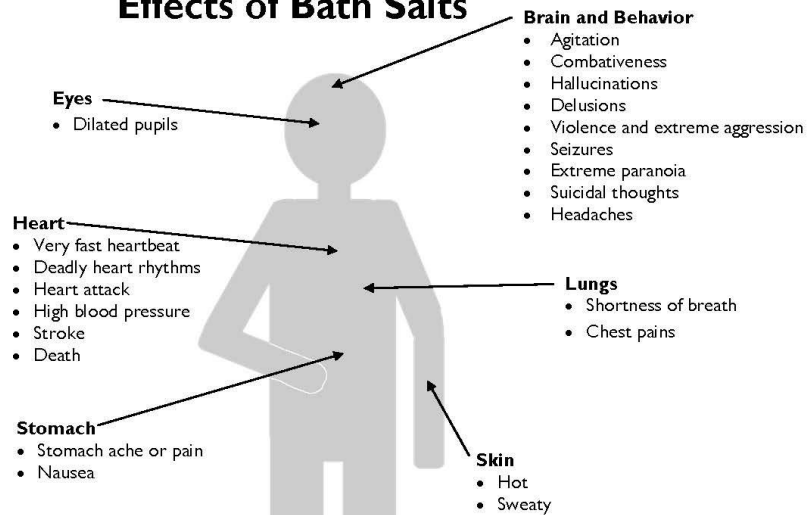
Labeling Bath Salts as “not intended for human consumption” helps drug makers get around the law, even though the intent is for users to consume it.

Makers of Bath Salts continue to create new formulas of the drug that are still technically legal.

Don't be fooled by labels.

- The name on the label might sound mellow, but the effects of Bath Salts can be 10 times stronger than cocaine.
- There may be other chemicals added to Bath Salts that can cause serious or deadly side effects.
- There is no way to know what you are actually taking. No one is regulating what drug makers put into Bath Salts.

Effects of Bath Salts



How long does it last?

The effects of Bath Salts can last from 2 hours to a few days or even weeks. There is no way to predict how each person will be affected and for how long.

Bath Salts can affect users in different ways, even if taken from the same packet. The strength of the drug can also be very different from packet to packet.

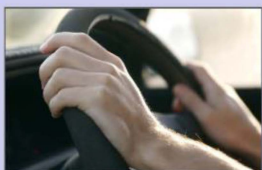
Bath Salts are a white, powdery substance that can be eaten, snorted, smoked or injected. Some common brand names:

- Bliss Ivory Wave Cloud Nine
 Blue Silk Red Dove Stardust
 Sextasy Loco-Motion
 Stairway to Heaven Tranquility

Did you know?

Marijuana can impair driving!

Driving while under the influence of marijuana is just as dangerous as driving after drinking alcohol.



What to expect when cutting back or quitting:

- Your doctor or Behavioral Health Specialist can help you set up a plan.
- Change takes time.
- You will need support.
- You may have some withdrawal symptoms.
- Contact your doctor if you are having any medical concerns.

Where can I go to learn more?

- www.drugabuse.org
- www.nida.nih.gov

Something to try:

1. _____

2. _____

Community Resources:

1. _____

2. _____

Behavioral Health Specialist:

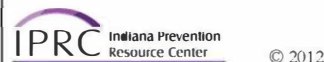
Phone number:



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Marijuana



Marijuana



The active ingredient in marijuana is delta-9-tetra-hydrocannabinol also known as THC.

THC changes the way your brain works. You may not notice the changes, but marijuana may be affecting everyday things.

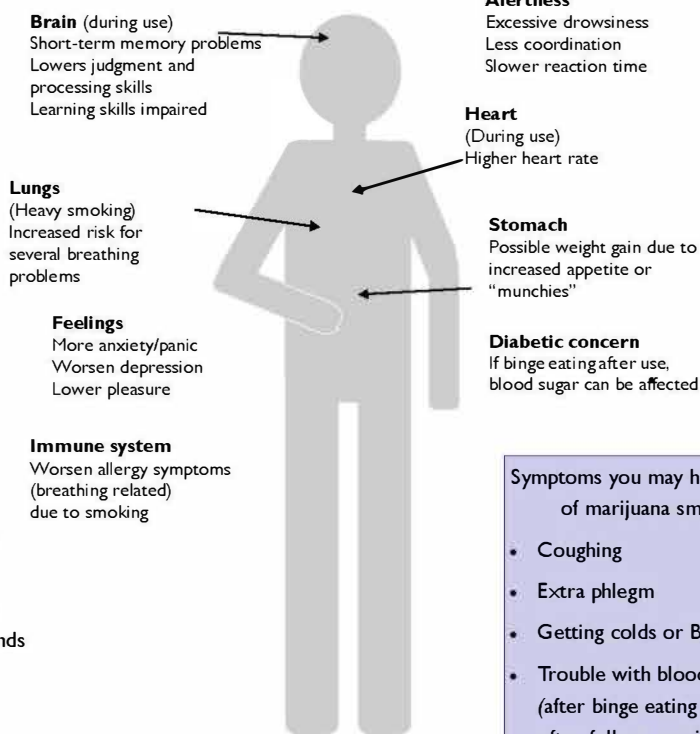
Marijuana can:

