Speaker 1: You're the one who's afraid of being buried alive in a box?

Speaker 2: Yes. That's me.

Speaker 1: Should I lay down? Oh no, we don't do that anymore. Just have a seat and let me tell you a bit about our billing. I charge $5 for the first five minutes and, and then absolutely nothing after that. How does that sound?

Speaker 2: That sounds great. Too good to be true, as a matter of fact.

Speaker 1: Well I can almost guarantee you that our session won't last the full four or five minutes. Now we don't do any insurance billing. So you would either have to pay in cash or by cheque.

Speaker 2: Wow. Okay.

Speaker 1: And I don't make change.

Speaker 2: All right.

Speaker 1: Go.

Speaker 2: Go?

Speaker 1: Well, tell me about the problem that you wish to address.

Speaker 2: Oh, okay. [crosstalk] I have this fear of being buried alive in a box. I start thinking about being buried alive and I begin to panic.

Speaker 1: Has anyone ever tried to bury you alive in a box?

Speaker 2: No, but truly thinking about it does make my life horrible. I mean I can't go through tunnels, or be in an elevator or in a house, anything boxy.

Speaker 1: So what, what you're saying is you're claustrophobic.

Speaker 2: Yes, that's it.

Speaker 1: All right. Well, let's go Catherine. I'm going to say two words to you right now, I want you to listen to them very, very carefully. Then I want you to take them out of the office with you and incorporate them into your life.

Speaker 2: Should I write them down?

Speaker 1: Well, if it makes you comfortable, it's just two words. We find most people can remember them.

Speaker 2: Okay.

Speaker 1: You ready?

Speaker 2: Yes.

Speaker 1: Okay. Here they are. Stop it!

Speaker 2: I'm sorry.

Speaker 1: Stop it.

Speaker 2: Stop it?

Speaker 1: Yes. S-T-O-P, new word, I-T.

Speaker 2: So what are you saying?

Speaker 1: You know, it's funny. I say two simple words, I cannot tell you the amount of people who say exactly the same thing you're saying. This is not Yiddish, Catherine, this is English. Stop it.

Speaker 2: So I should just stop it?

Speaker 1: There you go. I mean, you don't want to go through life being scared of being buried alive in a box, do you? I mean that sounds frightening.

Speaker 2: Yes.

Speaker 1: Then stop it!

Speaker 2: I can't, I mean it's been with me since child-

Speaker 1: No, no, we don't go there. Just stop it.

Speaker 2: So I should just stop being afraid of being buried alive in a box?

Speaker 1: You got it. Good girl. Well, it's only been three minutes, so that will be $3.

Speaker 2: Actually, I only have a five.

Speaker 1: Well I don't make change.

Diane: Lenisha, you liked that one, huh?

Lenisha: Yeah, that was funny. I wasn't expecting him to shout stop that...

Diane: So what type of communication was that? Do you call it communication? What's your feedback on that? This is a clinician who's supposed to help a client or patient, right? So I understand it. I know it's kind of funny, but there's a whole reason behind this whole thing. What was going on between those two people? Oh, I see Vicky put down direct and confrontational. Not much empathy, very direct. Any other feedback? You folks want to add? Not engaging. Anyone want to verbalize some of this. Hi, Anna. Elena, that's who it is. Okay, I thought it was you. Brian, Tamara, Sarah, anybody wants to add to what you think you saw in terms of the interaction.

Elena: Hi, this is Elena. Yeah he was not caring, definitely not person centered, and very casual. Really not compassionate at all.

Diane: Okay. Very good. So the lack of empathy, lack of compassion. Did not validate patient's feelings. Yeah, pretty abrasive. A lot of folks are coming out with all the different aspects of being direct. And here's the whole point of the communication process. When we are working with clients and people in need, what kind of care are we supposed to be giving them? What approach are we supposed to be using with the clients or the patients that we work with?

Speaker 3: I just think about things like the desk being a barrier. Having trained with Fritz Perls a little bit in California, I don't like to sit behind the desk and have a patient on the other side of it. I find the desk to be a barrier. And how many of us think that way? I didn't think that way for a long time. So I try and have an office so that I can sit next to the patient, close to the patient, something like that. I find it much easier to build rapport that way.

Diane: Okay. That's true, that's good. That's really about setting that environment. I'm going to read out what Robin was saying. Robin was talking about person centered care, and that's the whole point. And you all hit on it because most of you put down in the chat that the clinician was being directive. And so how many times we might have gotten caught up on what we have to achieve in our work, how many clients we have to work with, what the ultimate goals, what those treatment plans are supposed to look like and there outcomes should be. And when we are sharing very naturally in a wonderful way of engaging with our clients and our patients, how many times have we caught up?

You give them the information and it's more directive than more than eliciting, more provider focus than patient centric. Sometimes we can get caught up in that, and that happens. It's the most human thing providers can do, particularly with all the different

things that you have to do in your daily routines. And so part of this is to remind ourselves of how to be more intentional, more conscious, more intentional in how we engage folks. So I'm going to go to my slides now... Before I go to my slides, so this is the foundation to what we're going forward with. And this is part of really what we all led to yesterday. Let's recap yesterday a little bit, okay? So screening brief intervention, SBIRT. All right. What type of approach does it use? This model uses a particular approach for practice, what is it? Anybody? Huh?

Mance: Patient centered.

Diane: It is patient centered.

Brian: It uses a public health approach.

Diane: It uses a public health approach, thank you, Brian. The other thing is when we do screening, SBIRT encourages us a particular type of screening, to facilitate screening a certain way. How do we do it? What does SBIRT say about screening? It should be done how?

Brian: It should be universal.

Diane: Universally, that's right. We want to do it for everyone. We don't want to target any community, we have communities already going through a heck of a lot of different challenges, even more than usual. We don't target anyone. These are folks in need and we don't want to push them away, we want to provide them care. So what else can you tell me about SBIRT, that we talked about yesterday? What else did you remember about SBIRT?

Lucian: It's not just screening, you need to do some form of intervention.

Diane: Okay. It's screening, it's brief intervention, and then it's a referral to treatment. We'll talk about that more specifically, because that's the words, but that's not exactly the concept behind it. When we facilitate a screener, validate a screener, it can't be just any kind of screener for SBIRT, they totally encourage you to have a validated screen. How do you facilitate that?

Elena: It's a conversation. It's a-

Diane: That's the brief intervention part, that's the dialogue, that's the conversation. You are encouraged before you start the screen to create that atmosphere. I'll stress this again, no matter what topic we're talking about, whether we're talking about CBTs or we're talking about partner violence, it doesn't matter what it is, SBIRT or anything else. There's always a cultural piece, there's an affirming approach you should also consider, and we should be trauma informed. Always, with everything.

That is part of how we set that atmosphere. Not just physically, but also cognitively in how we engage. So it's really important to keep that upfront. Just because it's not a super mandate by the grant that you're funded by to do this particular CBT, doesn't mean that we leave all that stuff out. That has to align with everything we do. Okay. So we're losing a lot of folks, and we're not getting folks into services, even though you get to see what seems to be like a million people, there's so many more out there that need help. And so it's the environment that you create, it's the approaches that you use, that word gets out and so more folks can access your services.

So it's important to frame it all, everything that you do, in a culturally and linguistically appropriate and inclusive manner. What I will say is when you facilitate a screen, remember if you have to do it as a person to person interview - we're going to talk about how if somebody self reports - but if you have to do it as a person to person interview, you have to facilitate it verbatim. You have to do it word for word exactly the way it was designed. That's really, really important. Once we deviate from any evidence based practice, it's not evidence based anymore.

So any outcomes is not contingent upon on anything else but how we facilitate it. So we compromise the fidelity that way, we don't want to do that. Things are working really great. This happens to be one of those interventions that it's not hard to incorporate and it's not hard to get with, it's not difficult to understand. It's not complicated to integrate and practice. So this one's one of the easier ones and it's effective. So I'm going to go to my slides and we're going to talk about some of these core skills that we started to talk about yesterday, because yesterday we were talking about motivational interviewing. So I'm going to go to my slides here. Let me go to the next one. So motivational interviewing, we talked about it be being a goal oriented, evidence based practice. It's a person centered approach.

So we're going to use the spirit of MI in this SBIRT model. You do not have to be a proficient clinician on motivational interviewing in order to do SBIRT. Even if you didn't know MI, you will get enough of the skills here before you'll be able to facilitate a conversation here. So the spirit of MI uses the partnership and we covered this yesterday. This is going to segue us into what we're going to speak about today. We want to collaborate, we want to be in partnership with folks. When we are in the helping field we want to level off those dynamics between person of authority, which is yourselves, and someone who's in need of your resources and your services, which is your clients. And so we want to level that off. We also want to consider, even if someone says something that you disagree with, or they don't really want to do something about a particular behavior, or they don't agree with you. It's something that might come up about their situation. We want to meet somebody where they're at.

There's ways to have a conversation and still acknowledge where they're at and keep going forward. And so MI is always about the compassion that you folks already bring really, you already bring this in the job that you are in because you like to help other

people. So it's really about their best interest. And so there's an evocation process, a strength based approach in SBIRT that helps you engage the other person in conversation. So here I'm going to ask, the next question is... Oh, acceptance is also about demonstrating autonomy, and we talked about this a lot yesterday, because we were talking about eliciting versus imparting information and listening, and you typically we ask permission, if we're thinking about the MI perspective.

So asking information as opposed to being directive, like the clinician in the video. We want to ask inform before we go forward and we want to work with what the client gives us. So we want to work with their perception, we want to incorporate that. That's going to help inform how we reframe a conversation in their benefit. And we also know that ambivalence is a normal part of change. So this one, avoid the righting reflex. A lot of you folks already do MI, so this should not be unfamiliar, but a lot of folks who don't do MI or are not familiar with MI, can someone raise their hand and explain what avoiding the righting reflex is?

Mance: Avoiding the righting reflex sometimes, refereed to as the multitasking, be present. Don't do double things, just stay with the client and you can write after. Take your notes after.

Diane: Oh okay. Let me show you the slide again. Okay so avoiding the righting reflex, the righting, look how it's spelled here, it's a different kind of righting. I like what you said though because that makes so much sense, and I think you bring up such a good point, so I'm going to bring it up. Just see how it's written here, avoid the right like right and wrong, righting reflex in that sense.

And before we go to explain that, I just want to go back to what Mance said. So that's one of the things that in order to have a very approachable, very engaging type of conversation, it's kind of hard for you to remember absolutely everything. And I know I had been trained years ago where we would let or allow the client to let us know if it will be okay if we sometimes write certain things, because we didn't want to forget what they said. That can help in certain situations. I think in this situation though, and when we are thinking about having a conversation or dialogue, you may not need to do that. I don't typically include it included in this strategy, that's not how the developers and authors included it, but that is really a good point. I used to let folks know ahead of time. So avoiding the righting reflex-

Mance: Yeah, that was the wrong context, okay.

Diane: It was the wrong.

Mance: Yes. In that context what they're saying is don't correct. Don't feel that you have to be right in a situation or correct the person. Just go with it-

Diane: Okay.

Mance: Use your reflective listening skills to get clarity, to give them an opportunity to clarify, and go from there.

Diane: Okay.

Elena: Yes. We have a tendency sometimes to correct, or to give instructions on how to do things better, and how to make life better for the client, and start sort of quote unquote educating them, directing them how to correct, how to make it right. We want to go beyond our limits if we could, to right their life that seems to be wrong to us. So we need to avoid... We need to be fully aware of ourselves so that we don't fall into that sort of practice in trying to right or correct their lives.

Diane: Okay. I think you both were hitting it, you were both speaking to different aspects of the same thing. Thank you. Yes, Lucian. Hi, Lucian. I didn't know you was here. Nice to see you, go ahead.

Lucian: I think it's to focus on what's going on with the patient, what the patient says, or rather than what we usually feel or what we think.

Diane: Repeat that.

Lucian: No, I think it is to focus on what the patient has really said or what's going on with the patient treatment, the patient request, rather than what we usually feel about the patient.

Diane: Okay. Okay. All right, Tina.

Tina: Yes, I like the saying that acceptance is the beginning to any problem. And my favorite saying is, accept me for what I am, so I know what I can become.

