

***Substance Use Disorders:
Best Practices in Screening
and EAP Case Finding***



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EAPs AND WORKPLACE SUBSTANCE USE INTERVENTIONS

*“Empirically in combating addiction, four methods: parole, methadone maintenance, self-help groups and EAPs – have enjoyed the greatest success.” – Harvard addiction researcher George Valliant, from his 1995 book, *The Natural History of Alcoholism*.*

Employee Assistance Programs were once marketed to employers based on their success in helping workers with alcohol and other substance abuse problems. However, the expansion of EA services in other problem areas has blunted the effectiveness of this seminal EA core component. Today, 50 years after the establishment of the first Occupational Alcohol Programs, EAPs have assumed an important role in the global workplace by addressing a myriad of issues in addition to employee alcohol and drug use – critical incidents, stress, marital and relationships, compulsive gambling, financial difficulties, legal, child and elder care. However, intervening with workers suffering from alcohol and drug problems continues to be one of the more common and yet, the most challenging issues EA professionals face.

Understanding the dynamics of substance abuse has been a part of EA practices since its earliest origins in Occupational Alcohol Programs. In an early attempt to define the essential functions of EAPs, Paul Roman and Terri Blum specifically referred to “a focus on alcohol problems” as one of the EAP core technologies. Moreover, like their predecessors, EAPs have historically demonstrated their unique benefit to businesses by intervening with individuals suffering from substance use disorders and returning them and their families to productivity and health – and thus producing significant cost savings to their work organizations. These savings have often been anecdotal, but widely accepted by the sponsoring work organizations.

The emergence of Drug Free Workplace efforts in the 1990s could have provided an excellent opportunity for EA professionals to demonstrate their unique prowess in addressing addiction and related problems in the workplace. Unfortunately, a focus on punitive drug testing methods and a lack of employer commitment to full treatment coverage undermined this potential key EAP’s utility to work organizations – by returning those affected by SUDs to full productivity and health. These concerns about the current levels/methods of EAP case finding for substance abuse problems contribute to the view that employee educational efforts and worksite drug testing are insufficient to identify the majority of substance abuse problems in the workplace. In addition, market forces have influenced many EAPs to shift their focus away from addiction issues, by reinventing themselves to address a broader range of "work-life" issues, such as financial, childcare, and elder care consultations. Another factor is the changing nature of EAP staffing, with more social workers and family therapists enlisted as affiliate or network Employee Assistance providers, and the result that fewer of those serving in EAP functions are knowledgeable about workplace substance use disorders.

According to a recent national survey, just 1 percent of individuals admitted to treatment for an alcohol problem in 2002 were referred by their employer or an EAP, even though conservative estimates are that nearly 20 million US workers have problems with alcohol and/or other drugs of abuse. When one considers the total health and productivity costs to employers, as well as to workers and their families, the toll is staggering. These findings and concerns point to the need for EA professionals to sharpen their skills in assessment, case management, appropriate referral, and follow-up monitoring of substance abuse and dependency among their EA client caseloads.

QUALITY OF EAPS AND PROFESSIONAL PRACTICE

“Millions of employees are suffering from problems such as addiction, depression and obesity -- employers who invest in EAPs are finding the quality of services deteriorating.”
– Employee Benefit Plan Review, January 6, 2005.

This unflattering description of the current state of EA professional practice is further illustrated by some quotes from the above-cited article:

“The current service and price structure are built around managing mental-health claims, whereas the original EAP model for early identification and intervention to maximize employee productivity in the workplace.” - Rob Kramer, Product Manager, Ceridian EAP.

“Because the EAP market is so competitive, prices have not increased in years. Purchasers are looking at price as a primary factor, rather than at what program provides good outcomes. Thus, it is nearly impossible to provide quality services.” - David Sharar, Managing Director Chestnut Health Systems.

“EAPs traditionally have been a tool to enhance workforce productivity and leverage human capital assets. But in recent years, EAPs have created the impression in employers' minds that they are waiting for someone to call with a problem, not reaching out. A good, effective system includes methods of early intervention.” - John Maynard, CEO, EAPA

As another example, the results of a survey of HR professionals presented at EASNA's 2003 Institute noted the following:

- *“EAPs don't provide demonstrations of value, reporting tools fail to inspire belief in EA services”*
- *“EAP education and training efforts appear inadequate”*
- *“EAPs are not viewed as a major contributor to health and productivity; i.e., in reducing absenteeism.”*

Although the emergence of an employee assistance program which combines behavioral health services, treatment for substance use disorders, and work-life benefits via one interface and for one low price is attractive to many employers at a time when costs for such services are rising, the capitulated pricing approach for such a practice model has, many believe, contributed to increased addressed competition in the EAP marketplace, and a subsequent drop in the quality of services provided.

Given the move toward pay for performance that is already sweeping the medical surgical sector of healthcare, and the current continuing trend of escalating health insurance premiums - it seems that a closer look at the effectiveness and quality of services we as EA professionals profess to offer around substance use disorders - one of the 'core technologies' of the EA profession - is indeed justified.