- Change how we experience events
- Slow reactions or lower coordination
- Make problem solving and concentration difficult
- Cause problems with learning and memory

Does my marijuana use lead to:

- Missing work or being late to work
- Problems at work (accidents or fights)
- Fights or arguments with family or friends
- Money issues or financial concerns
- Arrests or legal problems
- Using before important events
- Needing more to feel high

Effects of Marijuana



Symptoms you may have because of marijuana smoking:

- Coughing
- Extra phlegm
- Getting colds or Bronchitis
- Trouble with blood sugar (after binge eating which often follows marijuana use)

Did you know?
Heroin withdrawal symptoms vary in each person.

Many people feel symptoms that are similar to the flu, while others may have more extreme withdrawal symptoms.

Symptoms can start as early as 6-12 hours from the last time of use.

Overdose symptoms to watch for include:

- Slow and shallow breathing
- Clammy skin
- Blue lips or blue fingernails
- Convulsions or seizures
- Coma

Thinking about change?
 Talk with your doctor about treatment options. Together you will set up a plan for a safe way to make a change.

Where can I learn more?
www.drugabuse.org
www.nida.nih.gov

Something to try:

1. _____

2. _____

Community Resources:

1. _____

2. _____

Behavioral Health Specialist:

Phone number:



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Heroin

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Heroin

Heroin is a highly addictive narcotic drug that often causes dependence.



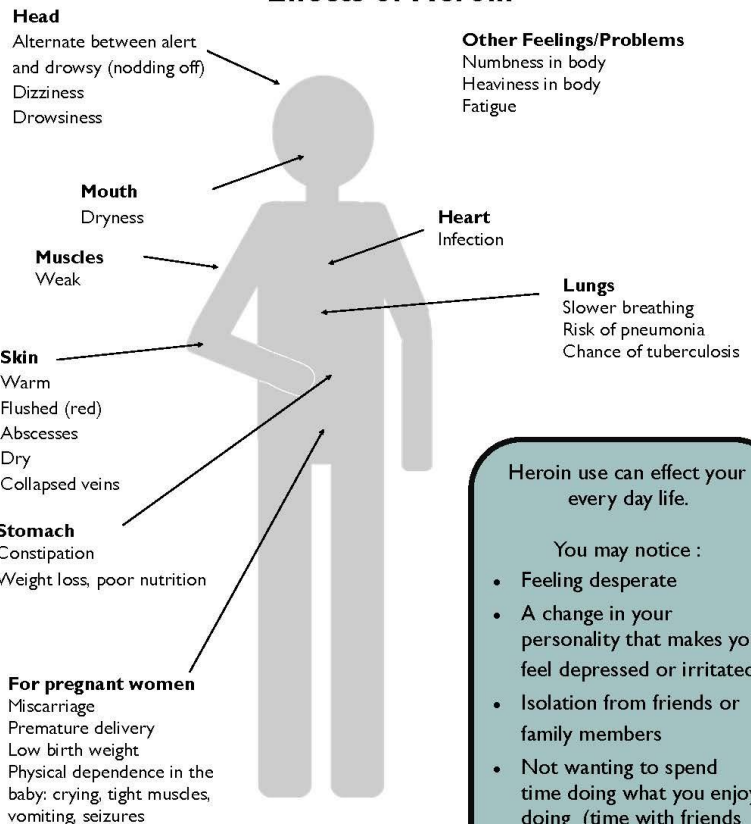
Heroin is made from morphine, which is a very powerful painkiller. Heroin acts like a painkiller in the body too, but over time it breaks down the parts of the brain that make people feel pleasure.

Heroin sold on the street is rarely pure. Instead, it is "cut" with other drugs or substances. It is difficult to know the strength of each dose, so users are at a high risk of overdose or death.

- Needles and Heroin:**
 Sharing needles to inject heroin is very risky. When people share needles, they are at risk for getting:
- HIV
 - Hepatitis B
 - Hepatitis C

Needle use can also cause complications such as an air bubble in the blood, which can cause a stroke.

Effects of Heroin



Heroin use can effect your every day life.