Diane: Thank you for that, Tina. I like that. Everybody is really speaking to pretty much the same thing. So let me give you a scenario, because when it comes down to it, it's really about us not trying to correct the other person. That's what it comes down to it. But I want to just give you a scenario of what it might look like. So remember why you do this work, okay. And then you have a client, and you have a lot of experience on your belt, and you have a client that comes in and tells you yourself, "I really don't think I could do it. I've tried so many times, I can't do it." In your heart of hearts, you know what comes out of you? You say, "No, but I can help you. I can help you. I have so many resources." I say, "I have helped other clients who have had very similar situations and I can help you."

So at the end of the day, it really is about correcting even though our emotions and our heart and our own personal motivations get in the way. So I wanted to just to give you a particular context, that's the righting reflex we want to avoid despite our good motivations, it's not about our motivations, it's about the outcome. It's really about meeting that person where they're at, no matter what it looks like. So thank you for those comments from Mance and from Elena and Tina. That all adds to it, but that's what it can look like, and sometimes when the good heart is in the way, we don't necessarily include those scenarios as part of those righting reflex. So I want you to consider that.

When your experience comes out and you see folks, especially these days, we see so many folks who are overdosing and so many folks who have their homeless issues, and folks who are dealing with people who have transitioned off in their life, that can't be too easy for you. You know? So let's just be mindful of that as well. So that's the righting reflex we want to avoid, because even no matter the internal motivation on our part, we want to stay person centered, not provider focused, because we don't want to be directive, no matter what tone, what feeling comes up. We want to be mindful of that.

So remember that someone can be ambivalent also. Okay, this is another thing. If you press or push somebody, a lot of times folks will move away. You know, they'll gravitate toward the negative side of their ambivalence or if you push them when they're not ready, you can lose the opportunity or that open door that you just got, they can close that door right on. And so we want to use brief intervention, essential motivational interviews, because we're going to talk about very, very basic communication skills that you already use. And Mance already mentioned some of them. As a matter of fact, I think yesterday we mentioned a few of these as well. So let's talk about the MI shift that we are going to use in this brief intervention in this conversation. So it's really reminding us that we are not responsible for changing a person's behavior.

In motivational interviewing when we use that in practice, or when we use those at least core communication skills, and we use it intentionally, let's put it in our minds that we want to support our patients and our clients in thinking about their own reasons for why they might want to make change. Looking at a behavior and being able to potentially consider changing it, we want to support them in that process. We don't want to do it for them, we don't want to be responsible for it, we want to kind of partner up with them and do that. So we do that with the open ended questions, affirmations, reflective listening, and summaries. And these are the OARS. Even before MI, these are basic, this is counseling 101. These communication skills have been around forever, but this is very important for us to get into the habit to use these more frequently.

We can use these not just in our work, we could use it with our friends, with our family, in our social circles, we can use it anywhere. It's a matter of getting into the habit of doing it, and doing it consciously or intentionally. So let's just go through a few of these. So I might rush a little bit through certain things because I want to cover a certain

amount of content to ensure that I give you folks opportunities for your interactions. So this is one of them. What's the thing about open-ended questions? Why do we always profess the benefits or the use of open-ended questions? Who can speak to that. Lets see. I see Sharon and then Elena. Sharon?

Sharon: Good morning everyone. Open-ended questions gives the individual an opportunity to give you more information. It gives them an opportunity, it's not just a yes or a no type answer from the individual.

Diane: That's great, thank you Sharon. Elena? Or maybe Elena just had her hand up. Savannah?

Savannah: Yes.

Diane: Sure, go ahead.

Savannah: Open-ended questions leads to a conversation. Me as a facilitator, I can continue with the conversation, I can use reflective listening, because if they say yes or no, so now it's like the conversation is done. I have to keep going and going, but open-ended questions use more opportunity to be expressive.

Diane: Okay.

Savannah: Yeah, I guess.

Diane: No, that was good. I like that about initiating conversation. Go ahead, Tina.

Tina: My favorite open-ended question game is called The Ungame, and it was created by a woman that had multiple surgeries and couldn't speak to her family. There's many versions of it, a couple's version, a children's version, teen version and then the regular version. But it's a game of open-ended questions, there's a family game. So it really works, and I used to play game with my children every day at the dinner table. What was the best thing that happened to you today? And what was worst thing that happened to you today? Game, to encourage family communication.

Diane: So that's great because you've already got some experience in using that. So now we're going to practice, first of all discussing how that can be part of the conversation. Not the only skill, but it's certainly part of the first skills or strategies that we use to initiate a conversation. So thank you for that. I also see some folks who added here being open to how, let's see... Open-ended question helps avoid force responses. I like that, force responses, and I like that you put that that way, Tina, because force responses are not necessarily accurate ones. If you're pushing someone to respond some kind of way, are they telling you the information? Are they being completely real and open with you? Are you forcing it out of them, and they're not ready?

But it does create a deeper conversation, this is so true. And that's what Savannah was talking about, initiating the conversation. Helps to see things from the clients perspectives as feedbacks in their words. That's from the other skills, and we're going to talk about that. Okay, all right so let me go back. I'm going to have post about four or five different close-ended questions, and I would like you to raise your hand and just look at them, and rephrase it as an open-ended question. So first one, do you feel depressed or anxious? That's a yes or no question. That's a yes or no response. How can you rephrase that close-ended question? How could we make it into an open-ended question? Any suggestions? James.

James: Tell me how your mood's been lately.

Diane: Okay, that's better than what is there right now. Any other responses? Okay Tiffany has when you become anxious, what does that look like? Robin says, what are your feelings when we discuss this? Okay. How are you feeling? I feel fine. Okay so remember, open-ended questions, we invite collaboration, invite information, invite the person to take part in a conversation. So open-ended questions are your way to listen information from them. Not just about the specific topic you're asking about. So we have some more options here, how do you manage depression and anxiety? That's cool too. So that's like what James was saying, he started out with that word, how. Have you been feeling depressed lately? That's a yes or no. Tell me more about the feeling around your anxiety and depression.

Awesome. That is really great. Describe how depression and anxiety looks for you, excellent. Okay, that's nicely done. Another clue is that a lot of times the experts have told us, coming from back in the day when we first started to understand about these very simple but very effective communication skills, that open ended questions often can be... One quick tip is you can start it off with the word what. You say, what does it look like when you're depressed or anxious? And a person, if they're going to respond, it's hard to respond with a... It doesn't look like anything. It just invites somebody to explain. And the fact that you are even asking about things, especially when you're saying what and you are asking for all this elaboration, it's also helping the other person understand or perceive that you seem to want to hear about it. You're interested. So let's try the second one. Do you like to smoke marijuana? That's a close-ended question. Some folks might say yes, some folks might say, no. We won't put anybody here on the spot, but we wanted to make this an open-

Diane: Anybody here on the spot, but if we wanted to make this an open-ended question, what might we say?

Speaker 4: I would say, how does smoking marijuana affect you or how's it help?

Diane: Oh, okay. That's very good, I like that. Yes. That was certainly one that would make me engage with you in a conversation. How do you feel about smoking MJ? Okay.

[inaudible] game was my favorite game concerning. Okay. What are your thoughts about marijuana? Very cool. And did you see how effective the word is also? Why do you smoke? Because I like it. Okay. So give me your take on this. On the third bullet. So you're here because you're concerned about alcohol, correct? Is that the kind of question we've asked before? Do we want to use that in the future again? How do you feel about that? Anyone?

Speaker 5: If you don't allow the conversation to stop there and you follow it up, but you don't want to bombard them either so rather than, so you are here because you are concerned about alcohol, I understand that you have some concerns about alcohol. Why don't you tell me what you like about that and then invite the more detail.

Diane: So I appreciate what you just said. You know what I think though? I think if you start with the second question would be better. Here's my take on it. So you're here because you're concerned about alcohol, correct? If I start off anything or include any comment like that, in any context I'm telling you, I'm being directed. Not only that I'm also being judgmental. I'm making assumptions, I'm not asking any information from you. That's where we've got to start to kind of be careful because sometimes when we have conversations and go our different ways, I like your second and third comment, with the follow up, I think that makes sense. But we can't make assumptions.

We have to elicit the information from the person and if we make assumptions then we are already starting on an inappropriate foot because we're not doing patient centered care. We're not doing patient center, we're starting off with misinformation. So that's the worst part about this question, but I like how you rephrased it. Can you tell me what your concerns are about alcohol? That I appreciate because that is an open-ended question. That's a reframe. That is appropriate. Let me see. I have some comments in the chat. I know I want you folks to use the chat box too I said, but I want you folks to kind of speak to me. So I'm going to hear some voices, I hope. So at what times of the day do you smoke? Okay. In your own words, can you tell me why you're here today? Oh, very good. Things that you do to calm yourself.

Okay. I guess I can understand that these comments here are very specific about a particular point. They want to explore. It's just that the way it's being asked is not as effective as it can be. For instance, the fourth one, do you agree it would be a good idea for you to go treatment? What's your take on that? What that question is asking about and how it's asking. Anyone want to share, raise your hand? Do you agree it would be a good idea for you to go to treatment? So I'm talking to Laneisha. Laneisha is my client and I'm saying, don't you agree that you should be going to treatment?

Speaker 5: My answer would be no.

Diane: Yeah. I feel you.

Speaker 6: It sure would be.

Diane: I don't think Laneisha will be waiting hand and foot for that referral. No. So I think what might be better here is, what's your thoughts about treatment?

Speaker 6: Right.

Diane: Or, what do you know about treatment? But the what is really specific here, it really is helpful because I don't want to make assumptions. I don't want to give directions. I certainly don't want to make judgements. So I have to bring you in. I got to listen to what you have to say. What you say is going to direct the next thing I say. Although I have a golden mind myself, I have to work with what you say. So open-ended questions are that critical. So Mia if I tell you, when do you plan to quit drinking? I don't know how to put that in a nice way. I can do a sarcastic, I can be, when do you plan to quit drinking?

Speaker 5: When they run out of alcohol?

Diane: Oh yeah.

Well, we seem to have more of that during the pandemic than ever. So that's not happening.

Speaker 5: Right.

Diane: So when do you plan to quit drinking is also my perspective, the provider's perspective. I am giving that judgment. I am making that assumption. I am giving that directive. That is not effective. If you include any of that, I'm not saying you don't do it or do it anywhere else. But in this process, when it comes SBIRT we don't want to include any of that. And it is possible. It's just a matter of practice. These simple things that you already do. It's just a specific context. So let me go back to my slides. And those were open-ended questions.

So affirmations are really simple. So when we think about affirmations, when we listen to someone who is open enough and comfortable enough to share certain things with us, it's not so much as a job, if you think about every interaction you have with the person that you providing services, that they're engaging with you, you want to acknowledge and recognize some of the things they go through. Like you persevered or I might think you've gone through some pretty tough times. Acknowledging that, recognizing that. When they're busy sharing how the struggles or the stressors, of how many times they stop using or the family member who is very sick, and you say something like that, that could be so supportive. So you've gained a lot of knowledge and experience in your past attempts to stop drinking or to stop using. So that is important to say every once in a while. Let's get into the habit.

Sometimes we find it easier to do these with family members or with close friends of ours, we can use these affirmations with our clients too. What it does is helps them to feel heard. It helps them to feel supported and it helps them to continue to participate in the conversation. It's kind of like a prompt. It certainly is acknowledging. Affirmation is really important, especially for a lot of the folks who we provide services to, and not necessarily used to hearing affirmations.

Reflective listening. This is one of the neatest and easiest things to do. Reflections are just statements. It is just about repeating back and what are some of the benefits of reflections? What are we doing when we do reflections? What's the benefit of that?

Speaker 7: It makes the patient feel that you pay attention.

Diane: Yeah, like you're present with them. That's right. Tamara?

Tamara: When you're paraphrasing, you're actually able to make sure that you're understanding what they're trying to tell you. So if it's incorrect, they have a chance to correct it, but it also gives you a chance to try and maybe restate something or reframe something that they said that they might hear differently than the way they actually said it.

Diane: Yes. And we're going to build on that point. Exactly what you're saying, because there's a way to do it with double reflection that is very key to the conversation we're discussing today. Thank you for that. A lot of times, when I say something, when I hear it from someone else's mouth, it's like, wait a minute, I didn't mean to say that. And so it gives them an opportunity to kind of realign themselves. So I got some folks hands up, Tamara, go ahead. Tina, did you want to add?

Tina: Yeah. It makes people feel heard.

Diane: Yes. Makes people feel heard. That's exactly right. I'm also going to suggest one more thing that we don't always think about. See, confirming what we heard about their concerns, clarifying, ensuring a mutual understanding, checking so important that we have transparency. We have clear communication.