STIGMA AS A BARRIER TO SUBSTANCE ABUSE INTERVENTIONS

Regrettably, negative effect of stigma about substance use disorders often discourages employees from utilizing whatever employer-provided treatment benefits they may have. Some employees fear that once they access their benefits their employers will know about it, even though there laws to protect the confidentiality of records. Others fear their work reputation may suffer, or that they will encounter discrimination and unfair treatment. Decreasing stigma for substance use disorders is critical to becoming more effective in successfully reducing the harmful impact of these problems – some historical examples are leprosy, epilepsy, AIDS, and depression.

Reforming the language we use to describe things related to substance use disorders is not merely an exercise in semantics. Words can be an effective tool in helping to destroy the stigma encountered by people with substance use disorders. Note the use of the value neutral phrase, ‘substance use disorders’. It is not one that you will frequently find in the newspaper or even in much of the literature from government agencies or treatment programs. More likely, you will find such people described as ‘substance abusers, alcoholics, drug abusers,’ or the even more pejorative ‘addicts.’

In a field historically laden with stigma, describing people suffering with substance use problems as ‘abusers’ of alcohol, tobacco or other drugs helps ensure that the onus of addiction remains solely upon the shoulders of the individual, discounting the role that environmental factors, genetics, and the neurological effect of such drugs themselves have in such conditions. Of the terms used to describe these disorders and recovery, the ‘abuse’ terms are among the most pernicious. Terms such as alcohol abuse, drug abuse, and substance abuse all spring from religious and moral conceptions of the roots of severe alcohol and other drug problems. They define the problem in the willful choices of the individual, denying the power of the mind-altering substance, and the culpability of those whose financial interests are served by the status quo.

To label individuals with substance use disorders as alcohol, drug, or substance abusers misstates the nature of their condition and calls for their social rejection and punishment. There are no other medical or behavioral health conditions where the term ‘abuse’ is applied. Of course, many people in the treatment field and in recovery use terms like ‘addicts’ or ‘drunks’ in casual conversation to describe themselves and their peers. But, these terms can be just as damaging about substance use disorders as words like ‘n_____’ -- another term used casually by members within some certain peer groups -- can be in discussions about race, but one that has become unacceptable in any other context. Noted research scientist and substance use professional educator Carlton Erickson notes the terms ‘addiction’, ‘alcoholism’ and ‘substance abuse’ are too often used interchangeably and in a stigmatizing fashion, and are best replaced with appropriate DSM definitions in clinical situations and public discussions.

The Institute of Medicine, in its 2006 publication, *Increasing the Quality of Health Care for Mental and Substance Use Conditions*, notes that the shame, stigma and discrimination still experienced by consumers of services for substance use disorders can prevent them from seeking care, and these individuals face a number of unique obstacles to patient-centered care that are generally not encountered by consumers of other types of health care services. Insurance coverage for substance use disorders is also frequently more limited relative to general health care, adding to the difficulties in obtaining and utilizing the requisite care for these conditions.

THE ‘NEW SCIENCE’ OF SUBSTANCE USE DISORDERS

While alcohol and drug dependence may be the result of a lot of alcohol or drug use, it is not the same as using alcohol or drugs a lot. Substance use disorders do not neatly reside along an automatic path of first initiation, then experimentation, more frequent use, abuse and ultimately, dependency. Perhaps it is helpful to draw the similarity to mood disorders: just as depression is not merely a lot of sadness, neither is alcoholism merely a lot of drinking. Initial low-level involvement with alcohol and drugs may result from peer pressure, availability or other risk factors in the social or family environment. Subsequent escalation and maintenance of increased levels of use is likely a result of biological, psychological or psychiatric characteristics of the individual. In some individuals, vulnerability may be inherited in the form of heightened susceptibility to a certain type of substance. Typically, however, such escalation will be caused by psychological traits or psychiatric conditions, only some of which are inherited.

Although psychoactive drugs have potent addictive properties, most people who experiment with drugs or even use them regularly for a time do not develop dependence. For psychologically healthy individuals, some experimentation with drugs does not normally have adverse future consequences. For others who already have some emotional or psychological difficulty, alcohol and drug use can easily become part of a broad pattern of self-destructive behavior. Drug abuse is a voluntary behavior, but once dependency develops, the brain differs in a fundamental way from a non-dependent brain and use becomes involuntary. Such long-term use results in substantial changes to brain functions that may persist long after an individual discontinues use. Another way to explain the difference is that abuse is a problem to be solved, whereas dependence truly qualifies as a disease to be treated.

Alcoholism and drug dependency have been recognized disease states for a long time, but only recently have advances in brain mapping begun to clearly demonstrate its biological mechanisms, and clearly established substance use disorders as brain diseases - with multiple and significant neurological features. In the early 1970s, there arose an unscientific division between alcoholism and other drug addictions. Actually, alcoholism fits into the same addiction pathway as these other substances and its effects are similarly mediated by similar neurochemical transmitters, under the influence of the mesolimbic dopamine system. This is the basis of the substance use/dependency disease theory as it is understood today, and this new understanding of neurobiology has led to the development and refinement of ever more effective pharmacological and behavioral treatments.

Twenty years ago, conventional treatments for substance use disorders were intensive, abstinence-only oriented therapies. In its defense, this approach enjoyed a certain level of success, particularly with those meeting clinical criteria for dependence. However, many individuals with less severe constellations of involvement with alcohol and drugs are inappropriate for such intensive placements. This is where the explosion has come in treatment for these different conditions – not unlike the current approach to treating different types of cancers. This change is supported by treatment practice studies that demonstrate more extensive treatment does not necessarily lead to better outcomes, thus for some individuals, outpatient treatment may be both more successful and more cost-effective.

One very important change in the current evidence-based approach to substance use disorders is the goal of reaching more clients earlier – with a focus on addressing incipient alcohol and other drug problems before they become serious enough to have health (and other) consequences and require intensive treatment. A critical realization is that initiating earlier, more focused treatment of less severe substance use problems is: 1) ultimately easier to provide, and 2) typically leads to better outcomes. Unfortunately, our existing framework for addressing these problems does not always support early interventions.

INCREASING EFFECTIVENESS IN THE EAP SETTING

Contemporary approaches to case finding for substance use disorders in medical and other health care centers have now incorporated a wider use of universal screening methods. When screened for alcohol problems, one in five men and one in ten women who visit their primary care providers meet the criteria for at-risk drinking, problem drinking or alcohol dependence. Screening tools like the AUDIT and the UNCOPE provide an indication of whether or not an individual appears at risk for a substance use problem. Confidential screening often opens the door for intervention and treatment. Screens are however, inappropriate for use as treatment intake tools and insufficient for supporting diagnoses.

One economical and user-friendly approach for self-screening of alcohol use is via web-based screens. Interactive health communications has been shown to be a successful method to enhance public health. A recent Harris poll estimated 101 million U.S. web users have sought health care information on line in the past year. And according to the Wall Street Journal, more and more Americans have been turning to the Internet to get information, screening, and even intervention services aimed at problem drinking. In the last few years, many employers have begun promoting National Alcohol Screening Day, a nationwide program to encourage confidential screening for alcohol problems held each year in April to encourage employees to self-assess their drinking behavior.

Brief interventions for substance use and related disorders can involve a variety of approaches, from unstructured queries and informational feedback to a more formal, structured brief counseling approach, lasting from one to four sessions. The content and methods of such brief interventions will vary depending on the problem severity, but the underlying goal is similar – to motivate the client to contemplate a new view or take action, i.e., changing a particular attitude, reducing risky behavior, entering treatment, or even just returning for a subsequent session.

- ❖ Example: *How much does a guy like you drink in an average day? -- He answers, then your response might be: Are you aware of the medically accepted guidelines for daily alcohol use?*

For those individuals with a level of substance use disorders which meet clinical criteria (as shown by a comprehensive assessment) setting individualized, realistic goals for treatment are the essential next steps for effective treatment interventions. Successful treatment approaches are not one-dimensional measures, but consider multiple factors – the context for intervention, client diversity, outcomes other than abstinence, workplace/employer expectations, and addressing client changes in outcomes over time.

In 2000, Dr. Michael Fleming, published a study of nearly 800 heavily drinking patients in 17 community clinics. Project TrEAT (Trial for Early Alcohol Treatment) participants reported that they had at least 11 drinks weekly. Dividing the subjects into two groups, the control group simply received written materials on the health risks of drinking, while the second group received more personal and focused interactions with the clinic staff in their once a month clinic visits over two months. In between the 15-minute face-to-face sessions, the clinic followed up with a phone call to the patients. The researchers found, compared to the control group, the intervention group had significantly fewer accidents, hospital visits and other events related to problem drinking. The cost for each brief intervention was \$166 per patient. The counseling sessions generated \$523 in medical savings for each patient, and a benefit-to-cost ratio of 3.2 to 1 over a 12-month period. Over all, the researchers calculated that the brief intervention generated nearly \$56,300 in savings for every \$10,000 invested.

MOTIVATING FOR CHANGE

Among the numerous issues encountered in behavioral health care, one that is not particularly well understood is the notion of client non-compliance. Numerous studies have documented that many individuals receiving mental health services either cannot or will not follow through with agreed upon treatment plans. As with all human behavior issues, the reasons are as varied and complex as the client themselves. However, one promising approach to encouraging better client compliance is applying a counseling methodology focused on assisting the individual to make the necessary changes to improve their health, commonly known as ‘coaching’.

Coaching - that is, to motivate, influence, compel or persuade - has often been used to change executive and employee behavior in work organizations. Executives, managers, supervisors and even team members success often depends on their ability to communicate effectively. The goal of coaching in these programs is to develop effective skills in persuasive internal and external communications; to assess personal style and hone skills that result in strategic, precise, persuasive presentations, and motivational messages. Using corporate coaching as a model, another use of coaching has evolved to meet the needs of those attempting to make lifestyle and behavior changes. This coaching may be referred to as healthy lifestyle coaching, motivational interviewing, co-active coaching, etc. The commonality of these tactics is the goal of helping an individual to first make and then act on decisions to prevent, intervene with, and/or better manage chronic diseases and other health conditions.

People with substance use disorders (and other behavioral health conditions) are often ambivalent about change. They may be choosing to continue such behavior due to unconscious behavior paradigms – i.e.; attraction to a particular lifestyle or want to be included in a peer group; or a conscious one - they may philosophically disagree with marijuana laws, etc. When the destructive nature of these behaviors is pointed out, they are then faced with the reality of giving up most of the people, places and things they have come to enjoy and strongly identify with. Additionally, without a clear picture of the future, these individuals may be reluctant to proceed with any change. Thus, a considerable effort initially may be to focus a client with a substance use disorder on his or her willingness to make (or not make) a commitment to change. This objective, which serves to crystallize client ambivalence to problematic involvement with alcohol and other drugs, is the basis of an emergent framework known as the Stages of Change and the Transtheoretical model.

STAGES OF CHANGE AND THE TRANSTHEORETICAL MODEL

Developed by Prochaska and his colleagues, this approach is an extremely powerful paradigm that reveals a great deal about how people prepare to change their lifestyles and how they can alter behavior patterns successfully. The Transtheoretical Model posits that people move through stages as they attempt to modify a particular behavior. These stages are well documented for many different conditions. Prochaska and others have used the Stages of Change to examine such lifestyle issues as smoking cessation, exercise adoption, dietary changes, quitting cocaine, weight control, reducing adolescent delinquent behaviors, condom use for safer sex, sunscreen use, encouraging mammography screening, prevention of substance abuse among youth, psychotherapy, and much more.

Other medical and behavioral health practitioners have begun applying these research findings and using the stages of change approach to help patients alter negative behaviors for disease prevention, long-term disease management, and notably in addressing addiction and lesser substance use problems. Among the most important conclusions of this growing body of research is evidence that tailoring

interventions to an individual's current stage of change is most effective in promoting a positive trend in behavior change.

The Stages of Change are: **PRECONTEMPLATION** [an individual not contemplating change and may be totally unaware of the need to make the change], **CONTEMPLATION** [an individual is aware and is contemplating making the change, e.g. speaking with a health professional about the health impacts of smoking], **PREPARATION** [an individual is making the preparations needed to make the change, e.g. setting a date to quit, enrolling in a smoking cessation program], **ACTION** [an individual is taking specific steps to actively make the lifestyle change] and **MAINTENANCE** [an individual has successfully made the change and is able to maintain the changed lifestyle over time].

- ❖ As an illustration of the stages of change, it is simple to ask an individual - *On a scale of 1-10, on a scale of 0-10, where 0 = not at all motivated to make this lifestyle change, and 10 = very motivated to make this change -- tell me how motivated are you to make this change?*

In the past, many health professionals have often focused on outcomes of patient non-compliance and failure at implementation of requisite behavior changes. However, emerging evidence from research on the Stages of Change model indicates that understanding patient motivation for and readiness to make changes, appreciating barriers to changes, and a greater effort in helping patients anticipate relapse can markedly improve patient satisfaction and lower provider frustration during the change process.

For example, we now know that on average, individuals who are trying to stop smoking may backslide and smoke again up to seven times before finally quitting for good. This is an important understanding of the practical dynamics of smoking cessation for health professionals as well as for patients. Having this level of understanding of the chronic nature of nicotine cravings and relapse potentiality is extremely helpful so that neither party becomes discouraged and views these incidents as 'failures' -- which (as the Stages of Change model illustrates) are actually just steps along the path towards a smoke-free lifestyle.

A MOTIVATIONAL INTERVIEWING PRIMER

Supported by a plethora of empirical research studies and grounded in the Stages of Change model, Motivational Interviewing (MI) has become a behavioral health best practice approach. Developed by William R. Miller, this technique holds true promise in many diverse counseling settings, and addresses both negative behavior and adherence to treatment by employing strategies focused on supporting individual readiness. MI is a person-centered, directive method of communication used for enhancing intrinsic motivation by helping an individual resolve ambivalence to change.

MI techniques have been repeatedly documented in the research literature as successful in counseling those with alcohol and other drug use disorders (Smith, Shepherd, and Hodgson, 1998; Compton, Monahan, and Simmons-Cody, 1999; Miller and Moyers, 2002; Carroll et. al. 2002; Solomon and Fioritti, 2002; Miller, 1996; Sellman et. al. 2001; Cisler et. al., 1998). Other applications of MI have been utilized in many diverse settings for many different behavioral and lifestyle changes, ranging from the prevention of unhealthy behaviors, to interventions for both acute and chronic disease conditions, as well as for maximizing treatment adherence.

Most people are ambivalent about making changes in their behavior, and will often respond, "Yes, but..." when queried about why they do not implement obvious necessary actions. Their expression is a common sign of avoidance conflict and may involve such statements, as "*I want to stop smoking, but I not sure if I'll be able to...*" Ambivalence is the 'mental mechanism' that keeps most people stuck in such patterns and unable to make lifestyle/behavior changes - even when they readily acknowledge they may need/want/wish to do so.

The motivational counseling approach accommodates this circular process of behavior, in contrast to the traditional more linear view. It recognizes that clients may cycle through these stages of change more than once, perhaps reverting to an earlier stage for a period of time or difficulty, before continuing and embracing the next stage. More specifically, MI attempts to modify unrealistic treatment expectations, to resolve client ambivalence and enhance client self-efficacy, thus ensuring and maintaining client participation in the treatment and recovery outcome.

Components of MI include initial screening and assessment, feedback on personal risk, advice about how to change the drinking behavior, assessing motivation for change, establishing goals, identifying an appropriate referral for further assistance/counseling/specialized treatment, and follow up. Treatment goals may be geared toward reducing drinking, rather than abstinence. Feedback is aimed at increasing a client's awareness of the negative consequences of the drinking behavior. This helps to change misperceptions or misunderstandings of the severity of the alcohol problems. Educational information is focused on identifying action steps to change the drinking pattern. This is followed by formulating goals about drinking patterns (establishing daily/weekly consumption levels), and making plans for achieving them. Follow-up is a particularly important part of the process: 'booster' sessions may be helpful to many clients, allowing them to review progress, reinforce and/or reevaluate various issues. Together, these strategies help to mobilize the patients' coping resources, stimulate and reinforce positive change.

Many of the historical clinical postures to helping individuals adopt behavioral changes have involved client confrontation, patronizing education, and wielding authority. Empirical research has confirmed that these aforementioned ways of influencing lifestyle changes are not particularly efficacious, and specifically that:

- Giving advice, especially unwelcome advice, can often elicit resistance to change;
- 'Knowing what to do' is only weakly correlated with an individual's efforts at actually adopting new behavior; and
- Individuals vary widely in their motivation to change. Thus, for optimum effect, the style of assistance must match an individual's motivation. This requires assessing an individual's current stage of change (or change readiness) and proceeding from this point.

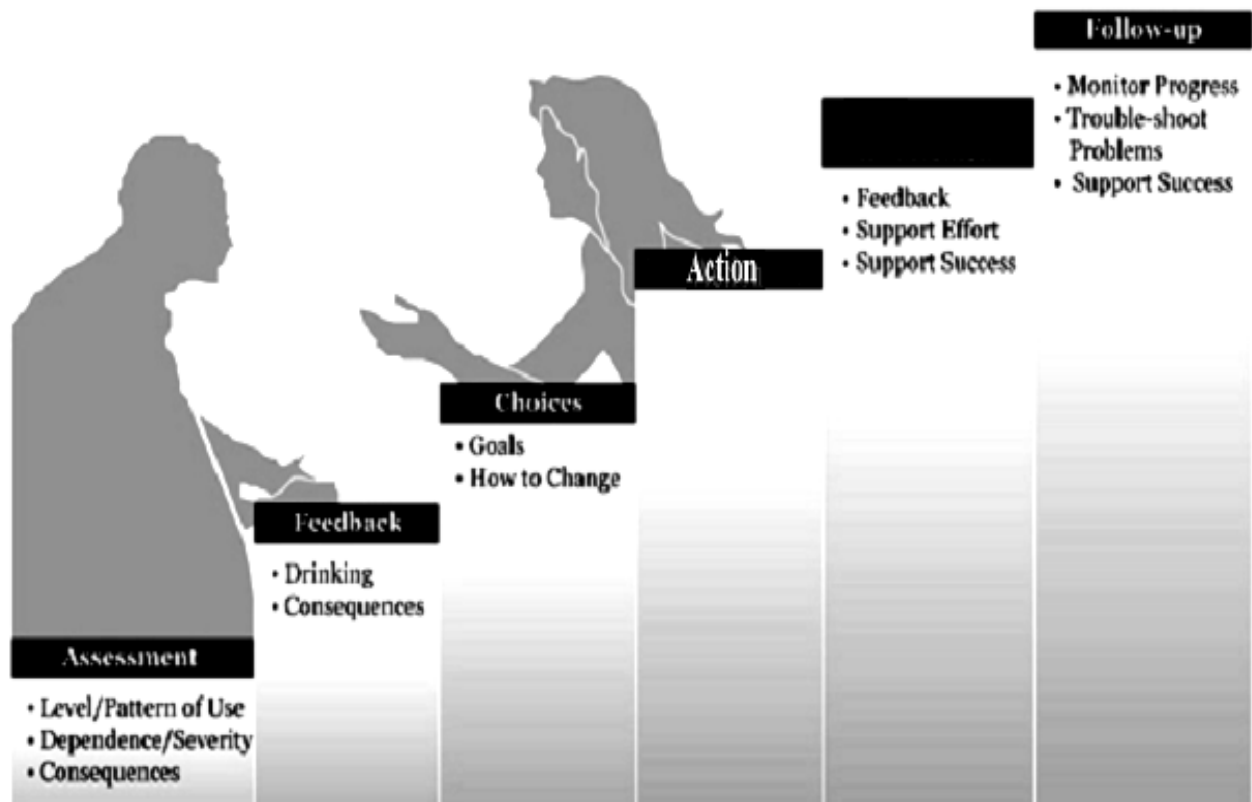
MI, by contrast, involves close counselor-client collaboration, values client evocation, and encourages individual autonomy. It utilizes therapeutic listening and reflective counseling skills coupled to counselor genuineness, positive regard, and empathy for clients to encourage or coach them along the stages of change continuum. MI is most successful with participants who are:

- a) willing to believe that the change in behavior is important;
- b) have confidence that she or he can make the change, and,
- c) able to move to action to make changes, however small.

Throughout the course of applying the MI approach, showing respect and empathy for the client is one of the primary goals for the counselor, who strives to recognize and respect the client's autonomy. A number of important session outcomes can indicate a productive MI encounter:

- The client does most of the work;
- The client accepts the possibility of change;
- The client accepts the responsibility for making the change;
- There is an upward slope of commitment language within and/or between sessions; and,
- Sessions should feel more like ‘dancing with’ and not like ‘wrestling with’ the client.

To ensure successful outcomes with MI techniques, practioners will find it helpful to remember that the keys to successful, enduring behavior change reside within the client. Ultimately, the long-term maintenance of such transformations are dependent on the client's motivation, behavior, values and goals. Adopting a MI approach can help EA professionals better understand where an individual may currently reside in the stages of change sequence, help a client avoid a prolonging resistance to change, encourage a client to accept needed treatment, and ultimately to achieve positive results.



Some useful techniques for Motivational Interviewing in the EA setting:

- ❖ **Suggest strategies or options** - when offering information or advice, use a mutual brainstorming approach, rather than one that restricts or limits choices.
- ❖ **Asking open-ended questions** - Strive to delve deeper into the client's intentions, inquires about their previous experiences with behavior change (both general and specific), and to understand their current state of mind.
- ❖ **Reflective Listening** - this is the heart of the MI approach – try to include 2 - 4 reflective statements for every question asked. In this technique, restate the information using the client's own words or similar words. Try using phrases such as: *It sounds as though you are unsure about.....; It must have been difficult for you to...; You have been feeling discouraged about...; You are embarrassed that.....; and You believe that others view you negatively because...*
- ❖ **Further use of Reflective Listening** - This next level introduces content into the discussion - *You see a connection between your inactivity and being overweight and getting diabetes* - as well as recognizes feelings - *You are scared that if you don't do something about your weight you'll end up with diabetes like everyone else in your family* - and draws meaning from the client's communications - *Your children are important to you and you want them to be healthy and learn from your example.*
- ❖ **Elicit 'change talk'** - With Motivational Interviewing it is helpful to encourage individuals to articulate their intentions while contemplating change, as this reinforces the commitment to take action. Facilitate these types of statements by stressing the advantages of the behavior change, while reiterating the disadvantages of the status quo, and offering optimism about the client's intentions and ability to make changes.
- ❖ Similar to the '*quick assessment*' of an individual's readiness to change is the technique of the '*confidence ruler*' to gauge the person's understanding of their ability in successfully making the lifestyle change - *On a scale of 1-10, how confident are you that you will make this change?*
- ❖ **Exploring Ambivalence** - Responding to change talk by reflecting and elaborating, by affirming the intention, and by summarizing what the person is saying is important to develop the therapeutic alliance for change and to point out discrepancies between current behavior and the client's core values.
- ❖ **Offering a menu vs. single solutions** - *Here are some things that have worked for other people...which of these do you think might work for you? or Controlling your weight may involve several different strategies, such as...which of these do you think are most important for you to work on?* - The focus is on the client's level of problem recognition and ability in articulating reasons for making the desired changes. If the client shows ambivalence, summarizing the pros and cons of the behavior change provides encouragement that the change(s) can be made.
- ❖ **Ask for feedback** - Counselors can elicit additional information and explore new avenues by asking the individual - *What have I missed?*

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying " Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by " alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of " standard drinks" . Place the correct answer number in the box at the right.

| | |
|--|--|
| <p>1. How often do you have a drink containing alcohol?</p> <p>(0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week</p> <p style="text-align: right;"><input type="text"/></p> | <p>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?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p> |
| <p>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more</p> <p style="text-align: right;"><input type="text"/></p> | <p>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p> |
| <p>3. How often do you have six or more drinks on one occasion?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p><i>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</i></p> <p style="text-align: right;"><input type="text"/></p> | <p>8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p> |
| <p>4. How often during the last year have you found that you were not able to stop drinking once you had started?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p> | <p>9. Have you or someone else been injured as a result of your drinking?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <p style="text-align: right;"><input type="text"/></p> |
| <p>5. How often during the last year have you failed to do what was normally expected from you because of drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p> | <p>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <p style="text-align: right;"><input type="text"/></p> |

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

Scoring of the Alcohol Use Disorders Identification Test – AUDIT

The AUDIT questionnaire was developed by the World Health Organization to identify persons whose alcohol consumption has become hazardous or harmful to their health.

BACKGROUND

- The AUDIT is a ten item questionnaire, it takes about 2 minutes to complete.
- Each question is scored from 0-4 for a maximum score of 40.
- Questions 1-3 are about alcohol consumption. High scores on the first 3 items, in the absence of elevated scores on the remaining items suggest hazardous alcohol use.
- Questions 4-6 are about alcohol dependence. Elevated scores on these questions imply the presence or emergence of alcohol dependence.
- Questions 7-10 are about problems caused by alcohol. High scores on these questions suggest harmful alcohol use.

DEFINITIONS

- **Hazardous alcohol intake** is defined as a level of consumption or pattern of drinking which, if it persists, is likely to result in harm. Men regularly drinking more than 3 units/day (21 units/week) and women regularly drinking more than 2 units/day (14 units/ week) can be regarded as hazardous drinkers.
- **Binge drinking** is also regarded as hazardous to health. Binge drinking can be defined as drinking over half the recommended number of units of alcohol per week in one session i.e. 10 units for men or 7 units for women.
- **Harmful alcohol intake** is defined as that causing harm to the psychological or physical wellbeing of the individual.

HOW TO SCORE

- Scores for each question are in brackets beside answers.
- A score of 8 in men and 7 in women indicates a strong likelihood of hazardous or harmful alcohol consumption.
- A score of 13 or more is suggestive of alcohol related harm.

SUGGESTED ACTION

- **For a score between 8-13 for men and 7-13 for women advise your patient to cut down on drinking.** Explain the harm excessive drinking can do, give positive reasons for drinking less and advise on sensible drinking limits.
- **For a score of over 13 in men and women advise your patient to abstain from alcohol.** Further assessment is advised e.g. physical examination, blood tests and assessment for dependence.

Sensible limits

- Sensible/low risk limits for men are no more than 3 units/day or 21 units/week.
- Sensible/low risk limits for women are no more than 2 units/day or 14 units/week.

1 unit of alcohol is equivalent to

- 12 oz. of beer
- 5 oz. glass of wine/ 1 wine cooler
- 1.5 oz of liquor
- Small glass of fortified wine, brandy

The UNCOPE Screen for SUDs

The UNCOPE consists of six questions found in existing instruments and assorted research reports. This screen was first reported by Hoffmann and colleagues in 1999. Variations in wording are noted for several of the items. The more concrete wording of the revised versions were found to be slightly more effective when used as a generic screen. Either version of the six questions may be used free of charge for oral administration in any medical, psychosocial, or clinical interview. They provide a validated, yet simple and quick means of identifying risk for abuse and dependence for alcohol and other drugs. Please maintain author attribution when citing or discussing in reports. For further information contact: Norman G. Hoffmann, Ph.D., Evinco Clinical Assessments 828-454-9960, evincoassessment@aol.com; or Bill Calhoun, The Change Companies at 888-889-8866, bcalhoun@changecompanies.net

- U** - “In the past year, have you ever drank or **used** drugs more than you meant to?”
Or “Have you spent more time drinking or using than you intended to?”
- N** - “Have you ever **neglected** some of your usual responsibilities because of using alcohol or drugs?”
- C** - “Have you felt you wanted or needed to **cut down** on your drinking or drug use in the last year?”
- O** - “Has your family, a friend or anyone else ever told you they **objected** to your alcohol or drug use?”
Or “Has anyone **objected** to your drinking or drug use?”
- P** - “Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs?”
Or “Have you found yourself thinking a lot about drinking or using?”
- E** - “Have you ever used alcohol or drugs to relieve **emotional discomfort**, such as sadness, anger, or boredom?”

UNCOPE Response Key:

Two positive responses indicate a strong likelihood of an alcohol and/or drug abuse problem.

Four or more positive responses strongly indicate an alcohol and/or drug dependence problem.

A CAUTION REGARDING ALL SCREENS

Screens provide an indication of whether or not an individual appears at risk for a given condition; but are inappropriate for use as treatment intake tools and insufficient for supporting diagnoses. The UNCOPE and other substance use disorder screens are most appropriate to identify potential risk for abuse or dependence when neither is clearly identified as a problem. Appropriate venues for screening would be mental health and medical clinics, employee assistance counseling, marital and family counseling. Screens are inappropriate for evaluating persons arrested for driving under the influence, those presenting for treatment, or those being evaluated for any issue associated with substances. These latter individuals are already identified as being at risk, so a screen would be redundant. For these cases, more extensive diagnostic assessment tools are recommended. Such diagnostic instruments are required for documentation when treatment recommendations or decisions other than referral for further evaluation are to be made.

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)

INSTRUCTIONS: Please read each of the following statements carefully. Each one describes a way that you might (or might not) feel about your drinking or drug use. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle only one number for each statement.

| | NO! Strongly Disagree | No Disagree | ? Undecided or Unsure | Yes Agree | YES! Strongly Agree |
|--|-----------------------------|----------------|-----------------------------|--------------|---------------------------|
| 1. I really want to make changes in my drinking or drug use. | 1 | 2 | 3 | 4 | 5 |
| 2. Sometimes I wonder if I am an alcoholic or drug dependent. | 1 | 2 | 3 | 4 | 5 |
| 3. If I don't change my drinking or drug use soon, my problems are going to get worse. | 1 | 2 | 3 | 4 | 5 |
| 4. I have already started making some changes in my drinking or drug use. | 1 | 2 | 3 | 4 | 5 |
| 5. I was drinking or using drugs too much at one time, but I've managed to change my drinking or drug use. | 1 | 2 | 3 | 4 | 5 |
| 6. Sometimes I wonder if my drinking or drug use is hurting other people. | 1 | 2 | 3 | 4 | 5 |
| 7. I am a problem drinker or drug user. | 1 | 2 | 3 | 4 | 5 |
| 8. I'm not just thinking about changing my drinking or drug use, I'm already doing something about it. | 1 | 2 | 3 | 4 | 5 |
| 9. I have already changed my drinking or drug use, & I am looking for ways to keep from slipping back to my old pattern. | 1 | 2 | 3 | 4 | 5 |
| 10. I have serious problems with drinking or drug use. | 1 | 2 | 3 | 4 | 5 |
| 11. Sometimes I wonder if I am in control of my drinking or drug use. | 1 | 2 | 3 | 4 | 5 |
| 12. My drinking or drug use is causing a lot of harm. | 1 | 2 | 3 | 4 | 5 |
| 13. I am actively doing things now to cut down or stop drinking or drug use. | 1 | 2 | 3 | 4 | 5 |
| 14. I want help to keep from going back to the drinking or drug use problems that I had before. | 1 | 2 | 3 | 4 | 5 |
| 15. I know that I have a drinking or drug use problem. | 1 | 2 | 3 | 4 | 5 |
| 16. There are times when I wonder if I drink or use drugs too much. | 1 | 2 | 3 | 4 | 5 |
| 17. I am an alcoholic or I am drug dependent. | 1 | 2 | 3 | 4 | 5 |
| 18. I am working hard to change my drinking/drug use. | 1 | 2 | 3 | 4 | 5 |
| 19. I have made some changes in my drinking or drug use, and I want some help to keep from going back to the way I used to drink or use drugs. . | 1 | 2 | 3 | 4 | 5 |