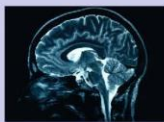
You may notice :

- Feeling desperate
- A change in your personality that makes you feel depressed or irritated
- Isolation from friends or family members
- Not wanting to spend time doing what you enjoy doing (time with friends or family or hobbies)

Did you know?

Meth changes the way the brain works.

- Meth actually damages the part of the brain that helps us feel pleasure.
- When used in high doses or over a long period of time, the brain may not be able to recover.



What to Expect when cutting back or quitting:

- Your doctor or Behavioral Health Specialist can help you set up a plan.
- Change takes time.
- You will need support.
- You may have some withdrawal symptoms.
- Contact your doctor if you are having any medical concerns.

Where can I go to learn more?

- www.drugabuse.org
- www.nida.nih.gov

Something to try:

1. _____

2. _____

Community Resources:

1. _____

2. _____

Behavioral Health Specialist:

Phone number:



WE ASK EVERYONE.



Methamphetamine



Methamphetamine

“Meth” is a powerful stimulant that affects every part of the body.



At first, a person using meth may feel extra energy. The energy-filled high can stop a person from sleeping for several days.

Lack of sleep can cause:

- Paranoia
- Hallucinations
- Irritability
- Anxiety

Meth causes the heart to race and the blood vessels to tighten.

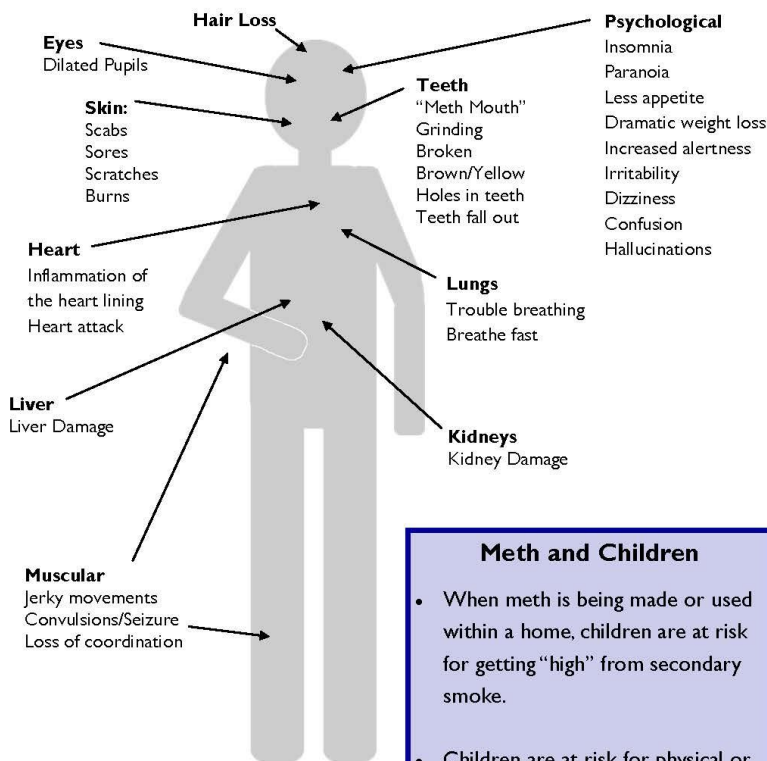
Serious health risks are:

- Heart attack
- Stroke
- Overdose/Death

Other Risks:

- **HIV and Hepatitis B and C:** Needle sharing is common and can spread these diseases.
- **Sexual Assault:** Adults and children are both at risk when around people using meth.
- **Skin Burns:** Getting a burn is common when around meth “cooking.” Anyone in the location or near by is at risk for a chemical explosion.

Effects of Methamphetamine



Meth and Children

- When meth is being made or used within a home, children are at risk for getting “high” from secondary smoke.
- Children are at risk for physical or sexual abuse or neglect when around known meth users.

Did you know?

Mixing cocaine and alcohol increases the risk for sudden death!

When people mix cocaine and alcohol the body has a hard time deciding whether to speed up from the cocaine or to slow down from the alcohol.



Cocaine can cover up signs of too much alcohol use. This can lead to overdose.

What to expect when cutting back or quitting:

- Your doctor or Behavioral Health Specialist can help you set up a plan.
- Change takes time.
- You will need support.
- You may have some withdrawal symptoms.
- Contact your doctor if you are having any medical concerns.

Where can I go to learn more?

- www.drugabuse.org
- www.nida.nih.gov

Something to try:

1. _____

2. _____

Community Resources:

1. _____

2. _____

Behavioral Health Specialist:

Phone number:



WE ASK EVERYONE.



Cocaine



© 2012

Cocaine



Cocaine (powder) and Crack Cocaine (rocks) are stimulant drugs.

