Diana Padilla: So good morning, everyone. Welcome to the Screening Brief Intervention and Referral to Treatment workshop or actually it's a training, I'm new to this training. This training is brought to you by the Northeast and Caribbean Prevention Technology Transfer Center and this is a two part training and I will go over the logistics in a few. This is just part one. My name is Diana Padilla and I'm your trainer.

And so I just wanted to recognize some things that are going on in our world. I wanted to just bring to light and recognize that it's National Mental Health Awareness Month and so you have different dates. There was Mental Health Day on October 10th, there's another day, I'm not sure of the past date about depression screening and so there's a huge, extra focus and energy around mental health.

I also wanted to wish everyone happy Hispanic Heritage Month it's from September 15th to October 15th and so I thought this would be a nice way to highlight one of the artists from the community. This is mural of an Aztec warrior and the artist' name is Juan Velazquez, from Dallas and he was doing it as a commemoration for Hispanic Heritage Month last year and so I thought I'd showed off this year. Really beautiful work and a nice way to recognize the heritage. So my name is Diana Padilla, I'm a research project manager at the Northeast and Caribbean TTC team here in the New York State Psychiatric Institute division of substance use disorder services and we're at Columbia Medical University. And so that's where we all come from and we are physically housed in New York and so as I keep going along, I am going to go through just informational things that I'm required to tell you about that has to do with how we present, how this grant works and how we provide you this information.

So this disclaimer is really just speaking to SAMHSA. SAMHSA funds us to provide you with cutting edge information and the most research based, the most innovative strategies and workforce supports that we can probably give you and so they don't check every single little thing but that's what we do and a lot of times you can note that because what you see is the slides are cited, some sources and that's what we do as an organization. So the purposes of SAMHSA's Technology Transfer Centers is to provide workforce support. It's about providing you with the skills and not just the knowledge but even skills in terms of certain effective practices or what the current information on best practices when it relates to substance use mental health or treatment and recovery supports.

And so this is our TTC umbrella. So we are a Prevention Technology Transfer Center team right now. This is what our purpose is today. We're also Addiction Technology Transfer Center and we also have a Mental Health TTC arm. So this network is really huge. We're across the country and we have 10 regional

centers, that's region two, that's where we. Most of you may be familiar with those folks who aren't from the East Coast from HHS divisions. So we're region two. We cover New York and New Jersey. We have our associates in Puerto Rico and the Virgin island and so what you see here is the whole network across the country. We are available no matter where you are and I see folks from a lot of different places and so just to let you know, we are accessible any given time.

And if you need anything specific that you need from your region, just shoot me an email and I'll do my best to give you the appropriate contacts and so here we start and this is really important and most of you who are used to my trainings already know that I always use this slide to start everything with. So words have power, language matters. We are really focused on doing this. I'm trying to become more intentional with the words that we use. Some of us has been in the field for a while and we used to use terms that are not as conducive to supporting our client population or a client and patient population so we want to use affirming language to inspire hope. We want the folks that we are providing services to, to hear that we are motivating them and we're inspiring them.

And we're meeting them where they're at and we're walking along their process for their recovery wellness. So this is all about advancing evidence space and culturally informed practices and more of this will come out as we go along because it's very relevant to the content we'll cover today. So these are the core modules. This is what we're going to go through. What is SBIRT? Why use it? We're going to look at the public health perspective. If you don't know about SBIRT and the public health approach, this is really important and not just for SBIRT but for language and for our approaches in general today and it has a lot to do with stigma. And so evidence based practice screening tools are validated for screening tools for... This is focused mostly on substance use but we're going to consider it for different unhealthy or at risk behavior and we're going to brief interventions and referral to treatment.

So any questions? Anything that stands out? Tell me, have you ever got done SBIRT before? How many folks have done SBIRT before? Everybody's a newbie. Okay, all right. So I have a few people, excellent. How many folks... Nice, so you've done it before and I'll ask about how you use it in practice but how many folks are familiar and actually use motivational interviewing in their practice today? In whatever version there's been like a third version but motivation interviewing in general. Excellent, okay. This is not SBIRT in the context of MI but we will be looking at MI in the context of SBIRT and you don't have to be an expert and you could still feel very comfortable and competent in actually facilitating SBIRT. Thanks everyone for the hands. Okay, so I'm going to go back

to my slides and I'm going to look at some of these things. Why are we talking about SBIRT here?

And so let's look at just a little bit of the scope of the land because we have all of the information but this is a lot of what was going on before the pandemic hit. The prevalence of substance use included more than 165 million people who were past month's substance users. So there was reported usage of tobacco, alcohol, and other substances. The majority of more than nine million misusers of prescription pain relievers had misused prescription pain relievers in the past years and it was only prescription pain relievers. They did not end up using heroin. Almost 140 million people were past month alcohol users and almost 66 million were binge drinkers in the past month and over 16 million were heavy drinkers and so can someone share how do we define a binge drinker? What's binge drinking? If you have any idea we could share it here, please feel comfortable sharing here because this is where you want to exchange information or get your information accurate or share with other people and this is your laboratory so that way we can be accurate when we use this information and practice with our clients. Okay, Sharon?

Sharon: Yes, good morning.

Diana Padilla: Good morning.

Sharon: Let me put my camera on for a second here. Okay, so binge drinking is you drink for a certain period of time then you get a little bit of recovery under your belt, you stop and then for whatever reason, it could be an environmental issue, it could be a relationship issue, it could be any issue and you just start drinking again. So you're in and out, I guess that's-

Diana Padilla: Okay.

Sharon: As a recovering person, I was a binge user, so.

Diana Padilla: Okay. Awesome. James, did you want to share?

James: CDC defines bench drinking as five or more drinks within a one setting or-

Diana Padilla: Yes.

James: And with kids it's reporting in the past 30 days whether they've had five or more drinks in one time period.

Diana Padilla: Well, the way I understand it was that's more heavy drinking because you're doing more than the recommendations that they're providing and we're going

to go over that recommendations to totally agree with you on that and I see some folks that added that too. Someone who does not drink every day but they drink loosely, loose control of the quantity they take. Okay, so there're some perspectives there that I want to clear up. Thanks James, for that. So that's speaking more to heavy drinking because you're doing more than the recommendations. I'm going to tell you real specifically the way I've always described binge drinking, it has to do with... in case we didn't know this but it takes almost an hour or just about an hour just to process one standard drinking and we're going to cover that. And so when you have two or three drinks within that same hour, that's binge drinking. You're drinking more than you are allowing your body or your metabolism to process.

And so it doesn't necessarily mean you do that every day but you do a large quantity within a small frame of time and that's what binge drinking has to do with. So a lot of times we associate that with the person who won't drink during the week but will drink a lot on the weekends. So that certainly adds to that perspective. Okay, so that's part of it and then I have some materials for you that I will share with you between today and tomorrow. So you can have that full reference but the CDC has their guidelines. Do you know what the best resource is? And that SBIRT actually uses a lot is the national alcoholism and alcohol abuse website, the NIAAA. Law enforcement, criminal justice system will use... They're the ones who set the actual guidelines for drinking.

And this is not normally something that most people are aware but it's important for us to have some basic information about this because we are planning to eventually engage in a dialogue for the folks. So thanks for that. A pattern of drinking that brings a person's blood alcohol concentration to 0.08 or above. Yep and I like that it can also be episodic binge drinking and that is often really what we associate with binge drinking. So let me go back to my screens and so substance use, just to continue on, so more than 10,500 fatalities caused by drunk drivers in 2018. That's almost 30% of all traffic deaths and that's pretty substantial when you consider it. 17% of all traffic deaths among those age from adolescents up to 14 years of age involved alcohol some somehow whether the person that was drinking was driving and maybe the person who died was in the car even though they weren't drinking but alcohol was involved some way. 2016, over 10,000 deaths resulted from drunk driving collisions.

And more than one million drivers that same year had been arrested for being under the influence and at that time we had 0.5 as the level that identifies a DWI situation. And so it has increased and thank you for that information you put about 0.08, it has increased recently in the last I think couple years or a year and a half, something like that. So I wanted to include this because this is more recent and this is on the NIAAA website as well but college alcohol related

situations or prevalence of drinking is also a concern and many of us are familiar with sometimes the different factors that are involved when an individual say goes away for the first time and maybe has that freedom and then in their own experimentation, in their own process of being with other peers they might over drink or do things that they don't normally do.

But the prevalence of drinking in the college environment. According to the 2019 national statistics of drug use and health, more than 52% of full-time college students between 18 and 22, drank alcohol in the past month and with 44% of other persons of the same age. So prevalence of binge drinking also included 33% within the same age group or cohort drinking in the past month compared to almost 28% of other person's the same age and so drinking from the folks in that college environment is compared to the larger population. Heavy alcohol use within the same cohort was reported at more than 8% with the same cohort and compared to six and a half percent from other persons and so when we think about certain situations, certain risk factors for folks, environment has to do with it.

There are different types of stressors, let's put it that way. So tree has emailed you a couple of handouts so my intention is to give you a quick cheat sheet so to speak and so that way you can just become familiar with just certain things that are pretty basic. You don't have to be neuroscientist for this. Just know some basic impacts of what alcohol can do to the body because if you have a conversation with someone who starts to share with you about certain behaviors they engage in, you can connect it to some of the damage that can happen with the alcohol consumption and so we know that the alcohol certainly, well it affects the brain when we think about cognitive impairment.

And we think about the amount of alcohol and how a person uses, we know that it causes memory problems and concentration problems. It certainly impacts equilibrium and over time it can cause bronchitis and pneumonia. Folks who may have cardiac issues or this alcohol consumption can lead into risk of heart attacks, impacts arrhythmias or can lead arrhythmias. Most people understand the impacts of the liver as being specifically associated with alcohol assumption. One of the first things that most people would say was cirrhosis and the interesting thing is that with the liver impact, it's hard to have that conversation with the folks.

Let me just ask you folks, when someone is drinking alcohol and you have to have a conversation with a client or a patient about alcohol and you think about this cirrhosis, what information do you think you should be providing them? How do you include information about alcohol consumption whether you're working in treatment or outside of treatment, whether you're in recovery or support services and prevention, no matter what capacity you're serving right

now, what's the thing about the liver that you want to tell folks? Think from a behavioral perspective, let me be specific.

Manson: Oftentimes the liver, once it's damaged it's irreparable. You only get one and so generally when we see things involving the liver, I'm sorry, when we see things involving the liver, by the time we become aware of them unless we're doing certain tests, we don't really get that information until well too late often. So that's one of the things and then we often have questions around what times are they drinking, is it on a full stomach or as opposed to an empty stomach? What type of medications they're on? All of these things can impact the health of the liver.

Diana Padilla: Yeah, thanks for that, Manson. So the idea that the liver would have to have substantial damage before symptoms even present or observed not present, before symptoms can be observed. So the average human being would take two aspirins if they have a headache, right? Because you're feeling a pain in your head, you're going to take two aspirins. That makes sense but if you're having liver damage as a result of alcohol consumption and you're still keeping your job and everything is still okay in your world supposedly, it's not necessarily a conversation most folks may want to have because most people are not understanding that the liver is very silent. We always think about that as a silent disease when it comes to the impact of alcohol or hepatitis because the symptoms don't present until substantial damage has been done.

And so, because the symptoms don't present, we want to use prevention in terms of relaying or sharing information with our clients and our patients to be healthier, to make better or healthier or more informed decisions on consumption and when they are going to consume and provide them those recommended guidelines which James and Sharon were really referring to initially. Thanks for that, Manson. So let me come back. So when we think about the impact of alcohol, we do think about the liver but there's a lot of other things that it causes problems with. Folks with gastritis, increases cancer rick actually, the vulnerability increases for a lot of different diseases, intestinal issues with nutrient absorption, colon cancer.

One of the things we are becoming more and more familiar with and most of my friends who are in the addiction profession are more familiar now these days with the high hypertension, when it comes to consumption of alcohol and there's a lot of different perspectives that come into play here and we'll talk about that because a lot of folks say, if somebody's coming down off a stressful day, sometimes somebody wants to have a drink to relax and then what does a lot of people do, let not make absolutes here. A lot of people feel well, if one drink makes you feel relaxed, then two drinks can make me feel even more relaxed but there's a whole process with that because it comes to a point where

you are not feeling elated, you're not feeling relaxed. You're actually stretching your body organs more. So this all has to do with just some basic knowledge about the impact of alcohol in your body.

Long term use will result in being on dialysis. Yeah, it can if it gets identified early enough. So you have to take care of your liver, if you need a free life, yep and causes other health issues and the declining of your health overall and increased DV and other abuse. Yes and domestic violence has been a huge issue along with a lot of other things, have been exacerbated with the pandemic and so it has been involved in a lot of domestic violence or intimate partner violence situations. It's not the only factor but it can play a huge factor. Hazards of alcohol and other substances as we were talking about, increased risk for injury and trauma and so when we think about DWI, we think of someone behind the wheel getting ready to drive, they don't feel that bad.