So reflections are really important. You know what I found out, how it helped me and maybe for you too, you may or may not realize it, is that when I was doing reflections, it helped me reiterate it, keep it, retain the information in my mind because I wasn't always able to write things down and I would remember. It helps me remember it better. So I don't forget something in a conversation of someone who I'm speaking to. So as a provider, it helps me also. So Kenneth go ahead. Yeah. Being heard someone is feeling they can continue on. They can continue on in the conversation. Thank you. Helps ensure the client's goals are reflected back to them in their own words. Okay. Oh, correct me if I'm wrong. That's something that you might want to say. Go ahead Elena.

Elena : Yes. I think it allows the other person to hear their own words and maybe become aware of themselves because sometimes we just speak without really being conscious of what we're saying. So that raises within the other person.

Diane: Yeah. I think it was Nicholas that kind of brought up a very similar point, and also if they can hear themselves, they can also have an opportunity to kind of reframe and just be sure what they're saying. So there's a lot of different benefits and that's just one skill. But let me just talk about reflection just a little bit more. So this is a simple reflection. So I'm the patient. I'm going to say something to you, you're the practitioner, let me see. Yamien, you read the practitioner when I'm saying the patient, I had a really hard time sticking to my abstinence goal this week.

Yamien: It was difficult for you to stick to your abstinence goal.

Diane: Okay. So I know we're reading, but if I said that to you, I'm sure you can just say back and you can feel comfortable. My concern is that you all feel comfortable with repeating back, simple reflections with asking. Thank you for that, Yamien. My concern is that you get comfortable with open-ended questions, with doing reflections. Now, let me tell you a little bit more about reflections here. What we are looking for is Change Talk and that's definitely a DMI goal. What we want to hear in the conversation is a person's words or their reasons or the words that kind of reflect maybe an aha moment for them or that they see something differently. So their reasons desires a commitment to change. Anything that sounds like Change Talk, and we'll go over what that looks like.

Sustain Talk may be a situation that you might have to meet with somebody more than once. Have an extended brief intervention. Every once in a while, you may have someone who is just not wanting to change. They're not ambivalent. They're stuck in that precontemplation state and they don't want to move forward or for whatever the reasons maybe they and you need more exploration. And that's okay. Just the fact that you're able to engage them in conversation and they were receptive and participatory in a conversation with you, means they're more likely to be able to have another conversation with you. And maybe at the second time that you meet them, maybe that extended brief intervention, that's when it'll work for them. When they start to see something different, meanwhile, you will have given them information for them to consider.

And maybe, you can ask them about it again at another time. But most times what we're trying to look for is Change Talk. The strategies are very specific. Some of the ways that we want to think about Change Talk is asking you about questions. So when we use open-ended questions, when we ask questions in a way that prompts the other person to give you more information, we want to evoke that from them. We don't push them. We don't direct them, but we ask questions in a way that helps motivate them to give you all this extra information. We're going to talk about the Change Rulers. Change

Rulers in sbirt is only used when you hear the Change Talk. If you don't hear Change Talk, you could use a Change Ruler too soon and might actually push someone away.

And if they're ambivalent, it would be much harder to engage them back in the same conversation and consider looking at a behavior. And sometimes we can look back or forward, what was successful in the past that they did, that might come up or how we may want their future to look like in, I don't know, a couple of years from now, what are their goals? How does that speak to their goals? And their values? So all of that can come out in a conversation and we can use all that to our advantage. So how many folks use the Readiness Ruler. Miller and Ronick, did their third edition of MI and the book came on in 2013. And in the book, what they speak about is this Readiness Ruler. Many people, when they think of Readiness Ruler, they think about, okay on a scale of one to 10, how ready are you to do this or do that?

And what these authors are stating is that you can use a Readiness Ruler, with certain different concepts. How important might it be? How confident might it be? And you have to know how to used it because you don't want to be abrupt very early on and then lose the opportunity, lose the receptivity from the other person. So for instance, someone tells you about a situation, you give them some information. What do you think about that, or what does this do for you? On the one hand, it does this for you. But on the other hand, it doesn't do this for you. What does that look like for you? What's your take? And if the person said, well, maybe I have to do something about that.

That's more a Change Talk, right? That's Change Talk so that you might want to use a ruler then and say something like, well, on a scale of one to 10, with one being not as important and 10 being very important, how important might it be for you to make the change in your drinking if any? How important might it be? It's not directive. It's just asking a question. And what you're building on is what they just said is, maybe I have to do something. How important might it be? So with a client says a six, you want to recognize and acknowledge that six. And you want to ask why not a four? If someone says a six and we recognize, we acknowledge, why would we ask them, well, that's a great number, but you could have gone to five or four. Why didn't you do that? Why don't you choose one lower number? Why do we want to do that? Tina?

Tina: One of my favorite motivational interviewing examples, and this was before I learned motivational interviewing, which is kind of ironic is that there was a man that went to a psychiatrist and a psychologist for a year and a half, because he is very depressed because all of his closest friends had HIV and AIDS, and he was afraid that he might have it. So I just said, well, what's better knowing or not knowing. And he went ahead and got tested and he was negative. He had two tests within six months, like they suggested back then. So then he wasn't depressed anymore and he didn't need the psychiatrist or psychologist.

Diane: That's interesting.

Speaker 7: Your mind's a powerful thing.

Diane: It seems like there's more to that than that, but that's interesting. Thanks for sharing that, Tina. Okay. The question at hand. So just for the benefit of where we're at right now, I'm asking, okay, you responded as a sixth. And then I acknowledge that. And then I say, why would I want to say, you could have said a five or four? Why don't you do that? Why didn't you go for a lower number? Paul?

Paul: I think it's because one, you want the client to be able to state why they picked the answer they picked. A lot of times people would just throw a number out there. Sometimes without having a real reason behind it, this way, it allows the client to state thoroughly how they feel about the situation. And it also shows it shows some type of accountability for whatever decision they're going to make or they're making at that present time.

Diane: Okay. Do it with me right now, Paul. So you say ask me, how important might it be for me to do something about that behavior? Say that for me. And I'll get on a scale of one to 10, how important might it be. Do it with me, I'll be your client.

Paul: Okay. On a scale of one to 10, how is it important for you to, I forgot the rest of the question, change your-

Diane: Look at how important might it be for you to look at that behavior? Cause I just mentioned, I said, I might have to look at that behavior. So using the same words, you could say on a scale of one to 10 with one, not being that important or 10 being important, how important might it be for you to look at the behavior?

Paul: Oh, so you want me to say that now?

Diane: Say that to me.

Paul: Okay. So on a scale of one to 10, one being not important and 10 being extremely important, how is it important for you to change? I forgot the first question. I'm sorry.

Diane: To look at their behavior.

Paul: Look at your behavior.

Diane: Well, I would say a six, I would say a six.

Paul: So why'd you choose a six?

Diane: So first you recognize and acknowledge that six is a good number, that's great. But you could have gone lower. You could have done a five or four. How come? So do that.

Paul: Okay. All right.

Six is a great number, but why didn't you choose four or five? Why didn't you go a little lower? Why didn't you go a little higher with the seven?

Diane: Lower. You got a [inaudible].

Paul: Okay. All right.

Diane: There's a strategy. These are simple things. This is why I need you all to be comfortable with this. Check this out. There's a reason for this. So you asked me why not a five or four? Guess what I'm going to tell you. I'm going to come out and I'm going to say, well six, because I didn't think about it before, but now that you gave me that information, I'm starting to think that maybe that does have something to do with as to why I don't get up feeling the right way in the morning. So may I do have to do something about it. That's for you asking me why not a lower number. So when I'm doing that, what am I doing, everybody? What was I just doing? What did it sound like I was doing?

Speaker 7: I think it helped you to be aware of where you are or what you're doing, or if you have to do something to improve your situation and for to move on.

Diane: Okay, along that lines. But when I respond, just to kind of keep to what I just did. I'm the client, did it seem like I was defending my six?

Speaker 7: No.

Diane: Oh.

Speaker 7: I don't see it.

Diane: I said six and he asked me why I didn't go lower. The six, there was a reason I said I didn't realize the four and thinking maybe there's something I might have to look at here. So I think six is at the level of importance, six works for me. What I'm doing is defending my six. What I'm doing is giving you reasons why I chose that six. If I'm coming up with my own reasons, then I'm reiterating for myself my own Change Talk. You're inciting my motivation simply by asking me, you could have gone low and you didn't do that. It gives me an opportunity to defend why I said six. So I say, defend, you don't hear a lot of people say that with the sbirt. I say it that way, because that's how I seek folks.

They want to explain why they chose that number. By doing that, the person is reiterating, reconfirming amongst within themselves. It's not even coming from you. But you got me to say that, all you did, was ask me how come you to go lower? And then I ended up defending that and I ended up coming up with my own reasons and I'm doing

more Change Talk. And that's where you want me at as a client. That's where you want me. You want me in change talk. So that's really important. So just by doing something simple like that, and with the ruler, that's all we want to say. We don't want to go slower and higher. We don't want to do that. We just want to say, why not lower. It's strategic. First, get someone to kind of defend where they're at.

And then the conversation continues. Because what is likely to happen is more information could come out. We're in a conversation. I might come up with more reasons as to why I have to do certain things. Then you might want to ask me the question again. I'm saying I'm giving you more Change Talk. You might again want to use a change ruler again and use another word. Well, from the same scale, on a scale of one to 10, how confident are you that you can make a change? Prompts me a little bit more. So the authors say you don't have to use all three. You do not have to use readiness. You don't have to say how ready are you? You don't have to, if it's not appropriate, you don't have to beat somebody over the head, so to speak.

You got to kind of feel your way around and understand if they did it a couple times and there's energy and Change Talk going in a certain direction. Then you work with that. And that is awesome. You do that. You do that. You don't necessarily have to do all three. So the strategy is not so systematic that way. It's not so templated that way. Okay?

So let me go back to here. I'm going to do this. Hold on. So and there is a point where the authors do say when the conversation is robust and it has gotten that comprehensive, a lot of the information has gone back. The person has been doing a lot of Change Talk. The clinician might want to say, so on a scale of one to 10, how ready do you think you are to do this?

And what might push it over to maybe half a point up. But that is when the person, the patient or the client is already deeply engaged in changing and deeply saying how motivated they are and willing and open to doing certain things. So everything is done strategically, but you can work with just the first two. So I'll give you an idea. So the idea is that the speech favors some movement in the direction of change, and the behavior is linked to a particular goal. Or your clients come into your programs for particular reasons. Whether you working recovery support services, whether you are working an addiction, whether you're working at the health, folks are coming in for particular reasons.

And in the conversation, a lot of their goals comes out. A lot of their reasons for being there. And many times the behavior, the substance use, affects the ultimate goal that they want to achieve. And sbirt has a way of bringing that out. And so we are going to see how a conversation looks like. There is other opportunities here. There is such things that Sustain Talk. Let's not forget that sometimes somebody may no matter [inaudible]. Don't get frustrated, do not get directive. If somebody is just adamant and

[inaudible]. Going in a certain way or looking at a behavior, you work with them where they're at. At least you've had the conversation. You can come back and speak to them another time. And a lot of times we get pushed back when we're working with youth.

And so sometimes with the pushback, we say, well, look, I don't have a problem. They might say things like, I can quit anytime I want. And you could just support them in that and say, I understand you can quit at anytime you want. Any say, we can talk about this again at another time if that's okay with you. So you can do that. So it's actually about giving feedback to clients, providing them information, asking them if you can provide information and elicit the information and then ask them and get their take on it, write your feedback and then ask them for their response as to the information that you gave them. That's what we want to do. So here I am. Any questions so far, this should all kind of sound familiar, right? Or does it? That's a close-ended question.

All right. So we want Change Talk. We use open-ended questions. We practice being reflective. We're summarizing. Okay. We start doing that. We give affirmations when we can. I think it's really gutsy for anybody to be in treatment, to be in mental health services, to access our recovery support services, the HIV programs, the Hep C program. I mean, it's accessing partner violence resources. It's gutsy just to ask for help.

So that right there gives you a lot that you can affirm. That you can recognize, that you can acknowledge. So in the conversation, that part should not be difficult. If it is and think about it, think about it ahead of time. Some simple things that you could say, that might be more natural to who you are, because you don't want to have a forced conversation. You want to be genuine. You want to be authentic. Because folks will pick up on that. But affirming, recognizing people's strengths, that's important part of conversation. Let's just not leave that one out. It's fun, but it's not the only skill we're talking about all four.