These drugs speed up the body's heart rate, breathing and blood pressure.

Overdose can make a person's heart stop and often leads to death.

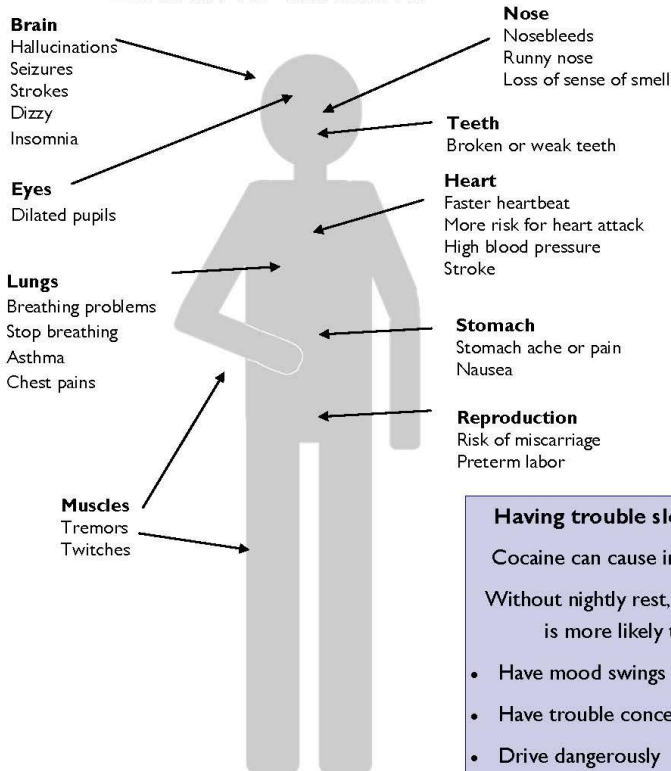
Things to think about:

- Do I ever have chest pain?
- Do I have trouble sleeping or stay up for a long time without sleeping?
- Do I get a lot of nose bleeds?
- Do I ever feel like people are watching me or out to get me?

Risks for Cocaine Users:

- Cocaine is often "cut" with other drugs or substances.
- Sharing needles raises risks for:
 - Hepatitis B or C
 - HIV

Effects of Cocaine



Having trouble sleeping?

Cocaine can cause insomnia. Without nightly rest, a person is more likely to:

- Have mood swings
- Have trouble concentrating
- Drive dangerously
- Use again to feel "normal"

Did you know?

Mixing prescriptions with alcohol or over-the-counter drugs can be dangerous!

- It can cause a drop in heart rate and breathing
- Increases risk of overdose and death



What to expect when cutting back or quitting:

- Your doctor or Behavioral Health Specialist can help you set up a plan.
- Change takes time.
- You will need support.
- You may have some withdrawal symptoms.
- Contact your doctor if you are having any medical concerns.

Where can I go to learn more?

- www.drugabuse.org
- www.nida.nih.gov
- www.justice.gov/dea

Something to try:

1. _____

2. _____

Community Resources:

1. _____

2. _____

Behavioral Health Specialist:

Phone number:



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Prescription Depressants

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Depressants

Prescription depressants are also called Benzodiazepines and Barbiturates. Depressants are medicines prescribed to help with:

- Sleep
- Anxiety
- Muscle spasms
- Seizures



Common Benzodiazepines:

Common Benzodiazepines:

Valium®, Xanax®, Halcion®, Ativan®, Klonopin®

Common Barbiturates:

Seconal®, Amytal®, Fiorina®, Nebutal®

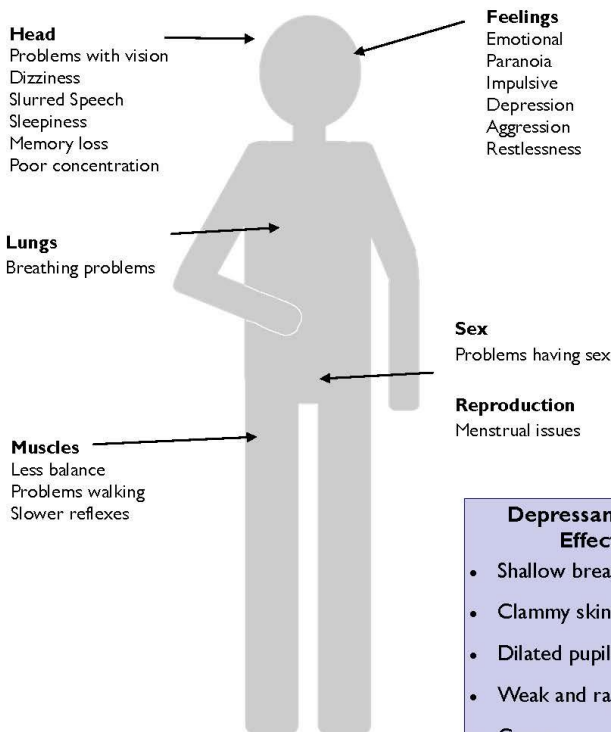
Important to know:

- It is easy to get dependent on these types of medicine.
- Stopping the use of many Benzodiazepines and Barbiturates can be dangerous! Talk to your doctor before changing your dose.