They don't feel that tipsy and so they feel like they can drive home but injury and trauma is not just that. It's just somebody coming out of the saloon or somebody's house after they drank a lot, after a party and just trying to get off the sidewalk onto the streets across to the other side, full face front and forward, break the front teeth. I've seen things like that this is why it comes to mind. So we have hazards of alcohol and other substances and array of different ways depending on the person or situation. Criminal justice involvement, we talked about DWI's also and we talked about partner violence and that's a heck of a way to get caught up with the criminal justice. Chronic health conditions you mentioned that your overall health can decline, it can exacerbate other issues.

We have mental health there. We think about anxiety and depression. So sometimes what I'll do is I'll work with organizations to help them understand just focus on screening for substance use if they're a mental health agency. A lot of times some mental health agencies a lot of times will only focus on mental health and not necessarily screening for substance use. The interesting thing about substance consumption is that a lot of the behaviors can almost seem like the symptoms of certain mental health conditions and so understanding that, particularly in the local and mental health disciplines, is important to make an inaccurate diagnosis, recommending the appropriate treatment strategies and approaches and actually developing an accurate treatment plan and so screening for substance use has always been encouraged by NIH, CDC, SAMHSA, for mental health agencies to do that because it can impact the overall help that you want to give any particular patient. We know hazards of alcohol and substance use also include social problems.

Think about the restraint relationships, the family members or with your social circle, yes. Reduce productivity at work, including call outs, missing work. Huge,

yes the absenteeism because of accidents or because of hangovers or because of just continued party. Let's just say it that way or health or trying to recuperate from actually doing that and the absenteeism. It really costs a lot of employers a lot of money too because you don't get your workers to come in. Insurance claims, let's see, you're giving me a lot, Richard, thank you. Isolation, increase in crime, consumption leads to comorbid mental health issues. A lot of what we were speaking to. Thank you. When we think about SBIRT, one of the reasons SBIRT can be used for a lot of different things.

We will have a major focus on how it works for alcohol as a model so you can understand how it works for different at risk behaviors or unhealthy behaviors. When we think about opiates and you have to consider the situation that has also increased just before the pandemic started June 2019, the opioid overdoses and the death rates started to increase, the use started to increase and while we were trying to get up to speed and how to provide services when we got shut down, especially on the East Coast because that's what it started. When we got shut down, we assured how to provide services, how to get a bed available, how to keep other people safe who are already in treatment and open doors for anyone seeking treatment. Opioids overdoses and opioid use increased, just went through the roof.

So it's important to understand okay, what are the different impacts that the opioids can do for your body? So you also got another handout that included the dilation of blood vessels, increased pressure in the brain hugely important to understand, respiratory depression. We know that folks who have overdosed units that has a large content, a large amount of heroin or other analogs can depress the respiratory system and so you also see folks whose body becomes dependent on the substance and so this is long term use but you also have other side effects for instance, sharing needles and how that can lead to hepatitis, HIV, brain abscesses we talked about, affected collapsed veins also the impact on the heart. So some of this information you probably already know because it's important to, in the context of SBIRT, to understand some of the basic impact so we can relay it in a conversation. Brian, would you like to tell us about that?

Brian: Yeah, so I just typed that alcohol and other drugs may actually impact the patient and the society at large in relation to the patient, they will actually experience physical [inaudible] I think we have highlighted most of them like [inaudible] and mental health issues as well and then in the society they may also experience social isolation but when it comes to the entirety there may be increased levels of crime and break down in law order.

Diana Padilla: Thank you for sharing that perspective. We are tasked as say addiction professionals. Thanks, Brian. We're tasked as addiction professionals to work

with the client but there are effects to the other environments that the person is at. It's not just families, it's not their social circle, but the communities and society at large. So we see the impact in different ways. We can also see the impact when I think about society, financially it causes the public sector millions of dollars to address a lot of these issues. Criminal justice, increased crime rate and as well as some of the other things that we talked about before that was mentioned like the partner of violence. The law enforcement gets involved one way or another for some folks, depending on how the behavior moves on and progresses.

All right. So one second, I'm going to go back. Thanks, Brian. I'm going to go back to my slides. So the idea is to understand some of the more foundational and information of a behavior you're going to address with SBIRT so here we talk about SBIRT from using substance use screening, a brief intervention referral treatment as a systems change initiative because it does challenge our perspective especially some of us who have been in the business for a little while. So we are required to look at things differently. So the paradigm shift, we're encouraged to reconceptualize how we understand substance use problems and we want to redefine how we address or identify these problems. So we're going to redesign how we treat, I'm going to say how we address these problems because when we're doing SBIRT, we're not exactly treating but it is talking but it's specifically referring to an approach.

What is the approach we're going to use when someone has a substance use problem? And so the idea here is that often we know that most of society and many of us back in the day, we used to think of services as being focused on either prevention, giving all that wonderful information, helping folks understand how not to get caught up with chronic substance use or treating someone who has a substance use problem and providing time, cost, labor and intensive care for folks who are acutely or chronically ill with substance use disorder and please be mindful. You see that there is specific terminology here that is intentional and so what we typically are used to, okay, a lot of our patients and a lot of society in general and maybe some of us still. The perspective is either a person can handle their drink.

They can stop after a couple of drinks and still go home and go to sleep and still be part of a family or still achieve their goals, their responsibilities. So they're either abstinence or they use responsibly, there's no issue. It's very social, it's very comfortable, it's not impacting, there's no negative connotations there or impact. Then you have those folks who are not responsible with their use and so have an addiction problem and so this is the perspective that society is used to having. Now these are folks who are not in the behavioral health field the way we are. So this is the binary perspective that they're used to seeing. Thank

goodness we have research, thank goodness we learn a lot because now we started to see some other things. In New York State OASAS, what we talk about is looking at any particular client or patient from a different perspective, understanding different psychosocial domains in their world to understand what are the factors that are increasing the consumption.

PART 1 OF 5 ENDS [00:32:04]

Diana Padilla: That are increasing the consumption and just is supporting the consumption of substances. And so you got the biological dimension, psychological dimension, cognition, perception, and attitude, personality. You have the social dimension at the bottom right. The culture, conditions, circumstances. In New York state and a lot of states across the country have also added, this has been the traditional perspective, these three psychosocial domains. Social, biological, psychological. But in the last, I don't know, I think about maybe 10 years, I think it is in New York state and a lot of other states, we've also included the spiritual dimension. Because that component plays a part in people's thinking, people's existence, people's motivation. And so the faith, spiritual experiences, higher levels of consciousness, understanding what it is for a given person can certainly impact all the other areas.

And so what do we do? We want to look at SBIRIT from a public health perspective because substance use is a public health problem. Just like Brian said, which I really appreciate you bringing up that point. Consumption of alcohol or any substance is not just an issue for that individual. Usually of course, we focus with that person, but it impacts the larger community and all the communities in between.

So first I want to come back and say and as we go forward, you notice that means using substance use. I'm going to come back here and wait a minute, stop sharing here. I'm going to ask you folks something. So I've been using substance use as opposed to substance abuse. Is there a difference? Does it matter? And if it does, can you speak to it? Some of us might be in the habit of doing the substance abuse, but what have you heard in terms of terminology? And I think this is something that even mental health specialists probably are very familiar with. Nancy, you wanted to add?

Manson: Yes.

Diana Padilla: Go ahead.

Manson: Typically, when you think of substance use disorder or SUD, substance use is the casual. Oftentimes we see it as the casual recreational use that hasn't crossed over to impact those other domains you were just speaking of. Where it's not

showing up to impact your work, your social environment, your home life and things like that.

Diana Padilla: Okay. Thank you. So I like the way you tied it into a perspective. Okay. All right. Anyone else would like to add? All right, so we have here Linda says, "Substance abuse promotes stigma, indicates the person has a choice. Substance use is less stigmatizing." It is less stigmatizing. And I think scientifically it's actually a little bit more accurate. Substance abuse can be anything that is being overused, uncontrolled. Okay. Use reduces stigma, use, misuse, abuse addiction. Okay.

Use reduces stigma lines with DSM-5 criteria. Thank you very much. And that's exactly. I have this course coming up on people first language, and it's going to speak to all of this more specifically. But it's really important that no matter who trains or whatever topic where we discuss a terminology. Stigma has been identified as a huge factor and as a barrier of why people do not access care. It's not that you guys don't do a great job it's that they hear so much.

They hear the jargon that that seems to not just... We call it stigmatizing, but for a person, for a patient, or a potential patient or a potential client, someone with a disorder. For them, it's even more depletive to even consider that all these words that they already thought that has such a negative impact and connotation, that they hear other folks saying it too. It doesn't promote motivation. It's not inspiring. It's not supportive. It actually adds to the stigmatization that they have already experienced. And so that has been part of the barrier of why they don't access care. So we've learned that using different words or using a public health approach is really key. So as per the model, the practice itself uses a public health approach.

Well seems like in your funding, your grants, your funding sources, the ones you're working under are also encouraging that we change our language so we could be more supportive. The DSM–5 was the first panel of experts that came out and started to do exactly that. So the DSM-5 even if you're not a mental health specialist, as an addiction professional, you have to make diagnosis anyway. And the substance use disorder is the diagnosis in the DSM-5. They changed the terminology. They don't use abuse. And dependence is only used in the context of physical dependence for alcohol and opioids, because the body does get dependent on that substance.

But substance use disorder is defined very specifically, according to an 11 point criteria in order to make the diagnosis. So if you look at it from that perspective, substance abuse really is judgmental. Really is speaking to like the way I think it was Linda that said, it's like if the person had a choice. If we remember back, we know this, we remember back what happens to the brain. After consumption

when someone is progressing in their consumption, the brain starts to just kind of lead.

Their capacity to make informed decisions starts to diminish. And over time, their capacity is almost nonexistent with some of our folks. So it's not a choice. It is the progression of substance use or alcohol use. And that impact, it's what really is leading that behavior, that drug seeking behavior, that substance seeking behavior. And so when we think about substance abuse, we know that's judgmental. So that's inspiring, that's not supportive. So we change the dialogue. We want to help people with their health issue.

They have a disorder, we're going to help them with that disorder. We don't want to use any kind of judging or labeling type of dialogue, just to be supportive and to help, not just engage them, but retain them in care. And I really believe if you can engage [inaudible]. Go ahead, Nicholas.

Nicholas: Yeah. Good morning. When you were talking about stigma, I work with Robert Wood Johnson Barnabas Health. We're out in New Jersey. And we as a system and as a manager with the Peer Recovery Program, we've done a ton of education throughout our hospital system on everything you were talking about with the use of language, stigmatizing language, in the emergency room. And prior to the launch of the Peer Recovery Program with trained Peer Recovery specialists, coming to the hospital staff was very open and honest about some of that language that had been used.

And it was such a big part of our education efforts and it still is. Using terms like a person who uses such substances rather than calling them an addict, an alcohol, a junkie, a substance abuser. And like even taking it a step further when you're talking about urine screenings, we don't use terms like a dirty drug screen, a dirty urine screen. It's an expected or an unexpected toxicology test. All these things tie into that stigmatizing language. And it's our responsibility as professionals to start that like on the front lines in the hospital, and hopefully that's what's going to carry through and really make a lot of systematic change.

Diana Padilla: Thank you for that all that. 110% agree with you. And it's so important. And there's so many different benefits that include not just with the patient's support. When we think about that, the words that we use ourselves also affects how we think and how we think affects what we say. So it's a cycle. Okay. So it's very important for us to understand that because we have heard and have taken in information from our environment that has many negative connotations to these labels, these terms that we used to call folks. And so within the context of their world, like for instance, I would never dismiss someone saying or put down, no not put down, try to convince someone to use

a different word if they call themselves an addict in recovery. For them, that might be empowering.

I'm the one as a professional that would look at them as a person who has a substance use disorder. That means I'm not thinking of anything negatively associated with anything. I'm looking at a person who has a health issue that I have to work with them with. And so the focus it involves and impacts how I think. And so that's really important about the terminology.

So it informs us, it helps us to be mindful of how more supportive we need to be and less stigmatic. And we didn't always realize that that's what we were doing. We didn't realize that. Well guess what, we have research. We've done a ton of focus groups with you folks. This is what's been coming out from field. And this is what's been coming out from our clients and patients themselves. So going forward, it's a great thing to keep in mind with any topic, not just SBIRIT, any topic that is behavioral health that you work with.