Speaker 8: What if the person starts to totally downplay it to the point where, is it appropriate ever to bring something up on your own? Say they're shooting the numbers real low, but they're there because they're on probation or something.

Diane: Oh, because they mandated, okay.

Speaker 8: Is it okay to say well, so and so asked you to come here and do this so clear. What if they are saying I'm a two, but you know, they're, you get what I'm saying? Is there ever a way for us as the person doing it to kind of, I don't want to say bait them, but

Diane: The way this works, sbirt, you can work with them where they're at, despite the fact that they're mandated. Cause even if they're mandated, you might be the only opportunity for them to be real and talk to somebody. Okay. So let's say they give you a two, let's say they give you a one. Let's say they give you a one. They say, well, one is one of those numbers, but you could have gone to zero. You know, why didn't you go to

zero? Okay. And part of the Sustained Talk part is when you also hear other things, they don't want to do anything. They don't want to move in any way. But if they stay with you talking, if any information comes out, because you're asking question and you're there saying I'm just here to help you wherever where you are at.

So we're supposed to be discussing so and so, and so, and so. Are you okay to talk about that? Start asking permission and starting to get them comfortable and give them some kind of autonomy so that can help folks who are mandated to programs. Practice it, practice it, to see how you can get comfortable with it so they can feel comfortable with you. I think that's kind of the harder part. And just cause somebody says, I don't care if they say zero and they say, well, you didn't even have to respond at all, but you did.

Diane: ... zero and he says that, "Well, you didn't even have to respond at all, but you did, so why did you say zero?" So work with that. So at least to hear that you're meeting them where they're at, you're not forcing them, that in and of itself can be very motivating for them. Lucien, you had your hand up?

Lucien: Yes. I was going to say in that case, it's to work with them where they are and to advocate for them. Because many time, even the people that have to refer to the institution, that they have to refer the patient, they don't know much about how treatment work. So if the patient is at one and they want a certain number, that's the expectation. I think in that case, it's to explain to them, this is where the patients are and we have to work with them from there to achieve the goal that they're expecting to achieve.

Diane: Yeah. And James is also reminding us that a couple slides ago, was something I mentioned, sometimes even the folks who are mandated, they're going to see you again. At some point they get comfortable and you can also talk about it, so what's your goal eventually? What is it you would like to do eventually? So you can look forward, or look back to some of the things that were successes in their life. That come out in conversation. So I would tell you that if you do some of the basic skills, you'll start to be able to navigate through the conversation a little easier. Okay. Tina, did you want to add?

Tina: Yeah. I think it's very important for people to let it be their decision, not my decision. For example, I worked with a woman, many, many years ago, that was a heroin addict and severe mental health concerns and then because she wasn't taking care of herself, she found out that she had cancer and she was resistant to the surgery and so I just mirrored back to her, "Yes." Because she said, "I'm a 35 year old woman and I can do what I want with my body." And then she also had a severe genetic disorder in her family, that she hadn't had a lab test for. And I just mirrored back to her, "Yes, you are a 35 year old woman and you can do what you want with your body," and accepted her where she's at and put the responsibility back on her. And because it was her decision,

she did get the lab test about the genetic disorder in her family and then she also had the cancer surgery and it saved her life, but it made it her decision, her responsibility.

Diane: Thank you. Yes. And I think you're speaking to what we're all discussing here. This is a person centered approach. It certainly is. It may take more than one sitting. It can happen. These are skills, but these are skills where I don't want to talk general, I want to talk specifically about these skills. These open ended questions of reflective listening, the affirmations, the summarizing, when you get into the habit of using them, even just once a while. It just doesn't have to be so expert. Just a few times. Those can prompt someone, can motivate someone to add information to the conversation, to play a bigger part in the conversation. We should be listening to information and hearing what they have to say and then what they say guides what we do.

And yeah, every once in a while, you're going to find somebody who's not trying to hear it, maybe not want to have a conversation. You still are encouraged to be person centered. You still meet them where they're at. You might be one of the few people who do. And they're likely to talk to you again, another time, get comfortable and offer you information then, so sometimes we do have extended brief intervention. But whatever they say, and this is important for anybody who's doing building, when we do an SBIRT, you want to make you're still person centered, you're not directive. You meet them where they're asked. So to give you some example, I know I have to be here. I'm still thinking about the situation that Tyler brought up and I'm here because I have to be here.

You can still engage in the process and maybe the session might be more about building rapport and you do that and then you build on it the next time you see them again and you can do that. And eventually, if folks always have someone to talk to and if you can be that someone, that would be key for you to actually go through with the full dialogue. So for most people, what I'm trying to say here, what I'm really trying to emphasize here, is the communication skills. We get taught that, because they are easy to integrate and practice and they're very effective. So what I'm going to ask you all to do is just give me a few minutes and pay attention to this next video. So our friend, our host, Clyde, is going to put up video A and we're all going to see it and I would love to get your feedback on it.

Allen Line: Well, hey, Ms. Clark. My name is Allen Line.

Ms. Clark: Hi.

Allen Line: Dr. Seal asked me talk to you about your drinking.

Ms. Clark: Okay.

Allen Line: Yeah. He said that you filled out the form and that you came to him for some medication for your stress, but that he's really concerned about your alcohol consumption, before he made any prescriptions for you. So let me see that form, please.

Ms. Clark: Okay.

Allen Line: Thanks. Yeah. Well, it says here that you drink four more times a week and that you have one or two drinks and that you go over that limit on a fairly regular basis. That's too much. That's too much. I imagine that he's already told you that he can't prescribe you anything, unless you do something about this drinking.

Ms. Clark: Okay. I'm really confused. He did want me to come and talk to you. I'm just not real thrilled with the way this is going.

Allen Line: Well, I'm sure you're not, because anybody that drinks at these levels isn't going to be thrilled talking about the drinking with a professional like myself. And what we know is that if you continue to drink at this rate, you're probably going to wind up drinking more and more and I imagine that's his concern, is you're going to become an alcoholic.

Ms. Clark: I don't think I was drinking that much. One or two glasses of wine a night.

Allen Line: Well, how big is the glass? This is a typical glass, which is five ounces of wine, but what I know is that most people drink a lot more than that. So-

Ms. Clark: Well, it-

Allen Line: ... I'm pretty sure that your glass is bigger than that, or wouldn't you say?

Ms. Clark: You're not in my household. You don't know what I drink.

Allen Line: Yeah, I know, but what-

Ms. Clark: It's about that size. Maybe a little more.

Allen Line: I've never been in a house where they have these stem glasses, that it's only at restaurants. Most people have tumblers. I imagine that's what I'd find if I opened your cupboards. Yeah?

Ms. Clark: No.

Allen Line: [crosstalk]. Well, anyway, so what he said was that you came to him for some benzodiazepine, something for anxiety and we can't prescribe anything like that if you're drinking at these levels, so we need you to stop, or at least cut back to reasonable levels, which for you, would be no more than three drinks in one sitting,

which you're drinking over that now, or no more than seven drinks in one week, which you are well over right now.

So if you can agree to that, then perhaps he can make that prescription for that. I can't promise that either, but that's certainly one thing. The other thing you need you to do is to read this. Take this pamphlet and read it and you are seeing there that it tells you about limits of alcohol and I think you'll find that if you can stick to that, you should be okay. He may be able to prescribe you the medication at that point. I'm not sure. I can't promise. But if you do have problems, then I suspect you may have problems cutting back to those levels, then we can make a referral for a counselor to come and talk about your increased drinking. So you have any questions for me?

Ms. Clark: No. No questions at all.

Allen Line: All right. Well, thanks and I'll tell Dr. Seal that you came in and that you were reasonably compliant and that you said you'd follow through.

Ms. Clark: You can tell him whatever you want.

Allen Line: All right, thanks.

Diane: I got feedback early, before I even asked, to see the chat box going crazy.

Speaker 9: That was atrocious.

Diane: Come on. Really? All right.

Speaker 9: [crosstalk].

Diane: So no, remember, we all went through some time together to go through the specific communication skills, so I'm very interested to hear your take on what they said. Let's start from the beginning and go through the conversation towards the end. That was pretty small. A few minutes only. So Kenneth, your hand is up.

Kenneth: He was not engaging. He was cold and judgmental and he didn't even allow her to speak. He led the whole session, so I felt that was horrible. And you could tell by her body language that she was very uncomfortable about the process.

Diane: Yeah. She got like really tight, didn't she?

Kenneth: Mm-hmm (affirmative).

Diane: Let me read some of the comments. "Her body language tells the tale." I saw that comment really early on, Marie. "Judgmental. Telling, not asking. Authoritative." Totally

not [inaudible]. "judgmental clinician was too judgmental. Not engaging, not listening. There was no MI there. That's for sure." There's a lot more that wasn't there too. "Body language, definitely." He wasn't paying attention to body language. "He knew how to really piss a girl off. He attacked her in a way." Hmm. That's that's an interesting perspective. Yeah. Confidentiality. Okay, Elena. Yes? Could you add?

Elena: Yes. Yes.

Diane: [crosstalk].

Elena: This person's listening skills are terrible. He needs to go for training and totally, he had his own agenda and he wanted to get it through, no matter what. And everyone has said, very judgmental, absolutely no compassion, no understanding of the client and no interest in hearing from her. So I would fire him.

Diane: Every time I hear it, I hear certain things. That just almost for the first time, some things. I like the part he said, "Well, I understand." I think that at some point he was trying to say something to her about not admitting how much she drank and says she won't talk to him. Nobody would really admit with a clinician like myself." I caught that part. I thought he was a clinician extraordinaire, in his world. Go ahead, Lucien. I see you.

Lucien: Yes. I think he's just saying what he want to say, without giving the patient a chance to explain, or to engage her in any way, of getting her into treatment. And then when the patient come to treatment, they are dealing with some trouble, that when they need help with that, I think one of the things I really do when patient do this kind of thing, even though later, [inaudible] work, but I commend them for coming. But I think he's probably pushed the lady away, by the way he is defending what he need to do, instead of engaging her in any way of getting into treatment. It's terrible.

Diane: Oh, sure. Definitely. And I appreciate that perspective, because when we're directive and when we come out with it that way, we can push people away and that's the whole thing. If you can't engage this, nothing else can happen. Go ahead, Tyler.

Tyler: He started by saying, "The doctor told me you drink too much," when he totally missed opportunity, because he could have said, "Why are you here?" And she could have said, "I think I drink too much, or the doctor thinks I drink too much." And that could have helped the person gauge her mindset coming in and he totally just blew by that and told her the doctor said it.

Diane: Yeah. Thanks for picking up on that. And here's the thing, now as providers ourselves, we don't usually tell people. Yeah, I know he said, "You drink too much." That's not even the words. That's not even a phrase. That's not how we will frame it and phrase it anyway. So it was like, "Oh my goodness. He said it completely personally and judgmental, so thank you.

Lucien: Patient can say it, but not us. Yes.

Diane: There you go. That's not how we put things together. That's not our language. That's not how we communicate. And let's just say that the psychiatrist or the psychologist really spoke to the clinician. That's not the way he would convey information. You guys don't do it that way. We don't do it that way. So the fact that he came out like that, thought it was like, "Whoa." That's there in your face. Go ahead, Sharon.

Sharon: I had put it in the chat, but I saw this scaling, this tool to gauge. He evaluated her without even asking her, "Where are you on a scale of whatever." I saw it on his lap. He kept looking at this evaluation tool like, "Well, you're right here in this percentile," or whatever he was saying to her.

Diane: Actually, that's a good point. Thank you for reminding me. Did everybody get the handouts earlier today? Okay. I hope you looked at them because, you all received that scale that he used. You received a few things, because we're going to do our own practice here. You received a few things. You received the scale and I labeled it as alcohol calculator and that's what he was using. One of the things that's helpful when we're interacting with patients and clients is to have a visual. So it can be very useful when we're providing new information, or information maybe they haven't heard in a while. But it's really useful to have a visual. Helps the person retain the information longer. And so the calculator he used, and not necessarily the way we would've liked him to use, does have to show the drinking guidelines.