Questions to Consider:

- Am I using my own medicine?
- Am I taking the medicine the way it was prescribed?
- Am I running out of pills before my prescription can be refilled?

Effects of Prescription Depressants



Depressant Overdose Effects Are:

- Shallow breathing
- Clammy skin
- Dilated pupils
- Weak and rapid pulse
- Coma
- Death

Did you know?

When taking a Stimulant RX:



Too much caffeine can be harmful!
Limit use.

Alcohol should be avoided !



What to expect when cutting back or quitting:

- Your doctor or Behavioral Health Specialist can help you set up a plan.
- Change takes time.
- You will need support.
- You may have some withdrawal symptoms.
- Contact your doctor if you are having any medical concerns.

Where can I go to learn more?

- www.drugabuse.org
- www.nida.nih.gov

Something to try:

1. _____

2. _____

Community Resources:

1. _____

2. _____

Behavioral Health Specialist:

Phone number:



WE ASK EVERYONE.



Stimulant Prescriptions

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Stimulant Prescriptions



Stimulant medications are prescribed to help with:

- ADHD
- Trouble Sleeping
- Weight Problems

Common Stimulant RX:
Dexedrine®, Adderall®, Concerta®, Ritalin®

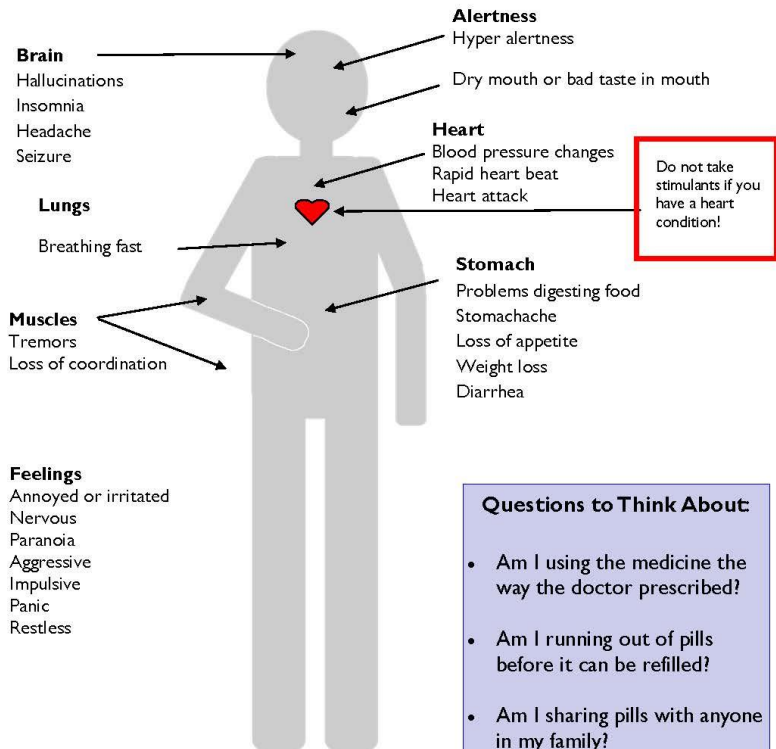
Will these pills help me focus?

- For people with ADHD, stimulants may calm people or help them focus.
- Stimulant pills can lead to more hyper or aggressive behavior for people that don't have ADHD.

Don't borrow or share! Be aware:

- Using a medicine that is not yours could cause health problems.
- ADHD Pills that are bought on the street may not be the real medicine.
- A lot of pills look the same but are many different types medicines.
- Not all stimulant medications have the same amount of medicine in each pill.
- Adult doses and children doses are not equal and can be dangerous to share!

Effects of Stimulant Prescriptions



Questions to Think About:

- Am I using the medicine the way the doctor prescribed?
- Am I running out of pills before it can be refilled?
- Am I sharing pills with anyone in my family?

Did you know?

Mixing prescriptions with alcohol or over-the-counter drugs can be dangerous!

- It can cause a drop in heart rate and breathing.
- Risk of overdose and death increases!



What to expect when cutting back or quitting:

- Your doctor or Behavioral Health Specialist can help you set up a plan.
- Change takes time.
- You will need support.
- You may have some withdrawal symptoms.
- Contact your doctor if you are having any medical concerns.