Thanks for that. All right. So let me come to here. So to be specific substance use refers to the consumption of psychoactive substances. At risk substance use, and I want to ensure that this is what we're talking about here. At risk substance use refers to consuming at levels resulting in either harmful or hazardous consequences. So we talked about hazardous consequences. I had a slide earlier that it showed the different things that can happen if somebody is behind the wheel, gets picked up for DWI, someone who stumbles and falls. Just staggering or just walking or trying to get walk through the street to the other side or the impact on the ability to get to work.

So there are hazardous consequences where people's health get involved. They get caught up in an accident. They end up in the emergency room. So those are hazardous consequences. At risk substance use has a range from harmful to hazardous. Harmful meaning that someone is starting to consume at a level where it puts them at risk of experiencing these consequences. Hazardous is folks who are experiencing consequences. So you have that brief range which speaks to folks who are at risk level. We are not used to seeing it.

Remember the binary perspective most people think you can either handle your drink or you have a problem. Well, we are looking at things from a little different perspective. So at risk substance use is really important to understand. Substance use disorder it meets a diagnostic criteria as we spoke about before. So when we think about rethinking how we see substance use and problems associated or using our own public health perspective, this is like a very simple diagram to give you an idea of the scope of the problem.

So most of us might know this. But we usually don't treat more than two to two point... maybe two and a half million people a year in substance use disorder treatment and treatment services. And that's really what you see. Substance use disorder is on the left. And usually there's about 20 to 22 million people on any given year that actually meets the criteria of substance use disorder. So that's what you see on the left. You see those four little images. They represent the folks who meet the criteria, the 20 to 22%. And we only admit and treat maybe two and a half million at best. Now those are the people on the left.

The people on the right are at risk binge drink... At risk consumption... At risk users. Or that's not the right way to say it. Now I'm going to start doing things stigmatically. Folks who have at risk levels of consumption or binge drinkers. So at risk levels of consumption doesn't include just alcohol it includes other substances. Psychoactive substances or it could be stimulus, it could be opioids.

So what you see here and you see a lot more people, a lot more images on the right. There's like four folks or four persons who are at this level of consumption for every one person that meets the substance use disorder criteria. I wouldn't mind knowing what your perspective is on that if you knew that. How many folks are familiar with that? We only treat two and a half million people on any given year. There's at least 22 million who meet the criteria and there's four times as many people at risk. I'm sorry you had your hand up, could you put your hand up. Somebody wanted to share.

Okay. All right. So let let me go on with the SBIRIT then. If we're using a public health perspective, we want to learn from that. We want to use the approaches that we see in public health. So public health system uses a routine of screening folks for potential problems. And it's a preventive approach. It's done prior to the onset of acute symptoms and delays or precludes the development of chronic conditions. So and I've told this story many times before, and I'll tell you, it's a true story.

So what happens is like, for instance, what happens in the emergency room? So my guy and I, we have to coffee every morning before we start our day. One day we sit down, we're ready to have our coffee. And he starts getting this chest pain and he's having a problem breathing and he can't move his left arm and he's left handed. And so of course, what am I doing? I'm asking him what's wrong. And so, even though he can't talk. But I see him going through all these changes and he barely whispered out, he says, "I'm having a hard time breathing." He says, "I can't move. I have a lot of pain in my chest."

And then when I said, "Can you move your arm? He goes, "No". So call the emergency. I call EMS. We end up going to the emergency room. And so when EMS picked him up, one of the first things they did, they checked for his pulse

rate. They tried to ask him questions. They asked me about the history of cardiac in the family, all the kind of the traditional things that the medical practitioners are going to do.

And then when they got the information and they saw that his symptoms seemed to be reflecting a potential heart attack. That makes sense, right? And so it seemed like it was a heart attack. So of course they wheeled him straight in. I was left outside. I had to do the insurance information. They took him in because they really wanted to prevent a heart attack. He seems to be showing all the symptoms. He was also a person of color between the age of 55 or 65, which means a high risk population for cardiac arrest.

So here's what's interesting. That approach, that screen approach, what they did immediately, this is what they routinely do anyway. They assess evaluate some of the vitals, the heart rate, the pulse rate, some of the history, some of the observable symptoms and then they make a quick assessment. And then they rushed him in because they wanted to stop him from having a potential heart attack. That is a public health approach. That is the approach that we use, it's preventive. So to potentially stop him from dying.

So that is a public health approach that conceptually, that we use in SBIRIT. We want to use a preventive approach. So just to tell you the rest of the story, what was happening with him was actually gastric and the next day he left without his gall bladder. Which is a lot better than the first thing we thought about, than the cardiac arrest. But he had all the symptoms of something else. So that's interesting. And a lot of times we see a lot of symptoms of different things with our clients and our patients. So it's important to take that preventive approach, to provide information, to elicit from them information. And that's all what SBIRIT is about.

So that public health approach is foundational to what we do in SBIRIT. And so this is what we are suggesting. So we are suggesting that instead of the binary perspective that we're used to is, yeah we know, think of this as the progression, this continuum of substance use, this line from the left to the right, as the potential progression of consumption of any psychoactive substance. And so you see the abstinence, experiment and the social use. And you see folks socializing, you see folks maybe trying drinks for the first time. Sometimes it's not an adolescent. Sometimes it's an adult who's trying to drink for the first time.

Or some folks do not engage or indulge at all. And so you have that perspective and of course, you have folks... We're not talking addiction, we're talking substance use disorder because it's very specific to our field. It's very specific to the diagnosis and the criteria that meets this diagnosis. So we're talking about

substance use here, but these are the folks. These are the folks, the four people to everyone that meets the criteria of substance use disorder. We want to look at the folks who are here, who are binge using, or are misusing.

That's like using prescription other than prescribed or consuming alcohol other than recommended. So when we are looking at folks, we are not using the binary perspective. We are looking at folks in this section here. Now, can anyone identify or share or think about what are the benefits of addressing consumption with folks who are in this point of the continuum of substance use. What would be a benefit or the benefits?

Sharon: I have a quick question before you go there and it revolves around what you're asking. And the only way that I can kind of identify with this progression is from my own... And is it okay for me to be transparent because I'm in recovery, but I'm also working as a recovery coach and I have a degree in social work. So I'm like nine years out there clean. And so it just springs a thought. Even though I was a binger at that one point where you had circled, I believe that I lost, how can I say this? That I crossed a line.

And maybe there was a substance use disorder that probably didn't get diagnosed. I don't know, you know what I'm saying? But I know I crossed a line because of lost control with the ability to stop. I knew that binge thing just wasn't there anymore. It was just like consequences told me that I had crossed over. But like I said, I don't know if I ever had a diagnosis of substance use disorder if that makes any sense.

Diana Padilla: [crosstalk] it makes perfect sense. And I celebrate your recovery, my guy is in recovery 26 years plus so I love that. That's great. And it's important for you to know this because you're going to work with a lot of folks who are in different places in their own process for recovery and wellness. Whether it's recovery of substances or recovery of mental health or recovery of health issues, whatever it is. So conceptually, it all applies.

Let me hear my voice while I show you the dialogue again. I mean the image again. So in this area in the middle here. So then just think about this whole line blue line as the progression, the potential progression where somebody can start and the phases they've gone through in their life and how they continue to consume. There are a lot of different factors and different situations and different reasons and different thinking and different motivations that all kind of came together at different times for the person to use. At some point, for someone who meets the substance use disorder criteria, someone who was admitted in treatment or someone who says they had an addiction problem where they were not able to control their use at that point.

However you want to define it but according to what we do in our field, whoever meets the substance use criteria probably went through their own progression. The details may be different for every person, but it went through this line where it started to progress over time. It became more chronic. A lot of times it's not that we necessarily think about a person's ability to not use substances. It's also the chemical reactions in the brain and how the brain actually kind of gets hijacked when we use that word, that [inaudible]. The chemicals themselves kind of rewire the brain to focus on doing nothing but using.

So just think about this line as a continuum, the progression of use over time to get to the point where you meet the criteria of substance use disorder. There are some folks whether you had a substance use disorder or not. I don't know and I don't want to ask and intrude on whether or not you went into treatment. But in terms of the population, we're talking about the folks who do go into treatment, it's because they meet that criteria. Because they meet the substance use disorder criteria.

I hope that helps a little bit. The thing is whether or not we as the person, let's say we are the ones that using, we as the person who are using are not necessarily aware or can see our own progression. This is really the perspective that we are using as providers, understanding how that works. So it's not necessarily that the person needs to understand, but it's more like, what do we see? So what we have understood over time is that before someone gets to substance use disorder, before someone starts to consume with a progression, with a frequency, with a higher amount. With all these other factors that kind of just exacerbates the situation and leads them to that end point where they meet a criteria. Before they get there, there's still a point there where you might be able to have a conversation.

So I was asking folks about what would be the benefits of addressing the folks who are at risk level. They're consuming where consequences are starting to show up or they're at risk to have those consequences. So the difference between someone who may be at an at risk level compared to someone who may be at a substance use disorder criteria at that point, the capacity is very depleted. It's no fault of their own. That's just part of the progression and what happens with our brains. But do you have an easier opportunity and this is what I like about it is that you have an easier opportunity to have a conversation with someone at that point.

You have an individual that can comprehend and have a conversation with you and maybe consider some things. Whereas you having that conversation with someone who just got through the two weeks of orientation in the treatment setting, you're not necessarily going to have that conversation, because their

capacities are still diminished. But at that point where they're still at risk, they haven't met the criteria. They haven't gone through that extreme in their life, in their progression, you have an opportunity to intervene.

And that's what makes SBIRIT so unique in the fact that it wants to address the folks at risk. It doesn't mean that if your screening tools identify someone with potential substance use disorder, that they can't get help. But we want to intervene with the folks at risk. Maybe we can't preclude that particular end stage for that person. And the other thing to consider is not everybody who is on a at risk level is going to progress to a disorder level. We can't make that assumption either.

So all that kind of really plays up into the... I really wish this was around when I was doing direct services, would've been great, but we have it now. We've been having it. And there's opportunities to use this. Even if you work in treatment, there's opportunities to use this model. So let me read what Brian put. The continuum shows that it's possible for individuals to progress to a disorder, public health approach would help identify those individuals at risk of progressing to a disorder based on their vulnerabilities and interventions can be implemented. Couldn't have said it better myself. Thank you Brian.

It's more of a prevention. It is a situation of prevention. If prevention can be better than treatment. Well, the thing is, if you're not at a point that you need treatment, why not do prevention so then you don't have to get there. It's always about the person's wellbeing, always. And so-

Sharon: I have another question.

Diana Padilla: Yeah, I was just going to ask you, does that help you?

Sharon: It absolutely makes sense. So I was going to ask you if you hear about co-occurring disorders or dual diagnosis. On the substance use disorder, are those mental health or behavioral health criterias a part of that substance use disorder,

Diana Padilla: They're separate disorders. All the disorders are separate. I'm just speaking about the substance use disorder. Depending on what mental health issue a person has, that has to be a different diagnosis. And then ideally an integrated treatment plan will help address both. But the process for how that's diagnosed and the criteria has a different criteria or diagnosis. It has different points that have to be met in order to meet that disorder, depending on what it is. But they do get diagnosed separately and you can integrate in a treatment plan or you work with other specialists for an integrated treatment plan. Nancy, go ahead.

Manson: And I just wanted to add too, that if you are doing SBIRIT correctly, typically you'll get some anecdotal information about potential mental health or co-occurring disorders that you can refer if you are not a provider that has those services in house. So it's essential that you do it with fidelity so that you can get this information because at some point a mental health professional will have to further assess to determine if they want to treat the substance use disorder first or the mental health dual diagnoses. We can't make a diagnosis. We just make an assessment that this person potentially has some issues that warrant further evaluation is how I like to look at it.

Diana Padilla: All right. Did you look at my slides already?

Manson: No.

Diana Padilla: What?

Manson: I couldn't see them. I-

Diana Padilla: Wait till you see the slide that has your name all over it. [inaudible].

Manson: Okay [crosstalk].

Diana Padilla: But it's such a good point. Right now really the part that we're covering right now it's the part that's so important to how we're used to looking at substance use with our clients. So we want to not change how you look at it, more to add another perspective. Different situations require different perspectives and different treatment approach, and that is helpful and your expertise is so important. But this is just adding another way of looking at things, for the context, for the purposes of doing this.

There's some clients you work with hey hey, you have a diagnosis of substance use disorder. That has a whole array of steps that you're going to do with them. Some people may not meet the criteria of substance use disorder, and this would be effective. So I want you to note, this is an added perspective and an added approach and an added intervention for your toolkit. Not to mention that it looks pretty good on your resume, but it's actually great when you see the outcomes with your clients and your patients. It's like awesome. Okay.

And yeah, I make a big [inaudible] when it comes to SBIRIT. So let me just go through just a couple of more slides, because I know we're coming up on a break. Hold on. So this is one of the most insightful images that I have in the whole training, because it really does challenge us to look at things a little differently. This field never used to include the folks at risk. We were so focused on trying to treat more people with substance use, sort of because as much as

overwhelmed as we get within our programs, and we only treat a certain amount of folks, not all the folks are available.

We always forgot about folks who are binge users or people who are putting themselves at risk for them. We never thought about that. So when SBRIT came around some years ago, it just made perfect sense. So we can help folks kind of get to a wellness place or help them consider getting to a wellness place before things get to an extent where the choices are different. So the goal of SBIRIT, the primary goal is to identify and intervene effectively. With those folks who are at moderate risk or at high risk of psychosocial or healthcare problems, that's related to their level of consumption. And this is what we're trying to do. The psychosocial and healthcare problems related to their substance use.

We also don't leave behind if we end up identifying folks with a potential for substance use disorder, we help those folks too. But they're not our primary target. So moving parts. So the whole SBIRIT model really includes a pre-screener. And we're going to talk about screening when we come back, screening and pre-screening. We'll talk about that. Brief intervention, brief intervention-ish. Really should be a conversation that doesn't take more than 15 minutes, maybe 20, maybe, while you're getting up to speed and getting used to it. But the difference is brief intervention here is very little. It's not like brief strategic family interventions, which is a series of maybe what is it like an hour and a half of maybe 12 to 14 sessions. This brief intervention here means we have a dialogue, we have a conversation just for a few minutes it doesn't take long and it will be a natural conversation and we'll talk about that later.

Extended brief interventions is because the reality is that sometimes you're going to conversation with someone and this persons [inaudible] as you like. And someone may not want to consider moving in any direction and trying to look at their behavior and trying to change it. And that's okay. We want to meet people where they're at. So what we do is we might have an extended brief intervention, which means we can make an appointment to hopefully have another conversation with them. And that's considered an extend-

PART 2 OF 5 ENDS [01:04:04]

Diana Padilla: Hopefully have another conversation with them. And that's considered an extended brief intervention, to meet with a person again. Many times, that first dialogue is very impactful for the individual. And so specialty treatment is for those who have a probable, again, specific terminology, a probable substance use disorder. We don't know, but this is our validated screening tools kind of give us some indications. So we will offer a potential next step. So screening, brief intervention, referral treatment. That's what SBIRT is. What kind of approach does SBIRT use, anybody?

Brian: Public health approach.

Diana Padilla: Thank you, Brian. Public health approach. I forgot to tell you folks. Didn't I tell you there was going to be a quiz? Okay. So, we have a public health approach. That's what SBIRT uses. And who are the folks that SBIRT actually targets first? Their primary goal. You know you don't pass the quiz, you don't get the certificate, right? Did I tell that Terry? I forgot to tell you that too. Oh my God.

Manson: Those that haven't gone on into chronic use yet or abuse, they have not crossed over. We take a preventive measure approach.

Diana Padilla: Yeah. Not abuse, disorder.

Manson: Yeah. Disorder, yes. Thank you.

Diana Padilla: That's disorder. Let's just change the language. Cool.

Manson: Yes. Strength-based language.

Diana Padilla: So, you know this stuff. Let's simplify that just a little bit more. At-risk people.

Manson: Yes.

Diana Padilla: Folks who are consuming at at-risk levels. It's important that we be familiar with that concept because we want to ensure that we can help these folks too. Not just the ones already in recovery, not the ones that are getting into substance use disorders treatment, but also the ones who are at risk. Really important. So at-risk level of prevention is what SBIRT is about. Okay. Public health approach. SBIRT stands for screening brief intervention referral to treatment. Primary goal is to intervene, identify and intervene with folks at at-risk psychosocial health risk issues related to their level of consumption. Right now I'm working with one of the projects at Columbia and we're using SBIRT for depression and general anxiety disorder. And we're doing that with the black and African American communities in New York city. And this process seems to be a really nice way to engage folks in a very type of, say personal or very approachable type of atmosphere.

An engaging approach to have a conversation with folks who have had barriers, cultural barriers in terms of accessing mental health services. And so this model is so key. So, we're going to go forward with what the components are. And so I'm going to go back and share my slide. So we can use SBIRT for a lot of different things. So, let me go full screen. So, screening for substance use in your practice setting. And the research has shown, and this is why it's been identified as evidence-based intervention, is that this has been replicated in a variety of

different settings and has been proven effective. And so why do we screen universally? So, that's my first question to you folks. We screen. We always do screen. Screen is part of all the protocols that we are involved with, whether we do it or someone else does it. But why are we suggesting that we do it universally?

Manson: One, is to have a universal system in place that recognizes across the spectrum, as far as different states. One of the things they came up with is to try that, is ASAM as you know. But SBIRT, they're trying to roll it out to make it more universal so that all treatment providers are providing and collecting the same data and information.

Diana Padilla: Okay, good. And then let me see what else we got here. We have, if you don't target everyone, you might miss someone.

Manson: Yeah.

Diana Padilla: Very well put, thanks Tamara. Tamara added to what you were saying. Nancy. Substance use disorder does not discriminate. That's for sure. Preventive measure and determine level of care. Yes. Extra focus and extra emphasis on the preventive. Nondiscrimination, it is a spectrum. Yes. So the idea is, we want to do this for everyone. So some of the benefits include, I'm going to bring up my choices here, early identification and intervention lead to better outcomes. We always knew. We've always known that that's kind of foundational to a lot of the conflicts that we use in practices. We know the earlier we can identify, the more successful we can be. Or the more effective we can be with helping someone get to that wellness place. And detecting alcohol and substance use patterns that can increase future injury and illness and risk. So that preventive measure can help folks kind of stay healthy. And so, intervening also gives you an opportunity to educate for at-risk, what at-risk levels of consumption can, what kind of impact it can have on a person.

And so, and that's why I like the image that I show you folks, because at that time it, in that progression or at at-risk level of consumption, is an easier time to have a conversation than when someone actually meets a substance use disorder criteria. And then also, I really should take this one out, because I don't think it belongs in this context, but research has shown that approximately 90% of substance use disorders go untreated. If 90% of substance use disorders go untreated, and those are the stats that I gave you where we got more than 20 million people in any given year and maybe 2 million get treated in care. And that leaves a good 18 million plus that are not treated. And if I'm sharing with you that the research is showing that there's four persons to every one person that meets the criteria substance use disorder, and we are not meeting 90% of

the people who have SUD, then imagine all the folks at risk who we can be helping and we not doing it.

So, SBIRT is really ideal for this. So, this has come. So this pyramid, I don't know if you've seen this before, but this pyramid is really based on a few surveys that NIAAA had done on the findings or outcomes of screening tools. And this is based on the audit, and we'll go over that. What it shows is really kind of the populations, the estimate of the populations that we'll be seeing. Really about 75% of the population that gets screened if you screened universally. A good 75% of them should not. It's probably not going to have an issue to explore. They're probably going to either be folks who are absent or folks who just use responsibly or socially, and so they're low-risk users. So that's a good 75% of folks. So, this is with perspective that you're screening universally where you're screening everyone. A good 20% will be screened and identify at at-risk level. At-risk, moderate-risk or high-risk. So, a harmful use. And that's a good 20% of the current population that gets screened.

Then 5% of those folks would be the folks that will have a potential substance use disorder. And so, if you think back at that slide that I showed you with the four little images on one side, and then 16 images on the right hand side, the five and 20% here in this pyramid reflects that image. And so, even though you have... When we think about the population of this country, we're talking about 330 some odd million people, plus. Give or take a few million. And so, only 5% will have a substance use disorder, or four times as much will present with at-risk levels of consumption. And so, the pyramid is a nice way of kind of reflecting that. So, the drinking levels. And James were talking. It was talking about this moderately drinking levels. And that's really put out by the NIAAA folks. And so, they put out this publication. And so, I'm offering it here because it's more of a current publication than what we had here for the SBIRT content, but it's actually the same recommendations. It hasn't changed.

So, it's incorporated here in the dietary guidelines for Americans and this was put out for 2015 till 2020. And so, it's reframing the recommendations as one drink per day for women of legal drinking age, and up to two drinks per day for men of legal drinking age. Let me go back to that. One drink per day for women of legal drinking age, no more than seven drinks in a week. And this is just trying to separate that as the drink a day. And then up to two drinks per day for men. And typically it's no more than 14 drinks in a week. And so, the guidelines used to be framed as, and this is just for me because when I decline services I think it would be more realistic because how you frame it, it kind of depends on the person that you're speaking to. And so we used to say, no more than three drinks in any given day for a female, on average healthy female. No more than three drinks in the day, but certainly no more than seven drinks in a week.

And so, we used to say no more than four drinks in a day for a male, and so it doesn't add up to be more than 14 drinks in a week. And it's really the same thing, it's just rephrased here. Let me see. We got some chat box here. Yeah, we used this approach. Bob, you want to tell us about it? I know you don't mind.

Bob: We had Oasis come down because I had taken this course about six years ago, and I think they were saying five drinks for men, which I really took issue with. I thought that was much too many. They didn't frame it out as 10 a week or 15 a week. They said five a day, and I thought that's excessive drinking. But in any event, after that training we got Oasis to come down and I got all the department heads and nursing involved, and the emergency room especially in our outpatient clinics so that we could get all the people coming into the ED, and the outpatient clinics would fill out a form that would be given by the person. They wouldn't have to hire somebody new to do it, you'd train somebody that already worked there to give out another form. And then those people, if they scored it, would then refer people either to whichever outpatient clinic was correct, if the person wanted to go.

They would have a screening at the methadone clinic or the abstinence-oriented program or the inpatient detox program or five pro mental health. All the different programs we had were involved. And we also got pediatricians involved, and one of the pediatricians actually started doing that in his office and had great successful people. He thought that it would turn people off, but it didn't. And that's grown a little bit in the... Unfortunately our hospital ended up I'm going bankrupt, not because of SBIRT, but because of Sandy. And it's no longer there. And the hospital closest to us isn't interested in any drug treatment at all, unfortunately. They do mental health.

Diana Padilla: Okay. So, let me just be clear on one thing. So, because I've known Bob for a little while and he's done so much of this work, he's one of our pioneers, what I wanted to be clear of because what I heard was from screening and then there was a referral. What about the dialogue? Is there a brief intervention in between?

Bob: Yeah. After this, I kind of left that part out. It pretty much though went the same way, trying to remember. It's a long time ago.

Diana Padilla: Okay.

Bob: The person that did this screening ended up talking to the person about a possible referral. How they feel about that? Did they see it as a problem? Depending where we were on the spectrum. And they were pretty successful in getting people not sent to the methadone clinic, that pretty much wasn't an

issue, but to the abstinence-oriented program or mental health, things like that came up.

Diana Padilla: So, what you shared had a lot of focus on the validated screening tools, which is great. In this model, what we're going to, and just to be clear for everybody else also, we want to include the screening, the brief intervention, and then the referral. The referral is going to be the result of having the dialogue, which is very specifically scripted. And we'll share about that. So, it's really speaking to what Bob's organizations was doing, what he had his staff do, and we're going to really highlight how that works out here. So, the reason why I'm being very specific... Thanks Bob. The reason why I'm being very specific, is I provide a lot of technical assistance with organizations and how to incorporate this, not just to train and build skills. It's not just a training, coaching. We help organizations understand one of the instruments they're using, how it works within the funded programs that they have to provide. So, the whole thing.

And so, one of the things that I found is some organizations is that they do screening and then they make a referral. And now I remember one organization. The department of health approached us and I started where working with the staff, with an organization that they were funding. And when I was working the staff, they identified that they would do a screening and specifically making a referral. The interesting thing about SBIRT, SBIRT has to have the dialogue. Without the dialogue, it is not SBIRT. So, one thing I want to kind of, and I will mention this several times and Nancy was the first one to mention about fidelity. So any evidence-based intervention has to be facilitated exactly the way it was designed to do. There's opportunities to phrase this and use your style of speaking and all that, and get folks comfortable and we're going to talk about that. But this is designed to work in a specific way.

So, what happened with this organization is they couldn't figure out why folks were not following through on the referrals. So I was asking, I said, "Were you having a conversation with them before that or were you just giving them a referral straight off from a screening tool?" That's what they were trained to do. I said this, "But this, you can't call it SBIRT because that's not SBIRT." So, that's why I want to be very specific here. And the thing is, it's just not that hard. It's just a conversation. And I know you might think I'm minimizing it, I'm not. It really is just that. Bob is one of the folks that have been using SBIRT since it first came out. And this is the model. It's screening, it's a dialogue and it's a referral. The referral is a result of a dialogue that gets folks receptive to that opportunity. Now, let's go back to screening. So, thanks everybody. Thank you, Bob. So, depending on how you frame it, you can still stick with the guidelines.

I know for some clients of mine, I couldn't say one drink per day because if it's so dismissive of what someone might naturally think is their... How they

normally socialize, they may not be open. So, if I were to say it the way it used to be phrased, you can do that too. You're still keeping within the guidelines if you were to say three drinks in a day for a healthy female. Those are recommended guidelines. And you can provide that and say that comes from the National Institute on Alcoholism and Alcohol Abuse. These are the experts in the field. And yeah. And when Bob talked about how it was five drinks than it was at one time, it had cut down to four drinks for men. It was five drinks for men. It cut down to four drinks for men. And so, more than four drinks is viewed as really heavy use. So anyway, these are the guidelines. This is important to know if you're going to have a conversation.

So, binge drinking is a pattern of drinking and I think it was Thomas who had put it down that it was 0.08% or higher as blood alcohol concentration or blood alcohol content. This typically occurs after four drinks for women or five drinks for men in about two hours. So, the binge drinking refers to the frame, the timeframe, the amount that's consumed within a small amount of time. If you don't give your body enough time to process, it's different. And then heavy alcohol use is anything more than the guidelines. So four drinks on any day. It's more than four drinks or more than three drinks for men and women perspectively. And the other thing to note is that there is different guidelines for men and women because the body needs water to process out ethanol, which is the ingredient in alcohol that creates our issues. That's the psychoactive substance of alcohol, is ethanol. Right? So, the water contained in the average male body is a lot more than the average female body, and that's why the recommendations are different. It's not BMI's, it's water content.

And so, if you get asked that question, that's what that has to do with. So this is what my clients used to think a standard drink was. I don't know how it is for you folks, but when I was working, I remember I was working in one organization. I was in The Bronx and oh yeah, I was doing HIV prevention at that time. And when I used to talk to my clients about drinking, we had to, at that time it was just before these wonderful medications that are out now, and at that time we had to get them to reduce drinking because it impacted the liver and liver needed to process these other medications for their HIV. And so it was really important to help them reduce or just not drink at all. And so that was coming from the AIDS Institute at the time, this was a while back. And so when I used to go to speak with my clients, one drink was something like this. So it's really... Again, it comes back to perspective. How does your client identify a drink? How do we identify a standard drink?

So a standard drink typically has around 5% of alcohol in it, but these are standard drinks. A can of beer, that's a standard drink that has about 5% alcohol. Or if you have malt liquor, you go to a bar or someone's house and has

to have your glasses. This is a standard drink of 7% alcohol, the malt liquor. Table one, you have other liqueur and brandies. And I see 80-proof, I automatically go to rum 151. And so, these are different standard drinks. So, it's important for you to know what your clients and your patients are drinking, so you can correlate the guidelines, what is considered the appropriate level of the drinking guidelines to what they're drinking. So, if I have a client that is drinking 151, I had a lot of clients who did, I would encourage sitting with that drink more than an hour. Sitting with the drink for a couple hours, for as long as possible.

But then, I used to also have clients who, hey, one drink was their Old English. I remember Old English, 48 hours used to be, in some neighborhoods, in some cultures, that was kind of traditional. It was more cultural to the communities at the time, where an Old English was a drink. Group of folks would get together and that would be what standard drink, was this. That's a 38, I think that, no 42 ounce, I think it was at the time. And so, helping someone understand how it can affect them and maybe helping them consider options of reduction, that's part of what we used to have to do. I used to use a lot of harm reduction with my clients who are HIV positive. And so, understanding that these are standard drinks and the alcohol content, you want to encourage them to kind of sit with the drink a little longer.

So, here's what Nancy was saying. Here's the slide that this slide belongs to Nancy. Screening does not provide a diagnosis. All the information we're covering is because this is part of the conversation we're going to have. This may be part of the conversation we'll have later. So, right now we're talking about screening. When thinking about screening, it doesn't provide a diagnosis. Again, this is another way to emphasize the need to use the right terminology. So as we go forward, how we present the information to the person we will be engaged with, that is key. So, screening does provide certain opportunities. So, when you aren't doing the screening, the education and the positive feedback that you can have with your folks who're at no risk... Actually, someone who may have self-reported on a screening tool, once they see you and you look at the score and you look at it and you score it, acknowledging, recognizing that they're not consuming it at any level, that by itself can be considered brief intervention. And this is more for folks who are doing [inaudible].

Screening does help you understand if there is a level of risk that you need to explore and have a discussion about, because in order to have a dialogue, it has to be justified. If the screening tool does not indicate a potential issue to explore, it doesn't provide a risk. Then you can't have a conversation just to have a conversation. It has to be justified by the interpretation of the screen. So screening does provide a lot of different things. You can address and bring up

issues around maybe how substances may be problematic in the person's life. It involves you providing a brief intervention, which is for their benefit. It identifies folks who might need that referral. So, that dialogue might include a referral if they score high on the screening tool.

Let me see what folks are saying in the chat box. Yes. That's why the conversation is an important piece. Yes, it is. So, let me just tell you before, brief intervention all by itself, was already evidence-based long before SBIRT came around. But when they put the components together, it just provided even more opportunities. So, let's talk about the screening tools. These are just some, these are not all of them. This is so many validated screening tools. So, the AUDIT is where that triangle of colors comes from. And so, the AUDIT is the alcohol use disorder identification test. And this is the one that we use in the content of this SBIRT training, because this is a screening tool that many practitioners are very familiar with. So, it's just to use the model for this gives you a conceptual understanding of how this can apply with any screening tool that you're using, whether it's alcohol, whether you're using it for other substances and whatnot.

But you have a variety of different tools. So, you have the DAST, you have the ASSIST. I work with an organization that included this on this slide. They used a two-item conjoint screen, which I had not seen until I met them. It's called TICS, which is not very... Anyway. So, it's just two questions. And then you have the single questions from NIAAA and NIDA. And so, you have pre-screens, you have full screens. And then over time, the same authors develop a shorter version of those screens. And I'll talk about that in a minute. So, you have screening tools specifically for youth. When I do adolescents SBIRT, I talk about the CRAFFT two. It was initially the CRAFFT, the adolescent screening tool is the car, relax, alone, forget, family or friends and trouble. And so what it does, it doesn't necessarily ask about consumption. It asks about associated consequences or experience with the consumption.

And so, it's a less intrusive approach to assessing risk. And so, it was eventually updated to CRAFFT two, and then it included other substances like K9, rather not K9, K2. Excuse me, and other substances. And it's worded that way in the tool. So, I tend to focus on CRAFFT two. So, the NIAAA also has alcohol screen for youth between nine and 18 years of age. S2BI, the brief screener for tobacco, alcohol and other drugs. And so, these are specific for youth. You do not want to use an adult screener for the youth population. And so, we also have screening tools for organizations who are working with pregnant women. We work with an organization to help them out with the 4P's PLUS. It was really a nice tool. Very specific. But you got the T-ACE, you got the TWEAK. So, you have an array of different choices.

I tend to focus a lot on this one, CAGE-AID. And this is just my own preference. Every organization has their preference or has their requirement depending on their funding source. But what is important is to understand which is the screening tool you want to use because you do not want to put together part of this tool, and part of that validated tool, part of this validated tool, come up with a hybrid form and call it evidence-based. It doesn't work that way. It has to be very specific to the tool that is, without taking it apart or combining it with anything else. And so, it can be part of a protocol. It can be part of an assessment instrument or an intake instrument that asks about different areas of a person's life. But a validated screening instrument is not one where components of several instruments are put into one. That's not validated. And so, just to be clear.

So CAGE-AID, these are questions, four questions, only four questions that are not as intrusive, that helps a person might feel or help a person feel just slightly more comfortable about responding, because it's not like some of these questions might be judgemental. They might still be judgmental depending on the person. And these ones to me seems a little bit less intrusive. And so these instruments, if you're doing an interview, then often this is well done with self report where the person does it themselves before they meet up with you. And then they give you the form and then you go and take it from there. Or you can do a person-to-person interview. And if you're going to do that, then you have to ask questions exactly the way they're written.

So, one. Have you ever felt you ought to cut down on your drinking or drug use? Two. Have people annoyed you by criticizing your drinking or drug use? Three. Have you felt bad or guilty about your drinking or drug use? Four. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? Now, I read it very quickly, but that is not how I would read it out loud to a person. I would certainly let them know what I'm about to do. Ask if I can do it and then ask the questions exactly the way it's written. There was a time where we were able or encouraged to paraphrase different questions from our assessment and intake instruments. These screening tools are not like that. These screening tools, you have to, if you're going to do it person-to-person, you have to read them verbatim. It's really key. Otherwise you can't. The outcomes are not necessarily accurate, based on how you did it as it's not based on how it was designed.

And that's the only way we can understand whether something is validated. It has to be done exactly the way it was designed to be done, facilitated. And so, what's good about the CAGE-AID and other instruments, whatever instruments that you have or whatever instruments that another person is doing before it comes to you, depending on what capacity you're serving in your organization, it

needs to have an interpretation. It makes no sense. It doesn't have an actual conclusion if you just have some screening questions where they say yes or no, or you can just put down a number for a particular response and it doesn't interpret, doesn't give you a score that indicates something. And I've seen a lot of protocols, a lot of intake forms like that. We need an interpretation. There's a reason why you are asking the questions in the first place. You are looking to it to see if there's something, a risk that you might need to identify and explore.

So, the scoring for these four questions here are scored from real simple, very binary here. Zero for no, or one for yes. So, a higher score is an indication of potential alcohol problems. So, two or greater is considered significant. And so depending on the protocols in your organization, most people think if it's two or more, you may want to have a brief intervention and offer a referral. So, the interpretation is one or more yes responses is regarded as a positive screening test and indication of possible substance use, and you want to offer that potential need for further evaluation. And we're going to talk about that. Let me see what folks have to say. Okay, excellent. So, let me go here. And I wanted to show you. So, that's the CAGE-AID. This is the CRAFFT two. What I like about CRAFFT two, and I often use this, this is for Massachusetts and sometimes I do SBIRT for school professionals, educational professionals, and so in New Jersey, there's a law that states that the school system has to have some protocol that has to do with screening, brief intervention and referral to potential treatment for students.

It doesn't emphasize or pushes SBIRT, but it pushes those three components. And so, they're required in New Jersey. In New York, we don't have that law. We could certainly use it but it's not a mandate in New York. But it is required in New Jersey. And so, the idea is folks... In Massachusetts, I believe the laws over there also required the educational system have these components in place, that this available for students. And so, and again, as a prevention of effort. And so SBIRT, so what they did is they not only put the tool on the left hand side, they also put the potential next steps on the right hand side. This is like a fold up one card. This is just a big blown up picture of it. And so what it is, the CRAFFT two screening has these four questions. Drink more than a few sip of beer, wine, or any drink containing alcohol.

I mean, again, these are questions that we're go going to ask verbatim, or you're going to give it to the student or the young person, or the youth to be able to self report. And so what happens, but usually this is an interview type of approach, because if in the first four questions, if they respond zero to the first four questions, you only ask one question. The last questions. Have you ever ridden in a car driven by someone, including yourself, who was high or had been using alcohol or drugs? A person may not have never used or doesn't consume,

doesn't engage and while other kids might be. But if they say positive, they have been in the car while someone else was drinking and driving, then you want to go...

PART 3 OF 5 ENDS [01:36:04]

Diana Padilla: In the car while someone else was drinking and driving, then you want to go on and you ask the rest of the questions. That's how this one goes. I'm not going to go into it any deeper. The scoring here does encourage the professional to follow this brief intervention strategy, outline strategy. That's what we're going to talk about, because that's similar to what we're going to do as adults in this context. Here we go back to the audit. The audit is usually 10 questions, and you ask these questions, and what you find is you can score it this way, depending on how often they indulge and how many they have on any given day, the appropriate answers circled, and there's a score towards the end.

I'm going to give you a copy of this, or rather I'm going to ask my colleague, Tree to give you a copy of this. We're going to send you a few handouts today, because I'm going to need you to have this for tomorrow. This is an audit. If you're not into doing that... If you're the counselor, if you're the social worker, if you are a director of some leadership position, we're going to ask you to be familiar with what intake does, how the screening process takes place, because that is key to understanding why you might be the person who might be doing the brief intervention.

One person doesn't have to do the screening and the dialogue and the referral. It could be a team approach. That's important to understand. A a lot of organizations incorporate it that way, so they have already protocols in place and it can fit right in certain places, certain ways that you could do that. Sharon, I see you have your hand up. Let me stop sharing for a second.

Sharon: That was an accident. I apologize.

Diana Padilla: Darn. Okay. I'm going to say, Yamir? You can tell me how to pronounce your name. I'm not sure.

Yamir: Yamir, yes. That was perfect.

Diana Padilla: Yamir is it fine? Okay, go ahead.

Yamir: Yeah. I think you brought up a very interesting point at the very end about it can be a team approach. I was wondering, I guess a timeline, because in my mind, this all has to be pretty sequential, very fast. There's no attrition. We want to make sure that once that they have agreed to referral that we try to refer them

as soon as possible. If it was going to be another person that were to do that brief intervention and that referral process, is that one room to the next room? Can there be time in between that? Or what does that look like?

Diana Padilla: No, there can be time in between. You have to do the best you can to keep that sequence going. Great question. Thank you for asking that. There's one organization that I had worked with and what they did was, actually, I was working for folks in housing works, hat they did was that they incorporate... Because they already have certain protocols in place for certain programs and certain priorities that they have to do. They would screen someone and they would score them, but they always had a follow-up appointment. That follow-up appointment, then the person was able to do an intervention, and then give the referral that. It was at least set in place. It wasn't done off the cuffs. The important part was always before you even do the screen, the report building is such an important part of this.

We'll talk about that. They would do the screen, get the appointment, and when they come back another person was in charge of doing the brief intervention. So it has to do with the capacity of the professionals and also has to do with what other things are going on. A lot of times they'll do intakes when they have on one of the balls. If they have a boss, that is not the time you're going to do a brief intervention. If someone was able to actually follow through on a screener, that's great. You give them an appointment and you meet with them after the event is taking place. That keeps the engagement. You can still have that conversation on the long term. That's part of the team approach.

So thanks for the question. Another way. Let me remind everybody, whenever you have gone for services yourself, Nina, notice that every if we go get our physical, because we practice what we preach, right? We go get our physical every year. I know we do. Sure. Okay. So when we do that every year, we have to always update these forms, they give you two or three papers, which is kind of annoying, but they need that to keep your information updated. I've seen that a lot of organizations, whether it's medical, medical communities or other social services, what they'll do is during that time, they'll also put an alcohol or a substance use screener in there. The person can self-report or a lot of times it's the one question and that's okay, that's all you need.

Have you used more than this much or this much in the last 12 months? And that's enough to potentially identify an issue to explore. So all of those is different ways of doing it and then the person would actually submit it. Then the nurse would come get the person, the case manager would come back, get the person, the social worker, the addiction professional, will come get the person. They'll you look at the forms and be able to indicate the next steps to do when they look at the forms. I'm going to give you a better idea of that.

That's part of the team approach. One person does not have to do everything that would kind of be unrealistic. That's a lot of pressure on one person to be able to do it. What is nice is, you can identify different persons within the organization, depending on the program services that can do it, not just one person or not two or three persons within one program, maybe a couple of point person on different programs might be able to do this. Thanks for bringing that up. Yamir. Sharon? Yes.

Sharon: Okay. I work for an agency that coordinates care. My specific role, I work with EMS first responders. I get referrals from a local ED department. I immediately connect with that individual, whether in person or by phone to do an intake. Some of the questions that you just mentioned, they may go there for something else, but during that assessment, that's how I get my phone calls.

Diana Padilla: Hmm.

Sharon: They also, this is just something I like to do. I like to first get their consent and then I ask them, okay, you're struggling with this. Would you like to go to detox? Would you like to go to an in-patient program? I try to gauge right off the top, what they want. Then I go through the rest of our questions, which is a great assessment tool for the next step for that person's recovery process.

Diana Padilla: Okay. Thanks for the insight as to how your protocols work. We're going to consider experts, going to be slightly different, because what we do in [inaudible] is we don't necessarily start off, right, do you want to go here, do you want to go there? We want to engage them a conversation first. What we want to do is build receptivity, build motivation for them to maybe consider doing something about their behavior. Even before we offer the referral, before we offer the further assessment piece. Hold on to that and just don't do anything without that yet. Just wait to see how we discuss it, how it comes out with the expert, and then you make your own choices. You consider, if this is another way of doing it, that you might want to also consider, because that's very similar to just doing screening and giving a referral and not having a dialogue at all.

It's almost the same thing. The thing is, the dialogue is where we want to engage. We want to engage. How we engage is, we're going to spend time on that. How we engage is really important. It's a very person centered process. It's really going to have you do intentionally doing strategies that's only about the other person. It's done in a certain way that will build their awareness and hopefully their motivation to maybe want to do something about changing a particular behavior. That will be the key point for you to offer that referral.

Sharon: That's not always the case. This piece that you're bringing in my world today will help me with those that are not ready or still want the recovery coaching. This is awesome and I'm just learning. This is going to be an added extra education for those that don't want to go straight from the hospital to a triage or whatever.

Diana Padilla: That's what I'm hoping for you, just another approach that you can use. That's exactly what I'm hoping for you, because people are in different places at different times and don't we always want to meet them where they're at? That's part of the other brief, the extended brief intervention, but we're not there yet. I'm still talking about screening even before we do screening. Remember we have to do this with Fidelity. Nancy said so, so we have to follow what he said. We have to do this exactly the way it was designed. We have to ask these questions, because if I'm your patient or if I'm your client, and you're going to ask all these questions, this assessment, you're going to have to help me feel like I'm in here somewhere. If it's only about your questions and I'm not really here, I might not be very forthcoming with my responses. So let's talk about that.

Here's the audit questionnaire. Oh, so the interpretation, one of the things, and we're going to use the audit as part of how we practice [inaudible]. So the audit also brings interpretation. The numbers all speak to different types, different levels of use, whether it's hazardous, harmful, or at a level where they're showing substance use disorder symptoms. What you see here really correlates with the criteria for alcohol use disorder. You're asking about that. That's how the audit screener was designed with these things in mind. Frequency of drinking, impair control over drinking, guilt after drinking, blackouts and that kind of thing. It talks about severity, talks about frequency, talks about amount. The scoring comes back to the same thing, these audit findings on an array of the year, the timeframe, but they did take a number of findings from the audits and it comes up the same way. A good 75% of population don't screen with any potential issue.

20% are at risk. And five percent tend to be more likely to have a substance use disorder. The audit has this, so the scoring has a particular level of risk. Then it also has the next steps. If somebody scores between 16 and 19, it tells you to have a brief intervention and if needed, because if they have a high risk use and if they need it, they might need an extra session with you. That's an extended brief intervention. What if somebody scores between eight and 15? Then you provide the dialogue that is focused on that behavior on reducing their hazardous drinking. Now, if someone scores between 20 and 40, because we will have folks who do score that high, then they're likely to have a substance use disorder, but you can't say that. Nancy says so, you can't say that, listen, you have a substance use disorder.

We're only screening. Diagnosing someone uses specific protocols, specific instruments. You folks who have the case act credentialing already know that. What we do is, we make the case, but not in a directive way. The brief intervention will give you the opportunity to make a referral for further assessment, because that further assessment is to a place where that has to be done by a credential individual. That further assessment can let you know whether or not you meet that criteria. It shows here that you have a likely substance use disorder, but I can't really tell you, but I know where I can send you to some place where that's what they do, and that would be able to share with you the findings and give you options. It's all in how you phrase it, but we'll talk about it that a little bit more.

Let me see, I see some folks here. It's never a question and answer process. Dialogue is so important. We are so caught up, listen, as providers, we have been tasked over time to do this, we got to meet this, we got to do this, this certain amount of times, there's so much, so many things that you have to achieve on any given day as the provider that you are in the capacity you're serving. Doesn't matter what title you have. You have, all of you, have so many different things that you have to achieve on a given day. What happens a lot of times and has happened to me, is that sometimes we're so much into having to make sure we submit this and meet that and do this staffing year and clinical evaluation and all this other stuff, but there's a person here. There's a person here that we have to engage.

There's not so much of the process and the things that we have to meet as providers. How do we engage that person? That's important. We are listening this information to help that person. Just to be mindful, because so much is pushed on us that we have to do and it can be very overwhelming, but we can't lose sight of what we're doing. We can't lose sight that there's a person we're trying to help. That's why we're doing all this other stuff that we're required to do. It all comes together to help them. So engagement. Let's talk about that. Before we do a screening tool, one of the things that has helped and the research has been showing this, especially if you work with youth adolescents, which I know not a lot of folks find this community a very hard community to work with. You really should be informed about developmental issues and other risk factors for youth in your communities and presenting issues.

There's a host of different things that can help you. Along with that, with adolescents folks who are under 18, whether they're 12 to 14 or 14 to 17 adolescent, when they are aware of confidentiality, when you explain confidentiality to them, they're more, we're willing to seek help and be forthcoming with their responses when you screen them, or when you process their information that they had just finished reporting on. Compared to people

or peers who are not aware of confidentiality. Perhaps I can remind you of when I was doing direct services, how do we explain confidentiality to people? How do we explain confidentiality when we're working with adolescents? The state laws govern minor patient rights, the confidentiality of information shared with healthcare providers about alcohol and substance use, but states vary.

Be aware of, if you're working with youth, how the laws apply in terms of confidentiality with your folks. You should explain the full policy regarding the disclosure of sensitive issues directly to the adolescent at the very beginning before screening, just before screening. Some of the schools, like some of the schools in New Jersey, there's a couple of private programs that have taken place in New Jersey, in New York, one of the things they tend to do when they do it in a school setting, it's not just in school settings, it's community based organizations, other places that that youth go to, but in school settings, you have to have, because the person is under age, you have to have a knocked out.

What do you call? A knockout clause and the paperwork that you're going to give to the parents, the parents have to actually sign off and give their permission that maybe your school can actually screen adolescents in a certain in age group. If their children fall into the, and most schools that do [inaudible], will do a universal screening for a potential age group or a couple of age groups. Let's say they do it for folks in the sophomore year. They do it for folks in the sophomore year, they can't do it unless there is a patient, a parent sign off that their child can participate in the program. If that's the case, then you want to explain to her when you screen someone as an adolescent, you want to explain how confidentiality works for them.

Most times what you want to say is, okay, so I'm allowed to do this. You let me know if you're okay with this, because the reality is anything you tell me, it could stay between us, but there are times I might have to share this information. Typically, when is it that confidentiality is not between them and us? What are the couple of different things that kind of change that? That makes that not a straightforward templated approach? When is it when confidentiality's not between that adolescent or that person and us?

Manson: When they're at harm or the potential to harm themselves or someone else.

Diana Padilla: Okay. Thank you, Mancy. Lawrence, you want to add?

Lawrence: Indication of harm to self or to others then all bets are off.

Diana Padilla: Okay. Here's the thing. Thank you. Here's the thing, when we tell them ahead of time what we've noticed and what we've seen in the research, because we've done focus groups as well, is that the adolescents are more likely to be more

forthcoming with you. It also depends on how you engage in style, but they're more likely to give you accurate information, right? If you let them know, listen it's going to stay here, unless of course, unless I see that you're going to cause harm to yourself or someone else is going to be at risk because of your involvement. Then, if there's a potential for an issue at a point, sometimes the screeners have a high score and maybe an adolescent does have a likelihood of substance use disorder, so at some point, if they do want treatment, guess what the parents are going to know. It's going to be the parents' insurance is going to cover it.

Those things may come into play. But initially, before you even give them a report, a screen, so they can self report. Before you even do that interview, you want to explain to them about confidentiality, because that's part of what's going to help them feel comfortable enough to be forthcoming with you. I have a question. Before starting, I want you to consider what might you need to think about to create and not, that was just an adolescent, but I'm thinking adults in general, the population just serving, if you were to do the screening as part of your capacity, just pretend that you're not doing whatever you normally do, you are going to do a substance use screener with someone. What might you need to consider to create an atmosphere of trust?

I want you to consider this, that an atmosphere of trust should be culturally appropriate, actually it should be culturally and linguistically appropriate, should be trauma informed and it should be affirming. There's a certain atmosphere of comfortability you want to set. Now, once you do the report, once you start doing the screeners, you have to use a verbatim. This is the opportunity to set the atmosphere, because you'll have to read off some words exactly how it's written. Before that happens, how do you create this atmosphere? I'm curious. Let's pretend y'all about to do a screener right now and you want information and you're doing this universally, you want folks to feel comfortable enough to be able to share with you the realities of their life, right, when you ask these screening questions. What might you do?

Let's see, Richard says, explain, educate person first as to the purpose, because mid four use MI. Okay. I think mindful you meant. Privacy during conversation is a tool to be used at the only at the interview, or can it be used during treatment when there is identified risk of recurrence? Good question. Hold onto that, Anna. If they have question, explain CF 44, introducing self meeting patient, where they at yes. Mindful explain where you're going to reason. Very good. Explain what you're going to do, reasons for doing it, and implications. Sharon, thank you. No judgements. This is all why we want to do it. What does that look like? So what is it that you will do? What do you do? What is it? What is it that it

might look like? What is the approach? How do you create the atmosphere? There's two, there's two sides for that.

Manson: One. I first introduce myself in my role and I then proceed to ask permission, would they like to talk to me and can we move to a more private setting? If they're comfortable, once I'm there, I'll ask them, do they mind I have the door open or close? What is their preference? I will ask, what about any cultural or preferred pronouns they would like to be used and things of that nature, and just kind of set the stage, invite them to stop me and ask questions at any given time and just go from there.

Diana Padilla: Okay. Anyone else? Okay. So I don't want to move on until we're clear on this part. Thanks for a lot of that information, Mancy. I'm about to do a screening with you. Creating uncomfortable atmosphere involves a couple of things. First of all, the environment is important. Okay. What the environment looks like. When we think about being culturally informal, we want to think about linguistically appropriate, you also want to think about being trauma informed and culturally appropriate, linguistically appropriate, approaches, align. They're right. They're like twins, they align, okay. All the concepts align.

A lot of the folks that we work with, we want to be preventive, so we don't want to re traumatize them. We want to be trauma informed. When we think about the cultural aspect, we also want to think about how we are going to engage folks. Actually, and what I am supposed to be doing, and I still don't have the hang of it, say, if I'm going to meet someone for the first time, I can always say my name's Diana. My pronouns are like she and hers. I said, how can I call you? What name should I use for you? They can follow suit. They can follow and give me their pronouns or not, because they don't have to respond exactly to say, wait, I can lead off and do that.

Then I would ask their permission, like Mancy was saying, I have a few questions to speak with you, do you mind if we go somewhere more private? Then I explain the confidentiality, because that's really important. Let's think about this. I explain the confidentiality. That is part of setting the atmosphere, but it's not just what we explained to them.

I remember back in the day, when I first got into the field, they told us, you explained this, and then you go on to this. Well, you know what, these days we don't just explain. We want to ask them, so what do you understand from what I explained from confidentiality? What's your perspective? It may differ from other social services. They have access. We want to be clear. So get them to give you some feedback. I need to explain to you about how we practice confidentiality here and what it means. I says, and could you tell me, okay, what do you understand about what I just said to you? I just wanted to be clear and

that you know. Your tone of voice and how you engage them, that's really important. If there's any kind of misconception or something they got confused with, that's your opportunity to clear that up.

Once you're doing that and it's always about the other person. Once you're doing that, you also want to be mindful that before you even have a person in a particular space that is private, that it's already inclusive and affirming ahead of time. Not when they get there, you want to have that ahead of time. So understand that the communities that you're serving you are likely aware of who you're serving. And so maybe around you can reflect some of that. Then how you approach. The tone of voice, looking at the DI when possible, because sometimes it's not appropriate, but if to be approachable, I'm not saying personable, approachable to be able to engage them like another human being, not as a client, because there's that power thing. We're persons of authority when someone's coming to us for services.

Even if they're coming for us, say if they're coming to us or services in the medical, in the healthcare location and they have gastric issues, and I'm still going to ask these questions of substance. I still have intentions of asking permission to ask these questions of substance use. I still want to make them feel comfortable and prepare them. I may want to tell them it says, so I have some questions that I typically ask for a lot of folks. I said, do you mind if I ask that of you? I let them know ahead of time, what kind of questions they're going to be, because I have to ask, when I do ask questions, they have to be exact.

Think about it. You also want to find out, with some folks you want to ask, I said, we, I typically use English if that's okay, are you comfortable? You are right we're using English? We don't get into the habit as much as we should about language of preference. Why would that be? If somebody seems to speak English fine, why would language of preference be something to consider and ask about? Not Mancy, somebody else ask me first, give him a break. Someone else tell me, why would that be important? Go ahead, Lawrence.

Lawrence: Cultural compliance.

Diana Padilla: Elaborate a little bit. Yeah.

Lawrence: If a person has a particular religious belief or you have to meet that person where they are. If you don't have understanding of their culture and their way of doing things, something as simple as shaking hands, could be a deal breaker for certain cultures. You have to understand the environment that you're in and the person that you're dealing with or you can sabotage the engagement.

Diana Padilla: Okay. That's important to do that. I had an experience myself and so I learned that to ask questions and sometimes when I meet someone I say, is it okay to shake your hands? It's not hard thing to say. Nice to meet you. Is it okay to shake your hand? Or I said is not, that's okay. Would you mind follow me? Asking permission, because they need to have ownership of their process of their situation. They are involved. I'm not talking to them or at them. I want to talk with them. That's really important. The thing about linguistically appropriate, you can have someone who speaks English, who speaks Spanish and speaks Portuguese, speaks Mandarin, comprehension is a big deal. Understanding information, knowing right from the beginning, because this can be a client that somebody who may be a potential client for a long term, with a lot of different issues.

Know right from the beginning, what is the language of their preference, because comprehension. What they understand in their preferred language may be differently understood in English. If that's not their first or preferred language. It's important to ask and we don't do that a lot. It's important to ask, ethically, got nothing to do with expert, ethically. We're supposed to be doing that, because we have to be clear, we have to be not just transparent, but we have to be clear with our information. We have to make sure that they understand. Think about that. Now I'm going to go back to my side.

I got some really good feedback on the chat box. I love this. Certain slang terms that may be used in... What is it? I missed it. Certain slang terms. Where was that? Certain slang terms that may be used in their culture. That's true. The person's going to feel more comfortable. You know, the fact that you ask which language is better, they prefer, this is something they're not necessarily used to in anywhere else. So this is key, it's about them, they're starting to feel that. Build re pore and comfort, comfort and presumed understanding. You may speak English well, but be comfortable with a different language. Yes. To me, it's more about the comprehension. I just want to be clear, because we deal with clinical jargon all the time.

Then we have to translate it in terms that our folks understand. Are they going to understand the English versions of the thing of the content we want to come back? We want to be sure. Boundaries, while a client may speak other English at times, they can talk about certain things in their own language. It's still important to ask of their preferred language. We are encouraging folks to be culturally and linguistically appropriate. There's a class standards training coming November. I hope you all are open to coming to that. Here is something that you might want to take advantage of. The only opportunity you have before you start to ask questions. When you answer this, before you ask the questions, verbatim, it's the only time you have an opportunity to just be you

and just use your wonderful style of engaging folks. Creating this atmosphere using your tone of voice and understanding what you're going to say, is really important.

Here's what I'm going to say. This is an example, just an example of a dialogue. I'm going to ask you folks. This is what I'm going to say to a client, what I might want to say to a client before I start asking these questions. I'd like to ask you some questions that I ask all of my patients, what am I conveying there? I want to ask you some questions that I ask of all my patients. Would that be okay? What am I doing there? Go ahead, Lawrence.

Lawrence: I guess you're saying that this is standard procedure for me. I'm treating you, or I'm doing exactly what I need to do for everyone.

Diana Padilla: Okay. It's kind of along the same lines. Yeah. Right. Knowing that a person is not being singled out, letting them know everyone gets the same thing. That's yeah. That's pretty much what Lawrence was saying. They're not being singled out. That's important. I really appreciate what you said, Sharon, normalizing. This process is really key. So we're not targeting anybody. This is just kind what we do.

PART 4 OF 5 ENDS [02:08:04]

Diana Padilla: Anybody? This is just kind of like what we do. Not isolating or victimizing anybody, we're normalizing this. Good. So the next one, the next potential statement might include these questions will help me provide you with the best care possible. What am I saying there?

Manson: Person centered?

Diana Padilla: Person centered, it is about them. That's right. And again, and then I follow up with, as with all medical information your responses are confidential. This is after I already explained confidentiality. As with all medical information, your responses are confidential and then we go. And then I suggested and I added this list also, we can stop at any time. Okay so giving them the right to stop. That's right, autonomy. It's up to them. They direct us so I can say, "We can stop at any time." Or and I had somebody one time ask me about, because they work with folks who are mandated, and I said to their programs, and I said, "Okay, well, you can also say so well, if you feel uncomfortable at any time, any point, we can stop at any time and we'll start again when you're ready." Which kind of still involves, we still have to follow through the questions but we still want to give them some sense of autonomy. We still want to help them understand, let them do some of the guiding. They're participating in this process.

Yeah. Individualizing their process, giving them autonomy. Exactly. So this is something that you might want to consider before you do the intake because once you do the intake, now you start to ask the questions very specifically so let's talk about this. So first of all, screening does not provide a diagnosis. We are not doing that, we're not providing a diagnosis. We're only screening. We're screening because we want to see if there's a potential issue to explore for or dig for, right? Screening does provide the identification of a level at risk and that can indicate what kind of screens, what are your next steps. So it says, there are two levels of screening. So I didn't go into any depth so the 10 question AUDIT has a mini AUDIT. In other words, three questions that some locations use for everyone and if they respond positively to those three questions, then they will follow through with 10 questions.

It's just a matter, it's the idea that you can use a shorter version of a screener developed and already empirically researched by the authors and developers. It's just a smaller question so someone doesn't have to go through a whole lengthy process if it's not necessary. It's just the way of being able to identify which folks you want to put extra energy with. And so there are four types of intervention and the interventions include, you actually looking at the pre-screener and the screener as an intervention. The four types of intervention, the feedback which we will talk about. Brief intervention, extended intervention and when we refresh for further assessment, that's an intervention tool. We haven't gotten into that yet. So any questions so far? I got a few minutes left with you and I really want to cover some stuff but any questions so far? It kind of seems straightforward though, right? Don't you think?

We really, really take an in depth view to any kind of screening. It's just a form. You fill it out and you keep going. That's kind of what we're used to. We're used to, if we working in treatment, we used to our clients coming in, two weeks of orientation, we [inaudible] them with the mental health, with the substance use, with this diagnosis. We might put them in medications for opioid use disorder, alcohol use disorder. We do a whole bunch of things. If we're working prevention, recovery supports, if we're working in HIV, if we're working in any other kind of capacity, mental health, we have an array of different things we ask. So folks, what we don't necessarily take the time to consider, wait a minute, we need, in order to do this, that's going to direct what we're going to do clinically or not clinically, depending capacity we're serving.

And before that goes through, we have to make sure that folks are going to respond accurately to what we're asking. If we're going to do that, we've got to make them feel comfortable. We have to engage so we start with an initial report at that point, even before. And one of the key things we ask for, is to ask permission, is listen I'm about to do this. And I say, "Is it okay if I do that?" And I

tend to do that with everybody. Do you mind? And then if it feels uncomfortable at any point, we can stop and we'll come back when you're ready, you let me know. And really doing it with a tone of voice that kind of makes me feel like, listen I'm just having a conversation with somebody else. They don't have to feel like, okay, they are "a clients". That's a little different and I think that over time, maybe sometimes because of what we're required to do, that might get lost sometimes. So we don't usually put this much effort or emphasis on this, but I think that's really important.

You don't want to find out 90 days when you do a reassessment about issues that you could have found out in the beginning, and a lot of times that's what happens. So well, this training discussed adolescent treatment or only adults? This is focused on adults but what I'll do Eileen is infuse adolescence all along the way. It's a different conversation, more in depth in a different way for adolescence, but it uses the same model. It's just that the dialogue might be just a slight bit different because folks who have the capacity at 14 and 15 are not necessarily having the same capacity as adults do. So I'll do my best, okay? Now, here's the next thing, so I want to ask you. Let's go into motivation.

So there's a concept here. How many folks, matter of fact, let me come back to you folks. How many folks, let's just pretend just for a minute, so I am your supervisor. I am everybody's supervisor right now. Don't worry, I can give you off three day weekends, four day weekends. I'm good like that. All right so I'm your supervisor and I tell you that if you stay on Friday... What's today? Today's Wednesday so in two days, I'm going to tell you today, right now, I say, "If you stay from, instead of leaving at five o'clock, if you could stay till 7:30, I'll give you Monday off."

How many people might like that idea? How many people would stay for that? Okay, I got a few hands. Well, what do you know? Look at that. Okay, all right. Thank you. Lower your hands. So how many folks would, if I tell you, okay now you folks have to... I know you usually have 25 people in your caseload, but now the problem with the refunding that we are getting for the program, for the same program you've been working with in the last four years. So the refunding requires that you have at least 15 more on your caseload and no, and we don't have any pay raises but that's kind of part of the job. So raise your hand if that is motivating. Not one. Camille, that's so cool. I like that. See, people's hearts are in their work. When we're talking about motivation, there are certain things that speaks to who you are. There's certain things that might motivate you. Everybody here is in this job because you love working with people.

I know that, used to be one of you guys. And so and your heart's there and that's great. You're motivated by working with people. You're not motivated for getting rich, not with this profession, not in what you doing right now.

Everybody pay [inaudible] but what you are motivated is this connection and what you could bring to a person's life and to help them in their process of getting better, in whatever issue they're presenting with and that's really great. And in that process, what we find is things that's motivating for us as providers, right? So I could say that it's a general way for everybody but as individuals, there's certain things that speaks to you. There's certain things. If somebody is telling me that if I stay, listen do this favor for me, what I'm going to do is compensate you with... Listen, I got a couple of tickets to the Mets game.

Well okay, I'm a Met fan, alright? Forget the Yankee fans, forget everybody else. I'm a Met fan so if you give me two tickets to the Mets game and I got box tickets, I will likely, "Yes, I will stay a little longer. I will cover for you." I'll stop. I saw that Nicholas. But...now you don't even want to hear my...I love the football. But it was something else, if you tell me, working harder and more and getting more on my caseload, not getting extra pay, how you frame it may not be as motivating. The idea here is we can personalize that. We can certainly understand what motivates us to move forward, to move in a particular direction.

And that concept is key to what we're going to do with the dialogue. So when we think about where people are in different places and what's going on in their world, think about the extra stressors that all of us, providers who assist our communities. Our client population, our families, our social world, how all that was impacted by the pandemic and the motivations to go forward, to continue to provide services for other people, to stay safe for ourselves and take care of those loved ones in our own life. All the different things that motivate us in one way or another, the things that are priorities, that are value for us, that are important to us. There's different motivations for every single person.

We don't want us to lose sight of that because that's the very thing that we want to capitalize on, or at least seek to identify with the clients that we're going to be talking to in the brief intervention. So people are in different places at different times so that brings me to this slide. So the stages of change or the transtheoretical model of change. So this was developed many years ago by Prochaska and DiClemente. I had the pleasure of co-presenting once with Dr. DiClemente. It was such [inaudible], one of the rock stars of our fields. He did so much. He and Dr. Prochaska done so much work that this really informed and some of those motivational interviewing process that we use in our work today. Huge and this makes so much sense.

People in different places at different times have different motivations, have different priorities, different things that they're maybe struggling with or different things that they prioritize so motivation is key. So before we even talk about motivation, let's understand that people can be in different places at

different times. So the stages of change are foundational to motivational interviewing, which is part of the brief intervention dialogue and so we have these six stages. Pre contemplation and so we already know that this folks is not considering change or they're unwilling or unable to change. I would not say necessarily unable to change. If someone is not considering change, they may not have processed [inaudible]. If they're unable to change, it could be part of that but that's certainly not in their purview at that moment. And so what we can do is approach them in a way and provide them information to raise their awareness about a particular behavior that might not so healthy for them.

And so the MI has the way of doing that. And I remember when I was doing work in HIV prevention and that time, we were not typing in the progress notes. We had to write them up. We had to assess where a person was, what stage of change they was, why they were in that and why we thought they were in that stage of change and we also had to write in what is the approach we're going to use the next time we meet up with them. I probably had carpal tunnel since those days. So pre contemplation... But it was a really great way to understand how people are, where people were at and what approaches we need. What are the next steps that I could use as a provider. And so pre contemplation, person's not thinking about changing and not looking at their behavior for whatever the reason.

So we potentially have the opportunity to raise awareness about it. It just kind of depends how we're going to do it, but we raise awareness. And the next stage would be contemplation, where the possibility of change, they're considering it. They kind of uncertain, maybe they might look at it but they might be ambivalent, they're on the fence about it. So maybe our job at that point will be to resolve that ambivalence, kind of help them to choose change without directing them which is really key. And then from contemplation, you have preparation when they're committed to do something about it and you help partner with them and support them in what potential strategies they can use. The action is when they actually start to implement some of these changes they want to incorporate. And then you have the other stage maintenance, which is they're maintaining, they're still doing things differently.

And you want to ensure that they have the skill sets and support systems in place so they can sustain what they're doing but there's always the potential of recurrence, what we used to call relapse, or return to the unhealthy behavior or these days we're terming it as recurrence. And so that is more natural than not. Folks are, we say, people are creatures a habit to be more specific and more clinical. Think of that, how we are more used to... Our brain is more used to us doing things in a certain way than when we start a new habit in three to six months where we might go back to what we already know without even

thinking about it, what we've been doing for years. So it's possible that recurrence can happen so the idea is if it happens, you cope with it, work around the consequences and discuss how you can move forward to go back into an action stage, but recurrence can happen at any different time. So these are different places a person can be at in terms of a particular behavior.

Yes, yes, yes. Definitely in the slides we will send to you. So here's the thing about these stages of change, okay. This can happen, anybody could be at any point to any one of these. Recurrence doesn't have to happen but it can, that would not be unusual but anybody could be at any place. A person can be motivated to stop smoking cigarettes today and then in two days, something happens and they're not ready to focus and put energy on that, they're prioritizing something else so motivation is key here. And so understanding this is really important because there are different... It encourages that we do certain things, that we use certain strategies to help folks consider looking at the behavior and how it affects and how it connects to their action goals.

Let me read some of the responses here. Okay, lots of confidentiality includes court subpoena stating that we are a mandated reporter, besides harming ourselves from other medical insurance. The treatment program [inaudible] team. Other staff may use confidential information. Okay. I think this has to do with what we were discussing before. Thanks, Tina. So let me go on to here. So this is foundational and I mentioned to motivational interviewing so I expect all of you will probably be able to speak to this. So long version. Mason, would you like to read this to the whole group out loud?

Manson: Motivational interviewing is a person-centered evidence-based, goal oriented method for enhancing intrinsic motivation to change by exploring and resolving ambivalence with the individual.

Diana Padilla: Thank you. Thank you so much. A lot of you folks raised your hand when you said you using motivational interviewing. And the nice thing about MI, and I'm going to call it MI for short, the nice thing about MI is that it is person centered and it helps us meet people where they're at. I encourage everybody use it all the time, not just in certain programs, not just in certain instances, use it on a regular basis. Some of the best ways to kind of get better with this is actually to use even components on this in our natural world, outside of our work which is what I want to encourage you to do with the [inaudible]. If you want to feel comfortable and feel competent in doing it after we're finished, I'm going to encourage you to use components to this in your everyday life.

That's how I got better with it, with my guy at home, with my social circle, with my friends and I started to practice certain things. It just kind of made sense to me. I see, does it mean that every client would have to pass through the

recurrence, considering cyclical nature in which the stages of change have been presented? No, not at all. The reason why it's there initially when Prochaska, DiClemente developed the transtheoretical model, the stages of change, the recurrence wasn't even in there, not the first developed model. But what they found out was that eventually, they realized and say, you know that once in a while, folks go back to what they've always known, what they've always done because you're more inclined.

You are more conditioned to do that so it takes extra effort to break habits, to break patterns and change into new habits and it can be done. And a lot of us know that, anybody who's ever stopped smoking cigarette. I have yet to stop eating chocolate, but I stopped smoking cigarettes. I got that part. If you've ever stopped a habit, it probably took effort. It may have taken a particular situation that was very impactful to help motivate you that way. So when Prochaska and DiClemente first developed this, this was a graduate study that they did in their university. And I forget where it was but it was about tobacco cessation. And they were looking at folk who were at different places at different time, with individuals who were trying to stop smoking, or some folks who weren't open to smoking.

So the study was targeting that particular risk behavior was tobacco consumption, tobacco use. And so it was found there, it was there that they started to realize, well sometimes a person can change, might have other priorities, something happens in their life and then all of a sudden, the new habit is not exactly a priority anymore, something else is. I'll give you an example, when I think of my clients, yes we used to help clients think about staying obstinate, doing things differently, thinking differently, addressing problems differently. And then a crisis happens, someone gets really sick, someone transitions or passes away and guess what? Their focus is not there, or their income is so compromised, they got an eviction notice. They're not trying to hear about stopping using drugs.

They want to hear how they can keep the roof over their head. So the priorities changed so the conditioned behavior that is more associated to when you're going through stresses and struggles might be what somebody might go fallback into. Doesn't mean everybody does that. It's just that we're not surprised when it does. And especially when it comes to substance use disorder, alcohol use disorder, opioid use disorder, where the capacity is compromised with someone whose brain has already been chronically using. It takes a little while before you get to relearn how to process information to, cognitively have healthy ways of engaging other folks and making informed decisions. So it can happen, it doesn't mean that everybody has to. It's just that we're not surprised and so you know

what? We get back on track, that's all. We have the conversation again with them.

So that's the whole thing about that. But motivational interviewing is such neat evidence based practice and when you do it, it's like it's more natural to just having a conversation so it's so helpful. So what it is and this is just the last. Let me just... Wait, I got less than a minute. And so the spirit of MI is really about partnership, collaboration and acceptance and understanding that we meet people where they're at. We don't always agree with what they want to do and don't want to do, but that's not our call. If we are doing person centered care, if we are meeting people where they're at then we want to accept what they say at any given moment at that time. But I'll give you the bigger context as when we come back tomorrow. The point is this speaks to being compassionate and really speaking to how you are partnering with them for their own best interests, for their own wellness process.

And it's really about a strength based perspective. It's on a process of invoking a kind of change talk, which will be fun to talk about tomorrow in practice. So right now, I'm going to stop this here. Right now, I'm going to stop right there. I'm going to ask you all. Are there any questions or anything that kind of is still, maybe did you still not clear about? No questions? Yes, okay. All right, I'm going to have a ton of them for you for tomorrow though. Okay. So come prepared. All right, so I'm going to leave it right here. Tina, you have your hand up. Hopefully that's a question.

Tina: This is Tina. I just wanted to say that SAMHSA has a really, really good book and it's all about assessments and screening tools. And it's very, very thorough and it's free to download. And the other thing I've always been concerned about is that the DSM-5 never addresses and it should be addressed, binge drinking. It's a real big concern.

Diana Padilla: What drinking?

Tina: Binge drinking.

Diana Padilla: Oh, the binge drinking. Okay.

Tina: Yeah, it doesn't discuss it. And I think it's a very serious issue because some people go to sleep, the body doesn't metabolize the alcohol when they sleep, they get a DUI the next morning or test positive at work the next morning. And also it's really serious for seizures or other health and mental health issues. And it takes this toll on the body and of course people justify, "Oh, I only drink alcohol on Friday or Saturday night," or something like that but maybe they'll

drink 12 beers or 10 beers. That's one of my concerns so I just wanted you to look at those two things.

Diana Padilla: Thanks, Tina. Well, that's part of what we were talking about here. That's why Expert is addressing those folks at risk. That's exactly what Expert is for. So the DSM-5 is a diagnostic tool. It's a tool just to make diagnosis so that speaks to a certain severity of consumption and other mental health issues. So that's why it doesn't necessarily address that. Might they include a component, who knows? They already have the CFI in there, the Cultural Formulation Interview, which is another thing I'll talk to you about tomorrow but they do. And they're working right now on the new version of the DSM, okay? But it's diagnostics so we here as we were talking about the Expert, we get to address the at risk use, because exactly for the reasons that you mentioned. Anna, go ahead.

Anna: Yeah. Hi, thank you Diana. That is great training. I just wanted just to reiterate the question that I asked in the chat, because it seems to me that when we are providing person centered services and we are using tools like motivational interviewing to continue to support the people we serve, it seems like Expert it sounds like a quite dynamic tool. And I'm wondering if that, like I asked before, it could be used even in the course of treatment. If there is high suspicion that there is possibility of high risk of relapsing or reoccurring use of substance.

Diana Padilla: It's a good question and let me tell you a couple of different ways that folks who use it. So the brief intervention by itself was already evidence based, as I mentioned earlier, before Expert came around. Expert models there but the brief intervention point you can use at any time. I know folks who have trained who I work with their, are given technical assistance to the organizations that included a couple of addiction professionals. They're using Expert for smoking cessation. The folks are already, they're helping them with their abstinence of substance use but they're helping them with... They're using Experts for the tobacco. So you can use this for different, any health related or psychosocial issue that presents a risk to them. So we can use this that way, but even with folks already in treatment, you could use components of this in a healthy way.

Part of this, the prevention ask us to provide information that helps folks understand the potential impact of what substance, what the consumption or the levels of consumption can use. So you can pick and choose some of this but when we're talking about Expert, Expert itself is a prevention matter. We're not necessarily talking about folks who meet the substance use disorder now, let me rephrase that. Folks who are going to be diagnosed, who might be diagnosed with a substance use disorder, we want to have a brief intervention dialogue. We do want to have a conversation. We want to see if we can build receptivity and motivation to get that referral for further assessment so that dialogue is so important. Folks who already in treatment, there's other ways you

might be able to use this aspect for other at risk behaviors but if for someone who has yet to be diagnosed, the brief intervention could be a key part of them accepting and following through. Not just following through and going to get the further assessment, they're actually considering retaining and being admitted for care.

Everyone else, thank you for the questions. Really good questions. We're going to see how much more malleable and applicable this whole process it is when we come together again tomorrow. Thank you so much. Everybody have a great rest of the day. Okay.

PART 5 OF 5 ENDS [02:36:00]