It also has a couple of other things. It says the guidelines. You don't have to think of it from scratch. It also has the scoring of the AUDIT, which is the form that she filled out. So remember, he started the conversation. One thing that he did do right, he started the conversation after he asked her for the form she filled. And I don't know if you remember, I mentioned yesterday, a brief intervention, that conversation does not take place unless you have the screening, that it has to be a justification. There has to be a reason to bringing up the risky behavior, so the screening and the score that interprets her at a risky level, high risk, or moderate level, that is the very thing that he was going with. So the only thing I would say he did right was he initiated a conversation as a result of the screening tool. How he did it was not the healthiest way to do it.

Lucien: Yes.

Diane: So for us, I gave you the calculator, so you don't have to memorize this stuff. Once you do it a few times, it'll come to you, but it reminds you about the recommended guidelines. It reminds you there's only going to be 20% of folks that does the screener. When you do it universally, that will be at risk, where you can have that conversation and only 5% might need the referral. It also tells you the score. Depending on how you add up the numbers, it tells you what's the next steps to do. If it's risky behavior or harmful behavior, so it tells you the very steps to do. Introduce yourself, ask the patient

to discuss the pros and cons. It has a very general way of doing it. I gave you something else. So you have the pocket card.

I sent you an AUDIT score. It's called SBIRT CRISP AUDIT score. It's an AUDIT. It's a screening tool that was already filled out. It has a score. And you also have a tool to interpret what to do with that score. And what else did we send you? Oh, the ATTC SBIRT BI pocket card, because that's what you're going to use, because you guys are going to practice this. Like Paul and I was doing, you're going to practice this. So the idea is that we don't want to be that clinician, or at least we don't want to practice the way that clinician just did. The directiveness and not paying attention to cues coming from the patient and losing opportunities. That person might go on to get [inaudible]. That person is not going to come back for services. Certainly not going to go back and see him.

And we want to engage folks. We want to engage them and we want them to feel like they're being heard. SBIRT is an intentional process of inciting motivation in the other person. So while it will be their intent, their ultimate decision to do anything about any particular thing, the process that you're going to engage and practice with in a little bit, that process is intentional on your part, but you're the one. Remember, we did the stages of changing. [inaudible] that there's certain things you can do to help prompt them, to help them consider going forward for themselves, yet it'll be them coming up with the reasons why.

You just use certain communicate strategies in a skillful way, in a way that it builds on each other, so they can continue the conversation and come up with that. You're just going to walk along with them. That's what you're going to do, okay? That's what SBIRT brief intervention has an opportunity for you folks to do. It's all the skills you already use, put in a particular context. It's just a matter of us breaking the ice with us and stuff. That's all. That's all. So any other comments? Any other questions? Any other feedback that you have? Forget the video. Anything so far that we've discussed since yesterday and today, that might be standing out, that might be confusing?

Lucien: Yes.

Diane: Yeah, Lucien.

Lucien: What I was going to say, when we saw patients, sometimes they come, they have a negative approach, is one of the reasons that happened, because the previous experience, if a patient experience something like this, when he go to the next treatment, he already expect the clinician will treat him the same. Sometimes they come angry and upset, before they even met with the actual clinician at the current treatment, to see what's going on. I think this is a very, very bad thing that have a bad reflection on the patient. And later on, some of us pay for that when we [crosstalk] the patient.

Diane: I think the that's a really good point and I think that makes this intervention, the way I'm suggesting it-

Lucien: Make it

Diane: ... even more important to consider. A lot of the folks that I had worked with when I was doing direct services were going through so many struggles and so many stressors. I always gave them credit, because they even came in to ask for help. Not the easiest thing. Most adults feel like they're supposed to grow up and take care of responsibilities and be accountable and do this and that. A lot of folks who come to our services are already going through so many challenges and that was before having this pandemic environment, where everything went crazy. So a lot of folks, who are also stressed, are the social services that they've tried to access and they get a hard time from, just further exacerbating their situations and everybody, as an individual, has different capacities, so I appreciate what you said, Lucien.

So when they get to us, we have an opportunity where we could do meeting where they're at in a very different way. I know that's the clinical approach. I get that, but I mean very approachable, very personal, to help have that conversation, to help partner with them. We can do this in such a cognitive and liberal way, simultaneously. SBIRT is a way that can help us do that very comfortably. It's just a matter for us to get comfortable with using these strategies in a particular way first and then we can do it with one or two other people, so I got some suggestions for you. But I'm glad we stayed together. We looked at what we don't want to do. We certainly want to be mindful. This is actually what happens with a lot other resources people access.

What we don't want to do, is we don't want to get caught up in so much of routine. There's so much responsibilities that we have, that we don't want to be this person and not be aware that we're that person. We want to do things different. So the goals of the brief intervention and I know I have to say the clinical reference is brief intervention, but I want to say it's a conversation and I say it that way so it can help us understand how uncomplicated it really is. It's based on a person's screening score, so you do have brief intervention. You have to get that somehow, all right? And you folks already have it, so we going to do it in a role play. So based on the person's score, that's just going to justify you having a conversation with them, a brief intervention. That score is going to indicate what you're supposed to do.

And then you have a conversation about them and you do it in a strategic way and the idea is to incite motivation and hopefully, they're receptive to actually thinking of doing something, or incorporating some of the information you're going to give them, okay? And so it's all specific to their needs, so it's very patient centered. So your role is to provide feedback and remember asking permission is always key. Provide feedback, or offer information and explore options will help them in making new decisions, but it's going to be using those core skills and you're supporting the patient and you'll give them

advice when the time [inaudible]. So you start with the person with that. It's always the process of change cannot happen, because we direct it, or because we incite it, or we initiate or suggest it. It's really about them. I'm going to ask you folks to go into groups in a few minutes.

And while I do that, I probably will try to come [crosstalk] on and I'll use my hotspot, okay, because it looks like my internet might be a little wavy, so that's my backup. So what I found that was helpful for me is that usually when I have a conversation, when somebody has a score that requires or justifies my having a brief intervention with them, it really helps understand their purpose, or their reasons for accessing our services. It helps to hear what that is. And then the behavior eventually connects, or either obstructs their ultimate goals, so there's a way of linking that together, okay? So that's part of the idea, but I'll give you something to consider.

So it's really about building rapport and this is what we're going to practice, but I want you to see it first. We're going to build rapport and then we're going to do an action plan. That means anything that has to do with what the person may be offering to do, need help in doing, or maybe they are open to doing certain things and they need resources and you provide that, okay? This is one thing I wanted to say about the reflective listening. This is what I was talking about. When someone says something like, "I like [inaudible]," and you asked me, "What's the downside?" I said, "I don't necessarily like waking up with hangovers." You [inaudible] listen. You could say, "Well, I do like the drinking," but on the other hand, you don't like the hangover that you wake up with, so where does that leave you? What do you think about that?

You give it back to the person. You're saying the same things they're saying, but using those words as an opportunity to reflect it back, so they can consider that. And then you don't want to do it in a different order. You want to do it that way. You said, "Okay. So you like how it makes you relaxed and all that." But on the other hand, the last thing that people tend to remember is the last thing you say. So on the other hand though, you say, "You don't like the hangovers that comes with it, so where does that leave you?"

So that's important to do, so we're going to see how that [inaudible], so that's the information and feedback. And we're talking about the importance of confidence and readiness rulers and we think about this, because this is really important. No matter what somebody says, when asked to acknowledge, recognize, "Okay, that's a great number. You're not on one. That's a good number, but you could have gone lower. Why didn't you pick a three or a two?" So go with that and listen, their information. You only use this if you heard the change talk, so then you come to an action plan. So this is what it all looks like together, but I'm going to show you a video.

Allen Line: I saw that you filled in one of the pink sheets. May I take a look at that?

Ms. Clark: Yeah. He told me to fill that out and bring it with me.

Allen Line: Okay. Thank you. So you say here that you have four or more drinks in one week. You mentioned that you may be increasing that a little bit as well and that you have one or two drinks in one sitting.

Ms. Clark: Typically.

Allen Line: Yeah. And that maybe monthly, you have more than that. What kind of drinks do you have? What do you drink when you typically drink?

Ms. Clark: Wine with my meals. Again, one or two, typically and more frequently, three or four, since my stress has increased.

Allen Line: So it's starting to increase. You're starting to drink a little more.

Ms. Clark: Mm-hmm (affirmative).

Allen Line: Okay. Well, based on what you put here, it gives you 6 points on this scale. The scale ranges from 0 to 40, so 6 points will put you in what we would consider an at risk zone, so if it's okay with you, just to talk a little bit about that.

Ms. Clark: Okay.

Allen Line: Okay. So the at risk zone's set from 0 to 40. It's not a super high risk, but it certainly could be a risk for maybe increasing stress. Maybe some physical ailments related to alcohol as well could start to show up, if you were to increase your drinking from there, or even stay there. This is a typical standard drink size over here. I'm not sure whether that fits your description of a glass of wine, or not.

Ms. Clark: I fill the glass up, so maybe a little more than that.

Allen Line: Yeah. Maybe that little space at the top, so perhaps a drink, drink and a half, each one, so that also increased a little bit more, so perhaps maybe drinking more than you indicated on here. And for a healthy women your age, no more than three drinks in one sitting is considered to be lower, or no risk and no more than seven in one week.

Ms. Clark: Seven total in one week?

Allen Line: Seven total in one week. And what you say here is that, even on this sheet, you are perhaps already drinking more than that. So what do you make of all that?

Ms. Clark: That's news to me. I thought red wine with your meals is supposed to be healthy and no more than seven in a week, that seems prohibitive.

Allen Line: Yeah. Yeah. It seems a little less than perhaps you've been drinking, or what you consider to be healthy drinking. And certainly, there's this conflicting information out there about what's healthy and what's not healthy. I imagine the increased stress is what concerned Dr. Seal, as your stressors increases. And if he were to prescribe you anything, maybe some interaction between the two, that would also be a concern for him, I would think. So if you would, what is it that you like about alcohol?

Ms. Clark: Well, it does, at least in the moment, temporarily reduce my stress and I like a good glass of wine. I don't don't drink the cheap stuff. I like the expensive.

Allen Line: Right. So you like the taste of it?

Ms. Clark: Mm-hmm (affirmative).

Allen Line: And it does help to lower the stress, even if it's just for that time you're drinking. What are the not so good things about alcohol for you?

Ms. Clark: Well, the nights that maybe I have a couple more glasses than I should, I wake up feeling yuck. And of course, part of my stress is finances and I mentioned I like the good stuff and so if I'm drinking more, then I'm increasing my...

Speaker 10: ...good stuff. And so, if I'm drinking more, then I'm increasing my financial burden.

Speaker 11: Yeah.

Speaker 10: So...

Speaker 11: So, your financial stress may be increased by the fact that you're drinking.

Speaker 10: Yeah. Kind of defeating the purpose there.

Speaker 11: Kind of a catch-22 that you're drinking to reduce stress and increasing stress at the same time. So on the one hand, it lowers it. And then on the other hand, it's increasing, like a seesaw, teeter totter effect there.

Speaker 10: Mm-hmm (affirmative).

Speaker 11: What do you make of that, given that on one hand it lowers and on the other hand it increases, and now it's increasing even more?

Speaker 10: Maybe I need to find some other way to deal with my stress.

Speaker 11: Yeah. And I imagine you've had some thoughts on that. What have you thought of trying, if anything?

Speaker 10: Well, I've exercised in the past and that helps. Right now, my schedule is out of whack and I just really don't know what to do. That's why I came to see Dr. Seal. I thought maybe he could prescribe me something that would help me when I'm feeling overwhelmed.

Speaker 11: And he might be able to. I'm not saying that he cannot. I just imagine that he's concerned that if you continue to a drink on the level that you are drinking, that whatever he prescribes you, there may be an interaction with the two. I imagine that's his concern. I'm not completely sure.

So, you've had some success in the past with changing behaviors. And if you were to decide to make any changes here, it sounds like you could draw upon that to make those changes. How important would it be for you on a scale of zero through 10 – I have a little kind of visual here of that, if zero is not important and 10 is very important – to do something about your drinking right now?

Speaker 10: Well, if it means that it's increasing my stress, or he's not going to prescribe me anything because of my drinking, then it's fairly important. Maybe about a seven.

Speaker 11: That's pretty up there. Why did you choose a seven, not a five or a four?

Speaker 10: Well, again, I've got to get things under control. My kids are dependent on me, and I've got to go to work to help ease this financial stress. And so, all those responsibilities-

Speaker 11: So, there's a lot riding on your decision here on what to do with this. What, if anything, would bring it up to an eight or nine on that scale?

Speaker 10: Well, the risk that you mention about the drug interaction. I certainly can't afford to have any more stress. So...

Speaker 11: Yeah. So, you choose to lower your stress rather than increase it. And if lowering your drinking would have that effect, that's something you'd be willing to do?

Speaker 10: Mm-hmm (affirmative).

Speaker 11: How confident are you that you could do something about your drinking?

Speaker 10: Pretty confident. Probably about a seven or an eight.

Speaker 11: Okay. So, it's pretty high up there again. And what, if anything, would you choose to do? Would it be to cut down? Would it be to quit? I'm just curious about what-

Speaker 10: Well, like I said, I like a good glass of wine. I don't want to quit altogether. I'd be willing to try cutting back, but if it's going... If Dr. Seal would agree to prescribe me something

for the anxiety and it meant that I had to not drink at all, I'd be willing to do that at least for a period of time.

Speaker 11: So you'd be willing to stop altogether if that's what was indicated by the physician?

Speaker 10: Mm-hmm (affirmative).

Speaker 11: Okay. So, based on that, how ready are you do anything right now, whether it's to cut back, whether it's to quit?

Speaker 10: Well, again, if I can get something to help me manage, if maybe I can find some other way to deal with the stress, then I'd be pretty ready. Again, maybe about an... On that scale, maybe an eight.

Speaker 11: Okay. So, that's pretty high up there as well. It sounds as though you're pretty motivated to do something about this right now, given your responsibilities, given your children relying on you at this point, and just on lowering your anxiety in general. It sounds that that's one of your goals as well.

Well, I'm pretty confident that once you decide to do whatever it is you decide to do, you'll be able to follow through with that, based on your experience in the past of making behavior changes. I imagine there are some things that you can draw upon. What's one thing that you could do – I imagine you've thought of some things – that might help grow your stress?

Speaker 10: Well, I... The exercise, but again, that's difficult to fit in right now. I'm hoping that Dr. Seal will prescribe something for me to take when I'm feeling particularly overwhelmed. And maybe just having somebody to talk to, to bounce some things off of.

Speaker 11: One of the things we can offer here is for you to come in and talk to one of our behavioral health specialists, who may be able to help you talk through this area of your life, this area of increased stress and anxiety. And we can make an appointment for you if you like, before you leave today, to talk to somebody.

Speaker 10: That'd be nice.

Speaker 11: Great. I also has some information here, if you're interested. A pamphlet on alcohol and how... What healthy limits are and how it may be affected by medications that you take as well. And I wish you lots of luck. It sounds as though you're really committed to making this shift and this change. And I imagine Dr. Seal will want to follow up with you and see how you do with your change within a few weeks. And again, I look forward to speaking to in the future.

Speaker 10: All right. Thank you very much.

Speaker 11: You're very welcome.

Diane: Tell me... Tell me how... Where you may have heard... This obviously is a more productive, a more effective interaction with a patient or a client. Right? Does that make sense? I'm sorry I'm posing a close-ended question, but we all know that. But I wanted to understand if you were able to identify where he may have used some of the communication skills that we were talking about, about [inaudible]. So, where did you hear open-ended questions? Did you hear any of the reflective listening? Did you hear any summarizing? Can you tell... Can you identify when he used the change ruler, which he did use – or rather the readiness ruler? Tell me about that.

Speaker 12: Yeah. So, I like the way he used the ruler in several instances to encourage her in her motivation to stop or to lower her drinking. He used it when she's talking about the possibility of stopping and when she spoke about her readiness to change her behavior. And I thought that was a very good use of the tool. I like that.

Diane: Good. Thank you. Thank you for that. Anyone else? What else did you pick up from this whole interaction and any specific tools? Yeah, Lucian.

Speaker 13: Yes. I think it's very productive compared to before, because even the eyes contact is there. It's like a communication, it's like a dialogue they have. He keep the eyes contact and he got more response from the client. So, the interaction was very productive, and unlike before it's totally different.

Diane: It can sound very natural. It should always be like that. Intakes assessment should always be like that. It's not always easy, but it should always be like that. That is part of the atmosphere building, or that you're creating or developing, so someone can feel comfortable enough to be forthcoming with you. Because that is key as to what you're going to use strategically in a conversation. But this is happening... So, one of the things we missed at the beginning, because the video, it was shared after it had already started, he introduced himself and he asked her what she's doing there, which is different from the first video. Right?

So, right from the beginning he engaged her, he introduced himself. She got to introduce herself and she got to share why she was... She shared with him what her reasons were for being there. He already knew, but he engaged her. That was awesome. Simple stuff. Stuff that we do. Simple stuff, but it started to develop an atmosphere, that rapport between two people. And so, it wasn't so much a clinician, the authority figure and a patient, they were like two people talking. And that's the coolest thing about the conversation, that, okay, even though she's there for resources and services, they were just two people talking, and the tone of voice, the atmosphere seemed comfortable.

So, you heard how he used the communication skills, the open-ended questions and all that. He did it skillfully. And Helena just spoke to this about... The readiness ruler, when he got to that point, that was done after she started to look at her... When he gave her information, and she thought about it and said she didn't realize that she was drinking more than what she initially thought. So, that started to... That was afterwards. But in the beginning, he first asked her for what? We saw this when the video first... When we were able to see it, when it was shared with all of us. After she shared why she was there, what did he do?

Speaker 14: Did he ask her for her assessment?

Diane: Yeah, that form.

Speaker 14: That form, yeah.

Diane: She said... Yeah. Yes. Dr. such and such asked me... Yeah. To give this to you. Yeah. So, that... He did not start doing a brief intervention before that. He had that, he looked at the scoring and he was able to explain. He was very transparent. He told the assessee, well, on this form, what I can tell is that this puts you at a certain category. And, if you don't mind, I'd like to talk to you about that. It was very neat. It was a very neat way to start. Right? And that started the whole conversation. And then he started to ask, if you don't mind, could you tell me... According to your average category, it says... If you don't mind, what do you drink? And so, she started to explain. Okay? And he kept reflecting back.

So, that whole process and the [inaudible] he just went through about building a rapport, going through the pros and cons strategically and then giving information. And wasn't he asking permission and said, okay, so on the one hand, it does this for you. But on the other hand, this is... Well, I have some information about that. Do you mind if I give that to you? And he kept asking. He was never directive. He was saying, perhaps, maybe. He was never directive. I think that about him because I picked up a couple of things for myself. I like the non-directive style, because then you're asking the question and if the person wants to respond, the person responds and you are meeting somebody, and you are there present with them without being pushy. And many services are pushy, despite the fact that the heart is in the right place. We want to not do that. Okay?

So here's what I'm going to ask you all to do. We are... We have a really healthy group here today. So, what we're going to do is I'm going to ask my colleague, our tech guy, our tech guru, to put you all in groups. You have handouts. I just put them in the chat box. You just need three of those handouts. You have the expert, you have the alcohol calculator, because it's also helpful to understand, you have to have some base information that you offer somebody so they can consider why it may not be a good idea to continue the same behavior. So, he was telling her about alcohol.

Does anybody remember why she was there? Yeah. Remember that she was there... Just to remind you all. So, she was there because she wanted to get some benzodiazepines, or some medication. And the screening form came up hot and the psychologist was concerned. And so, that's what... So, his conversation, if you think about it, it was connecting back to that. What she filled out when he was asking her about what she drank, he was able to kind of bring up. So, this is a visual of what it might be. So I imagine this is what you have. And then she offered. She said, maybe it's a little bit bigger than that. Also, maybe a little bit more than that. Maybe more than you indicate on this form. It's really reflecting back what she's saying.

The three handouts I want you to consider is the alcohol calculator, because you could use that... That reminds you of the recommended guidelines that you could use. The expert BI pocket card. What I did is, I took what those strategies are, those five rapport pros and cons – I listed them for you –readiness ruler and action plan. I took that and I simplified it. So, you have a document that has a little square. So, eventually you can cut it down and make it a cheat sheet for yourself. But please access that because that's the script you need to follow. You're going to follow that script. So I'm going to...

And the other one is Chris's score. So, we are going to talk... Somebody's going to be Chris and someone's going to practice doing this expert, this brief intervention conversation with Chris. I sent you, and I put in the chat box and you got it in your handouts this morning. Chris has a score already, an audit, a screening tool already filled out. It has a particular score. You look to the second page, it tells you what to do. That directs you, how you're going to do... Why you're going to do the brief intervention. Now, the scenario is, we're going to have four of you. I'm going to give you eight minutes. I'm going to give you four minutes for one person to be Chris and the other person to be the provider. Then you can switch around in four minutes and someone else can have the opportunity. Because this is a big group, I'm going to put you in groups of four, but only two people are going to have the opportunity to practice.

But it's good to observe within your smaller group. It gets it a little more personal. And then you can see where you might do it different, where you might have a challenge. And we can work with that when we come back. Okay? Does that make... Okay. So do you have your handouts accessible? Are they ready for you? Did you put them on your desktop? I put them in the chat box. There's three PDF documents I put in the chat box. You can just... I uploaded it there so you can just save it on to your desktop. Okay? And before we go anywhere, I'm going to give you the... We're going to read the case study now.

Speaker 15: You are a 40-year-old divorced parent of two boys, aged nine and seven. You have your catering business, which is struggling. You have high blood pressure, feel stressed and have bouts of... Does that say bouts? Bouts of depression from time to time. You are most likely... I mean, you are mostly a beer drinker, but occasionally add hard liquor to the mix. You find that drinking is both a social activity and a stress reducer. However, it

has had some negative effects on your work and your relationships with your son and your ex. You have driven after drinking on more than one occasion, but have never been arrested for a DUI. Your doctor is concerned about your stress and how it is affecting your blood pressure, so he recommended some counseling to address your stress and depression.

Diane: Fabulous. Thank you so much. That is the case study. So, Chris can be anybody. So whoever are the two people or the first person who wants to take on the role, whatever gender you want to apply, that's on you. It really doesn't matter. It's just... See if you can work from that case study. The person who's interviewing doesn't have to know anything about the case study, because that person is the one who's practicing using the brief intervention, those steps. You're going to elicit the information from the individual. Okay? So, do that for four minutes. Get to as far as you can. And after four minutes, then switch roles and have someone else do that opportunity. One of the hardest things to do is do this on a massive scale the way we're doing, but we're going to give it a try anyway. Okay?

All right. So, Cly, can we put everybody... And you have eight minutes once we put you in group. Cly, can we put it everybody in their groups?

We are back to the large group. Hi everybody. This is my first question. Very specific. Not enough time. Yes. I got you. Very specific. When you started to go and use the brief interventions, the little box of the steps, that was really your script. Was that uncomfortable for you to use those words?

Speaker 11: No.

Diane: It wasn't?

Speaker 11: No.

Diane: Okay.

Speaker 11: Although we didn't get to use them.

Diane: Okay. How far did you get?

Speaker 15: Nobody wanted to play.

Diane: Oh.

Speaker 10: Well, my-

Speaker 12: Yeah. We had some technical difficulties in my group as well, where people weren't able to get their audio working or weren't in a place where they could, or the computer didn't have that feature.

Diane: Okay. Okay. Kenneth, what were you going to add? And then Sharon. Kenneth.

Speaker 11: Yeah. As soon as we got into the dialogue it switched off, because at first Vicky was being the client and we were having... They were doing it from just a made up scenario. Then we went to the actual script and we started to dialogue from there, and it switched over as soon as she started giving me the score and explaining things to me. So, we never really got a chance to get to-

Diane: Let's back up a second. You said a made-up script? Made-up scenario?

Speaker 11: No, no. When we first started, Vicky was being the... Was going to be the client. And Tanya was... But thought she could just come off the top of her head and we had refer back to the script. So, once I became the client and Vicky became the counselor... And so we had just started getting into it before it switched over.

Diane: Okay.

Speaker 12: Yeah. Actually, Tina was... I was the client. Tina was the counselor, but she didn't follow the script. And then I became the counselor. I guess, because Kenneth and I were the only two that had the handouts available, we took on the roles.

Diane: Okay. But as long as you did, as long as you started. Okay. Sharon, what were we going to add?

Speaker 10: Actually, I think we did pretty good. We had the script, but Lawrence was the patient, client. I was the counselor. He came into the office. I introduced myself. I said, you can have a seat. I want you to know this is a safe place. So, we went through that building the rapport situation. And then I said, tell me what brings you here. And he began to tell me that his doctor sent him because he was concerned about his medical condition. And so, when we finally was on the road to doing these steps, we had to come out. So...

Diane: Who... Did you ask for... Did you refer... Did anyone refer to the audit form?

Speaker 10: Yes. As a matter of fact, I did ask him for his form. Yes. Okay. That's when we had to come out.

Diane: Very cool. Very cool. I just wanted to make sure, because we can't really have the conversation when we don't have a form. That's what initiates it, but that's going to guide the whole thing. So, let's just say you are going to try to do this intervention and you don't want to lose the opportunity once you want to start engaging someone. Well,

there are times where you can have the visual. If you're doing telemedicine, you can have the visual and shut off your computer audio, use the phone. So that way, you do not lose them. So, that's a good workaround. So think about that. Think about that. And then that's something to consider when we're attending webinars or getting our CDUs from whatever topic we have to attend at the time. But when we are engaging our clients, the phone has always worked. That's not going anywhere. So we can use the visual here and the phone at the same time. So we can do that. Just learn how to turn off your audio from the computer, with the setting. So, that's a workaround with that. Anyone else would like to share on how... Was it uncomfortable for anyone to start to use these words? Go ahead, Lucian.

Speaker 16: Yes, I was... My group, I was with Jonathan, I believe. I was the counselor and it went very well. Everything went very well. The audio worked very well. And I went as far as I can remember, and after that we have time to switch and the time was off. For us, it was fine.

Diane: Awesome. Okay. And Lauren's giving props to Sharon for doing such a good job. Thank you for that. Nice. We've had a lot of folks who've tried to engage. How about... We can take a couple of minutes. I'm more than happy to be a client. What if, without putting anybody on the spot... I love to call out names, but I won't do it for this. So, without putting anybody on the spot, you have your script. While we do have a connection right now, I'll be Chris. And all you folks have to do is just engage me in a report, initiate a report. And let's go through this a little bit. It doesn't have to be one person. One person can start and then another person can continue. One person can do the rapport-building, another person can do the pros and cons. The other person could do the information or the feedback, the other person could do the readiness ruler. Last person can do an action pack.

That means I need five volunteers. I know you're dying to do this. So, I know there's five people who are so motivated to do this. Because I know you want to do this. If it will help you, I'll ask everyone else to turn off your camera. Thank you, Lawrence. Awesome. Tom, that's two. Three more. Lucian, thank you. Linda, thank you. And one more person. So we got Lawrence, we got Tom, we got Linda, and we got Lucian. Okay. Let's work with those four folks, and let's see how we take it from there. Maybe as we go through, then Lawrence, you can pick up the last part again. Okay? All right. So I am Chris. Let's just start this off, and this shouldn't be more than a few minutes. We'll be fine with this. Okay. So whenever you're ready, unmute yourself. Lawrence. You start.

Speaker 11: Good morning. How are you?

Diane: Good morning. I'm fine, thank you.

Speaker 11: My name is Lawrence Lowe and I'm the peer specialist for this group. What's your name?

Diane: My name's Diane Padilla.

Speaker 11: Okay. And how would you prefer that I address you, Ms. Padilla?

Diane: Diane is fine. Diane is fine. Thank you for asking.

Speaker 11: Hey, no problem. If you would like to get started, we can go into my office and we can discuss why you're here.

Diane: Sure.

Speaker 11: Okay. As I said, my name is Lawrence Lowe and I'm the peer specialist, so I'll be doing your interview. I would like to leave the door open, but we do have to be clear with confidentiality. So if you're comfortable with the door closed, let me know, but I prefer to leave the door open. How do you feel about that?

Diane: I'd rather have it closed.

Speaker 11: Okay.

Diane: I don't know who's coming in here. I've never been here before, so I...

Speaker 11: Wonderful, wonderful. And that's the reason why I bring it up, because confidentiality is critically important to us. Okay? All right. So Diana, give me a brief description of why you're here today.

Diane: I don't know, it's the silliest thing. My doctor's just concerned about my high blood pressure. He just wants me to address... I have depression and he wants me to address my stress because he thinks my high blood pressure's going to get worse. So, I'm coming here because he asked me to, to tackle some health issues.

Speaker 11: Okay. I understand your doctor's concern, but do you have any concerns in regard to what's going on?

Diane: I deal with a little stress every once in a while. So it's not... He's not totally off, but it's nothing I can't handle.

Speaker 11: Okay. Well, I heard you say stress and you've had experiences with depression. Can you talk to me about that a little bit?

Diane: Every once in a while, just once in a while, I have a business and sometimes it's just... It can be really draining, and sometimes I just... It can be so impactful and sometimes I just get into... I call them episodes where every once in a while I just don't want to talk to anybody and I just... I got to have my space so I can debrief with the world. So... Yeah.

Speaker 11: All right. Thank you for sharing that with me. That's critically important in terms of us being able to go forward. I really, really appreciate you coming in and I would really like for us to talk about how you deal with that. That isolation that you were discussing.

Diane: Okay. Time. Thank you, Lawrence. I thought that was really good, how you started. I didn't mention it, but remember I'm Chris and you already have a screening form.

Speaker 11: Okay.

Diane: Okay. So that also helps you, so you don't have to brainstorm or struggle with what else to say. You could say, "Okay, so thank you for being here, thank you for sharing that." I have this form that you filled out. Yeah. Because that's going to make it easier for you.

Speaker 11: I feel that.

Diane: I felt you trying, and it's like, oh wow. This doesn't have to be that hard. If you have the screening tool, that's your in. That's your in. So that way you don't think this is a completely different animal. So that's cool. Okay. Thank you for making me feel comfortable and asking me about the door. That was important. Go ahead. Okay. So we have the screenings for... You did the report. That's great. Tom.

Speaker 17: Well, Diane, I do appreciate what you had been sharing with us today. And I'm wondering... Looking at your form here, you've identified some struggles, it looks like, with alcohol. Would you mind if I ask you a couple of questions?

Diane: Yeah. Sure.

Speaker 17: So what is it that you enjoy about your drinking?

Diane: Well, at the end of the day, after putting in 14 hours at the business, it's hard to just come home and just sit. I got some other issues in my life that I deal with. And so, coming off the day, it just makes sense for me when I come home and I have a couple of beers, just to just relax and come off my day. It's almost the time where I feel like I earned it and I can come down and relax a little bit. So I have a couple of beers every day. I don't see a problem. I don't see an issue with that.

Speaker 17: All right. And my second question would be: what's not so good about the way you've been drinking?

Diane: In the last couple of weeks, there were... Now that I think of it, there were a couple of times that I didn't wake up feeling too hot. Hangover makes it harder for me to get up at the right time to go open up my business, and so that's made it a little harder. So maybe that's not so good.

Speaker 17: Yeah. Has it impacted your... I know your children are important. Has it impacted any relationships?

Diane: Actually, now that you mention it, yeah. I don't like dealing with my ex. That's why he's my ex.

Speaker 17: Yeah.

Diane: But it gets a little... It's a little harder with the kids. It gets a little hard. I'm not as energetic when I want to be with the kids. And then I get into fights with my ex because of it, because she sees the energy that I bring, which is hardly any, because I'm so tired. And then we start having arguments and that affects them too.

Speaker 17: Okay.

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Diane: And then we start having arguments and that affects them too.

Speaker 18: Okay. Thank you for sharing that. Have you ever considered other options for stress relief?

Diane: No, time. Okay, so I want to hear back also the reflective listening. When I'm sharing such lines, share it back with me. Share it back with me because I'm sharing it with you. So the reflective listen. Okay, so you have issues with the drinking and the hangovers. So, that way it would've been a good opportunity. This is a good opportunity to do the pros and cons, which is like, so on the one hand, it helps you come down off your day. But on the other hand, lately, you've been having these hangovers, where does that leave you? So you give it right back to me. You give me my words right back to me. So that's a good time to do that because that's how you are going to prompt me to start to think, "Well, maybe I need to do something different."

Because you want to motivate me. You want to incite my motivation to look at a behavior. Remember coming in from stress to depression and the basics about drinking that we do know that we want to understand. So we can connect in the conversation is... Since I'm here for stress and depression and I'm drinking, I'm making that my situation worse. So in order to get to that point, first you got to tell me like, "Okay, so you drink because it helps you come down off your day. But on the other hand, you also aware that, lately you've been experiencing hangovers. What do you think about that?" So give it back to me, so help me. So I have to process that. I'm already comfortable with you, so I'm already processed that. So good job, but always reflect back when you have those opportunities. Okay. Let's go to Linda.

Linda: Okay. Diana, when you went to see your doctor, he gave you a form to fill out and it was an audit. Would you mind, if you and I discussed that today?

Diane: Yeah, sure. No problem. Here it is.

Linda: Thank you so much for feeling comfortable. When I'm looking at your audit score, it indicates that you're engaging in some risks due to your alcohol use. If you want to look at this table, I can share with you. As you can see, moderate drinking limits for women are no more than one drink per day. How do you think that fits into your drinking on a daily basis?

Diane: One drink?

Linda: One drink per day is-

Diane: Doesn't fit in my world. One drink per day. Then whoever put up... Whoever came up with that needs to have your own business. So, that's all.

Linda: I can understand that how you feel that way. However, studies show that women consuming more than seven drinks per week or more than one drink per day are at risk for problems, including hypertension and not only physical problems, but mental health problems too, including anxiety and depression, which can be exacerbated by your drinking. Have you ever thought about those consequences?

Diane: You know what? I didn't know that. I never thought about it because I didn't know.

Linda: Well, I'm so glad that you felt comfortable in sharing that with your doctor and sharing it with me. Is it okay if we talk about some potential ways to help you reduce your stress and maybe bring you back more in line with moderate drinking or possibly not drinking at all?

Diane: Okay. Time. That's good. I like your tone. I like where you were going towards where we were at when you were giving me information. It's okay. It would be okay for you to ask me. This say, "I have some information about that. Can I give it to you?" Because then when you gave me the information about the depression and stuff like that, and I said, "Wow, I didn't know about that." That's your cue. That's your cue for you to say, "Okay, so you didn't know about that." I said so, "So, tell me on a scale of 1 to 10, one not being important and 10 being very important." How important might it be to consider doing something? Consider. Don't lead. Don't direct. Just consider just bringing up the question. So it's all about me responding. So is really my idea. Really well done. I know this is different than what we usually do. So thank you for that. We're going to Lucian.

Lucien: Yes.

Diane: Linda just did... Between Linda and you, you're doing the scale. So practice doing the scale with me.

Lucien: I understand you not aware that your drinking would also affect your depression.

Diane: Yeah. I didn't know that.

Lucien: Yeah, your depression and maybe your blood pressure and who knows, some of the time, maybe. So, on a scale of 1 to 10, which one would be the lowest and 10 would be the highest. How motivated you feel that to do something positive to address that problem?

Diane: Important, try it with the word important. Instead, I'm motivated.

Lucien: How important it is on a scale of 1 to 10, which one would be the lowest and 10 would the highest, how important you think it is to do something to address?

Diane: To reduce the amount of alcohol. Okay. You can even call, might it be to do, okay. So now that you told me that, maybe a five.

Lucien: Five? You pick five. Why not four?

Diane: Don't you think it's a good number?

Lucien: It is. This is what you feel. But-

Diane: This is what I want you to tell me. Just say, "Well, five is a good number. Thank you for giving me that. That's great." Yeah.

Lucien: Yeah.

Diane: So this way you can say, "Five is really good number. You know what? So you could have picked a four. How come you didn't do that." That, go for it.

Lucien: Yes. Thank you for giving me that. Why don't you pick a four?

Diane: No, because I didn't know this before. I didn't know that, I can't take the chance of making my blood pressure worse than maybe my pressure. I need to run my business because I take care of my kids. And I know that my health can get bad and I want to be around my kids. So I didn't know that. So I guess, I probably should look at it and do something about it.

Lucien: I understand you feel you need to be, but when you look at in a role, what's going on, the way that affecting the rest of your business. And I think it would be a good idea for you to think about doing something.

Diane: So, you're directing me or are you being person centered?

Lucien: No, I'm not directing you, I don't think. I'm just-

Diane: Nice. Okay.

Lucien: It's the suggestion, because I don't think it's direct and I don't think-

Diane: Oh, were you repeating back what I said? Because I didn't tell-

Lucien: Yes, I did repeat what you said.

Diane: Oh, okay. So maybe, I caught that wrong.

Lucien: Yes.

Diane: Okay. I'm going to say technical difficulty. Sorry. Okay, great. All right. So then what happens is, right, so yes, I'm not sure what I can do. What might I be able to do? Can you help me with that?

Lucien: Yes, we have... Once you meet with the doctor, the doctor will look at your screen. I think he will refer to some of the counseling here that we can address, can make some referral to address the issue that going on.

Diane: Okay. All right. Thank you for that, Lucian. At that point, you can also think about, what were some of the things that you've tried before? Like, looking back and looking forward.

Lucien: Yeah.

Diane: Because I still need to be the one who comes up with the ideas. The reality of that... And you already know this, all of you already know this is that typically has a more realistic view of what they can do in their world and what their capacity's about. And this helps you because it's not so much about meeting me where I'm at. It's I get to do something that's realistic for me. And what you want is to have me call in that direction. [Yamir], you have your hand up.

Yamir: Yeah. I was wondering if we could do, or if I could try doing the action plan with you. I guess that last step.

Diane: Sure.

Yamir: I guess, just picking off where Lucian left off, but also like one of respectful time. Great. Okay. Well, Diane, I think, again, five is a very high number. It seems like you're very motivated and it's very important for you to, potentially make some changes. It seems like you're very motivated by your children as well as your business. And I just wanted to ask you a couple more questions, for example, what are some steps that you could potentially take to stay healthy and safe for maybe make a change in that behavior?

Diane: Well, I know one of the things that the doctor mentioned was about cutting back on the drinking. I guess I could, because I really don't like the hangovers. I suppose I can chill out with the drinking during the week. Maybe just leave for the weekends. Sundays, I don't open up the business. So, I might be able to at least cut back.

Yamir: Absolutely-

Diane: No promises. But at least from two drinks to one, at least.

Yamir: Absolutely. And I think that's definitely a very great step that could be taken. Can I ask you like maybe, what are some things that you can do to potentially make sure that, that could happen or something that you could do to support yourself to make that change happen?

Diane: Actually, I'm not sure. Maybe, you can give me those guidelines, again. I'm not used to them. So maybe you could give me a copy of that. I could probably post it on my refrigerator home.

Yamir: Yeah, absolutely.

Diane: Maybe that can remind me, I don't know.

Yamir: Absolutely. We could definitely send you these resources, make sure that they're readily available to you to make sure that you could always take a glance at them. I guess, in terms of just next steps, what would then help you to motivate you to like, look at those guidelines to make sure that you're creating a little action plan for yourself to see that you're following that?

Diane: But then, if I post someone on the refrigerator, I'm more likely to start practicing doing less than two beers a night. Because I know sometimes it's really three. So I could start. At least that'll be my reminder. I could start doing that.

Yamir: Absolutely.

Diane: And maybe, think about Sundays, maybe not every day.

Yamir: Yeah, definitely. So I think one very last question that I wanted to ask you is, if you have any experiences of overcoming a challenge in the past, and if there's anything you could take away from that experience and apply to this one?

Diane: Actually, I would have to think about that. Here's what I'm going to say. That was good to think about, before I came up with the solutions without potential strategies. So if your client is having challenges with potential strategies, then that's a good question to bring up impromptu to consider what they've done in the past. Like the clinician, which is is really great. So, since I'm already giving potential things that I want to do, that is the action plan. So you already got me there. So that part wasn't necessary. Nice job and good job. Hey, everybody, could you unmute and give all these folks a little hand. Okay, or electronic hand, if you want to. Come on, these are gutsy people who actually have in front of you that they counsel with me.

Speaker 19: [crosstalk] a good job.

Diane: Yeah. I might go to alcoholics anonymous, who knows. So anyway, but thank you so much for being participatory in this. So here's the thing. If you break the ice, it's just a matter of breaking the ice with the wording, because it's not what we're used to. It really isn't. But when you look at it, it's stuff that you already do, but it has a particular context. It's a great way to practice, how to be person centered and not add practice, not adding more. Because if you're going to reflect back what I'm saying, reflect what I'm saying. Don't add more. If you're going to do a script at least to start off to get familiar with this, then go by the script, because it gives you something to practice with a few times. You could take parts of this, do the pros and cons in your social circle with your family. Do reflective listening with other people in your life.

The more you practice it in your life, the more likely you're going to do it at work. So, one of the examples I've been using very recently with the expert trainees and call my girlfriend over the summer, she had gotten married. So my friends and I wanted to take her out. And because of the pandemic and the restriction and stuff, we had to be very careful. So, we were just going to do something simple, just take her out to dinner. So one of the girls decided to... Suggested a place. And supposedly, it was a nice place. So, I had asked her, I said, "Margarita, what do you like about that place?" And so she told me all the really nice things. It was a nice place, nice vibe, had good music. It was going to be an outside tap jazz. So that, I said, "Okay, great. Sounds so good."

And I reflected back to different things she said. It says, "Good food, an outside environment. We're going around a certain time. We see the sun come down. That's great. Are there any kind of downsides to that place?" She told me about the parking. And the parking was bad. But when we got there, somebody just pulled out. So it worked out for us. But what I'm saying is, I took it in a regular situation on everyday situation. And, but it takes intentional, a conscious thought, a conscious commitment to practice it. If you do that a few times in your natural world, you're more likely to do that

with your clients. It's not like you could do this in the wrong way, which is going to hurt the client. Just even if the whole script is uncomfortable, at first. It seems like a whole new animal. Do components to that. But if you follow the script... And the point of giving you this script is just to get you familiar. Use that as your cheat sheet.

If you facilitate seeking safety. If you run cognitive behavioral therapy with your patients. If you do any of these different interventions, you had to practice, some way you had to start somewhere. This expert happens to be something that can be applicable in your daily life. So if that makes you comfortable do it there, but use this component with your clients, see how it can work in the different points of contact that you have with them. I think you'll find it easier than you might think. So it's just a matter of getting into the habit, just like all the other skills that you have, okay? Any comments, any questions?

Lucien: No.

Diane: Nicely done, everybody. That is really awesome. So I have... Any questions about this? Anything that was a little bit of a struggle because the brief intervention is typically the biggest struggle of doing the whole expert. Tell Yamir.

Yamir: Yes, I do have a quick question just about the follow up portion for the expert and if there's any best practices for that and what that looks like. Or if that's something that we establish on our own.

Diane: It has a lot to do with your protocols. And I'm going to go to my slides because we haven't talked about the referral to treatment part. Okay. So the action plan is that they are motivated to do something, and that something is usually something that they suggest themselves. So that's good for you. At that point, you know that you've had a successful conversation with them. That's the brief intervention. Now, if the scores high enough of your time, it shows that you're at high risk, and you run them through and you walk with them through the conversation. Folks who have a probable or potential substance use disorder, alcohol use disorder, opioid use disorder tend to share about all the consequential experiences that comes with that.

Let's just say somebody for the first time, who likely has a substance use disorder, in that conversation, you can always offer... And I think the clinician did it in the video. You can always offer towards the end of conversation, once they're open, they're receptive to wanting to do something different. Well, according to this, it says that you have a high risk for a potential substance use disorder. What I can do... I appreciate you sharing all this, but what I can do is offer you a referral for further assessment. I can't tell you that, you might have a substance use disorder. I said, "But with what we've discussed, I can offer you a referral." I said, "It takes a credential person to do it. They will do an assessment with you and they'll let you know what it is. And they'll let you know where you fall and they'll give you the options."

And if they ask you about those options, that's how you offer the referral. We know it's a referral to treatment, because it's that treatment locations that case act persons can facilitate the assessment. It has to be that person. So that's why we say referral to treatment. But our terminology, our approach says a referral for further assessment. Because, we can't tell anybody, you have a substance use disorder. We're only screening folks. So be really mindful of the wording, of how you phrase it. And so, it's really good question. So in that brief intervention, builds receptivity, builds motivation. That is the opportunity to be able to offer that referral. And if they've been engaging with you in conversation, they're more likely to be open than not.

So let me go back to that and use a couple of minutes I got left to talk about that, good job everybody. Hold on. So this is... So I suggest that you all consider the handout that... I don't know why this doesn't want to go anywhere. That the handout, you can cut it out or making it to a card and just post it on your desk or your cubicle or your office, if you have an office and just have it. So you can refer to it when you're speaking to someone. And after you do it two or three times, you will know it. You'll pick up on it on your own. So refer the term is really referral to further assessment. The idea with referral for further assessment is to understand some of the things that you already know.

First of all, 5% of the patient's screen that will come up with the likelihood of a potential, a disorder, substance use disorder, you would have to make the referral to. So we know that treatment... I got a few minutes. So treatment includes... You're going to have this in your slides. They may ask you questions of, what so well, "What is treatment? What exactly does treatment have?" Everybody might have people who are not experienced might have their own perception of what treatment is. If they think it's only medication, they may not want to go. They will need to understand, if they feel comfortable with you and they trust you, then they may ask you, "Well, what is treatment? If treatment is available, well, what kind of treatment might be available?"

You don't have to be the case act, but you should know something about it. So you tell them, there are a lot of different options. There's inpatient, there's outpatient, there's counseling. Sometimes some situations need medications, but a lot of times they have some other things. They help you understand, how to engage in certain skills. To help you deal with situations in your life. So there's a whole combination of stuff that you can do. But they're going to be able to provide you those options. But it depends, if that assessment shows that you fit the criteria for substance use disorder. So these are some of the things. So it's already here, and what the key things that I want to stress here is that, 50% of patients with an alcohol substance use disorder issue will not show up at their first referral.

If they're put on a waiting list. They won't show up at a referral. You give them a certain days of the week. So some of the things to make a successful referral, Asper really encourages a warm-handoff. And that means, either some kind of accompaniment, we have a lot of recovery coaches and peer recovery advocates that work with us. And this

is an opportunity to help accompany them to a follow up appointment. And they become such an important part of the work we do. And they're so essential. And so, that is really a wonderful opportunity to take advantage of. And so warm-handoff is going to help the person one to follow through.

Also, they're trusting that you are sending them to somewhere, that's going to help them. They may not help them the same way you do, but they're trusting that this is going to be a good source. So you should be aware of the treatment facilities that are available. The different levels of care. Understand what the referral criteria is. Do they have to have insurance? What is it? What's the eligibility for potential admission. So understand what it is, schedule the appointment immediately. Don't give them a number here, call when you have a chance when your schedule fits, do it right there and then when they're open, when they're receptive. And we never do it on a Friday, okay? So it's really important to understand what that is. You know what's helpful? What I used to use was, I didn't just send people. I didn't just refer folks to a place.

I knew the name of the person. So when I was talking to my patients, I rather... Excuse me, my clients. I would say, "Well, I'm going to give you a referral. You're going to go see Lena. And Lena"... She was one of the ladies that would do the intake assessments. And so, "I'm going to give it to Lena." So it sounded like I knew the person and that continued to know that was just building on the rapport I already had with them. So that was easier for me to follow through. And then I would tell them, I said, "I tell you what, about a week or so, if you don't mind, let's connect again and let's see how that worked out for you." So you always want to leave the door open and, and still, it just sounds like a regular natural conversation. That's what you want to do.

So, I sped through the last of it, but really those criteria you need to know ahead of time, what treatment can look like, have options. The options are not always the nearest option to where they live. Have options that are at a distance because stigma is really big. Not everybody wants to be seen going into a place that is known in the community to be a treatment center. Understand those different logistical issues. So, have those who already ready. Be able to have a conversation. Again, you don't have to be the case act professional. You just have to know that. Well, I know they have outpatient. I know they work with folks with, who have jobs. There's different opportunities available. I said, "So, I can tell you some of this, but will be in the best position to tell you about what those options are." If they say that you qualify for those services. And keep it like that, just be mindful of the conversation and the tone of voice. So, that's the referral. It's a referral to treatment. What you're doing is actually giving a referral for further assessment.

We, from our perspective, we know it's a referral to a treatment facility, because that's where the further assessment can take place. So be mindful who you're speaking to and how you use the words. Everything we say, and we do is still about being supportive and affirming and motivating. It's not about being stigmatic. So we got to be mindful of that.

But this is really about using your skills that you already have in a particular context. Okay. So I know this is a lot, even for the six hours we've been together. If you think it's worth it sometimes what I do is when I do a six hour training, I also schedule like a two hour brief intervention, separate also training. You could also get CV use for that, if you feel you need it, shoot me an email, let us know, and I can schedule that, okay? And then we can follow up and give you even more practice. Right now, what I'm going to encourage you to do. This is an informal homework, practice some of this in your daily life.

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