Where can I go to learn more?

- www.drugabuse.org
- www.nida.nih.gov

Something to try:

1. _____

2. _____

Community Resources:

1. _____

2. _____

Behavioral Health Specialist:

Phone number:

INDIANASIBIRT

WE ASK EVERYONE.



Opioid Prescriptions

IPRC Indiana Prevention Resource Center

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Opioids



Opioids are a narcotic drug. These medications relieve:

- Pain
- Cough
- Insomnia

Opioid overdose can be fatal!

Common Opioid Prescriptions:

OxyContin®, Vicodin®, Opana®, Lomotil®, Morphine, Methadone and Fentanyl

Common Over-The-Counter Opioid Medicines:

Robitussin AC®, Robitussin DAC®, Triaminic Expectorant with Codeine®

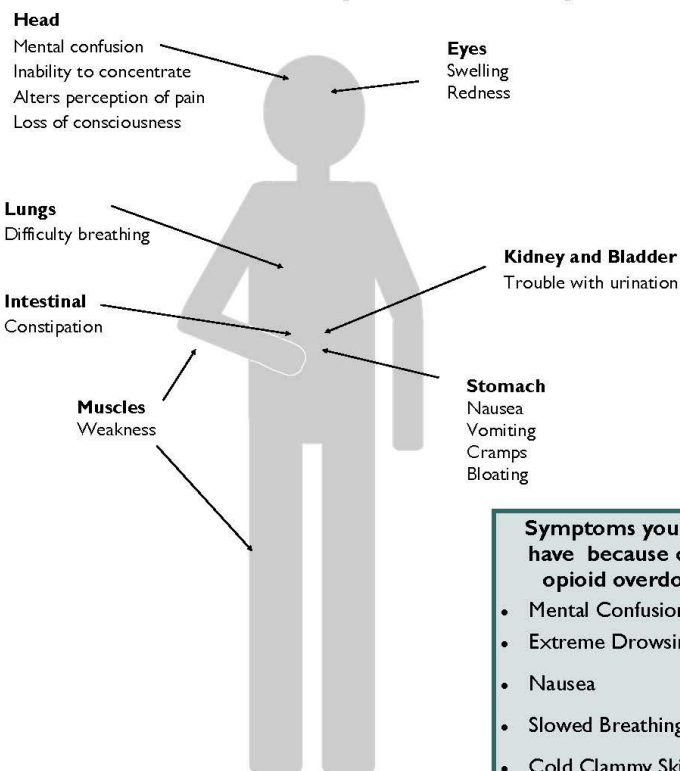
Don't borrow or share! Be aware:

- Not all pain killers have the same amount of medicine in each pill.
- Pills may look the same but could be different medicines.
- Using a medicine that is not yours could cause health problems.

Questions to Consider:

- Am I using my own medicine?
- Am I taking the medicine the way it was prescribed?
- Am I running out of pills before my prescription can be refilled?

Effects of Opioid Prescriptions



Symptoms you may have because of an opioid overdose:

- Mental Confusion
- Extreme Drowsiness
- Nausea
- Slowed Breathing
- Cold Clammy Skin
- Convulsions or Seizures

If it's illegal, why is it still sold in stores?

15 of the most common chemicals in K2/Spice are banned by the Food and Drug Administration (FDA).

However, makers of K2/Spice have created new formulas that are still technically legal, as long as they are labeled as "not for human consumption."

Even though the makers of K2/Spice intend for users to consume it, the labels help them get around the law.

What to expect when cutting back or quitting:

- Your doctor or Behavioral Health Specialist can help you set up a plan.
- Change takes time.
- You will need support.
- You may have some withdrawal symptoms.
- Contact your doctor if you are having any medical concerns.

Where can I learn more?

- www.drugabuse.org
- www.nida.nih.gov

Something to try:

1. _____

2. _____

Community Resources:

1. _____

2. _____

Behavioral Health Specialist:

Phone number:



WE ASK EVERYONE.



Synthetic Marijuana (K2/Spice)



