Screening and Brief Intervention (SBI):

Guide & Resource Manual for Workplace Practitioners

Screening and Brief Intervention (SBI): Guide & Resource Manual for Workplace Practitioners

Table of Contents

Forward

Statement of Purpose for the Guide

Workplaces are underutilized for the delivery of alcohol prevention and early intervention programs. Yet, they offer the opportunity to reach people in a place where they spend most of their day. Workplace resources including employee assistance programs, health promotion and wellness programming, and occupational health and safety clinics are ideal settings to identify and intervene.

The purpose of this guide is to present promising, feasible approaches to implementing evidence-based alcohol screening and brief intervention (SBI) methods in work-related settings. The processes and protocols are designed specifically for the following types of workplace professionals: employee assistance professionals (delivering services telephonically through centralized call centers or onsite in-person services); occupational health and safety staff (delivering in-person medical services, physical exams, and health screens); health promotion and wellness practitioners (delivering health promotion program offerings, educational/awareness outreach, automated screening, health risk assessments), and administrators of alcohol/drug testing programs.

This guide was developed with funding and support from the Network of Employers for Traffic Safety, National Highway Traffic Safety Administration, and Ensuring Solutions to Alcohol Problems at The George Washington University (through a grant from PEW Charitable Trusts). The development of this guide was also informed and supported by members of the Ensuring Solutions' Workplace SBI Product Development Work Group consisting of employers, employee assistance and behavioral healthcare vendors, and vendors of alcohol/drug services, representatives from government agencies and professional groups, experts, researchers, and clinicians.
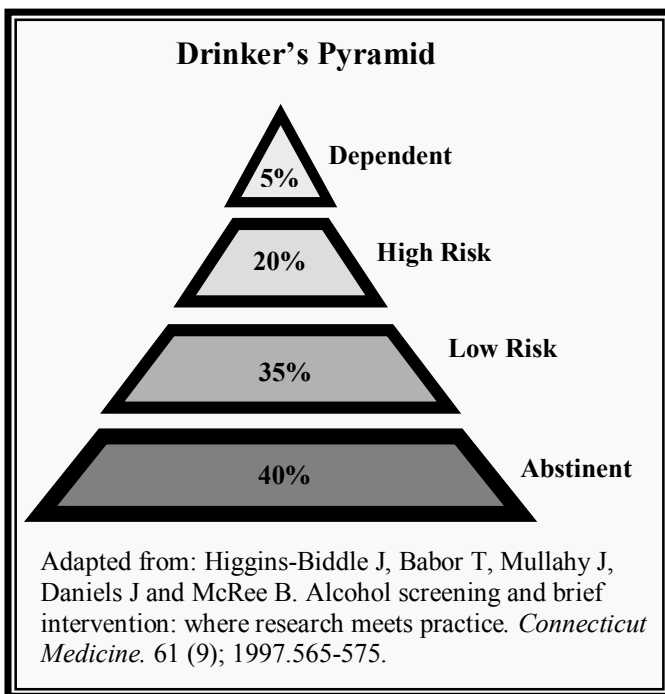
The guide is divided into sections for ease of reviewing and synthesizing screening and brief intervention techniques. Each section is based on the best scientific evidence available. Materials and resources are available throughout the guide and in the Resources section.

The Problem

Impact of Alcohol Use in the Workplace

More than half of the U.S. population aged 12 years and older report current alcohol use, making it the most widely used drug in the nation (SAMHSA, 2007). Occasional alcohol use can, over time, grow into a damaging physical and psychological addiction wrecking havoc in the lives of individuals and their families.

While excessive drinking causes problems in the home and community it also has a costly impact in the workplace as almost 80 percent of problem drinkers are employed either full- or part-time (SAMHSA, 2007). The latest estimates report that the total cost of alcohol problems in the U.S. are upwards of $185 billion. These costs include more than $50 billion spent on excess healthcare, traffic accidents, crime, and property destruction. Still, alcohol problems affect the workplace more profoundly, costing over $134 billion in lost productivity due to absenteeism, presenteeism, disability, and job turnover. In addition, 20 percent of employees surveyed reported being injured, forced to cover for a co-worker, or required to work harder because of a colleague's drinking (SAMHSA, Issue Brief #5, 2007).

Drinker's Pyramid

Dependent 5%
High Risk 20%
Low Risk 35%
Abstinent 40%

Adapted from: Higgins-Biddle J, Babor T, Mullahy J, Daniels J and McRee B. Alcohol screening and brief intervention: where research meets practice. *Connecticut Medicine*. 61 (9); 1997.565-575.

The *Drinker's Pyramid* describes four types of drinkers:

- Abstinent: Abstainers are people who never drink alcohol.

- Low Risk: Low risk drinkers tend to have no more than two standard drinks per day. Examples of a standard drink include one 12 oz. can of beer, a 5 oz. glass of wine, or a 1.5 oz. shot of hard liquor.

- High Risk: High risk drinkers are people who drink more than two standard drinks per day and whose alcohol use is likely to cause problems.

- Dependent: Dependent drinkers include people who drink alcohol to such a degree as to cause intense and sustaining emotional, physical or financial troubles.

In 2006, over 60 percent of full-time employees aged 18 or older drank alcohol. Among 16.3 million risky drinkers, almost 13 million were employed (SAMHSA, 2007). Low and high risk alcohol users cover a larger percentage of the drinking population than people who are dependent. Yet, these moderate drinkers cause 60 percent of alcohol-related absenteeism, tardiness, and poor work quality. In addition, reports estimate that up to 40 percent of industrial fatalities and 47 percent of industrial injuries are linked to alcohol use. Misuse of alcohol is linked to almost 50 percent of all trauma and injury visits to hospital emergency rooms which tends to increase employers' health insurance expenditures and drive up the cost of insurance premiums (SAMHSA, Issue Brief #5, 2007).

Healthcare costs for employees with alcohol problems are twice those for other employees. The Ensuring Solutions to Alcohol Problems *Alcohol Cost Calculator for Business* shows that employers with 500 workers can loss almost $160,000 annually due to alcohol-related healthcare costs. Additionally, more than $29,000 will be lost due to emergency department and hospital costs. When large and small employers, alike, help their employees address alcohol problems by offering appropriate services that include screening and brief intervention they are likely to experience lower healthcare cost growth rates and a return on investment of at least 2.15 percent.

Number of Employees	100	500	1000
Likely number of employees who are problems drinkers	9	46	91
Likely number of work days lost to hangovers and alcohol-related health problems	23	120	238
Costs of lost work days	$2,880	$15,024	$29,798
Likely alcohol-related healthcare costs	$31,883	$159,415	$31,829
Emergency department and hospital costs	$5,860	$29,300	$58,600
Savings associated with providing alcohol treatment to 100% of employees identified as problem drinkers*	$13,514	$68,858	$137,073
Costs associated with providing alcohol treatment to 100% of employees identified as problem drinkers*	$4,284	$21,828	$43,452
Return on investment in alcohol screening and brief intervention	**$9,230**	**$47,030**	**$93,621**

*Savings include provision of treatment to employee family members identified as problem drinkers. Source: Ensuring Solutions to Alcohol Problems Alcohol Cost Calculator for Business at http://www.alcoholcostcalculator.org/business.

The Solution

Alcohol Screening and Brief Intervention

Identifying that risky alcohol use has a far-reaching and deleterious effect on work environments is the first step that employers can take to counteract the negative impact of alcohol misuse and abuse. The second step is to use the best, most cost-effective approach to identify employees with alcohol problems and provide them access to appropriate treatments and information. Alcohol screening and brief intervention (SBI) is one of the leading ways to address alcohol problems in the workplace.

Alcohol SBI is an evidence-based technique that uses a valid, brief (five minutes or less) questionnaire about the frequency and quantity of alcohol a person drinks. The questionnaire can be given as a printed document or an online assessment. It can also be given via interview with another person. The results of the questionnaire identify risky/hazardous alcohol users as well as those who may possibly be dependent. Depending on the results of the questionnaire a trained practitioner will provide health education, simple advice, motivational counseling, help in developing an action plan, and referral for further treatment, if needed.

Four Basic Components of SBI

1. Screening: Through a series of questions people who are screened identify whether or not, and to what degree, their drinking places them or other people at risk for negative consequences of alcohol use.

2. Brief Intervention: After the screening is completed the person is provided with information and feedback about the screening results, risks of alcohol consumption, guidelines on healthy drinking behaviors, and methods to reduce over consumption of alcohol.

3. Referral: During the brief intervention phase, if the person is identified as being alcohol-dependent or if some other specific need is identified as a result of screening and brief intervention, he or she is offered referrals to appropriate care which can include in-patient treatment facilities and out-patient programs, like Alcoholics Anonymous.

4. Follow-Up: By using the above steps the person goes away with a set goal and roadmap to cut down or abstain from drinking. Follow-up is an important component of a complete SBI process that uses face-to-face contact, telephone or online systems, or printed materials to check-up on the person's progress on changing their drinking behavior.

This simple, brief process is well-respected—and validated—in the scientific community. In fact, SBI have proven to be an effective approach in many settings for addressing alcohol problems. In 2002, a group of researchers analyzed more than 360 controlled trials on treating alcohol use disorders and found that SBI was the single, most effective treatment method of more than 40 other methods studied (Miller & Wilbourne, 2002). Additionally, in 2007, researchers found that SBI conducted in emergency departments helped to reduce alcohol consumption in high-risk drinkers. The study showed that when patients received a brief intervention by a trained SBI counselor about 37 percent reported their drinking was no longer at high-risk levels. However, when patients in the same study received a written list of local referral resources without brief intervention only 19 percent of them reduced their alcohol consumption (Academic ED SBIRT Research Collaborative, 2007).

Alcohol SBI has also proven to be beneficial in non-emergency, primary care settings. Results from a research project, known as Project TrEAT (Trial for Early Alcohol Treatment), showed that a person's primary physician can successfully address alcohol problems by using SBI. After enrolling patients across 10 counties in Wisconsin, Project TrEAT researchers found that not only did patients significantly reduce their drinking levels after six months, but they also maintained those lowered levels for at least four years. Project TrEAT researchers also found that people who received SBI from their physicians experienced 20 percent fewer emergency department visits, 33 percent fewer nonfatal injuries, 37 percent fewer hospitalizations, 46 percent fewer arrests and 50 percent fewer motor vehicle crashes. Project TrEAT also showed that SBI counseling of nondependent, risky alcohol users allowed for a cost savings of $4.30 in future healthcare costs for ever $1.00 invested in intervention (Fleming et al., 2002).

<table>
<tr><td colspan="2">Select Federal & State Agencies, and National Organizations Supporting SBI</td></tr>
</table>

- American Academy of Child and Adolescent Psychiatry
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Emergency Physicians
- American College of Obstetricians and Gynecologists
- American College of Surgeons
- American Psychiatric Association
- American Society of Addiction Medicine
- Department of Defense
- Michigan Quality Improvement Consortium
- National Business Coalition on Health
- National Highway Traffic Safety Administration
- National Institute on Alcoholism and Alcohol Abuse
- National Quality Forum
- Network of Employers for Traffic Safety (NETS)
- New York State Department of Health
- Substance Abuse and Mental Health Services Administration
- Veterans Administration
- White House Office of National Drug Control Policy

These studies, and many others, show that SBI is an efficient and cost-effective option in many healthcare environments. The validity of this approach in the health field is further evidenced by the Centers for Medicare and Medicaid Services (CMS) instructing its fiscal intermediaries to pay on recently approved medical services codes for health professionals that conduct SBI. More information on SBI codes can be found at the Ensuring Solutions website at http://www.ensuringsolutions.org.

Because of its advances in the health industry, alcohol SBI—given its quick screening tool and simplified approach to brief intervention—is also well-suited for the workplace. Despite a limited amount of evidence-based literature validating the implementation of SBI in the workplace, researchers have found evidence supporting the effectiveness of workplace SBI.

The Network of Employers for Traffic Safety (NETS) and the George Washington University (GWU), through a Cooperative Agreement with the National Highway Traffic Safety Administration (NHTSA) embarked on a study on alcohol SBI that included an extensive literature review and assessment the SBI practices of over 700 employers and insurance vendors. After gathering and analyzing Year One data, NETS researchers determined that the effectiveness and success of SBI programs in healthcare settings could be transferred to workplace settings. "SBI could be offered to workers and their families through a

number of company resources such as employee assistance programs (EAPs), health promotion and wellness programs, occupational health and safety clinics, health fairs, employer-sponsored health insurance plans, disease management, or disability/rehabilitation programs" (Ensuring Solutions to Alcohol Problems, 2007).
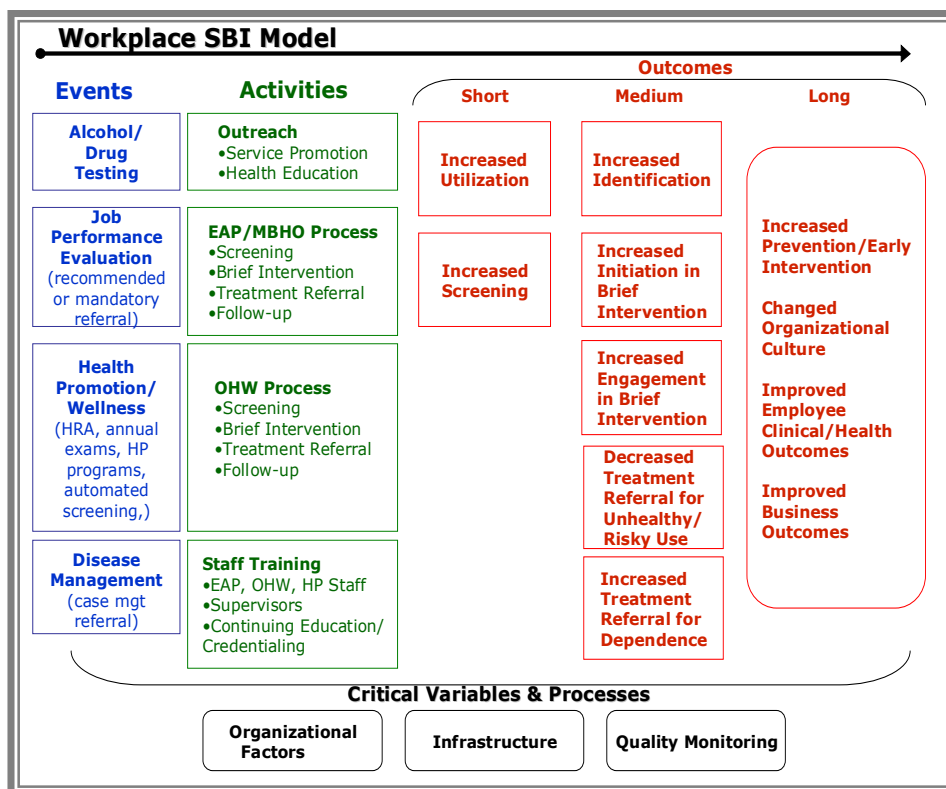
By incorporating alcohol SBI into workplace settings employers can expect to save money on healthcare costs, raise productivity, and contribute to employee well-being. Many workplaces—whether through health benefits packages, safety clinics, health promotions, or EAPs—are prepared to address alcohol problems through workplace SBI.

Alcohol Screening & Brief Intervention

A Conceptual Model for the Workplace

Due to the sensitivity of health information, and the need to conduct SBI by using trained professionals, workplace SBI is most cost-effective, and appropriate when delivered via employer EAP counselors, or state-licensed professionals at occupational health clinics, health promotions/wellness programs, or healthcare facilities. Though alcohol SBI can be a quick process, laying the groundwork for workplace implementation takes substantial effort and coordination of key roles in order to ensure that people most likely to benefit from its proven support obtain appropriate care and information.

Based on findings from Year One of the project, NETS researchers developed a conceptual model of workplace SBI to operate as a framework from which employers can build tailored approaches for specific work-related settings. Over the course of Year Two, NETS researchers further refined the model made it more operational. A conceptual framework is presented below, the components of the model are fleshed out in this guide and will assist practitioners conducting SBI in workplace settings to select the most relevant components and tailor their approach to each workplace.

Workplace SBI Model

Events	Activities	Outcomes		
		Short	Medium	Long
Alcohol/ Drug Testing	Outreach •Service Promotion •Health Education	Increased Utilization	Increased Identification	Increased Prevention/Early Intervention
Job Performance Evaluation (recommended or mandatory referral)	EAP/MBHO Process •Screening •Brief Intervention •Treatment Referral •Follow-up	Increased Screening	Increased Initiation in Brief Intervention	Changed Organizational Culture
Health Promotion/ Wellness (HRA, annual exams, HP programs, automated screening,)	OHW Process •Screening •Brief Intervention •Treatment Referral •Follow-up		Increased Engagement in Brief Intervention	Improved Employee Clinical/Health Outcomes
			Decreased Treatment Referral for Unhealthy/ Risky Use	Improved Business Outcomes
Disease Management (case mgt referral)	Staff Training •EAP, OHW, HP Staff •Supervisors •Continuing Education/ Credentialing		Increased Treatment Referral for Dependence	

Critical Variables & Processes

Organizational Factors	Infrastructure	Quality Monitoring

This guide is a culmination of two years of joint effort between NETS and GWU to offer employers instruction on developing an effective alcohol SBI program in the workplace. It also offers two approaches that have proven most effective in conducting workplace SBI. This guide illustrates how employers can customize either approach from development through implementation and includes step-by-step guidance on the four basic parts of alcohol SBI.

Two Promising Approaches to Workplace SBI

Applying the Conceptual Model

Two promising approaches to conducting SBI in work-related venues emerged from the synthesis of the NETS web assessment and resulting qualitative data collected in the interviews with employers and vendors. The first approach is a **Post Bioassay/EAP** approach and the second is an **Occupational Health & Wellness/EAP** approach. Although these options have been conceptualized and presented here as two different and unique alternatives, they could potentially be combined into one integrated conceptual model in which program components could be selected and tailored to an individual employer. For the purpose of this discussion, each approach will be presented separately to reflect how they developed from complex data to workable models. Still, each approach holds shared components that can be combined to for a tailored program for a given workplace.

Post Bioassay/EAP Approach
The *Post Bioassay/EAP* approach illustrated below reflects a subset of employers who primarily use an alcohol and drug testing program to identify alcohol misuse in the workplace. In these cases, some employers may test for alcohol consumption due to reasonable suspicion or to assess whether an employee is fit for duty. The post bioassay approach can also be used as part of a random drug and alcohol testing program or as on-going follow-up after an employee had tested positive in the past.
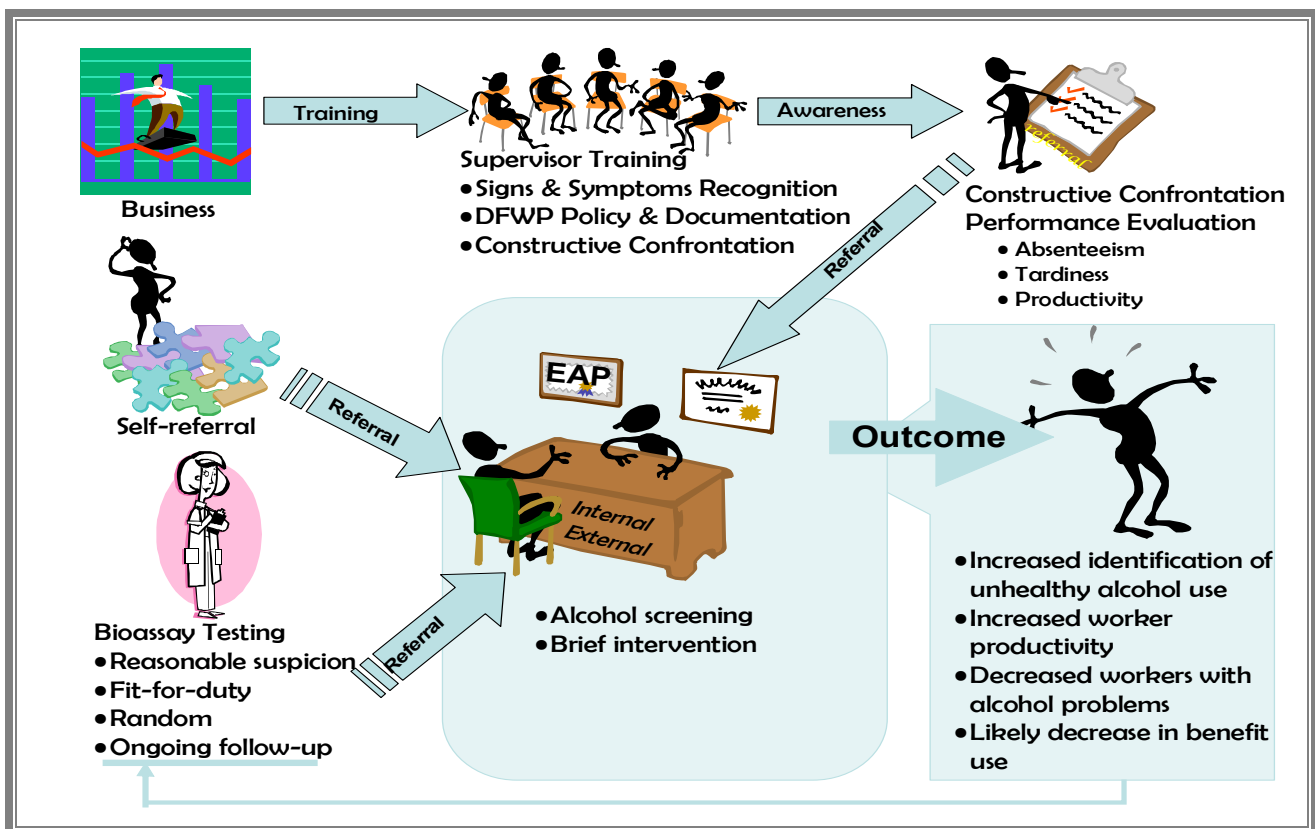
The post bioassay/EAP approach relies on management and employees receiving the right training to build their awareness of the signs and symptoms of alcohol misuse.

➔ **Supervisor Training** – Signs and symptoms recognition training for supervisors and leadership/management and SBI training for EAP counselors are essential. Staff should be trained to conduct administrative and clinical follow-up to continue engagement in SBI process.

➔ **Alcohol Screening and Brief Intervention** – EAP counselors must be able to conduct alcohol screening and initiate brief intervention (immediately, if possible). In addition to providing SBI, EAP counselors can provide referrals for more in-depth assessment and treatment (e.g., diagnostic assessment of alcohol dependence, referral to inpatient or outpatient treatment center) in cases where more treatment is needed beyond brief intervention.

The post bioassay approach employs three mechanisms for an employee to be referred to an EAP for SBI.

➔ **Bioassay Testing** – With this approach, if an employee tests positive for alcohol use or being under the influence of alcohol while on the job, that employee is then invited to participate in alcohol SBI. In this scenario, employees are referred to the internal or external EAP.

➔ **Self-Referral** – Another inherent trigger for engaging employees in SBI is self-referral to the EAP. An employee may refer themselves to the EAP due to a host of personal concerns which may include problems at work, emotional issues at home or financial troubles, among others.

➔ **Constructive Confrontation/Performance Evaluation** – The post bioassay approach relies heavily on supervisors' awareness of substance use issues, ability to identify signs and symptoms of alcohol misuse, knowledge of and ability to follow organizational protocols around alcohol-related incidents (e.g., how to confront an employee, document the events of the encounter) and ability to conduct supervisory referrals (e.g., mandatory referrals or encouraging self-referral to EAP).

After following the appropriate training and awareness activities, as well as encouraging referral, employers that engage in the post bioassay approach may realize many of the positives benefits of conducting workplace SBI.

➔ **Outcomes** – The expected outcomes of this approach include increased identification of alcohol misuse, increased worker productivity, decreased number of workers with alcohol problems, and decrease in perceived benefits of alcohol use over time.

Occupational Health & Wellness/EAP Approach

The *Occupational Health & Wellness/EAP* approach illustrated below reflects a different subset of employers who primarily use occupational health and safety clinics and health promotion/wellness programs—including routine health risk assessments (HRA) and 24-hour automated telephonic or web-based screening—to identify hazardous alcohol use and assess risks associated with drinking behavior.
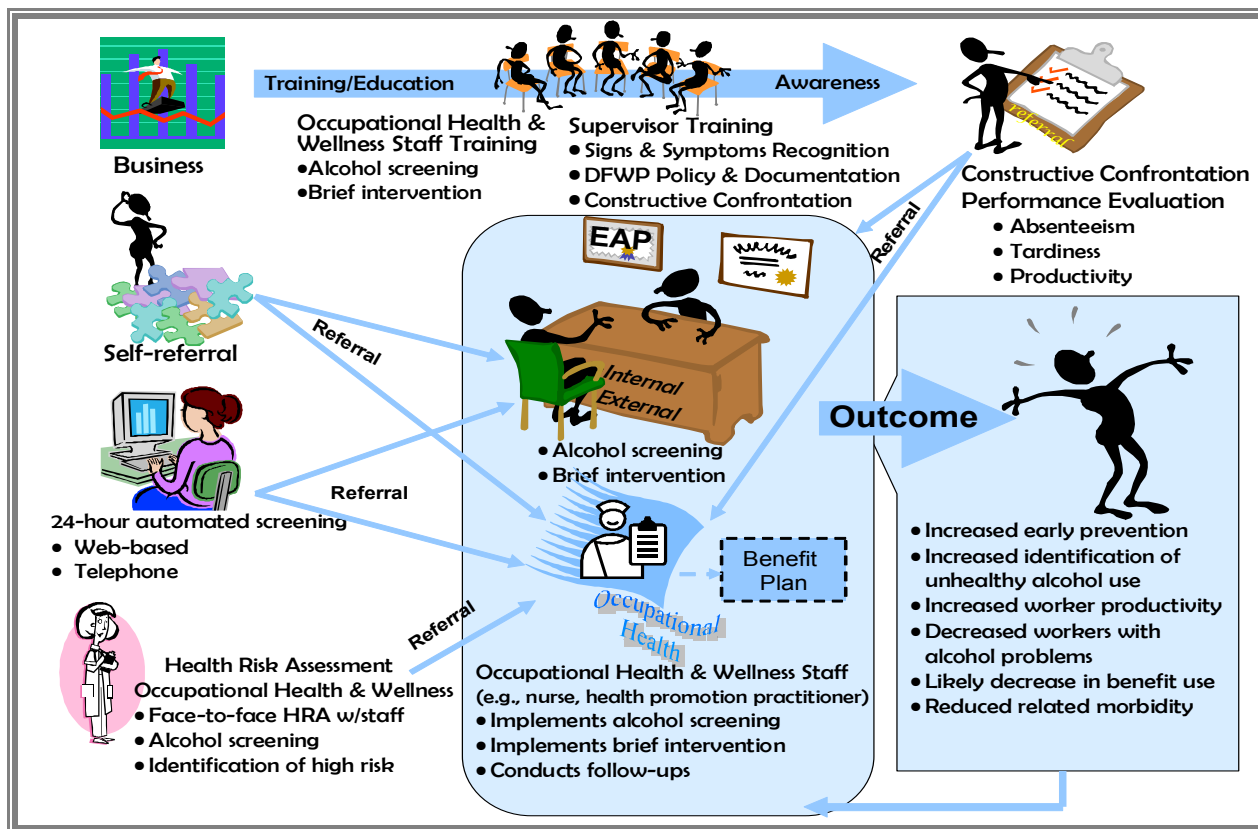
Training and education help to build awareness with the occupational health and wellness approach.

→ **Occupational Health & Wellness Staff Training** – This approach relies heavily on nurses' and physicians' ability to effectively conduct alcohol screening and brief intervention, awareness of substance use issues, knowledge of signs and symptoms of alcohol use, knowledge of a wide variety of substance abuse treatment resources, and ability to properly refer employees or encourage self-referral to a treatment provider if more intensive treatment is needed.

→ **Supervisor Training** – Signs and symptoms recognition training for supervisors and leadership/management is also essential. As with the previous approach supervisors need to be able to effectively and ethically confront employees with alcohol problems and document the events of the encounter according to organizational protocols around alcohol-related incidents.

→ **Alcohol Screening & Brief Intervention** – SBI training for nurses, physicians, and EAP counselors is essential. Staff should also be trained to conduct administrative and clinical follow- up. In addition to providing SBI, nurses, physicians, and EAP counselors may provide referrals for more in-depth assessment and treatment (e.g., diagnostic assessment of alcohol dependence, referral to inpatient or outpatient treatment center) in cases where more treatment is needed beyond brief intervention.

With the occupational health & wellness/EAP approach there are four mechanisms of referral to engage in workplace SBI.

> ➔ **Self-Referral** – Self-referral is inherent in this approach. Nurses, physicians, and EAP counselors can receive self-referrals, supervisor referrals, or referrals from automated screening.
>
> ➔ **24-Hour Automated Screening** – This approach also effectively employs the use of many validated online tools and resources as well as telephonic services offered through some EAP vendors to engage employees in SBI.
>
> ➔ **Health Risk Assessment (HRA)/Occupational Health Wellness** – The results of the HRA and automated screening are the catalyst for engaging employees in SBI. SBI is delivered by occupational health and safety staff nurses or physicians, or by EAP counselor (internal or external). Nurses and physicians are in a unique position to immediately engage workers in SBI at the time the HRA is administered.
>
> ➔ **Constructive Confrontation/Performance Evaluation** – The occupational health and wellness/EAP approach also relies on supervisors' awareness of alcohol's effect on absenteeism, tardiness, and productivity. Supervisors also need to be able to conduct supervisory referrals, including mandatory referrals or encouraging self-referral to occupational health and safety staff or EAP.

Similar to the previous approach, the occupational health & wellness/EAP approach may deliver beneficial outcomes to employers that conduct workplace SBI.

> ➔ **Outcomes** – The expected outcomes of this approach include those experienced in the post bioassay approach (e.g., increased identification of alcohol misuse, increased worker productivity, decreased number of workers with alcohol problems, decrease in benefit use over time, and reduced related morbidity). However, this approach carries with it the added benefit of offering early prevention and identification of alcohol problems.

Developing Your Own Approach

Step-By-Step Planning For Your SBI Program

♦ **Step 1: Identify the appropriate departments and resources available in your company to house and support an SBI program.**

Do you have an internal EAP, occupational health, or health promotion/wellness department? Identify staff persons who will receive training on how to administer SBI, and who will monitor and evaluate program activities. The person providing oversight does not have to be the same person delivering SBI, but he/she should be trained in SBI and in how to monitor and evaluate staff performance (e.g., quality

and fidelity). Consider external resources such as working with your EAP or behavioral healthcare vendor to provide SBI services to workers.

> ◆ **Step 2: Identify organizational factors that will impact the implementation and sustainability of the SBI program.**

Consider organizational and departmental policies, standards of practice statements, contractual agreements, business practices, leadership support and other factors such as organizational culture. Policy statements may need to be revised to reflect the procedures, processes, and protocols used in your SBI program. Many workplace policies (e.g., Drug Free Workplace) addressing alcohol and drug use are written in a way that is punitive and criminalizing. Contracts with EAP and managed behavioral healthcare organizations (MBHOs) may need to be modified to include language on SBI services delivered to workers. Contracts with alcohol/drug testing vendors may need to include language on conducting referrals (e.g., to EAP provider) with workers who test positive. This guide contains additional resources that will be of assistance. You may also want to review the Organizational Factors within the Ensuring Solutions Workplace Screening and Brief Intervention webpage at http://www.ensuringsolutions.org/moresolutions/moresolutions_show.htm?doc_id=467701&doc_parent_id=450551&cat_id=963.

> ◆ **Step 3: Identify how staff will be trained to conduct SBI.**

Decide who, when and where training will be conducted. Identify available resources (e.g., money to pay for training, classroom space to hold onsite training). Consider whether all staff can be trained at the same time and/or whether training can be conducted over a full day or if you need to break up the sessions across a couple of days. Also, consider whether staff need to travel to receive training or whether you have the resources to pay a trainer or hire a training consultant. Self-guided or web-based training may also be viable options. The Ensuring Solutions Workplace Screening and Brief Intervention webpage holds many examples from participating NETS programs that may be of assistance by going to http://www.ensuringsolutions.org/solutions/solutions_show.htm?doc_id=450551&cat_id=963.

> ◆ **Step 4: Identify the target population of workers who will be screened.**

In an ideal world, you might aim to screen all of your employees; however, this may not be feasible. Who gets screened is determined to some degree by where the SBI program is housed. If the goal is universal screening for all employees, the program must be housed in a department that has the potential to reach the largest number of workers. An example of this would be through a health promotions department and wellness activities such as annual health risk assessments or health risk appraisals given to all employees. On the other hand, you may want to target screening for workers identified as being at higher risk for an alcohol use problem (e.g., young adult workers). You might also determine that screening is best performed on workers who have specific types of encounters (e.g., those who contact the EAP, workers in safety sensitive positions required to have an annual physical, workers who received a mandatory referral to EAP based on supervisor evaluation of job performance, or workers with a positive bioassay test result for on-the-job alcohol or drug use). Another example would be targeted screening of workers who participate in disease management programs or wellness activities for specific conditions such as diabetes, obesity, stress, or depression. In attempt to manage health and productivity related business costs, employers are often interested in identifying the segments of their workforce that are driving the costs and productivity losses. And moreover, once identified, decisions are made about what kinds of health promotion/wellness programs and services are offered. If your resources (financial, staff, etc.) are limited,

it may be difficult to implement a universal alcohol screening program initially. However, you can start off small and build your program over time.

♦ Step 5: Develop an alcohol education and service outreach strategy for the target population of workers.

There are numerous ways to reach workers with health promotion and service outreach messages. Health promotion programs and activities are the most recommended way to embed alcohol prevention messages and materials into the broader employee culture and build awareness without suffering from the consequences associated with stigma, shame, or professional penalty. Alcohol misuse may occur alone in some people but it often co-occurs with or exacerbates other conditions. Health promotion messages should make the connection between alcohol use and other mental and physical health conditions (e.g., depression, stress, diabetes, obesity). You can build your own health promotion website that incorporates information about alcohol and drug use, and mental and physical health at http://getfit.samhsa.gov/. Here are example of activities you can do: workshops, brown-bags, in-service trainings, health fairs, annual screening days, web-based and classroom-based prevention programs, posters, flyers, mailings, email, 24/7 telephone numbers, intranet site, paycheck stuffers, kiosks, and self-help library. Sample resources can be found at
http://www.ensuringsolutions.org/moresolutions/moresolutions_show.htm?doc_id=467665&doc_parent_id=450551&cat_id=963. .

Vendor materials and outreach services are another way to take advantage of existing materials and resources available through your EAP or behavioral healthcare provider. Vendors often provide consultation with employer clients about how to disseminate educational and service promotion materials to workers. Vendors also offer training to supervisors on how to recognize the signs and symptoms of problem alcohol use among workers and how to refer workers to a provider (e.g., EAP counselor).

♦ Step 6: Develop an alcohol screening protocol.

Decide what screening tool will be used, who will conduct screening, and when and where workers will be screened. Use an evidence-based screening tool such as the Alcohol Use Disorder Identification Test (Babor et al., 1989) that assesses alcohol use at different levels of severity (e.g., hazardous/risky alcohol use not just whether or not an employee is alcohol dependent) since brief intervention is not an appropriate treatment for dependence (for more information on screening tools see the next section on how to conduct alcohol screening). Your workplace SBI protocol should delineate which staff (EAP counselor, occupational health nurse, or a disease management health educator) will administer the screening to workers. Please note that the person who conducts the screening may be different from the person who conducts the brief intervention. Paraprofessionals or by bachelors level staff with minimal training can conduct screening but not brief intervention since the latter requires more advanced training. In some cases, screening will be automated through an online health risk assessment (HRA) or health screen, not by a staff person. The protocol should also specify when (e.g., during EAP intake, during annual medical exam) and where (e.g., in person at the EAP counselors office, telephonically by EAP counselor, in the occupational health clinic) screening will take place. When screening is conducted by a different person than the one doing the brief intervention or when it is automated, the protocol should specify the "hand off" process (i.e., how the workers will be connected to brief intervention, whether by "warm transfer" by telephone to a licensed counselor or if the HRA results will be sent to a nurse who conducts telephonic outreach).

♦ Step 7: Develop a brief intervention protocol.

The protocol should specify what the elements of the brief intervention will be and who, when and where brief intervention will be conducted. The protocol should specify who (e.g., nurse or doctor, certified EAP counselor) will deliver brief intervention and the minimum training requirements. Brief intervention should only be conducted by persons specially trained in providing it for the full-spectrum of drinkers. The protocol should also detail when and where brief intervention will take place (e.g., in-person by EAP counselor, in the clinic by nurse following health screen, or telephonically by life coach). In developing the protocol, consider what brief intervention method you will use, for example, FRAMES (Miller & Sanchez, 1993), FLAGS (O'Connor & Simmon, 2002), or AIMS (Ensuring Solutions, 2007). Although these differ in terms of the specific elements, at the root of them is the use of cognitive-behavioral therapeutic techniques used in psychological and social work settings. Motivational interviewing is one technique (or style) that is used by practitioners who follow these various methods. This style was developed by William Miller and Stephen Rollnick (1991) and has been found to be very effective in motivating people to change unhealthy alcohol use behavior. The brief intervention method recommended in this guide relies heavily on MI.

♦ Step 8: Develop a referral to treatment protocol.

A protocol for treatment referral should provide the person conducting brief intervention with guidance on determining when and for whom referral for more intensive treatment is appropriate. The treatment protocol should also include the process for making a referral, where workers should be referred, and what information should be given to workers to take with them when they leave (e.g., list of self-help and community resources, alcohol education pamphlet, etc.)

♦ Step 9: Develop a follow-up protocol.

A follow-up protocol should specify the types of follow-up that will be conducted and who, when, and how it will take place. Consider which employees will receive administrative follow-up (e.g., to check if he or she made and/or went to the appointment set with the EAP counselor or nurse) and which will receive clinical follow-up (e.g., to reassess self-reported alcohol use, well-being, productivity, conduct a brief intervention booster session, or determine if other services are needed). It should also state when (e.g., administrative follow-up at seven days, clinical follow-up at 30 days) and how follow-up will be conducted (e.g., telephone).

♦ Step 10: Develop a system for collecting, storing, and analyzing data that will help you evaluate your SBI program.

In order to evaluate the utilization and/or impact of an SBI program, during the planning phase it is essential that a needs assessment be conducted to determine how data will be collected (e.g., hardcopy records, computer-based), stored (e.g., databases), and analyzed (e.g., statistical software). Adaptation of the technology infrastructure may be needed and should be done during the planning phase (not the evaluation phase). Keep in mind that platforms on which data is collected, stored, and analyzed vary significantly depending on the type of data and the department/business unit collecting it. Platforms may not be originally built for the purpose of sharing data or communicating between them. EAP data, referral and treatment data, customer satisfaction data, HR data, productivity data, and pharmacy and cost data may be stored in different places.

As you conduct your needs assessment, keep in mind what outcomes you are most interested in measuring. Consider what outcomes are the most important to your leadership and would be most helpful in demonstrating the performance of your program. A basic evaluation of your SBI program will likely include the following outcomes: number of workers screened, number who refused screening, percentage who screened positive for hazardous/harmful use and number who screened positive for dependence, number of workers who received and refused brief intervention, number of brief intervention sessions provided, number who were referred to treatment, number who received and refused follow-up, and number who report initiating and/or completing treatment.

Implementing Your Program

How to Conduct Alcohol Screening

Once you have planned your SBI program and appropriate staff have received training, you will be ready to implement workplace SBI. Guidance on how to conduct brief intervention and additional training resources can be found in the sections that follow. In this section you will find the tools you need to screen for unhealthy, hazardous alcohol use, how to score and interpret the results, and guidance on the recommended level of intervention.

There are several screening tools available for alcohol screening. However, the Alcohol Use Disorder Identification Test (AUDIT) is highly recommended for SBI programs because it detects hazardous and harmful use as well as suspected dependence. Other alcohol screening instruments such as the CAGE (Ewing, 1984) only screen for alcohol dependence and is, therefore, not appropriate for SBI as brief intervention is not recommended for people with alcohol dependence.

The AUDIT is an evidence-based screening instrument developed by the World Health Organization (Babor et al., 1989, Babor et al., 2001). It screens for alcohol problems experienced in the last year. It is not a diagnostic tool. The AUDIT consists of 10 items which can be administered by a practitioner, in-writing, or via computer. Screening using AUDIT takes approximately five minutes. It can be administered alone or embedded into a health risk assessment (HRA) or health screen. It can also be used in conjunction with other tools for substance abuse screening (e.g., ASSIST or DAST) or behavioral health screening (e.g., PHQ-9 depression screener). More information on these tools is available in the resources section.

Presented below are the questions and scoring protocols for conducting alcohol screening using AUDIT. When reviewing the AUDIT, please keep in mind that items 1–3, referred to as the AUDIT-C, can be administered as a prescreen in approximately one minute. The AUDIT-C is used to determine whether or not the remaining seven questions (items 4–10) need to be given.

Scoring the AUDIT:
- Questions 1–3 are scored using 0, 1, 2, 3, or 4 points.
- Questions 4–8 are scored are scored using 0, 1, 2, 3, or 4 points. Please keep in mind that
- Questions 9 and 10 are scored using 0, 2, or 4 points only (other scoring columns for these questions are not applicable).

Interpreting AUDIT:
- An AUDIT-C score of 4 for men and 3 for women indicates a positive alcohol prescreen, thus the remaining 7 questions should be asked.
- An overall AUDIT score of 8 or higher generally indicates at-risk, harmful, or hazardous drinking.

Alcohol Use Disorder Identification Test (AUDIT)

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

*Questions that use the term "alcohol" refer to any form of alcohol, including beer, wine, liquor, or any other alcoholic beverage.

Determining Level of Intervention:

Use the AUDIT score to determine the level of intervention most appropriate for the person screened. The table below presents AUDIT score ranges, risk levels (Zones I–IV), and recommended interventions. See the next section for more information on risk levels and resulting interventions.

AUDIT score	Risk Level	Intervention
0-7	Zone I	Alcohol education
8-15	Zone II	Simple advice
16-19	Zone III	Simple advice plus brief intervention and follow-up with continued monitoring if possible
20-40	Zone IV	Referral to a specialist for diagnostic evaluation and treatment

Implementing Your Program

How to Conduct Brief Intervention, Referral & Follow-Up

Brief intervention is an evidence-based procedure aimed at treating risky, problem, or hazardous alcohol use, including binge drinking and other forms of heavy drinking. It is not intended to be the sole intervention for people who can be classified as being alcohol dependent. In cases of alcohol abuse or dependence, brief intervention can be used as a motivational tool prompting more intensive treatment or referral to specialized alcohol treatment providers (e.g., certified alcohol counselor or outpatient clinic). For others classified as at-risk or heavy drinkers but not dependent, the primary aim of brief intervention is to help them become aware of their hazardous alcohol use and to understand that their current behavior increases their risk of health, social, relationship, legal, and financial problems.

Brief intervention sessions should be personalized and delivered in a supportive, nonjudgmental manner. Information provided to the person receiving brief intervention should be tailored based on the person's readiness to change their behavior. Brief intervention sessions can range from about 5 to 10 minutes (for brief health education and simple advice) or 15 – 45 minutes in cases where brief counseling is required along with health education, simple advice and motivational interviewing. Because brief intervention involves person-to-person contact, it is during these sessions where the counselor may determine that it is best to refer the person to more intensive alcohol treatment.

Practitioners who conduct brief intervention must receive specialized training. Not all licensed, certified professionals have training in the area of alcohol/drug abuse. They may not know how to talk about alcohol use to workers or provide brief counseling to address an alcohol problem. For these reasons, this guide contains the three steps of brief intervention – the elements of brief intervention in the AIMS method (Ensuring Solutions, 2007). Step 1 is to **inform** the person about the consequences of heavy alcohol use. Step 2 offers information on how to **motivate** a person to change their behavior. Step 3 contains information on conducting **follow-up (support)**. In addition to the required specialized training, the following steps and detailed information can be used to effectively conduct brief intervention.[1]

♦ **Step 1: Inform**

All clients screened should receive feedback regarding their AUDIT scores and risk level in addition to being offered educational information about unhealthy alcohol use
1. Inform worker about his or her screening score
2. Inform worker about health risks and other problems (social, financial, legal, relationship) associated with current pattern of alcohol use
    - AUDIT Zone I & Abstainers – Inform worker that he or she is *at low risk*. Offer congratulation to people at low risk or those who abstain from alcohol use and encourage them to remain that way. If possible, set a follow-up appointment to re-assess and monitor behavior (in-person or telephonically).
    - AUDIT Zone II - Inform worker that he or she is *at low risk*. Congratulate and encourage the person to remain that way. Continue to Step 2 in order to motivate.
    - AUDIT Zone III- Inform worker that he or she is *at risk* for health and other problems associated with risky alcohol use. Continue to Step 2 in order to motivate.
    - AUDIT Zone IV - Inform Worker that he or she is *at high risk* of experiencing severe problems associated with heavy alcohol use and may be dependent. Continue to Step 2.

---

[1] The information and materials (e.g., sample dialogue) presented in this section are adapted from several seminal sources, including Babor et al., 1989, 2001; Miller & Rollnick, 2002; World Health Organization (2003a); and Martino et al., 2006.

3. Inform worker of recommended standard drink guidelines (e.g., World Health Organization recommends no more than 2 drinks per day for men, 1 drink per day for women and older adults, and 0 drinks per day for pregnant women). Use the standard drink guidelines found in the next section (Resources) to help him or her understand what amounts of alcohol are found in a "standard drink" and how much alcohol constitutes low risk drinking.

4. Offer worker simple educational information on unhealthy alcohol use, including information on the risks associated with heavy drinking. If the client discloses the use of other substances, offer educational information for those specific drugs and risks associated with drug use. The Resources section offers the additional resources to help in these instances:
   - Verbal Resource: See "Alcohol Use Risks and Effects of High Risk Drinking"
   - Printed Resource: Pamphlets, fact sheets, self-help guides, etc.
   - Web-based Resources: Web-based prevention and self-help programs, links to credible health information.

♦ Step 2: Motivate

Based on a person's AUDIT score, he or she is classified into risk levels which correspond to zones between I and IV.

1. Use the table provided in the previous section to determine the level of brief intervention to provide.
   - Clients scoring in AUDIT Zone II receive "Simple Advice."
   - Clients scoring in AUDIT Zone III receive "Simple Advice plus BI." Motivational interviewing is also used to motivate client to change behavior.
   - Clients scoring in AUDIT Zone IV receive "BI plus Referral to Treatment," motivational interviewing is used to motivate client to seek treatment.

2. Review detailed tables for Zones II thru IV for more insight into specific intervention techniques. (Below)

AUDIT Zone II - Simple Advice
1. **Provide simple advice** and suggest cutting back or abstaining, limiting drinking to no more than 1 drink per hour. Inform client no to drive after drinking and to avoid social situations that encourage drinking (e.g., going to happy hour or a party at a friend's house after work) and, instead, encourage client to engage in healthy alternative activities (e.g., choose to drink soda, go for a walk when feeling stressed instead of having a drink).
2. **Set Follow-up Appointment** to re-assess and monitor behavior (in-person or telephonically).

AUDIT Zone III - Simple Advice Plus Brief Intervention
1. **Provide simple advice** as described in AUDIT Zone II
2. **Conduct brief intervention using motivational interviewing** with the primary focus of motivating the client to change alcohol use behavior. It is also essential that rapport be established with the client. Be sure to emphasize that responsibility for changing behavior belongs explicitly to the client. Several steps and techniques exist within

motivational interviewing to help clients decide to change their behavior.

> ➤ Assess/explore client's concern about their alcohol use as well as their understanding of relevant risks and negative consequences. Additionally, you will want to use the following resources (provided in Resources section) to assess client motivation:
>   - Readiness to change behavior (see "Readiness-To-Change Rulers" and "Stages of Change Characteristics and Strategies")
>   - Reasons for wanting or not wanting to change
>   - Pros and cons of change (see "Decisional Balance Assignment")
>   - Strength of commitment to change (see "Importance Ruler")
>   - Strength of confidence to change (see "Confidence Ruler")
>   - Client's thinking about change (see "Questions to Think About")
>   - Skills (coping, resistance, and assertiveness skills)

> ➤ Use "Summary Statements" to reflect back what you've heard. Summarize client's concerns, their pros and cons, the importance/confidence findings, and client's reasons for change. The following statements may be useful:
>   - *What you said is important. I value what you say.*
>   - *Here are the salient points we've talked about….*
>   - *This is what I heard you say about….*
>   - *We've talked a lot about…. Let's talk about….*

> ➤ Elicit "Self-Motivational Statements." The following examples categorize client statements into four groups.
>   - **Problem recognition**
>   *I didn't realize how much I was drinking.*
>   *I thought most people drank as much as I do.*
>   *I didn't realize I was putting myself at risk for health problems.*
>   - **Expression of concern**
>   *I'm really worried that my drinking is affecting my relationship with my husband.*
>   *I'm afraid I'm going to lose my job because of my drinking.*
>   - **Intentions to change**
>   *I really want to cut down on my drinking.*
>   *I don't know how but I want to stop reaching for a beer every time I feel stressed out.*
>   - **Optimism**
>   *I really think I can cut back on my drinking.*
>   *I am going to overcome this.*

> ➤ Elicit "Change Talk" during exploration by facilitating client's verbalization of desire, ability, reason, need, and commitment to change behavior. The practitioner should use open-ended questions as illustrated below:
>   - *I'd like to hear your thoughts about….*
>   - *What are some of the things that bother you about using alcohol?*
>   - *What role do you think drinking played in….?*
>   - *How would you like your drinking to be in a year from now?*

- ➤ Assist client in setting achievable goals.
  - ▪ Use open-ended questions to initiate dialogue (e.g., "What changes are you thinking about making?", "What do you think you will do?", "What do you see as your options?")
  - ▪ Use SMART goal setting (**S**pecific, **M**eaningful, **A**ssessable, **R**ealistic, **T**imed). The following statements are useful examples:
    What will be your first (next) step?
    What will you do in the next one or two days?
    What goal have you set to achieve by our appointment next week?
    What help or support will you ask for from your family to help you achieve this goal by next week?
  - ▪ Use goal setting exercises (see "Setting Goals for Change")

- ➤ Use 5 Principles of Motivational Interviewing (READS) while exploring and eliciting "change talk" to enhance motivation to change:
  - ▪ **Roll with resistance** (e.g., blaming, arguing, negating, minimizing). This principle emphasizes to not directly oppose resistance, and instead to "roll with it." It provides information about the factors that foster or reduce motivation. Use these opportunities to engage clients in problem-solving (e.g., client says: "Look, I don't have a drinking problem. I can quit anytime I want to. I just like the taste." Practitioner response: "I'm not here to convince you that you're an alcoholic. I'd just like to give you some information. What you do is up to you.")
  - ▪ **Express empathy.** This reinforces the rapport established with the client and is the basis for engaging the client in a process of change. Use reflective listening to understand the client's feelings without judging, criticizing, or blaming. Use statements such as "I hear you", "Please tell me more", "I'm accepting, not judging you" in order to express empathy. For example, if a client says: "My wife gets really angry at me when I drink too much." As a practitioner you might say "She gets mad when you do that." Or perhaps is a client says: "I've got to be honest, I really enjoy drinking. It makes me feel good." You might ask: "You like drinking alcohol? Using alcohol makes you feel good?" With expressing empathy it is important to convey an attitude of acceptance and respect to foster a therapeutic relationship and enhance the client's self-esteem (e.g., "I understand why this has been difficult for you", "You've tried very hard to quit", "You are courageous to talk about this openly", "It sounds like it's been very difficult for you to cope with pressures at work" "I can understand why drinking feels so good to you.")
  - ▪ **Avoid argumentation.** Direct confrontation typically results in the client reacting defensively and increases resistance. Instead, focus on helping the client recognize his or her problems rather than forcing them to admit them (e.g., avoid using statements such as "You are in denial", "You are an alcoholic", "You refuse to address your alcohol problem head on"
  - ▪ **Develop discrepancy.** Identify any discrepancy between the client's current behavior and personal goals they have set for future behavior. Amplify the discrepancy by asking the client what is positive and what is

negative about the same behavior, reflect back and examine what the client says (e.g., identify how drinking negatively impacted work performance and resulted in not getting a raise, and the client's desire to do a good job and to earn a job promotion).

- **Support self-efficacy**. Provide recognition and support for the client's small, positive steps toward behavioral goals. Convey to the client that you believe they can achieve their goals (e.g., "It's great to hear that you are interested in getting more information about safe alcohol use", "I'm glad that you have cut back on your drinking from four to two drinks per day", "It's great that you decided to take a taxi rather than drive home after having a drink", "What difficult goals have you achieved in the past?", "I believe you can reach the goals you've set for yourself").

---

3. **Set Follow-up Appointment** to re-assess and monitor behavior (in-person or telephonically).

---

4. **Provide Referral to Treatment** (if needed). If alcohol use issues are not resolved through brief intervention sessions, refer client to a treatment provider.
   - ➤ Have treatment resource list readily available
   - ➤ Provide a written referral with information for local treatment providers and/or programs (e.g., addiction specialist, treatment facilities, self-help programs, community-based programs such as AA, community mental health clinics)
   - ➤ Whenever possible, make immediate referral using "warm transfer" (i.e., connecting client directly to treatment provider by telephone while client is in the office)
   - ➤ If immediate referral is not possible, connect client within 24 hours.

AUDIT Zone IV- Brief Intervention Plus Referral to Treatment
1. **Provide simple advice** as described in AUDIT Zone II
2. **Conduct brief intervention using motivational interviewing** as described in AUDIT Zone III paying particular attention to the following techniques and resources: ➤ Primary focus is motivating client to seek treatment and to connect with referred treatment provider ➤ Establishing rapport with the client is essential ➤ Explore client's understanding of the issues and readiness for treatment using the following resources (provided in the Resources section):   - Concern about their alcohol or drug use   - Understanding of relevant risks and negative consequences   - Readiness to change behavior (see "Readiness-to-Change Rulers")   - Readiness to seek treatment   - Reasons for wanting or not wanting to seek treatment   - Pros and cons of seeking treatment (see "Decisional Balance Assignment")

> - Strength of commitment to seeking treatment (see "Importance Ruler")
> - Strength of confidence to seek treatment (see "Confidence Ruler")
>
> ➢ Assist client with setting short-term goals aimed at treatment seeking (e.g., set an appointment with a counselor, check into a treatment facility)

3. Provide a referral to treatment. There are several tasks to complete in order to do this effectively.
   ➢ Have treatment resource list readily available

   ➢ Provide a written referral with information for local treatment providers and/or programs (e.g., addiction specialist, treatment facilities, self-help programs, community-based programs such as AA, community mental health clinics)

   ➢ Whenever possible, practitioner should make immediate referral using "warm transfer" (i.e., connecting client directly to treatment provider by telephone while client is in the office)

   ➢ If immediate referral is not possible, practitioner should connect client within 24 hours

---

♦ Step 3: Follow-up

All clients can be provided follow-up to re-assess and monitor their behavior change. If this is not feasible or if resources are limited, conduct targeted follow-up with clients who scored at higher levels of risk (start with AUDIT Zone III as a first priority, followed by Zone IV). If resources remain, follow-up with clients at the lowest level of risk - AUDIT Zone II "Simple Advice" and AUDIT Zone I "Alcohol Education". Two types of follow-up can be conducted:

1. **Administrative Follow-up**
   Practitioner conducts short-term follow-up (e.g., within 72 hours, within 7 days, etc.) by telephone to check if the client has made an appointment with the referred provider and/or has begun treatment. This is may be particularly beneficial to clients at the highest level of risk (e.g., alcohol dependent) who were referred to treatment.

2. **Clinical Follow-up**
   Practitioner conducts intermediate and long-term follow-up (e.g., at 30, 60, and 90 days; 6 months; and/or 1 year) by telephone or in-person to re-assess level of alcohol use and monitor behavior. This type of follow-up provides another opportunity to conduct a 3-5 minute brief intervention session and to assess progress with treatment, recovery, and need for additional services.

Evaluating Your Program

♦ **Why Evaluate**

It is important to evaluate your program regardless of whether you are implementing your SBI program on a small scale (e.g., in one worksite) or on a large scale (e.g., in all worksites in your region). The information gleaned from conducting a pilot test evaluation or field test evaluation can help you make strategic decisions about program processes and training needs as well as assess the impact of your program at both the individual employee level and organizational level. Evaluation data can also be a valuable asset when developing performance and accountability reports for leadership and key stakeholders.

♦ **Things to Consider**

During the program planning stage it is essential that you keep in mind the types and sources of data you will need to conduct your evaluation. SBI data can come from many different sources—EAP or managed behavioral healthcare organization (MBHO) case records and utilization claims, pharmacy or cost databases; health plan databases, occupational health and safety records; health promotion/wellness programming data; human resources records; employee/client surveys; health risk assessments; training data; records from interviews, meetings, focus groups with leadership and other key stakeholders; and quality assurance data (e.g., audiotapes, checklists, standardized SBI coding instruments). Keep in mind that the data are likely stored in various formats and locations. An assessment of your IT capabilities and infrastructure is recommended early on during the implementation and evaluation planning stage. Consider bringing in representatives from the various departments that collect and warehouse the data you want to ensure that it is feasible to gather, store, analyze and report the data you need.

♦ **Developing Your Evaluation Plan**

There are numerous methods and designs that can be used to evaluate your program. You may want to consider consulting with an SBI researcher or a program evaluator to develop an evaluation design specific to your program. In this section you will find information to help you decide which outcomes and processes you are most interested in evaluating in order to help you develop an evaluation plan.

You can begin by thinking of your evaluation plan as having three main components:
- Process
- Impact
- Outcome

Process Evaluation

Process (or formative) evaluations are used to assess the implementation of an intervention or program that is in the early phases of design or operation. This is done in order to answer research questions related to the delivery and structure of the program and to gather estimates of the magnitude of the impact to be expected. Many new programs fail because insufficient time and resources are invested in conducting formative activities prior to full scale implementation. A process evaluation verifies what the program is and whether it is delivered to the target group as intended and in the intended dosage.

The process evaluation for your SBI program should include an assessment of *fidelity* and *quality*.

> ➢ Specific evaluation questions may include:
> - Is the SBI service delivery process being implemented with consistency (fidelity)?
>   Examples: The AUDIT is administered during all intake assessments except in emergency cases; brief motivational counseling is delivered to alcohol workers who score positive for hazardous alcohol use; annual physical exams include alcohol screening by occupational health staff; workers who screen positive on HRA receive telephonic outreach for brief intervention.
> - Are staff implementing SBI services with a high level of skill and attention to protocol in the manner in which they had been trained (quality)?

The process evaluation should assess the relationships between program components and the affect components have on one another.

> ➢ Specific evaluation questions may include:
> - How does the adoption of an SBI program affect policies and protocols of an organization?
> - How does it impact IT infrastructure and data collection and management/what needs to be in place?
> - What impact does it have on HR procedures?
> - How does it impact contractual relationships/do contracts need to be modified (e.g., between employer and HRA or EAP vendor)?

The process evaluation should help you to not only identify who the key stakeholders are, but also which stakeholders are responsible for the day-to-day implementation and which will advocate for or authorize the full adoption, continuation, and expansion of your program. Thus, it should include an assessment of key stakeholders' priorities, expectations, and intended use of the information that is generated by implementing the SBI program—all of which may vary considerably from stakeholder to stakeholder.

Gaining an early understanding of desired program outcomes is most important and valuable for determining the likelihood of a program's future success. If programs fail to meet expected outcomes they are likely loss supported and not be sustained over time. The outcomes that are most important to leadership may include preventing unintended consequences on performance standards (e.g., increased "talk time" between a counselor and worker), demonstrating a positive return on investment (ROI), building organizational capacity, building a more highly skilled EAP or occupational health staff. For staff conducting SBI, the most important outcomes may be the opportunity to gain knowledge and skills around alcohol use and motivational counseling, and credentialing (e.g., certifications in SBI, continuing educations units or CEUs). For workers, important outcomes may include the ability to access services paid for by the employer for alcohol-related issues rather than more expensive fee-for-service treatment options.

> ➢ Stakeholder questions may include:
> - What would you like this SBI program to accomplish?
> - What outcomes are priorities for you?
> - What is most important about this SBI program to you?
> - What do you see as the critical evaluation questions?
> - How will you use the data that is generated from the evaluation?
> - If an effective SBI program was fully implemented in your organization, how would you use data that was generated from the program?

Another aspect of your process evaluation should be the assessment of attitudes and beliefs of stakeholders (e.g., counselors, nurses, workers) about the materials and resources that will be used to implement your SBI program.

> ➢ Stakeholder questions may include:
> - Training – Are the training materials interesting, easy to understand, user-friendly, comprehensive? Are the materials (videos, online programs) engaging? Do you believe these materials will be effective in teaching staff how to conduct alcohol screening and brief intervention? Would you recommend these materials to other practitioners?
>
> - Education/Outreach Materials – Are the promotion materials interesting? Can you identify/relate to the materials? Would the materials motivate you to seek assistance or change your behavior in any way? Is there anything in the material that is offensive? What do you believe is the message of the promotional material? Does this material provide you with information you would need to seek assistance if you decided to?
>
> - Policies – Are the materials and resources on policy development helpful in writing less criminalizing, less punitive workplace alcohol use policies? Is the language around promotion of alcohol prevention and access to treatment for all employees appropriate? Do you have any concerns about the use and applicability of specific language either for the entire workforce or subgroups of workers (e.g., DOT regulated, safety sensitive) in your organization? Do the policy development tools help you to balance the integration of preventive, treatment oriented language while maintaining the message that on-the-job alcohol use is a violation of company policy that will not be tolerated?
>
> - Screening Tools and Protocols – Do you think the alcohol screening tools and protocols can be seamlessly integrated into existing procedures and activities (e.g., as part of intake assessment, screening at health fairs, conducting annual physical exam)? Are the protocols easy to understand? What are the challenges in using these tools and protocols? Can these tools be integrated into your HRA or health screen?

Impact Evaluation

The impact component of SBI evaluation includes an assessment of the effect of the training program on the staff that will provide the services (e.g., EAP clinical care managers, occupational health and safety nurse or physician, health promotion and wellness practitioner). A pretest-posttest questionnaire and supervisor performance feedback/coaching assessments can be useful in collecting this data.

> ➢ Specific evaluation questions may include:
> - Does the training program increase knowledge about alcohol use issues?
> - Does the training program increase knowledge of alcohol screening and brief intervention skills (i.e., how to administer, score, and interpret the AUDIT; how to conduct motivation interviewing)?
> - Does the training program increase knowledge of SBI delivery self-efficacy (perceived confidence/difficulty in delivering SBI effectively)?

Preliminary Outcomes Evaluation

A preliminary outcomes evaluation can provide short-term outcome data that can help you estimate the outcomes that can be *expected* once a program is fully implemented. It can help you make preliminary judgments about whether the desired effects are likely to occur if the program is implemented with fidelity and quality (as determined by the process evaluation). It can also serve as a blueprint for evaluating intermediate and long-term outcomes as data is collected over time.

Short-term program outcomes of interest may include:
a. *Rates of worker contact* with practitioner (counselor, nurse) for any reason,
b. *Rates of identification* of alcohol problems (misuse, abuse, dependence),
c. *Rates of referral, initiation and engagement* in treatment (brief intervention and/or intensive treatment), and
d. *Individual-level worker outcomes* (e.g., alcohol consumption, stage of behavior change, absenteeism, job performance, presenteeism, health risk). Recommended tools include the Work Limitations Questionnaire (WLQ) and Health and Performance Questionnaire (HPQ).

> ➢ Specific evaluation questions may include:
> - Does implementing or modifying existing educational outreach efforts targeted at employees and supervisors result in greater contact with the provider of SBI over time (i.e., rate of worker contact before SBI compared to rate after implementing the SBI program)?
> - Does modifying internal service processes (e.g., modifying EAP intake assessment and referral procedures, modifying annual physical exam protocols used by occupational health nurses to include alcohol screening) result in increased rates of identification, referral, initiation and engagement in treatment over time?
> - Does modifying internal services improve worker outcomes?

In summary, a basic evaluation containing these components will allow you to systematically collect information about the processes, activities, characteristics, and preliminary outcomes of your workplace SBI program. This information will help SBI program managers and decision-makers make judgments about the current form of the program, inform decisions about ways to improve program materials, and implement processes to improve program effectiveness.

Resources

Alcohol Use Guidelines
Below is information on what defines a standard drink in the U.S., recommended safe drinking guidelines, and the risks associated with unhealthy alcohol use. People often are unaware of what a standard drink is and underestimate their consumption when responding to screening items such as "How many drinks containing alcohol do you have on a typical day of drinking?" The standard drink table below can be used during screening to help a person more accurately quantify the amount of alcohol consumed.

What's a Standard Drink?

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

(Source: Helping Patients Who Drink Too Much: A Clinician's Guide – Updated 2005 Edition http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf)

A standard drink in the U.S. is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents. These are approximates, since different brands and types of beverages vary in their actual alcohol content. Many people don't know what counts as a standard drink and so they don't realize how many standard drinks are in the containers in which these drinks are often sold. Some examples:

For **beer,** the approximate number of standard drinks in

- 12 oz. = 1
- 16 oz. = 1.3
- 22 oz. = 2
- 40 oz. = 3.3

For **malt liquor,** the approximate number of standard drinks in

- 12 oz. = 1.5
- 16 oz. = 2
- 22 oz. = 2.5
- 40 oz. = 4.5

For **table wine,** the approximate number of standard drinks in

- a standard 750 mL (25 oz.) bottle = 5

For **80-proof spirits,** or "hard liquor," the approximate number of standard drinks in

- a mixed drink = 1 or more*
- a pint (16 oz.) = 11
- a fifth (25 oz.) = 17
- 1.75 L (59 oz.) = 39

*Note: It can be difficult to estimate the number of standard drinks in a single mixed drink made with hard liquor. Depending on factors such as the type of spirits and the recipe, a mixed drink can contain from one to three or more standard drinks.

U.S. Adult Drinking Guidelines and Drinking Patterns

The two primary sources used to define recommended drinking guidelines in the U.S. are the World Health Organization (WHO) and National Institute of Alcohol Abuse and Alcoholism (NIAAA). At the time of this report, the guidelines somewhat differ and are as follows:

WHO recommended guidelines:
- Men - no more than 2 drinks per day or 14 per week
- Women - no more than 1 drink per day or 7 per week
- Older adults (men and women) – no more than 1 drink per day or 7 per week
- Pregnant or breast feeding women - 0 drinks per day

WHO also recommends that persons not use any alcohol when:
- Driving or operating machinery
- Taking medications that react with alcohol
- Have medical conditions made worse by alcohol
- Cannot stop or control your drinking

NIAAA guidelines:
(Source: Helping Patients Who Drink Too Much: A Clinician's Guide – Updated 2005 Edition. http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf)

- Men - no more than 4 drinks per day or 14 per week
- Women - no more than 3 drink per day or 7 per week
- Pregnant or breast feeding women - 0 drinks per day

As part of providing normative feedback after screening and simple advice during brief intervention, practitioners can use the guidelines presented above and NIAAA's drinking pattern chart below to advise a person on what constitutes safe and normative alcohol use as well as build awareness about how the persons alcohol use compares to the general population of U.S. adults. The chart shows that (1) most people abstain or drink within the recommended limits and (2) the prevalence of alcohol use disorders rises with heavier drinking. It should be noted that though cutting down within the limits of safe drinking is recommended, doing so is not risk free since motor vehicle crashes, injuries, and other problems can occur at lower drinking levels.

WHAT IS YOUR DRINKING PATTERN?	HOW COMMON IS THIS PATTERN?	HOW COMMON ARE ALCOHOL DISORDERS WITH THIS PATTERN?
Based on the following limits—number of drinks: On any **DAY**—Never more than **4** (men) or **3** (women) **– and –** In a typical **WEEK**—No more than **14** (men) or **7** (women)	Percentage of U.S. adults aged 18 or older*	Combined prevalence of alcohol abuse and dependence**
Never exceed the daily *or* weekly limits (2 out of 3 people in this group abstain or drink fewer than 12 drinks a year)	**72%**	less than **1 in 100**
Exceed *only* the *daily* limit (More than 8 out of 10 in this group exceed the daily limit *less than once a week*)	**16%**	**1 in 5**
Exceed *both daily and weekly* limits (8 out of 10 in this group exceed the daily limit *once a week or more*)	**10%**	almost **1 in 2**

* Not included in the chart, for simplicity, are the 2 percent of U.S. adults who exceed only the weekly limits. The combined prevalence of alcohol use disorders in this group is 8 percent.

Alcohol Use Risks and Effects of High Risk Drinking

(Source: WHO-ASSIST: Guidelines for use in primary care. 2003)
http://www.who.int/substance_abuse/activities/en/Draft_The_ASSIST_Guidelines.pdf

Excessive alcohol consumption is a risk factor for a wide range of health and social problems and is a major cause of premature illness and death.

Acute intoxication with alcohol is associated with:
- aggressive and violent behavior
- increased risk of accidents and injury
- nausea and vomiting
- hangovers (headaches, dehydration, nausea, etc.)
- reduced sexual performance

Chronic excessive consumption can affect every part of the body and lead to long-term health problems. High risk drinking is associated with:
- high blood pressure and stroke
- anxiety, depression and suicide
- liver disease
- digestive problems, ulcers and inflammation of the pancreas
- blackouts and hallucinations
- difficulty remembering things and solving problems
- premature ageing
- impotence
- permanent brain injury leading to memory loss, cognitive deficits and disorientation
- impaired mobility as a result of osteoporosis, gout, and muscle and nerve damage
- cancer of the mouth, throat and breast

Tolerance and dependence may develop after chronic excessive use of alcohol and dependent drinkers may suffer withdrawal symptoms if they reduce or stop their alcohol consumption. Severe alcohol withdrawal complicated by delirium tremens is a medical emergency. Withdrawal symptoms include:
- tremor
- sweating
- anxiety
- nausea, vomiting and diarrhea
- insomnia
- headache
- hallucinations
- convulsions

Women who consume alcohol during pregnancy are at risk of having babies who suffer from fetal alcohol syndrome which is associated with deformities and impaired brain development.

Effects of High-Risk Drinking

Aggressive, irrational behaviour. Arguments. Violence. Depression. Nervousness.

Cancer of throat and mouth .

Frequent colds. Reduced resistance to infection. Increased risk of pneumonia.

Liver damage.

Trembling hands. Tingling fingers. Numbness. Painful nerves.

Ulcer.

Impaired sensation leading to falls.

Numb, tingling toes. Painful nerves.

Alcohol dependence. Memory loss.

Premature aging. Drinker's nose.

Weakness of heart muscle. Heart failure. Anemia. Impaired blood clotting. Breast cancer.

Vitamin deficiency. Bleeding. Severe inflammation of the stomach. Vomiting. Diarrhea. Malnutrition.

Inflammation of the pancreas.

In men: Impaired sexual performance. In women: Risk of giving birth to deformed, retarded babies or low birth weight babies.

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

(Source: AUDIT: Guidelines for use in primary care. 2001
http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

<u>Drug Use Risks</u>
Source: WHO-ASSIST: Guidelines for use in primary care. 2003)
http://www.who.int/substance_abuse/activities/assist_v3_english.pdf

Cannabis (marijuana, hashish)
- Problems with attention and motivation
- Anxiety, paranoia, panic, depression
- Decreased memory and problem solving ability
- High blood pressure
- Asthma, bronchitis
- Psychosis in those with a personal or family history of schizophrenia
- Heart disease and chronic obstructive airways disease
- Cancers

Cocaine
- Difficulty sleeping, heart racing, headaches, weight loss
- Numbness, tingling, clammy skin, skin scratching or picking
- Accidents and injury, financial problems
- Irrational thoughts
- Mood swings - anxiety, depression, mania
- Aggression and paranoia
- Intense craving, stress from the lifestyle
- Psychosis after repeated use of high doses
- Sudden death from heart problems

Amphetamine (stimulants)
- Difficulty sleeping, loss of appetite, weight loss, dehydration
- jaw clenching, headaches, muscle pain
- Mood swings –anxiety, depression, agitation, mania, panic, paranoia
- Tremors, irregular heartbeat, shortness of breath
- Aggressive and violent behavior
- Psychosis after repeated use of high doses
- Permanent damage to brain cells
- Liver damage, brain hemorrhage, sudden death (ecstasy) in rare situations

Inhalants
- Dizziness and hallucinations, drowsiness, disorientation, blurred vision
- Flu like symptoms, sinusitis, nosebleeds
- Indigestion, stomach ulcers
- Accidents and injury
- Memory loss, confusion, depression, aggression
- Coordination difficulties, slowed reactions, hypoxia
- Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys)
- Death from heart failure

Sedatives
- Drowsiness, dizziness and confusion

- Difficulty concentrating and remembering things
- Nausea, headaches, unsteady gait
- Sleeping problems
- Anxiety and depression
- Tolerance and dependence after a short period of use.
- Severe withdrawal symptoms
- Overdose and death if used with alcohol, opioids or other depressant drugs.

Hallucinogens
- Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory
- Difficulty sleeping
- Nausea and vomiting
- Increased heart rate and blood pressure
- Mood swings
- Anxiety, panic, paranoia
- Flash-backs
- Increase the effects of mental illnesses such as schizophrenia

Opioids
- Itching, nausea and vomiting
- Drowsiness
- Constipation, tooth decay
- Difficulty concentrating and remembering things
- Reduced sexual desire and sexual performance
- Relationship difficulties
- Financial and work problems, violations of law
- Tolerance and dependence, withdrawal symptoms
- Overdose and death from respiratory failure

Injected Drugs
Risks associated with the substance:
- Injecting any drug increases likelihood of becoming dependent
- Injecting amphetamines or cocaine increases likelihood of experiencing psychosis. Risk of psychosis can be reduced by avoiding injecting and smoking and avoiding use on a daily basis
- Injecting heroin or other sedatives increases likelihood of overdose
- For use of depressant drugs like heroin, risk of overdose can be reduced by avoiding use of other drugs (especially sedatives or alcohol) on the same day, using a small amount and always have a trial "taste" of a new batch, having someone with you when using, avoiding injecting in places where no-one can get to you if you do overdose, knowing the telephone numbers of the ambulance service

Risks associated with the injecting behavior:
- May damage skin and veins and cause infections
- May cause scars, bruises, swelling, abscesses and ulcers
- May cause veins to collapse
- Injection into the neck can cause a stroke

Sharing of injecting equipment (needles & syringes, spoons, filters, etc.):
- Increases likelihood of spreading blood borne virus infections like Hepatitis B, Hepatitis C and HIV

- It is safer not to inject
- If you inject, always use clean equipment, a new needle and syringe, don't share equipment with other people, clean the preparation area, clean your hands, clean the injecting site, use a different injecting site each time, inject slowly, put used needle and syringe in a hard container and dispose of it safely

Educational Materials for Workers

<u>Pamphlets</u>
Strategies for Cutting Down
English http://www.niaaa.nih.gov/NR/rdonlyres/99F90B78-D784-42B1-8009-EA8B8654472D/0/StrategiesForCuttingDown.pdf
Spanish http://www.niaaa.nih.gov/NR/rdonlyres/83FE739F-3AB6-4352-83D1-A340F19765E6/0/StrategiesForCuttingDownSP.pdf

How to Cut Down on Your Drinking
English: http://pubs.niaaa.nih.gov/publications/handout.htm
Spanish: http://pubs.niaaa.nih.gov/publications/spancut.htm

Tips for Cutting Down
English: http://pubs.niaaa.nih.gov/publications/Tips/tips.pdf
Spanish: http://pubs.niaaa.nih.gov/publications/Tips/tips_spanish.pdf

What is a Standard Drink?
English http://www.niaaa.nih.gov/NR/rdonlyres/1D2BE3DF-18D7-47EE-98C5-E907C7611929/0/StandardDrink.pdf
Spanish http://www.niaaa.nih.gov/NR/rdonlyres/0288989D-6328-43D0-8F79-46D87DC25655/0/StandardDrinkSP.pdf

U.S. Adult Drinking Patterns
English http://www.niaaa.nih.gov/NR/rdonlyres/E170A639-B684-41A6-8EB6-1237AF74E56C/0/DrinkingPatterns.pdf
Spanish http://www.niaaa.nih.gov/NR/rdonlyres/5D9B3217-8D34-4C7B-BD34-D509378CEFB5/0/DrinkingPatternsSP.pdf

Harmful Interactions: Mixing Alcohol with Medicines
English: http://pubs.niaaa.nih.gov/publications/Medicine/Harmful_Interactions.pdf
Spanish: http://pubs.niaaa.nih.gov/publications/MedSpanish/medicine.pdf

<u>Booklets</u>
Self-help Strategies for Cutting Down or Stopping Substance Use: A Guide (Draft Version 1.1 for Field Testing) developed by the World Health Organization 2003. This self-help guide contains materials on alcohol and drug use that practitioners can provide to persons who screen positive. http://www.who.int/substance_abuse/activities/en/Draft_Substance_Use_Guide.pdf.

What You Don't Know Can Harm You.
http://www.niaaa.nih.gov/NR/rdonlyres/117174C3-7821-4C09-90DB-BEE634DA686C/0/HarmAl.pdf

<u>Additional Instruments</u>

A number of additional instruments are referred to throughout this guide. More information is below.

<u>Behavioral Health</u>

The following behavioral health screening tools can be used by practitioners in conjunction with the AUDIT alcohol screening tool. Some of these tools are brief and can be embedded in a health risk assessment (HRA), health screen, employee survey, or intake assessment. Others are more comprehensive and can be used as a stand alone instrument for assessing the use of a broader array of substances (e.g., tobacco, marijuana, cocaine).

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST): Guidelines for Use in Primary Care (Draft Version 1.1 for Field Testing)
  http://www.who.int/substance_abuse/activities/en/Draft_The_ASSIST_Guidelines.pdf

- Drug Abuse Screening Test (DAST)
  http://www.ensuringsolutions.org/usr_doc/DAST.pdf
  http://eib.emcdda.europa.eu/html.cfm/index3618EN.html
  http://counsellingresource.com/quizzes/drug-abuse/index.html
  http://www.ireta.org/sbirt/pdf/SBIRT_TOOL_KIT.pdf

- Patient Health Questionnaire - PHQ-9 Depression Screener
  http://www.phqscreeners.com/
  http://www.phqscreeners.com/pdfs/PHQ-9/English.pdf

<u>Productivity</u>

The following productivity measures can be embedded into a health risk assessment (HRA), health screen, employee survey, or intake assessment and may be useful tools for capturing performance measurement data that is important to key stakeholder.

- Work Limitations Questionnaire (WLQ) Short-form (8-item and 25-item versions)
  http://160.109.101.132/icrhps/resprog/thi/wlq.asp

- Health and Performance Questionnaire (HPQ)
  http://www.hcp.med.harvard.edu/hpq)

Brief Intervention Tools

The following tools are used by practitioners during brief intervention sessions. These are referred to throughout this guide.

Readiness to Change Rulers

The Readiness-to-Change Ruler is used to assess a person's willingness or readiness to change their behavior, determine where they are on the continuum between "not prepared to change" and "already changing", and promote identification and discussion of perceived barriers to change. The ruler represents a continuum from "not prepared to change" on the left, to "already changing" on the right.

The Readiness-to-Change Ruler can be used as a quick assessment of a person's present motivational state relative to changing a specific behavior, and can serve as the basis for motivation-based interventions to elicit behavior change. Readiness to change should be assessed regarding a very specific activity such as cutting down alcohol use, not drinking and driving, or seeking treatment, since persons may differ in their stages of readiness to change for different behaviors.

Below are two examples of readiness rulers that can be used during brief intervention. (Source: Facilitating Behavior Change from AdultMeducation.com, American Society on Aging and American Society of Consultant Pharmacists Foundation 2006. http://www.adultmeducation.com/downloads/Adult_Med_Facilitating.pdf)

Example 1

Download a copy: http://www.adultmeducation.com/downloads/Readiness-to-Change_TOOL.pdf

Example 2.

Take a moment to see where you are on the
Readiness-To-Change Ruler

Not ready for action (Precontemplation) 1

Seriously considering action this week (Preparation) 3

Maintaining new behaviors (Maintenance) 5

1 2 3 4 5 6

2 Considering action sometime in the next few months (Contemplation)

4 Already taking action (Action)

6 Relapse

*Adapted from Kaiser Permanente Northwest Region, Center for Health Research, Portland Oregon.

Administration:
1. Indicate the specific behavior to be assessed on the Readiness-to-Change Ruler form. Ask the person to mark on a linear scale from 0 to 10 their current position in the change process. A 0 on the left side of the scale indicates "not prepared for change" and a 10 on the right side of the scale indicates "already changing".
2. Question the person about why he or she did not place the mark further to the left, which elicits motivational statements.
3. Question the person about why he or she did not place mark further to the right, which elicits perceived barriers.
4. Ask the person for suggestions about ways to overcome identified barriers and actions that might be taken.

Scoring:
A score above 5 shows that the person is willing to consider change and should be supported and encouraged. Example 2 above illustrates where along the continuum of change the person is based on his/her score. For example, a score of 1 indicates the person is in the precontemplation stage, and so on.

After the readiness ruler has been administered, practitioners can use follow-up questions to elicit "change talk" such as those below. (Source: Zimmerman et al., 2000)

If the person's mark is on the left of center:
- How will you know when it is time to think about changing?
- What signals will tell you to think about making a change?
- What qualities in yourself are important to you?
- What connection is there between those qualities and not considering a change?

If the person's mark is near the center:
- Why did you put your mark there and not closer to the left?
- What might make you put your mark a little further to the right?
- What are the good things about the way you are currently trying to change?
- What are the things that are not so good?
- What would be a good result of changing?
- What are the barriers to changing?

If the person's mark is on the right of center:
- What is one barrier to change?
- What are some things that could help you overcome this barrier?
- Pick one of those things that could help and decide to do it by _____ (specific date).

If the person has taken a serious step in making a change:
- What made you decide on that particular step?
- What has worked in taking this step?
- What helped it work?
- What could help it work even better?
- What else would help?
- Can you break that helpful step down into smaller parts?
- Pick one of those parts and decide to do it by _____ (specific date).

If the person is changing and trying to maintain that change:
- Congratulations! What's helping you?
- What else would help?
- What makes it hard to maintain the change?

If the person has "relapsed":
- Don't be hard on yourself. Change is hard and may take time.
- What worked for a while?
- What did you learn that will help when you give it another try?

Stages of Change Characteristics and Strategies
The table below provides a description of the characteristics of persons in each stage of change and strategies used by practitioners to foster positive behavioral change.

STAGE	CHARACTERISTICS	STRATEGIES
Precontemplation	The person is not even considering changing. They may be "in denial" about their health problem, or not consider it serious. They may have tried unsuccessfully to change so many times that they have given up.	Educate on risks versus benefits and positive outcomes related to change
Contemplation	The person is ambivalent about changing. During this stage, the person weighs benefits versus costs or barriers (e.g., time, expense, bother, fear).	Identify barriers and misconceptions Address concerns Identify support systems
Preparation	The person is prepared to experiment with small changes.	Develop realistic goals and timeline for change Provide positive reinforcement
Action	The person takes definitive action to change behavior.	Provide positive reinforcement
Maintenance and Relapse Prevention	The person strives to maintain the new behavior over the long term.	Provide encouragement and support

Source: Zimmerman et al., 2000; Tabor and Lopez, 2004

Importance and Confidence to Change Rulers
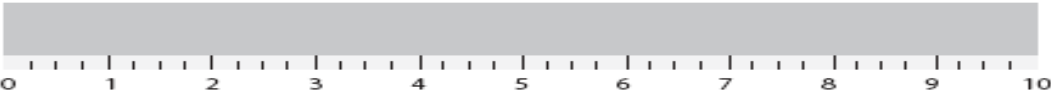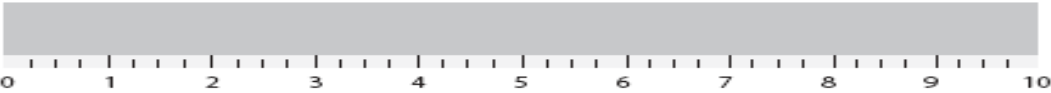(Source: Centre for Addiction and Mental Health (www.camh.net)

Two factors related to a person's readiness to change are "importance" and "confidence". "Importance" is the extent to which a person values making the behavior change. "Confidence" is the extent to which a person believes in their ability to change their behavior successfully (i.e., self-efficacy). Persons who report low importance or low confidence may be unwilling to commit to behavior change. On the other hand, persons who report high importance and high confidence are more likely to commit and be successful in their behavior change.

The rulers below can be used to assess importance and confidence as well as the extent to which the goal is realistic for the person. The wording of the questions should be modified to be specific to the behavior the person wants to change. Similar to the readiness rulers above, practitioners can ask follow-up questions such as those shown below.

THE READINESS RULER
People usually have several things they would like to change in their lives. Your substance use may be only one of the things you hope to change. Your **motivation** to change your substance use can vary, depending on other things that are happening.
      On each of the rulers below, circle the number (from 0 to 10) that best fits with how you are feeling right now.

1. How **important** is it to you to reduce or quit using alcohol or other drugs?

0   1   2   3   4   5   6   7   8   9   10

2. How **confident** are you that you will not use alcohol or other drugs?

0   1   2   3   4   5   6   7   8   9   10

3. How **realistic** is it that you will stay away from alcohol and other drugs in the long term?

0   1   2   3   4   5   6   7   8   9   10

SOME QUESTIONS TO THINK ABOUT
• Why are you at your current score and not at zero?
• What would it take for you to move to a higher score?
• What has made this change important to you so far—why are you not at zero?)
• What would it take to make this change even more important to you?
• What support would you need to make a change, if you chose to do so?
  This exercise can also be used to explore readiness to change other behaviours, such as taking prescribed medication, looking for a job or finding stable housing. Feel free to discuss any of the information on this form with me.

_____
Signature of Clinician

_____
Name and Credentials (print)

_____
Contact Information

Commitment to Change Exercises
Practitioners can use the exercise below to help a person making a clear decision on whether he/she wants to change. This exercise asks a person to articulate the pros and cons of changing and continuing their current behavior. (Source: Centre for Addiction and Mental Health (www.camh.net)

Decisional Balance Assignment

One of the first steps toward successfully changing your substance use is reaching a clear decision that you want to change.

In this exercise, you will think about and record some of the important advantages and disadvantages of changing or continuing your drinking or other drug use. You will stack up what you have to lose against what you have to gain.

Fill in the table below. When you are finished, review your answers and weigh your reasons for change. Which way does your decisional balance tip?

Changing Your Current Drinking or Other Drug Use

What's good about it?	What's not so good about it?

Continuing Your Current Drinking or Other Drug Use

What's good about it?	What's not so good about it?

Setting Goals for Change and Developing a Plan Exercises
The following exercises can be used to help a person set one or more behavior change goals. The goal(s) must be SMART (specific, measurable, attainable, realistic and timely). Although long-term goals may be stated, short-term immediate goals and specific actions/steps to be taken should be clearly stated. Persons only need to set 1 or 2 goals during the initial brief intervention session, setting numerous goals may be overwhelming. At subsequent brief intervention sessions, previously stated goals and progress made toward them can be revisited and new goals can be stated as goals are achieved. Setting and achieving smaller, fewer goals can build self-efficacy over time.

One goal might be to either cut down or stop drinking. Another goal may have to do with behaviors related to drinking (e.g., "I won't drive after I've been drinking."). The following exercise can be done verbally or written to assist a person with deciding on what the goals will be. This exercise can be followed-up with a decisional balance exercise whereby the person can write down the positives and the negatives of the goal (e.g., pros and cons of cutting down vs. quitting, or driving vs. not driving after drinking).

WILL I CUT DOWN – OR WILL I STOP MY ALCOHOL USE?

Now that you've decided to make a change to your alcohol use, your next decision is whether you'll drink less or stop drinking altogether.

To help you make up your mind, think about these questions:
- Do you have any health or psychological problems that might be made worse by your alcohol use? - Your doctor can advise you.

- Do you experience withdrawal symptoms when you stop drinking? If so, stopping drinking entirely is probably the best goal for you. - Your doctor can help you manage the withdrawal symptoms.

- Do you have any legal or financial problems as a result of your alcohol use?

- Do you have any relationship or family problems because of your alcohol use?

- Have you solved alcohol use problems before by stopping completely? - Then this might be your best way now.

(Adapted from: WHO Self-Help Strategies for Cutting Down or Stopping Substance Use: A Guide. Draft Version 1.1. for Field Testing. 2003).
http://www.who.int/substance_abuse/activities/en/Draft_Substance_Use_Guide.pdf

---

The goal setting exercise below is useful for helping a person articulate specifically what they want to change and develop a plan for change.

Change Plan Worksheet
The changes I want to make are:
The most important reasons I want to make these changes are:
My main goals for myself in making these changes are:
I plan to do these things to reach my goals: *Plan of Action* *When*
The first steps I plan to take in changing are:
Some things that could interfere with my plan are:
Other people could help me in changing in these ways: *Person* *Possible ways to help*
I hope that my plan will have these positive results:
I will know that my plan is working if:
Sources: Miller and Rollnick, 1991; Miller et al., 1995.

The practitioner can provide (verbally or written) the following considerations to assist the person in completing the worksheet

Change Plan Considerations
▪ *The changes I want to make are...* Be specific. Include goals that are positive (wanting to increase, improve, do more of something), and not just negative goals (stop, avoid, or decrease a behavior). ▪ *My main goals for myself in making these changes are...* What are the likely consequences of action or inaction? Which motivations for change are most compelling? ▪ *The first steps I plan to take in changing are...* How can the desired change be accomplished? What are some specific, concrete first steps? When, where, and how will the steps be taken? ▪ *Some things that could interfere with my plan are...* What specific events or problems could undermine the plan? What could go wrong? How will the person stick with the plan despite these particular problems or setbacks? ▪ *Other people could help me in changing in these ways...* What specific things can another person do to help them take the steps to change? How will the person arrange for such support? ▪ *I will know that my plan is working if...* What will happen as a result of taking the different steps in the plan? What benefits can be expected?
Sources: Miller et al., 1995.

Additional Training Resources

Many of the training materials in this workplace SBI guide are adapted from materials developed in the medical SBI arena. Below is a list of some of these resources, from which additional training can be obtained.

- AlcoholCME.com http://www1.alcoholcme.com/

- American College of Emergency Physicians (ACEP)
    - Alcohol Screening and Brief Intervention in the Emergency Department http://acepeducation.org/sbi/
    - American College of Emergency Physicians' (ACEP) Brief Negotiated Intervention (BNI) Manual: Screening and Brief Intervention for Unhealthy Alcohol Use in the ED http://acepeducation.org/sbi/media/bni_manual.pdf
    - AMA and ACEP CMEs offered

- American College of Surgeons Committee on Trauma (COT)
    - Alcohol Screening and Brief Intervention (SBI) for Trauma Patients: COT Quick Guide http://www.facs.org/trauma/publications/sbirtguide.pdf

- Australian Department of Veterans' Affairs
    - Creating Opportunities for Reducing Alcohol Related Harm in the Veteran Community: Alcohol Screening and Brief Intervention AS+BI – A Training Program for Veteran Service Providers (Version 2.3 December 2002). http://www.dva.gov.au/health/younger/mhealth/alcohol/training/manual.pdf

- Boston Medical Center Alcohol Clinical Training (ACT) Project
    - Alcohol Screening and Brief Intervention Curriculum http://www.bu.edu/act/mdalcoholtraining/index.html

- Boston Medical Center BNI-ART Institute
    - Emergency Department Alcohol Education Project - Screening, Brief Intervention, Referral and Treatment (SBIRT) http://www.ed.bmc.org/sbirt/index.htm

- CSAT/SAMHSA
    - TIP 35 Enhancing Motivation for Change in Substance Abuse Treatment. This guide shows how clinicians can influence the change process in their clients by developing a therapeutic relationship, one that respects and builds on the client's autonomy and, at the same time, makes the treatment counselor a participant in the change process. The TIP also describes different motivational interventions that can be used at all stages of change, from pre-contemplation and preparation to action and maintenance. http://ncadi.samhsa.gov/govpubs/BKD342/ http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.61302

    - Quick Guide for Clinicians. Based on TIP 35 Enhancing Motivation for Change in Substance Abuse Treatment. This quick guide is based entirely on TIP 35 and is designed to meet the needs of the busy clinician for concise, easily accessed "how to" information. This guide may be most useful as a "desk reference" for practitioners who have already received training.

- Enhancing Motivation for Change Inservice Training (EMCIT) Manual. This manual is based on Treatment Improvement Protocol (TIP) 35, Enhancing Motivation for Change in Substance Abuse Treatment. EMCIT provides materials for inservice training for practitioners on basic concepts of motivational enhancement. The manual is written so an extensive background in training is not needed. The inservice training is useful for new counselors or clinicians who are unfamiliar with the basic concepts of motivational enhancement. The manual provides eleven 1½- to 2-hour training modules that can be delivered over consecutive days or several weeks. Each module includes presentation instructions, PowerPoint slides (that can be copied onto overhead transparencies), homework assignments, and participant handouts. Online http://kap.samhsa.gov/products/manuals/tip35c/index.htm and in PDF http://download.ncadi.samhsa.gov/Prevline/pdfs/SMA06-4190.pdf

  - TAP 21 Addiction Counseling Competencies. This guide explains what fully proficient counselors do in clinical practice to address substance abuse. http://kap.samhsa.gov/products/manuals/pdfs/TAP21.pdf

  - TAP21-A Competencies for Substance Abuse Treatment Clinical Supervisors. This guide is intended for clinical supervisors who provide clinical training and monitoring of clinician counseling competencies. It has been used to develop and evaluate addiction counseling curricula, advise students, and assess counseling proficiencies. http://download.ncadi.samhsa.gov/Prevline/pdfs/tap21a.pdf

  - Mid-Atlantic ATTC's Motivational Interviewing Training Series http://www.midattc.org/accessed/mi.htm

- Motivational Interviewing Network of Trainers (MINT)
  - Training Resources http://motivationalinterview.org/training/index.html

- NIAAA
  - Helping Patients Who Drink Too Much: A Clinician's Guide – Updated 2005 Edition http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

- NIDA
  - Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA:STEP) is a collection of tools for mentoring counselors and other clinicians in the use of MI skills during clinical assessments. The aim of this guide is to provide supervisors and mentors with a systematic way for monitoring clinician MI adherence and competence and to provide clinicians with individualized supervisory feedback and coaching as a means to further develop and refine their MI skills. Available in hardcopy and online from Northwest Frontier ATTC http://www.nfattc.org/ and in PDF format http://www.motivationalinterview.org/library/MIA-STEP.pdf

- University of Vermont
  - Web BI http://dln.uvm.edu/webbi/index.html

- Veterans Affairs
    - HCRC Teaching Guide for Health Care Providers: Reducing Alcohol Use with Brief Intervention http://www.hepatitis.va.gov/vahep?page=prtop03-wp-01-res

- World Health Organization
    - AUDIT: Guidelines for Use in Primary Care http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

    - Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf

    - The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST): Guidelines for Use in Primary Care (Draft Version 1.1 for Field Testing) http://www.who.int/substance_abuse/activities/en/Draft_The_ASSIST_Guidelines.pdf

    - Brief Intervention for Substance Use: A Manual for Use in Primary Care (Draft Version 1.1 for Field Testing). The purpose of this manual is to explain the theoretical basis and evidence for brief intervention and to assist primary health care workers to conduct a simple brief intervention for risky or harmful drug use. Although the manual is particularly aimed at primary health care workers, it may also be useful for others who work with people who engage in risky drug use such as hospital physicians and nurses, social workers, counselors, or prison and probation officers. Together with the ASSIST guidelines for use manual, this manual presents a comprehensive approach to SBI for primary care and is designed to improve the health of populations and patient groups as well as individuals. http://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf

      A supplemental self-help guide for patients is also available. http://www.who.int/substance_abuse/activities/en/Draft_Substance_Use_Guide.pdf

Organizational Tools

Policy Development
- **Department of Labor** (www.dol.gov)
  - Sample Alcohol and Drug Policy - An example of a policy that encourages employees to use EAP services rather than being purely punitive and criminalizing. http://www.ensuringsolutions.org/usr_doc/Sample_Alcohol_&_Drug_Free_Workplace_Policy.pdf

  - Drug-Free Workplace Policy Statement Tool http://www.dol.gov/elaws/asp/drugfree/drugs/screen16.asp

- **International Labour Organization (ILO)**
  Code of Practice on the Management of Alcohol and Drug-Related Issues in the Workplace http://www.ilo.org/public/english/protection/safework/drug/codepr.htm - A preventive approach to alcohol and drug policy and practice change.

  ILO Code Excerpts
  - Developing an Alcohol and Drug Policy http://www.ensuringsolutions.org/usr_doc/Developing_an_alcohol_and_drug_testing_policy_(ILO_Code_excerpt).pdf http://www.ensuringsolutions.org/usr_doc/Developing_an_alcohol_and_drug_program_policy_(ILO_Code_excerpt).pdf

  - Policies Related to Practice Change to Reduce Alcohol and Drug Problems http://www.ensuringsolutions.org/usr_doc/Practice_change_to_reduce_alcohol_and_drug_problems_(ILO_Code_excerpt).pdf

  - Policies Related to Providing Assistance, Treatment, and Rehabilitation to Workers http://www.ensuringsolutions.org/usr_doc/Providing_assistance,_treatment,_and_rehabilitation_to_workers_(ILO_Code_excerpt).pdf

  - Policies Related to Providing Prevention Through Information, Education, Training and Identification http://www.ensuringsolutions.org/usr_doc/Providing_prevention_ILO.pdf

Supervisor Training
- **Department of Labor** (www.dol.gov)
  - Training on Drug-Free Workplace Policy http://www.dol.gov/elaws/asp/drugfree/drugs/supervisor/screen45.asp

  - Signs & Symptoms Recognition and Intervention Techniques http://www.ensuringsolutions.org/usr_doc/Supervisor_Symptom__Intervention_Techniques3.pdf

  - Sample Supervisor Assessment of Suspected Alcohol Use - Signs & Symptoms Recognition http://www.ensuringsolutions.org/usr_doc/Reason_Cause_Med_Eval.pdf

References

Academic ED SBIRT Research. (2007). The Impact of Screening, Brief Intervention, and Referral for Treatment on Emergency Department Patients' Alcohol Use. *Annals of Emergency Medicine,* 50(6), 699-710e.6.

Babor, T, de la Fuente, J, Saunders, J, and Grant, M. (1989). AUDIT The Alcohol Use Disorders Identification Test: Guidelines for use in primary health care. WHO/MNH/DAT 89.4, World Health Organization, Geneva, 1989.

Babor, T, Higgins-Biddle, J, Saunders, J, and Monteiro, M. (2001). AUDIT The Alcohol Use Disorders Identification Test: Guidelines for use in primary health care. WHO/MSD/MSB01.6, World Health Organization, Geneva, 2001.

Bernstein, M and Mahoney, J. (1989). Management Perspectives on Alcoholism: the employer's stake in alcoholism treatment. *Occupational Medicine*, 4(2), 223-232.

Center for Substance Abuse Treatment. (2006). *Enhancing Motivation for Change in Substance Abuse Treatment* (DHHS Publication No. (SMA) 06-4190). Rockville, MD. Miller, W.R.

Ensuring Solutions to Alcohol Problems. (unpublished). *Alcohol Screening and Brief Intervention in the Workplace: Year One Executive Summary*. Washington, DC.

Ewing JA. (1984). Detecting alcoholism: The CAGE questionnaire. *JAMA,* 252, 1905–1907.

Fleming, MF, Mundt, MP, French, MT, Manwell, LB, Stauffacher, EA, and Barry, KL. (2002). Brief physician advice for problem alcohol drinkers: long-term efficacy and benefit-cost analysis. A randomized controlled trial in community-based primary care settings. Alcoholism, Clinical and Experimental Research, 26 (1), 36-43.

Higgins-Biddle, J, Babor, T, Mullahy, J, Daniels, J and McRee, B. (1997). Alcohol screening and brief intervention: where research meets practice. *Connecticut Medicine*, 61(9), 565-575.

Mangione, TW, Howland, J, and Lee, M. (2000). Alcohol and work: results from a corporate drinking study. In SL Issacs & JK Knickman (Eds.), *To Improve Health and Healthcare*, *1998-1999*. San Francisco, CA: Jossey-Bass.

Martino, S., Ball, S.A., Gallon, S.L., Hall, D., Garcia, M., Ceperich, S., Farentinos, C., Hamilton, J., and Hausotter, W. (2006). *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency*. Salem, OR: Northwest Frontier Addiction Technology Transfer Center, Oregon Health and Science University.

Miller, WR and Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York, NY: Guilford Press.

Miller, WR and Rollnick, S. (2002). *Motivational Interviewing: Preparing People to Change Addictive Behavior, 2nd edition.* New York, NY: Guilford Press.

Miller, WR and Sanchez, VC (2003). Motivating young adults for treatment and lifestyle change. In: Howard, G., ed. Issues in Alcohol Use and Misuse by Young Adults. Notre Dame, Indiana: University of Notre Dame Press.

Miller, WR and Wilbourne, PL. (2002). Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. *Addiction*, 97, 265–277.

National Institute of Alcohol Abuse and Alcoholism. (1995). *Motivational Enhancement Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence* (Project MATCH Monographs Series, Vol. 2 NIH Publication No. 94-3723). Rockville, MD. Miller, W.R., Zweben, A., DiClemente, C.C., Rychtarik, R.G.

National Institute of Alcohol Abuse and Alcoholism. (2000). *Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update Methods, and Data* (NIH Publication No. 98-4327). Rockville, MD: Harwood, H.

O'Connor, M and Simmon, M. (2002). Creating Opportunities for Reducing Alcohol Related Harm in the Veteran Community: Alcohol Screening and Brief Intervention AS+BI – A Training Program for Veteran Service Providers (Version 2.3 December 2002). Australian Department of Veterans' Affairs, Alcohol and Mental Health Policy Section, Younger Veterans and VVCS Branch, Health Division.

Substance Abuse and Mental Health Services Administration. (2007). *Results from the 2006 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-32, DHHS Publication No. SMA 07-4293). Rockville, MD.

Tabor, PA and Lopez, DA. (2004). Comply with us: improving medications adherence. *Journal of Pharmacy Practice*, 17(3), 167-181.

World Health Organization. (2003a). *Brief Intervention for Substance Use: A Manual for Use in Primary Care* (Draft Version 1.1 for Field Testing). Geneva, Switzerland: Henry-Edwards, S., Humeniuk, R., Ali, R., Monteiro, M., Poznyak, V.

World Health Organization. (2003b). *Self-Help Strategies for Cutting Down or Stopping Substance Use: A Guide* (Draft Version 1.1 for Field Testing). Geneva, Switzerland: Humeniuk, R., Henry-Edwards, S., Ali, R.

World Health Organization. (2003c). *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Guidelines for Use in Primary Care* (Draft Version 1.1 for Field Testing). Geneva, Switzerland: Humeniuk, R., Henry-Edwards, S., Ali, R.

Zimmerman, GL, Olsen, CG, and Bosworth, MF. (2000). A "stages of change" approach to helping patients with change behavior. *American Family Physician*, 61(5), 1409-1416.