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)

Scoring: Transfer the client's answers from questionnaire (see explanatory note below):

Recognition Questions:

1 _____ 3 _____ 7 _____ 10 _____ 12 _____ 15 _____ 17 _____

Ambivalence Questions:

2 _____ 5 _____ 6 _____ 9 _____ 11 _____ 14 _____ 16 _____

Taking Steps Questions:

4 _____ 8 _____ 13 _____ 18 _____ 19 _____

Totals:

Recognition: _____ **Ambivalence:** _____ **Taking Steps:** _____

| DECILE SCORES | Recognition | Ambivalence | Taking Steps |
|-----------------------|-------------|-------------|--------------|
| 90 (Very High) | | 19-20 | 39-40 |
| 80 | | 18 | 37-38 |
| 70 (High) | 35 | 17 | 36 |
| 60 | 34 | 16 | 34-35 |
| 50 (Medium) | 32-33 | 15 | 33 |
| 40 | 31 | 14 | 31-32 |
| 30 (Low) | 29-30 | 12-13 | 30 |
| 20 | 27-28 | 9-11 | 26-29 |
| 10 (Very Low) | 7-26 | 4-8 | 8-25 |

The above scoring guide provide generalized information about client scores (low, average, or high) *relative to people already seeking treatment for alcohol or drug problems*. The following characterizations are only general guidelines for interpretation, it is best to closely examine a client's individual item responses for additional information, or for use as discussion points.

RECOGNITION

HIGH scorers directly acknowledge that they are having problems related to their drinking, tending to express a desire for change and to perceive that harm will continue if they do not change.

LOW scorers deny that alcohol is causing them serious problems, reject diagnostic labels such as "problem drinker" and "addicted," and do not express a desire for change.

AMBIVALENCE

HIGH scorers say that they sometimes *wonder* if they are in control of their drinking, are drinking too much, are hurting other people, and/or are addicted. Thus a high score reflects ambivalence or uncertainty. A high score here reflects some openness to reflection, as might be particularly expected in the contemplation stage of change.

LOW scorers say that they *do not wonder* whether they drink too much, are in control, are hurting others, or are alcoholic. Note that a person may score low on ambivalence *either* because he "knows" his drinking is causing problems (high Recognition), *or* because he "knows" that he does not have drinking problems (low Recognition). Thus a low Ambivalence score should be interpreted in relation to the Recognition score.

TAKING STEPS

HIGH scorers report that they are already doing things to make a positive change in their drinking and may have experienced some success in this regard. Change is under way, and they may want help to persist or to prevent backsliding. A high score on this scale has been found to be predictive of successful change.

LOW scorers report that they are not currently doing things to change their drinking and have not made such changes recently.

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- Screening for Mental Health's National Alcohol Screening Day** based on the depression-screening model, this national alcohol-screening program includes a screening questionnaire and an opportunity for participants to receive immediate follow up as well as referrals for further evaluation and/or treatment as appropriate. The Workplace Alcohol Screening Campaign provides educational and promotional materials for conducting a worksite campaigns; tips from successful sites, suggestions for recruiting special populations, how to target ready-made audiences, and free publicity materials to download and customize. www.mentalhealthscreening.org/events/nasd/index.aspx
- The Substance Abuse and Mental Health Services Administration (SAMHSA)** is the primary agency tasked with addressing substance use and mental health disorders in the US and a reliable source of information on prevalence of substance abuse problems and the characteristics of those who suffer from these problems. <http://www.samhsa.gov/>
- Canadian Centre on Substance Abuse** Canada's national addictions agency, its mission is to provide objective, evidence-based information and advice that will help reduce the health, social and economic harm associated with substance abuse and addictions. Includes links to research, policy, professional development and job opportunities. <http://www.ccsa.ca/ccsa>
- Substance Use Screening and Assessment Instruments Database**, University of Washington, Alcohol and Drug Abuse Institute. This database is intended to help clinicians and researchers find instruments used for screening and assessment of substance use and substance use disorders. <http://lib.adai.washington.edu/instrumentsearch.htm>