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Synthetic Marijuana

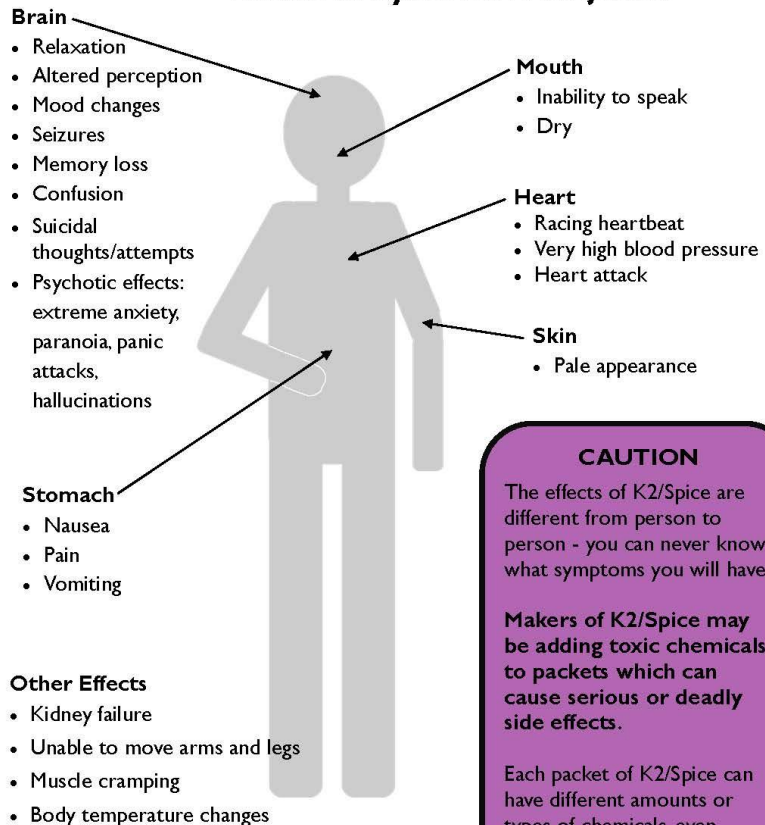


- Synthetic marijuana, also called **K2** or **Spice**, is made using chemicals created in a lab.
- The chemical is sprayed onto dried plants or herbs to make it look like marijuana. It is often artificially colored and flavored. It is also sold in a liquid form.
- K2/Spice is sold illegally in gas stations, tobacco shops or online as a potpourri or incense, with names like *Blaze* or *Mad Hatter*. It is labeled as "not for human consumption".

Labels can lie.

- Those who make and sell K2/Spice intend for users to smoke it.
- There is no "safe" dose or brand of K2/Spice. Don't be fooled by words like "natural" or "clean". No-one is regulating what is actually in a K2/Spice packet.
- Synthetic marijuana is illegal, even if the packet has a label that says the product is legal.

Effects of Synthetic Marijuana



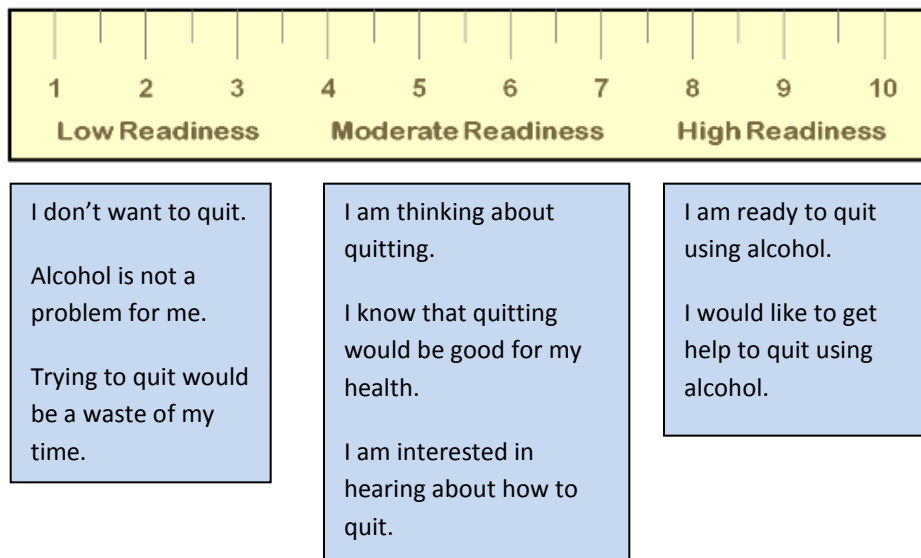
CAUTION

The effects of K2/Spice are different from person to person - you can never know what symptoms you will have.

Makers of K2/Spice may be adding toxic chemicals to packets which can cause serious or deadly side effects.

Each packet of K2/Spice can have different amounts or types of chemicals, even within the same brand.

Readiness Ruler



Instructions:

Use ruler to explore each person's level of readiness or confidence. This tool elicits an individual's desire for change (change talk), the barriers to change and can help move toward making a change plan.

One statement that can be used to start the conversation is:

"Looking at this ruler, with "0" being *not at all ready* (haven't even thought about it) and "10" being *the most ready you will ever be* (you are ready to change immediately) how ready are you to make a change (even a very small one) in your right now?"

To elicit change talk, say:

"Why are you a ____ [insert # reported] and not a ____? (2 digits↓)"

To elicit the barriers to change, say:

"Why are you a ____ [insert # reported] and not a ____? (2 digits↑)"

PROJECT ED HEALTH
BNI Adherence & Competence Checklist

	Yes	No
1. Ask the patient for permission to discuss alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
2. Review patient's drinking patterns	<input type="checkbox"/>	<input type="checkbox"/>
3. Express concern about these patterns	<input type="checkbox"/>	<input type="checkbox"/>
4. Ask about a connection	<input type="checkbox"/>	<input type="checkbox"/>
5. Reflect the patient's statement	<input type="checkbox"/>	<input type="checkbox"/>
6. Provide medical facts and information that there is a connection between the fight and drinking. (For example, not seeing cues that things were getting out of control)	<input type="checkbox"/>	<input type="checkbox"/>
7. Inform patient of NIAAA guidelines and norms by using show cards	<input type="checkbox"/>	<input type="checkbox"/>
8. Ask patient to identify readiness to change on readiness ruler show card	<input type="checkbox"/>	<input type="checkbox"/>
9. Ask why they choose that number and not a lower one	<input type="checkbox"/>	<input type="checkbox"/>
10. Reflect patients statements regarding change	<input type="checkbox"/>	<input type="checkbox"/>
11. Elicit response (How does all this sound to you?)	<input type="checkbox"/>	<input type="checkbox"/>
12. Negotiate the goal (What would you like to do?)	<input type="checkbox"/>	<input type="checkbox"/>
13. Give advice if necessary	<input type="checkbox"/>	<input type="checkbox"/>
14. Summarize (This is what I've heard you say..)	<input type="checkbox"/>	<input type="checkbox"/>
15. Have patient fill out agreement card	<input type="checkbox"/>	<input type="checkbox"/>
16. Provide health information sheet	<input type="checkbox"/>	<input type="checkbox"/>
17. Suggest Primary Care Follow-up	<input type="checkbox"/>	<input type="checkbox"/>
18. Thank the patient for his/her time	<input type="checkbox"/>	<input type="checkbox"/>

Optional Question:

Ask EP, "What if the patient had chosen a 1 on the readiness ruler?"

Yes

No

- 1. EP would ask patient, 'What would make this a problem for you?'

Comments: _____

EP Name: _____

Reviewer: _____ **Date:** _____

Start time: _____ **End time:** _____

SBIRT Proficiency Checklist

Taken directly from the SBIRT Proficiency Checklist Validation Study (PERU, 2014)

Pringle, J.L., Kowalchuck, A., Meyers, J.A., Seale, J.P. (2012). Equipping residents to address alcohol and drug abuse: The national SBIRT residency training project. *Journal of Graduate Medical Education*, 4(1), 58-63.

SBIRT Short-Form Proficiency Checklist- Clinical Version

Screening (3 items)	Present	Not Present
Practitioner accurately assesses quantity & frequency of alcohol and/or drug use.	<input type="checkbox"/>	<input type="checkbox"/>
Practitioner accurately identifies the patient's level of risk related to their alcohol or drug use using an appropriate evidence-based screening instrument.	<input type="checkbox"/>	<input type="checkbox"/>
Practitioner assesses possible consequences of the patient's behavior, such as physical, psychosocial and other consequences.	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Brief Intervention (4 items)	Present	Not Present
Practitioner asks permission to provide feedback about the patient's substance use.	<input type="checkbox"/>	<input type="checkbox"/>
Practitioner uses reflection and/or open-ended questions to allow patient to react to screening result.	<input type="checkbox"/>	<input type="checkbox"/>
Practitioner provides feedback about the risks associated with patient's substance use behavior.	<input type="checkbox"/>	<input type="checkbox"/>
Practitioner negotiates a goal with the patient based on steps he/she is willing to take.	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

	Present	Not Present
Referral to Treatment (2 items)		
Practitioner recognizes the patient's need for substance treatment based on their screening score and/or medical/behavioral factors.	<input type="checkbox"/>	<input type="checkbox"/>
Practitioner suggests the use of specific community and specialty resources.	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

	Present	Not Present
Follow-Up (1 item)		
Practitioner arranges appropriate follow-up (MD follow-up, referral to treatment, counseling, medication, etc.).	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

	Present	Not Present
Motivational Interviewing Spirit (3 items)		
Practitioner summarizes patient's stated reasons for change	<input type="checkbox"/>	<input type="checkbox"/>
Practitioner negotiates a treatment plan in a collaborative manner	<input type="checkbox"/>	<input type="checkbox"/>
Practitioner affirms the patient's strengths, ideas &/or successes.	<input type="checkbox"/>	<input type="checkbox"/>

Comments: