

**A Nurse-Delivered Brief Motivational Intervention for
Women Who Screen Positive for Tobacco, Alcohol, or Drug Use**

An Intervention Manual for Project START

(Screening To Augment Referral and Treatment)

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PROJECT START

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Introduction

This manual has been written to guide a nurse's delivery of a brief motivational intervention for women who screen positive for tobacco, alcohol, or drug use in reproductive health care centers. The intervention is part of an overall approach called SBIRT, which stands for Screening, Brief Intervention, and Referral to Treatment, and being implemented as part of a National Institute on Drug Abuse funded grant called Project START (Screening To Augment Referral and Treatment). The manual describes how the study nurse will intervene with women who are using tobacco, drinking in harmful or hazardous ways, misusing prescribed medications, or using illicit drugs to (1) motivate them to stop using these substances or to reduce their use to less problematic or prescribed levels, and (2) refer them to treatment services. Treatment services for the purposes of this project include formal substance abuse treatment programs, self-help or 12-step programs, health care providers, and medication management.

The intervention relies heavily on the principles and techniques of motivational interviewing (MI) developed by William Miller and Stephen Rollnick. In particular, the information in this manual is adapted from several sources, primarily Miller and Rollnick's 2002 book, *Motivational Interviewing: Preparing People for Change*. Other materials from which material is adapted include: the Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol (TIP) #35 (1999), The Project MATCH MET manual published by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (1992), and the computer-delivered variant of these same approaches as developed by Steve Ondersma and colleagues under a series of grants from NIDA (DA330747, DA330694, and DA300047). We are grateful to the authors of these works.

The manual is divided into four sections. The first section provides a brief overview of SBIRT. The second section details the main principles and techniques of MI. The third section covers the SBIRT intervention used in Project START. The fourth section contains materials used as part of the intervention and the brochure which the nurse will use to discuss change options and plans. Key references used to write the manual follow these sections. The manual ends with a glossary of terms related to MI and SBIRT.

Overview of SBIRT

Substance abuse (tobacco, alcohol, illicit drugs, prescribed medications) is a major public health problem in the United States, with an estimated 22.6 million people with a diagnosable (DSM-IV) alcohol or illicit drug use disorder (15.6 million: alcohol disorder alone; 3.8 million: illicit drug use disorder; 3.2 million: combined alcohol and drug disorder) and an estimated 43.4 million (19.8%) adults currently smoking cigarettes. Most of these individuals do not recognize they have a substance use problem or do not access treatment or other services to help them reduce or stop their use.

To address this problem, the U.S. Office of National Drug Control Policy, Substance Abuse and Mental Health Service Administration, National Institute on Drug Abuse, National Institute on Alcoholism and Alcohol Abuse, Preventative Services Task Force, the Committee on Trauma of the American College of Surgeons, and American College of Obstetricians and Gynecologists have all supported the use and systematic research of methods to screen patients in medical settings for substance use and to provide those who acknowledge potentially risky use brief interventions and referral to treatment, as needed. This collection of interventions is called Screening, Brief Intervention, and Referral to Treatment or SBIRT. A positive screen prompts a brief intervention in which the practitioner attempts to motivate the patient to reduce or stop using the substance and to accept a referral to treatment (psychosocial or medication) or other support services (self-help, Quitlines, etc.).

Screening for tobacco, alcohol, and drugs can be achieved through the use of many different methods. One of the most commonly used instruments is the World Health Organization Alcohol, Smoking and Substance Involvement Screening Test (WHO-ASSIST). This instrument offers the advantage of screening for tobacco, alcohol, and drugs rather than needing different instruments to screen for different substances. Project START uses the WHO-ASSIST to screen women for substance use. For the Project START protocol, patients who score greater than 11 for alcohol or 4 for cigarettes or drugs are considered at least a moderate risk. The cut-offs for pregnant women are greater than 6 for alcohol and 4 for cigarettes or drugs. These individuals receive a brief intervention and a possible referral to treatment.

As with screening, there are several different approaches available to practitioners for conducting brief interventions. Often they rely on the principles and techniques of Motivational Interviewing (MI). Project START uses MI as the mainstay of its nurse-delivered brief intervention, as well as the conceptual basis for the computer-delivered version to which it will be compared. The next section describes MI in detail.

Overview of Motivational Interviewing

What is Motivational Interviewing?

MI is a well established evidence-based treatment for addictive behaviors and a variety of other problem areas. Miller and Rollnick have defined MI as a person-centered counseling method for eliciting and strengthening personal motivation for change. The approach is grounded in humanistic psychology, especially the work of Carl Rogers, in that it employs a very empathic, nonjudgmental style of interacting with peoples and presumes that the potential for change lies within everyone. MI is distinct from nondirective approaches, however, in that practitioners intentionally attend to and selectively reinforce people's motives that support change. Over the course of the interview, practitioners help people identify these change-oriented motives, elaborate upon them, and resolve ambivalence about change. If successful, people become more likely to commit to changing their behaviors and initiating a change plan.

The process of enhancing motivation in MI can be thought of as having two different phases. The first phase involves building motivation for change. In this phase practitioners work with people to understand and resolve their resistance to change and develop their sense of the importance and perceived ability to change. When people show signs of readiness to change (e.g., reasons for change are prominent, they ask for advice or direction, they state their intention to change), practitioners shift to the second phase of motivational enhancement in which they work toward strengthening commitment to change, most often through the development of a change plan (described below). This process activates or mobilizes people's motivations in that individuals identify how they will try to change and begin to enact these steps to reduce or stop their addictive behaviors.

Skilled practitioners try to match their use of MI strategies to the individual's level of motivation. For example, practitioners move more quickly to change planning with people who are already motivated to change. Extensive exploration of their motives for change might frustrate people who want to move forward. In contrast, attempting to develop change plans with people who are not yet committed to change will likely increase resistance in that this strategy would put people in a position in which they might assert in words or in actions how they are not yet ready. This latter interaction illustrates how motives to change (called "change talk") and motives to stay the same (called "sustain talk") can be thought of as opposite sides of the same coin, meaning that if practitioners give insufficient attention to addressing important issues that impede change, people are likely to raise these issues again during the interview. Concomitantly, practitioners expect people who initially argue against change to

have some intrinsic motivation for change within them. It is the responsibility of the practitioners to look for opportunities to draw it out.

MI is best construed as a style of communication that informs the way in which practitioners interact with others throughout the change process. In this regard, MI often is discussed within the context of the Stages of Change model by James Prochaska and Carlo DiClemente. The Stage of Change model posits that behavior change occurs sequentially across recurring stages. The earlier stages include precontemplation (people are unaware or do not believe there is a problem or need to change it), contemplation (people are ambivalent about recognizing a problem and shy away from changing it), and preparation (people are ready to work toward behavior change in the near future and develop a plan for change). The later stages include action (people consistently make specific changes) and maintenance (people work to maintain and sustain long-lasting change). Tailoring treatment strategies to achieve stage-related tasks is a hallmark of this model (e.g., conducting a cost-benefit analysis for someone contemplating change).

MI naturally fits into the Stage of Change model in that it can be used to help move people from one stage to another, especially in the early stages. Person-centered counseling skills may build rapport and engage people who are less motivated to change. Eliciting additional change talk might lead ambivalent individuals to conclude it is relatively worth it for them to change rather than to keep drinking or using drugs. Working with people to identify steps they are able to take might help them feel more prepared to initiate a change plan. In later stages, MI strategies are useful for attending to wavering motivation as people take action or try to maintain changes in stressful situations. Finally, the Stages of Change model illustrates how MI integrates well with other treatment approaches that are more action-oriented. For example, MI might be used to engage people in treatment that then teaches them relapse prevention skills. The combining of MI with more action-oriented treatments, such as cognitive behavioral therapy, is becoming more prevalent.

Finally, implied in the above discussion, MI is behaviorally specific and has direction. This means that practitioners need to be clear about what it is that they are trying to motivate people for. Motivation for change in one area does not guarantee motivation for change in another (e.g., a person may commit to cocaine abstinence, but not agree to reduce or stop drinking or smoking marijuana or to enter an addiction treatment program). Each behavior may require a separate motivational enhancement process. MI also requires that practitioners take a stance about the preferred direction for change. For addictive behaviors, this decision is relatively clear in that most people would agree that it is ethically sound to enhance motivation for the reduction or cessation of substances that are potentially harmful or

hazardous. However, some behavioral issues do not have a clear change direction. For example, decisions about organ donation or pregnancy termination likely would require a nondirective approach in which practitioners suspend their own values or goals and assume a position of “equipoise” (i.e., indifference or no clear attachment to a position or recommendation). In these situations, a person-centered counseling approach, devoid of evocation, would allow people to explore their ambivalence without intentional practitioner influence.

What Isn’t Motivational Interviewing?

For clarification purposes, it is helpful to consider what MI is not. Most antithetical to MI is a disease concept model of addiction in which individuals are seen as denying or rationalizing their addictive behaviors and needing to “hit bottom” before they will change. The use of direct confrontation, surrendering and accepting one’s powerlessness and loss of control in the face of addiction, and emphasis on total abstinence as the only acceptable goal are hallmarks of this approach and quite inconsistent with MI. Less obvious are several common misconceptions about MI. As noted above, MI is not based on the Stages of Change model, though it is complementary to it. Stages of Change is more of a comprehensive way of thinking about how people change, whereas MI is a clinical method that helps people prepare for change. Likewise, MI is not cognitive behavioral therapy. The latter approach supplies people with education and coping skill development and encourages the repeated practicing of these skills to better manage their problems. MI is fundamentally humanistic, not behavioral, in origin in that it elicits the people’s motivations for change rather than putting in place what is missing (knowledge and skills). MI also is not a way of manipulating others or making them change when they don’t want to. Behavior change in MI is born out of a person’s intrinsic motivations. Practitioners can only call forth motivations that already exist within people, not impose upon them other people’s concerns or wishes when individuals don’t see these issues as in their best interests. Finally, MI does not require that practitioners conduct a decisional balance or provide personalized feedback. These are techniques that often are helpful for eliciting change talk, but they are not essential to the conduct of MI, and they often are used in other treatment approaches. In this regard, MI is not a series of techniques, but rather a way of being with people in which principles organize the practice, as Miller and Rollnick put it, like music to words of a song.

Principles

Four key principles, embodied in the REDS acronym, compose the manner in which practitioners interact with people when using MI.

Roll with Resistance

Resistance in MI traditionally has referred to people's statements about what sustains their problematic behaviors. These expressions may be about the reasons for the behaviors ("Drinking relaxes me") or the difficulties of trying to change them ("I can't resist the urge to smoke"). Resistance informs practitioners about dilemmas faced by individuals, thereby providing opportunities for addressing obstacles to change. Practitioners avoid adopting a confrontational, authoritative, warning, or threatening tone (all inconsistent with MI), which might cause others to become even less engaged in treatment.

Express Empathy

Practitioners attempt to accurately understand people's dilemmas without judgment or criticism. Being able to listen carefully to what people mean and reflect this back to them is a critical skill. People are more likely to explore their motivations for change and speak candidly when they feel comfortable with and understood by their practitioners.

Develop Discrepancy

Motivation for change often depends on the existence of a discrepancy between an individual's current behavior and important values or goals. For example, a woman who prides herself in being a positive role model for her teenage children might stop smoking marijuana if she believes this behavior is discrepant with what she would want to teach her children to do. In MI, practitioners reflect these discrepancies and explore how behavior change might help people feel they are acting in accord with their preferred self-perceptions and aims.

Support Self-Efficacy

People typically become more motivated when they believe they can change their behaviors. When people lack confidence, they often shy away from change. Practitioners look for opportunities to support people's self-efficacy by helping them recognize their personal strengths and available resources. Likewise, they pay attention to people's past successful change efforts, which might inform how these individuals approach their current dilemmas.

By embracing these principles, practitioners adopt a style of interaction that is 1) collaborative by demonstrating respect for people's ideas and goals and seeing others as equal partners in the therapeutic process, 2) evocative by intentionally searching for the people's motives that favor change, and 3) supportive of people's autonomy and capacity to make decisions and initiate change. These three

components embody the spirit of how practitioners interact with others (formally referred to MI spirit in this approach).

Techniques

While MI is more of style or spirit of being with others based on the above principles rather than a mere application of techniques, MI incorporates several techniques that operationalize how practitioners use MI. These techniques include fundamental strategies, sometimes called microskills (open questions, affirmations, reflections, and summaries), and direct methods for evoking change talk. Practitioners attend to the balance of statements made by people that support or thwart behavior change (i.e., change vs. sustain talk) to gauge individuals' level of motivation and adjust their use of MI techniques accordingly. Practitioners' capacities to recognize and elicit change talk and reduce sustain talk through the use of these techniques, with the aim of strengthening people's commitment to change, are seen as necessary elements in MI.

Fundamental Strategies

Open questions, affirmations, reflections, and summaries (the acronym "OARS") are the mainstay of all MI sessions. In particular, MI relies heavily on the skilled use of reflective listening in which practitioners restate or paraphrase their understanding of what people have said to express empathy, as well as to bring attention to ambivalence, highlight change talk, and explore and lessen resistance. Reflections are coined "simple" in MI when practitioners essentially repeat what others have said and "complex" when practitioners have articulated new meaning implied by the original statements. Complex reflections demonstrate a deeper understanding of people's experiences. As an example, a person concerned about her HIV status says, "I've played around a bit in the past several months, but last year when I had a HIV test, I was negative". A practitioner could use a simple reflection to encourage more discussion about her risk behavior ("You've played around a bit"). A complex reflection would capture her implied concern and show more empathy (You're a little worried that you have put yourself at risk for HIV").

Open questions encourage people to talk more and may be used to strategically draw out motivations for change (e.g., "What would be good about not smoking?"). They stand in contrast to closed questions, in which practitioners seek specific information (e.g., demographics, history, symptoms), often with questions that can be answered with a "yes" or a "no" response. For example, a practitioner might ask, "Has your depression worsened with your crystal meth use? A person's positive response would support not using crystal methamphetamine; however, he or she would not have fully

elaborated on the negative effects of depression resulting from drug use, which an open question might have elicited (e.g., How has using crystal meth negatively impacted your depression?). Affirmations (i.e., acknowledgment of a person's strengths, attitudes, and efforts that promote behavior change) build collaboration between practitioners and others and promote self-efficacy. Sometimes, this entails reframing a behavior in a manner that helps people see it in a more positive light (e.g., "You were quite determined to get high, and now you are trying to use that same determination to stop using cocaine").

Summaries provide opportunities for practitioners to demonstrate fuller understanding of other people's experiences and help them consider the bigger picture of their motivations for change. Summaries also allow practitioners to collect multiple change talk statements as a strategy to enhance motivation, link discrepant statements that capture ambivalence, and shift focus to other behavioral areas (e.g., move from discussing drinking to prescription opiate use). The following is an example of a collection summary of change talk: "You're concerned that you have been taking more pain meds than you are prescribed, and you've noticed you need more pills to get the same effect. You feel badly about going to a doctor other than your primary care physician to get percocet when you ran out. Most importantly, you almost fell asleep at the wheel last week with your kid in the car, and you think that this literally is your wake-up call to do something about this problem before something terrible happens to you and others."

Direct Methods

Direct methods for evoking change talk hinge on the capacity of practitioners to recognize how people talk about change. Practitioners' selection of direct methods for motivational enhancement depends on the type and strength of change talk provided by people as the interview unfolds. Hence, an individual's statements continuously signal the practitioner about how to conduct the interview.

Change talk is embodied in the acronym DARN-CAT. DARN (desire, ability, reasons, and need) is sometimes referred to as preparatory language in that these statements represent the building of motivation that prepares people to make a commitment to change (consistent with the first phase of motivational enhancement). Desire statements indicate a clear wish for change ("I don't want my liver disease to get worse" or "I want to get my life back"). Ability statements indicate people's beliefs that they can change, given their skills and available resources ("I was able to stop using speed five years ago, so maybe I have a chance now"). Reason statements note the benefits of change and the costs of not changing ("I will have more money in my pocket" or "If I don't stop, I will go more in debt"). Need statements underscore how the problem behavior interferes with important areas of an individual's life

and how changing the behavior would likely improve matters (“I don’t even recognize myself; I can’t go on like this anymore”).

CAT (commitment, activation, taking steps) represents statements that suggest people are mobilizing themselves for change (consistent with the second phase of motivational enhancement). Commitment statements convey the stated intention to change (“My quit date will be this Thursday”). Activation statements indicate how people are getting ready to change (“I am going to an AA meeting tonight”). Statements about taking steps to change are the strongest demonstration of commitment in that the people have put their words into action and are reporting these early efforts to the practitioner (“Instead of going out to drink after work, I went to the gym and worked out”).

During the interview, practitioners identify the extent to which people express motivation in each of these areas, use their fundamental skills to support and develop people’s change talk and have them elaborate further, and in a goal-oriented fashion, directly attempt to draw out more motivations for change. MI offers multiple techniques for these purposes. For example, people who consistently report obstacles to being able to stop smoking marijuana might be asked about past periods when they have smoked less marijuana or none at all (appealing to past successes to enhance ability). People who don’t express much concern about their current levels of drug use might be asked to look to the future at some time interval (e.g., 1 year from now) and consider where their lives might be headed with continued use (attempting to reveal potential reasons or need to change to enhance the importance of change). Alternatively, a practitioner could ask someone to rate how important it would be to reduce or stop drug use on an 11-point scale, with zero representing “not at all important” and ten representing “extremely important”. Providing this person gives a response higher than zero, the practitioner would follow up by asking, “Why not lower, like a zero?” to elicit what lends some importance to changing drug use now.

Other Useful Techniques

Addiction treatment typically requires simultaneous attention to several behavioral issues (e.g., multiple substance, HIV risk behaviors, psychiatric and health concerns), and this reality often is overwhelming to people and their practitioners during any one appointment where time is limited. Practitioners can use a simple agenda setting chart in which they record the pertinent behavior change issues on paper and have people indicate which of them they want to discuss during the interview. These priorities are then dovetailed with any pressing practitioner concerns as a means to organize the conversation.

Education, advice-giving, and direction are commonplace in the addiction treatment, particularly because practitioners’ often have a natural tendency to try to fix people’s problems (referred to as the

“righting reflex”). When people have not solicited professional input, however, they may not be receptive to it. Instead, practitioners ask permission to provide information or advice and employ an elicit-provide-elicited (or ask-tell-ask) technique in which practitioners 1) elicit from people what they know about the topic being discussed, 2) provide information as needed, and 3) elicit people’s reactions to the shared information. For example, a practitioner may wish to recommend a treatment program to someone. Instead of providing the recommendation in an unsolicited manner, the practitioner would first ask the person what he or she knows about the program and then, with permission, talks about it and concludes by getting the person’s reaction. This technique promotes collaboration and reduces the chance that people experience their practitioners as lecturing or telling them what to do.

Use of a decisional balance activity (i.e., exploring the costs and benefits of changing and not changing) is common in MI. This activity provides a structured method for understanding the basis of a person’s ambivalence in that the benefits of change (“I’ll have more money if I get a job”) and the costs of not changing (“If I don’t seek employment, I will feel like I have given up on myself”) provide reasons to change, whereas the benefits of not changing (“I don’t have to present myself in an interview”) and the costs of changing (“I don’t have transportation”) provide reasons to remain the same. By strategically eliciting more reasons for change and, to the extent possible, resolving reasons to remain the same (e.g., practice interviewing, resolving transportation issues), a practitioner might help the person tip the balance toward change.

Another important skill is how to gauge patients’ readiness to change and to transition from the first to second phase of motivational enhancement. Practitioners typically recapitulate what others have said, especially those statements that suggest how they are now ready to change. Following this summary, practitioners then pose a key question to solidify commitment to change (“What’s your next step?” or “From what you’ve told me, how do you want to proceed?”). Miller and Rollnick have used the analogy of a person as a skier standing at the summit (assisted up the mountain by the practitioner). The key question provides a supportive nudge that helps the person go down the mountain.

Change planning is an overall strategy practitioners use to negotiate a plan with people about how they will change their behavior. Critical to this process is maintaining a person-centered stance in which the plan is derived by the individual, with the assistance of the practitioner, rather than the practitioner becoming prescriptive at this point. Practitioners ask people to set their targeted behavior change goal (“I am going to stop using heroin”), describe steps they will take to change (“I want to try buprenorphine”; “I need your help to get PTSD counseling”), identify who might support them and how (“I am going to stay with my parents”), anticipate obstacles (“I have to change my cell phone number to

keep people from calling me”), and reaffirm their commitment to the plan. If during the process of mobilizing their commitment, people become uncertain again (the cold-feet phenomenon), the practitioner reflects this ambivalence rather than trying to press through it and provides another opportunity to revisit the plan in the current session or at another time. Being in a hurry to complete the plan when people are not ready is a common trap into which practitioners fall.

Handling Resistance

Changing addictive behaviors is difficult for several reasons. People may like the effects of drinking or using drugs. They may be involved with others who use substances. People may feel unable to manage their urges to drink, smoke, or get high. They may not see their lives improving in the absence of alcohol or drug use. Moreover, they may have obstacles (transportation, financial, child care, safety concerns) that impede their treatment involvement. These issues may sustain people’s addictive behaviors, and practitioners must attend to them in a MI consistent manner, rather than with confrontation or warning, when people raise them.

Some strategies for handling resistance include: 1) simply reflecting the resistance to buy time or better understand the issue (“You don’t believe you have any problems even though others do” in response to a person who says, “I don’t care what everyone else thinks; I don’t have any problems”); 2) amplified reflections to determine the degree of commitment to a resistant statement (“Your wife has no basis for concern about your drinking” in response to a person who complains how his wife needs to stop bothering him about his drinking); and 3) double-sided reflections to pair the resistant statement with other things said that favor change, thereby introducing some ambivalence back into the conversation (“You feel like dropping out of the program, and you worry that you won’t be able to remain drug free without it”). These strategies are delivered with an attitude of genuine interest, not sarcasm or manipulation, and of seeing resistance as a natural part of the change process.










It is also useful to make a distinction between sustain talk and more contemporary notions of resistance in MI. Sustain talk is the stated motive to not change behavior. Resistance is the interpersonal style in which people interact with practitioners that conveys tension or trouble in the relationship (e.g., arguing, interrupting, negating, dismissing, ignoring). Often sustain talk and resistance occurs together. However, this is not necessarily the case and could lead to missed opportunities for motivational enhancement. For example, a person who says he is willing to drink less might become quiet when a practitioner warns him about the hazards of drinking any amount of alcohol. The person initially provided change talk, but his interpersonal style is now marked by resistance. The

practitioner might mistakenly assume the person is unmotivated for change even though the person has indicated a desire to reduce his quantity or frequency of drinking. A more empathic practitioner stance that supported and reinforced change talk, rather than a cautionary one, would have been preferable (e.g., “How come you think drinking less would be better for you?”).

A Nurse Delivered Brief Motivational Intervention for Project START

Format of the brief intervention

For Project START, the study nurse will use an adaptation of MI to motivate women who are using tobacco, drinking in harmful or hazardous ways, misusing prescribed medications, or using illicit drugs to (1) stop using their primary substance of abuse, reduce their use to less problematic or prescribed levels, or maintain either of these goals if self-initiated prior to the interview, and (2) follow-up with a referral to treatment or support services. The intervention takes 20 minutes to deliver and uses a step-by-step format to achieve its aims. The format is:

Steps	For women who initially express an intention to keep using unchanged or who are unsure about their goals	For women who initially express an intention to quit completely, cut down their use, or stay that way if self-initiated prior to interview
1. Understand the nature of the primary substance use		
2. Discuss reasons to use or change her primary substance use and ask key question about goals		
3. Provide personalized feedback and ask key question about goals		
4. Handle resistance skillfully and draw out change talk, including providing information about change options		
5. Develop a change plan, including a review of change options	Only if she commits to cutting down, quitting completely, or staying that way at the end of either Step 3 or 4.	
6. Summarize and support		

Step 1: Understand primary substance use

Step 1 aims to establish rapport with the patient, help her feel comfortable talking about her substance use, and clarify what she thinks about it. The components of MI spirit should mark the conversational style, and the nurse should be nonjudgmental, curious, genuine, and compassionate. Step 1 sets the tone of the intervention and increases the chance that the patient will talk with candor and receptivity.

Recognizing change talk, reflecting these statements, and encouraging elaboration on them is part of the process in Step 1. By the end of Step 1, the nurse may understand the patient's current goal for her primary substance use (quit completely, stay quit, cut down, maintain lower level use, no change, unsure) and may have already begun to informally gather the patient's reasons for quitting or cutting down her primary substance use.

- Begin with a brief orientation to the intervention.

I'd like to talk with you about your use of [primary substance]. Women who smoke/drink/use [primary substance] or use other substances sometimes think about cutting down or quitting. This may or may not be true for you. I just want to get your thoughts about it and then see what you want to do at this point. If you decide you want to quit or cut down, I can talk about options available to you that might help you make this change. How does that sound?

- Ask the patient about her primary substance use to understand her point of view. You might ask the following open question or request:

Tell me about your use of [primary substance].

- As she describes her use, reflect what she says to demonstrate you are listening and have understood what she has said.

You think you have had a bit too much to drink at times and it is causing trouble between you and your boyfriend.

- Take note of her statements that indicate change talk and sustain talk and strategically reflect her comments in a manner that lends support or emphasis to change talk.

You think he is the one that drinks too much and criticizes you to avoid looking at his own problems. At the same time, you feel you have been pretty stressed lately, especially around him, and you have drunk heavier than you have intended and think this could become a problem if you don't cut down.

- Use open questions, as needed, to encourage her to talk more about her point of view and elaborate on change talk.

If you were to continue to drink like you have been, what problems do you think you might develop?

- After discussing her primary substance use, summarize what she has said.

You've said you drink heavily on occasion, especially at night if you have had an argument with your boyfriend. While you feel you have not developed a huge drinking problem, you believe you could be heading in that direction and that makes you uncomfortable. You worry that you might drink and drive or end up meeting someone else at a club just to spite your boyfriend. You think it might make sense to cut down or quit drinking all together.

- Proceed to Step 2.

Step 2: Discuss reasons for using and changing her primary substance use and ask key question about goals

Step 2 aims to build upon Step 1. Most likely, the patient will have already provided some reasons that would support her ultimate substance use goal (quit completely, stay quit, cut down, maintain lower level use, no change, unsure). Step 2 structures and expands the discussion within a decisional balance framework. The idea is to use this framework for the purpose of enhancing her motivation for change (i.e., if further exploration of the patient's motivates for change would result in her moving from the goal of not changing or being unsure to cutting down or quitting). This means that the decisional balance is conducted in a manner that, relatively speaking, gives more emphasis to and draws out change talk (reasons for quitting/cutting down/maintaining the change if already initiated) instead of sustain talk (reasons for using without change). It is not conducted neutrally as in a stance of equipoise. Step 2 ends with a key question to determine the patient's substance use goal.

- Begin with a transition statement to Step 2

Let's talk more about what affects your decision about smoking/drinking/using [primary substance].

- Start with her reasons for using. Typically, the reasons for using consist of the benefits of using the substance (e.g., "It relaxes me.") and the drawbacks of not using it ("I would have a hard time with cravings or urges to smoke."). If the patient has not yet provided reasons for using, ask the following open question:

What is your main reason for using?

If the patient has already provided a reason for using, begin by first reflecting it and then use an open question to determine if there is anything else to add.

So far you've said that smoking is relaxing? What other reasons do you have for smoking cigarettes?

- Next, ask about the reasons for not using or cutting down. These reasons are the benefits of quitting or cutting down (“I’ll have more money.”) and the costs of not changing her primary substance use (“I’m worried about my health.”). Use the handout, **Reasons for Quitting or Cutting Down** (separate versions for tobacco, alcohol, and drugs) to help prompt the patient’s reasons. If the patient has not yet provided reasons for quitting, cutting down, or already initiating a change in substance use, ask the following open question:

What might be [were] your reasons for quitting or cutting down? Next, follow up with the handout – Here is a list of other reasons for quitting or cutting down. Please take a look at it and check off any other reasons that may apply to you.

If the patient has already provided reasons for quitting or cutting back, begin by first reflecting them and then ask her to check off any other reasons that may apply to her from the handout.

Earlier you said that you are concerned about the negative effect smoking has had on your health. You really want to be healthy and smoking is getting in the way of that. Here is a list of other reasons for quitting or cutting down. Please take a look at it and check off any other reasons that may apply to you.

- Summarize what she has said, linking together reasons to use and quit/cut down or maintain her change in use in a double-sided manner – ending on the side of reasons for change (to strategically give emphasis to it). Ask for the patient’s reaction to this discussion and reflect change talk, as indicated.

You’ve been smoking cigarettes for several years. Your main reasons for smoking are that it relaxes you. It also helps you get started in the morning and sharpens your concentration during the day when you are trying to get things done. As you said, it’s a crutch that you have come to rely on. You’ve also said you are worried about your health. You’ve continued to smoke despite having bronchitis, which has taken a long time to overcome. You are also worried about your risk for cancer, given your family history. In addition, the cost of cigarettes keep going up and there are lots of other things you could spend this money on, like better food choices or clothes that you have put off buying because your budget is so tight. In brief, if you were to quit, you

believe you would feel better, stay healthy, and have more money in your pocket and these things have become more important to you now that you are getting older. [pause]

- If patient needs more prompting to respond, ask:

What do you make of all of this?

- Ask the patient what her current primary substance use goal is (quit completely, stay quit, cut down, maintain lower level use, no change, unsure) or simply reflect it if the patient has already expressed an intention to change.

You've said you drink heavily on occasion, especially at night if you have had an argument with your boyfriend. While you feel you have not developed a huge drinking problem, you believe you could be heading in that direction and that makes you uncomfortable. You worry that you might drink and drive or end up meeting someone else at a bar just to spite your boyfriend. You think it might make sense to cut down or quit drinking all together. What do you think you want to do about your drinking at this point?

- For a patient who indicates she intends to quit completely, stay quit, cut down, or maintain lower level use already initiated, proceed to Step 5. For a patient who indicates an intention to keep using at current levels or who remains unsure about what she intends to do, proceed to Step 3.

Step 3: Provide personalized feedback and ask key question about goals

Step 3 provides another formal technique to enhance the patient's motivation to change her substance use, namely, the use of personalized feedback. Personalized feedback aims to raise the patient's concern about her current use. The key to this technique is to maintain a collaborative and objective tone. It is up to the patient to determine what she makes of the feedback and how it affects her motivation for change. To the extent the feedback process elicits change talk, the nurse reflects it and encourages the patient to elaborate. The nurse uses the **Feedback Form** designed for the patient's particular primary substance (tobacco, alcohol, marijuana, other drugs).

- Begin with a transition statement to Step 3.

I'd like to provide you with some feedback about your use of marijuana based on the information you provided [RA's name] and see what you think about it. Would that be okay with you?

- Review with the patient how her quantity or frequency of use compares to other women.

First, here is some information about how your use compares with other women in the United States. Only 4 out of every 100 women use marijuana each month. Even fewer pregnant women use marijuana. So, most women don't use marijuana or any other drugs at all. It just might not seem that way if you are used to being around others who use marijuana or other drugs, like you do. What do you make of that?

- Review with the patient how much she spends per month on her substance use. Calculate per year the total amount and inform her of it. Ask her what else she thinks she could buy with that amount of money.

Money spent is another interesting area to look at. I know the computer asked you something like this already, but how many days do you use marijuana in a typical week? And how much would you say you spend on marijuana each day you do it? Okay, Looking at the chart, if you use [primary substance] _____ days per week and spend on average \$_____ per day on it, then you are

spending \$ _____ per year. What do you make of that? If you could go back in time, what else would you do with that money?

- Ask the patient if she would like to know more about how 1) her own risk of problems related to substance use, 2) how a parent's use of substances affects children's risk of problem behaviors, or 3) benefits of not using substances during pregnancy. (Note: Feedback forms about risks posed to children by parental use are available for tobacco, alcohol, drugs [if marijuana is primary, use "drugs" version], and pregnancy. Also, present feedback about the benefits of not using substances during pregnancy to all pregnant participants.). If agreeable, present the information to her.

Often women are concerned about the impact their own substance use might have on their kids. Would you like to know more about this?

First, we know from research that teenagers are 5 times less likely to become addicted to drugs if their parents don't use drugs.

Another thing we know from studies is that children of parents who don't use drugs are 15 times less likely to have serious behavior problems at school.

Finally, children are 3 times less likely to experience physical or sexual abuse in a household in which the parents don't use drugs. In fact for kids who live in households where a parent uses drugs, there is a 50-50 chance they will experience physical or sexual assault during childhood.

For pregnant women or non-pregnant women who elect to receive feedback about the benefits of not using substances during pregnancy, say:

Women who do not use substance during pregnancy are more than 4 times less likely to have a baby that experience problems such as birth defects, difficulties learning in school, or behavioral problems. Most pregnant women avoid any use of tobacco, alcohol, or drugs during pregnancy for their health and the health of their babies. It's never too late to quit or cut down during pregnancy.

What do you think about this information?

- Summarize her reactions and give emphasis to anything she says that favors making a positive change in her use. End with a key question to determine her readiness to change.

Based upon the information I shared with you and our discussion about it, what do you feel ready to do about your use of marijuana at this point?

- For a patient who indicates she intends to quit completely, stay quit, cut down, or maintain a lower level use already initiated, proceed to Step 5. For a patient who continues to indicate an intention to keep using at current levels or who remains unsure about what she will to do, proceed to Step 4.

Step 4: Handle resistance skillfully and draw out change talk

Step 4 comes into play as needed throughout the intervention. However, it is given formal emphasis if, after exploring reasons for change and receiving feedback about use, the patient continues to be uncertain about changing or intends to keep using unaltered. Step 4 is one more conversational journey with the patient to search for something within her that might build her motivation to change her substance use. Options include:

- If the issue is that the patient does not believe reducing or stopping her substance use is important enough, try the following:
 - Ask: *What would make quitting or cutting down matter enough for you to change your substance use?*
 - Use the importance ruler technique
 - Ask her to look into the future under the circumstances of no change in use and if she were to stop or cut down her use
 - Ask her what the worst thing is that could happen if she tried to stop or reduce her use for a trial period and what the best thing is that could happen

- If the issue is that the patient does not believe she is able to cut down or stop using her primary substance even if she wants to, try the following:
 - Ask: *What would need to happen for you to feel more able to quit or cut down?*
 - Use the confidence ruler technique
 - Ask her about past successes in cutting down or stopping substance use (or in any other areas of her life) and how she might apply these experiences to her present situation
 - Ask her to identify her personal strengths, have her describe them to you, and ask her how she might use her strengths to cut down or stop using her primary substance
 - Ask her to describe the main obstacles to change and brainstorm some possible options that might remove them

- In either case, offer the patient the brochure about different change options and review them with her if in the future she decides she wants to try counseling, seek medication assistance, or access other self-help or support services (see Step 5 below for more detail). Reviewing the brochure also might boost her confidence/ability by revealing change options that the patient had previously not realized might be available to her.

Even though you haven't decided to change your use of [primary substance] right now, you might decide to do so in the future. May I go over this brochure with you? It describes different ways you could quit or cut down, should you decide to do so.

Step 5: Develop a change plan

The nurse uses Step 5 when the patient has committed to completely quitting, cutting down, or maintaining changes (stay quit, lower substance use levels) already initiated prior to the interview as her goal. Step 5 aims to strengthen the patient's commitment to her change goal by having her identify the steps she intends to take to reach it. This step includes reviewing several change options and referring the patient to them depending on her interest.

- If the goal needs clarification, begin by asking the patient about what her exact goal is. For example, if she says she wants to cut down drinking, ask her in what way (frequency, quantity) she will reduce it.

You've said you want to cut down drinking? What is the maximum number of days per week you intend to drink? On these occasions, what is the maximum number of drinks you intend to have?

- Review the change options described in the brochure with the patient (counseling, self-help/12-Step, talking with health care professional, medication, quit or cut down on my own).

I would like to provide you with information about different options that are available to you to reach your goal.

The first option is talking with a counselor. Many women find this helpful. Counseling often is a good idea when people are using a lot, have not been able to stop on their own or have been in counseling in the past, or when they have other problems that complicate stopping substance use, like feeling depressed or anxious or having significant relationship or family problems. The research shows that people who enter counseling and stay in it have a much better chance for stopping or reducing their [drinking/primary substance use] and keeping it that way than those who drop out.

Another option people often consider to help them change and stay that way is to attend a self-help group or 12-step meeting such as Alcoholics Anonymous, Narcotics Anonymous, or Alanon. These are meetings available for free in the community in which people who want to stop using

alcohol or drugs and stay quit come together to support each other. The meetings are available in most towns and are held throughout the day. There also are different kinds of meetings to suit different needs (women’s meetings, dual diagnosis meetings). People often try several meetings to determine which of them they like best. Sometimes people decide to get a “sponsor”. A sponsor is a person you call and rely upon for more individual guidance and support. The decision to involve a sponsor, which meetings you attend, and how often you go is completely up to you.

A third option is to talk with your doctor, nurse, or medical social worker here at YNHH or at other places where you typically receive your health care. Your health care providers can discuss your use of [primary substance] in more detail as you think more about what you want to do. They also often can prescribe medications for some type of substance use problems that you may find helpful.

The use of medications is a fourth option. [Information would be tailored to the primary substance]. Medications help in many ways such as by: 1) replacing the problematic substance with one that is prescribed, controlled, and safer to use; 2) blocking the main pleasant effects of the substance so that it is less rewarding to use; 3) reducing withdrawal symptoms that might otherwise prompt a person to use again; 4) reducing cravings; and 5) making someone sick if she were to use the substance. In your case, you have been using [primary substance]. Medications you might consider to help you reach your goal include... Any prescribed medications would require meeting with a medical professional to review your appropriateness for it.

○ Tobacco

- Varenicline – (brand name Chantix) is a non-nicotine medication intended to help smokers quit in two ways – by blocking some of the rewarding effects of nicotine (the addictive drug in tobacco products) and at the same time tackling the withdrawal most people feel after they quit.
- Bupropion SR – (brand names Zyban and Wellbutrin) is a non-nicotine medication that helps reduce cravings and can relieve symptoms of depression.
- Nicotine Replacement Therapies (NRTs) deliver small, safe amounts of nicotine to the body to try to help people with nicotine cravings and through nicotine withdrawal symptoms. They include the following medications:
 - Nicotine gum
 - Nicotine inhaler

- Nicotine nasal spray
 - Nicotine patch
 - Nicotine lozenges
- Alcohol
 - Antabuse, or disulfiram, works by causing a severe adverse reaction when someone taking the medication consumes alcohol
 - Naltrexone is sold under the brand names Revia and Depade. An extended-release form of naltrexone is marketed under the trade name Vivitrol. It works by blocking in the brain the "high" that people experience when they drink alcohol or take opioids like heroin and cocaine.
 - Campral, the brand name for acamprosate, is the most recent medication approved for the treatment of alcohol dependence or alcoholism in the United States. It works by reducing the physical distress and emotional discomfort people usually experience when they quit drinking.
 - Opiates
 - Methadone is a rigorously well-tested medication that is safe and efficacious for the treatment of narcotic withdrawal and dependence. It is most often used for people hooked on heroin. Methadone is long-acting and occupies the opiate receptors in the brain such that people addicted to opiates can stabilize, change their behavior, and discontinue illicit opiate use. Methadone for treating opiate dependence available only through licensed programs.
 - Buprenorphine is a safe and effective treatment for maintenance and detoxification of opioid-dependent patients. A sublingual combination tablet containing buprenorphine and naloxone, called Suboxone, is the most common formulation prescribed for use in the United States. It is prescribed by qualified physicians and administered by medical staff in primary care settings and within traditional licensed opioid treatment programs.
 - Naltrexone (see above)

Finally, a fifth option is to try to quit or reduce your use and maintain this change without counseling, self-help, health care support, or medication. This option might work for some people who have not yet developed a serious problem with alcohol or drugs or who don't have medical complications that should be monitored when trying to stop using.

What do you think about these different options?

- Ask the patient which of the options she is willing to try to reach her goal and go into more detail about what steps she is willing to take to initiate the selected options. The nurse should show the patient the contact information provided for each option in the brochure. If the patient wishes to

meet with a health care provider or wants further evaluation for medication, the nurse will assist her with this referral.

You've said you want counseling to stop using cocaine and that you live in New Haven. The program closest to where you live and that takes your insurance is [name of program]. [The nurse should circle relevant contact information on the brochure] What steps can you take to follow-up with this referral?

- Ask her who else might help her achieve her goal to cut down or quit and how this might happen.

Who can help you stop abusing your pain medications? What specifically do you think she could do that you would find helpful?

- Ask her about obstacles she anticipates might come up and how she might handle them if they were to occur.

What might interfere with your effort to change or be an obstacle for you? How could you handle that?

Step 6: Summarize and support what the patient has elected to do.

Step 6 wraps up the brief intervention. The nurse should offer a summary of the discussion, the plan going forward, and convey respect for the patient's decision about how she will approach her substance use in the future. If the patient developed a plan to quit or cut down, the nurse should complete the Change Contract to further strengthen commitment.

- For a patient who remains unsure about changing her substance use, thank her for considering the issue and encourage her to discuss the issue again at the Women's Center the next time she comes in. She might also decide to quit or cut down her substance use in the future and is free to pursue any of the referral options, including changing on her own, at that point.

I'd like to thank you for talking openly with me about your mixed feelings about using marijuana. You've been smoking marijuana a long time. It's very much a part of your daily routine and you don't believe it has caused you trouble. You like the way it makes you feel and see it the same as someone having a glass of wine each day. On the other hand, you are heading back to school to become a LPN. You want to do the best you can and wonder if smoking might interfere with your academic performance. You also know smoking anything for a long time won't be good for your health and you don't want to be hypocritical by doing something unhealthy as you get into the health care field. Right now, you are not ready to make any commitments about cutting back or quitting marijuana. You want to think about it some more. Feel free to talk about it again with any of the staff at the Women's Center or to try any of the options we discussed if in the future you decide to make a change. Best wishes to you.

- For a patient who intends to keep using her primary substance unchanged, thank her for talking about it with you. Summarize her perspective and be sure to include anything she said that indicates some ambivalence about continuing to use unchanged. Inform her that she should feel free to discuss her substance use again in the future with the staff at the Women's Center.

I'd like to thank you for talking openly with me about your use of marijuana. You've been smoking marijuana a long time. It's very much a part of your daily routine and you don't believe

it has caused you trouble. You like the way it makes you feel and see it the same as someone having a glass of wine each day. For now you have decided you don't want to make any changes. If marijuana were to cause you any problems, like if you were to get pregnant or had a job with drug testing, you would stop. Right now, that isn't the case, and you don't believe that continuing to smoke marijuana will have any harmful effect on your goals of conceiving a child or in getting work in the future. You know what options are available to you if you change your mind. Best wishes to you and please feel free to discuss your substance use with the staff at the Women's Center again.

- For a patient who has completed a change plan, thank her for considering the issue, summarize the main components of her motivation for change and how she intends to change, and affirm her for her participation in the interview and her plans for change. Complete the Change Plan Contract with her.

I'd like to thank you for talking openly with me about your use of marijuana. You've been smoking marijuana a long time and have decided that you are going to stop using it for several reasons, the main ones being that you want to go back to school and get a job as a LPN. One day, you also would like to have a child and don't think smoking marijuana is a good idea as a mother. You know what it is like to have a mother who abuses drugs and you never want to become like that. You've decided that going to 12-step meetings is the best option for you. You've been to them before and liked them and there is one nearby that you can get to conveniently. You also have a good friend who is in recovery and will support you not smoking. You intend to tell her your plan to quit, and she might even go with you to some meetings to help you get started. You seem pretty committed to this plan and have carefully considered where you want your life to head. Marijuana doesn't fit into the picture.

So to finish up, I have a Change Plan Contract for you to sign. It says that you intend to [restate the goal] and you will try to achieve this by [restate the specific change option(s) selected]. If you agree, please sign the contract here. [The nurse also signs it.] Signing it is like making an agreement with yourself. I'll sign it also to show you my support for your decision and plans.

Best wishes to you. The next time you come to the Women's Center, please feel free to let your doctor or nurse know how things are going and to seek extra support if you need it.

A Nurse-Delivered Brief Motivational Intervention

Step 1: Understand primary substance use

- Begin with a brief orientation to the intervention.
- Ask the patient about her primary substance use to understand her point of view.
- As she describes her use, reflect what she says to demonstrate you are listening and have understood what she has said.
- Take note of her statements that indicate change talk and sustain talk and strategically reflect her comments in a manner that lends support or emphasis to change talk.
- Use open questions, as needed, to encourage her to talk more about her point of view and elaborate on change talk.
- After discussing her primary substance use, summarize what she has said.

Step 2: Discuss reasons for using and not using/cutting down and ask key question

- Begin with a transition statement to Step 2
- Start with her reasons for using.
- Next, ask about the reasons for not using or cutting down. Use the handout “Reasons for Quitting or Cutting Down”.
- Summarize what she has said, linking together reasons to use and quit/cut down in a double-sided manner.
- Ask for the patient’s reaction to this discussion and reflect change talk, as indicated.
- Ask a key question to determine what the patient intends to do at this point about her substance use.
- If a change goal is endorsed (quit completely, stay quit, cut down, or maintain lower level use), proceed to Step 5. If the patient does not intend to change or remains unsure, proceed to Step 3.

Step 3: Provide personalized feedback and ask key question

- Begin with a transition statement to Step 3.
- Review with the patient how her quantity or frequency of use compares to other adults. Use the handouts for alcohol, marijuana, and other drugs.
- Using the chart, calculate the total amount the patient spends per year on her primary substance. Ask her what she makes of it and what else she thinks she could buy with that amount of money.

- For all pregnant women, present feedback about the benefits of not using substances during pregnancy.
- Ask the patient if she would like to know more about how 1) her own risk of problems related to substance use, 2) how a parent's use of substances affects children's risk of problem behaviors, or 3) benefits of not using substances during pregnancy. If agreeable, present the information to her and ask her what she thinks about it.
- Summarize her reactions and give emphasis to anything she says that favors making a positive change in her use.
- End with a key question to determine her readiness to change.
- If a change goal is endorsed (quit completely, stay quit, cut down, or maintain lower level use), proceed to Step 5. If the patient does not intend to change or remains unsure, proceed to Step 4.

Step 4: Handle resistance skillfully and draw out change talk

- If the issue is that the patient does not believe reducing or stopping her substance use is important enough, try the following:
 - Ask: *What would make quitting or cutting down matter enough for you to change your substance use?*
 - Use the importance ruler technique
 - Ask her to look into the future under the circumstances of no change in use and if she were to stop or cut down her use
 - Ask her what the worst thing is that could happen if she tried to stop or reduce her use for a trial period and what the best thing is that could happen
- If the issue is that the patient does not believe she is able to cut down or stop using her primary substance even if she wants to, try the following:
 - Ask: *What would need to happen for you to feel more able to quit or cut down?*
 - Use the confidence ruler technique
 - Ask her about past successes in cutting down or stopping substance use (or in any other areas of her life) and how she might apply these experiences to her present situation
 - Ask her to identify her personal strengths, have her describe them to you, and ask her how she might use her strengths to cut down or stop using her primary substance
 - Ask her to describe the main obstacles to change and brainstorm some possible options that might remove them

- In either case, offer the patient the brochure about different change options and review them with her if in the future she decides she wants to try counseling, seek medication assistance, or access other self-help or support services

Step 5: Develop a change plan

- If the change goal needs clarification, ask the patient about what her exact goal is.
- Review the change options described in the brochure with the patient (counseling, self-help/12-Step, talking with health care professional, medication, quit, cut down, or maintain changes on my own).
- Ask the patient which of the options she is willing to try to reach her goal and go into more detail about what steps she is willing to take to initiate the selected options.
- Ask her who else might help her achieve her goal to cut down or quit and how this might happen.
- Ask her about obstacles she anticipates might come up and how she might handle them if they were to occur.

Step 6: Summarize and support what the patient has elected to do

- For a patient who remains unsure about changing her substance use, thank her for considering the issue and encourage her to discuss the issue again at the Women's Center the next time she comes in. She might also decide to quit or cut down her substance use in the future and is free to pursue any of the referral options, including changing on her own, at that point.
- For a patient who intends to keep using her primary substance unchanged, thank her for talking about it with you. Summarize her perspective and be sure to include anything she said that indicates some ambivalence about continuing to use unchanged. Inform her that she should feel free to discuss her substance use again in the future with the staff at the Women's Center.
- For a patient who has completed a change plan, thank her for considering the issue, summarize the main components of her motivation for change and how she intends to change, and affirm her for her participation in the interview and her plans for change. Complete the Change Plan Contract with her.

**Reasons for Quitting or Cutting Down (T):
Check All that Apply to You**

I would have more money for things.	I would feel more right with my religious beliefs or God.
I would feel better about myself.	I would get along better with my family.
I would be healthier.	My child or children would never see me smoking.
I might be a better parent.	My breath and clothes would smell better.
I would get more done.	My family and friends would have a more positive view of me.
I would look better.	It would make my home healthier for my children or significant other.
I would not feel stressed by always having to have cigarettes or being short on them.	I would not have the inconvenience of having to smoke outside or in smoking only areas.
I would increase the chance that I will live longer.	I wouldn't feel bad or sick because of nicotine withdrawal.
My pregnancy would go better.	My baby's health would be better.
I would feel like I would be living my life according to my values.	Nothing. I really don't see any advantages to quitting or cutting down.

**Reasons for Quitting or Cutting Down (A):
Check All that Apply to You**

I would have more money for things.	I would feel more right with my religious beliefs or God.
I would feel better about myself.	I would get along better with my family.
I would be healthier.	My child or children would never see me drinking to much.
I might be a better parent.	I would be less likely to lose my child or children.
I would be safer.	My family and friends would have a more positive view of me.
I would look better.	I would be more able to get a job or to perform better at my work.
I would live a life that is less risky.	I would feel that I would be more able to help rather than hurt my community.
I would be less likely to get in trouble with the law or lose my driver's license.	I wouldn't feel bad or sick from drinking or because of withdrawal.
My pregnancy would go better.	My baby's health would be better.
I would feel like I would be living my life according to my values.	Nothing. I really don't see any advantages to quitting or cutting down.

**Reasons for Quitting or Cutting Down (D):
Check All that Apply to You**

I would have more money for things.	I would feel more right with my religious beliefs or God.
I would feel better about myself.	I would get along better with my family.
I would be healthier.	My child or children would never see me using.
I might be a better parent.	I would be less likely to lose my child or children.
I would be safer.	My family and friends would have a more positive view of me.
I would look better.	I would be more able to get a job or to perform better at my work.
I would live a life that is less risky.	I would feel that I would be more able to help rather than hurt my community.
I would be less likely to get in trouble with the law or lose my driver's license.	I wouldn't feel bad or sick from using or because of withdrawal.
My pregnancy would go better.	My baby's health would be better.
I would feel like I would be living my life according to my values.	Nothing. I really don't see any advantages to quitting or cutting down.

Feedback – Tobacco

You reported smoking cigarettes in the past month. Only 22 of every 100 women smoke cigarettes each month. Pregnant women are even less likely to smoke cigarettes.



Feedback – Alcohol

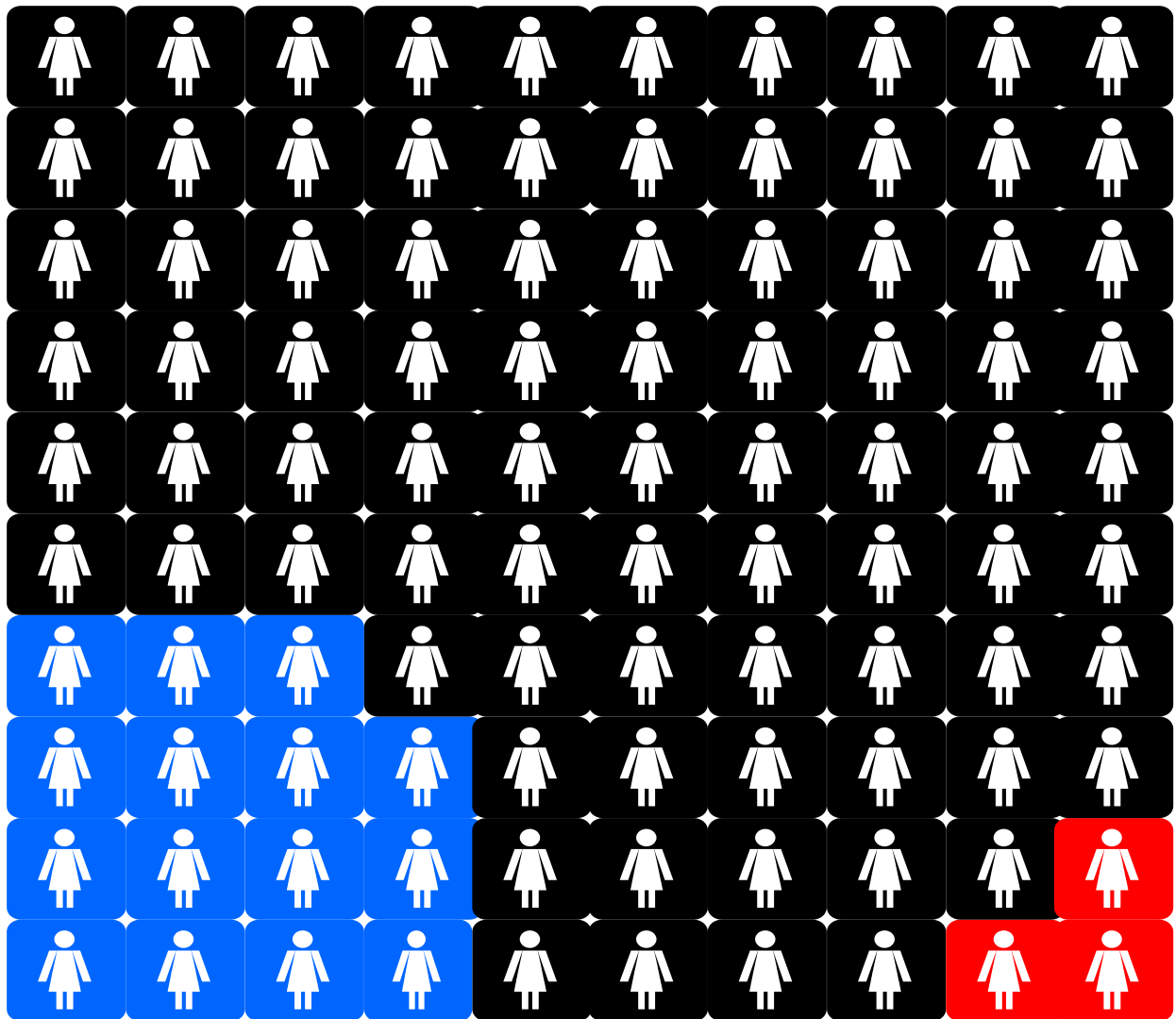
For binge use

You reported drinking 4 or more drinks on the same occasion on _____ days in the past month.

Only 15 of every 100 women drink like this once per month.

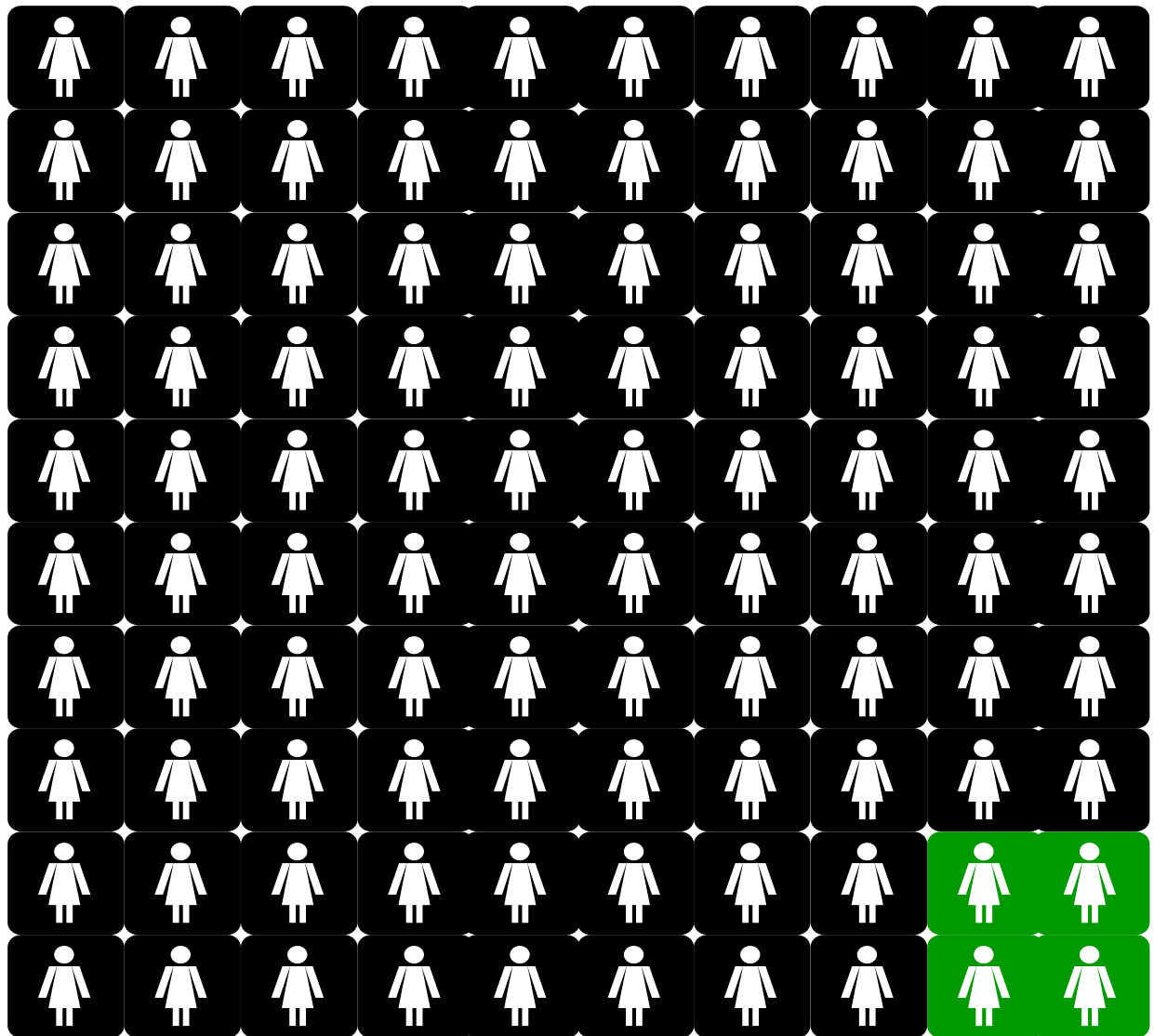
Only 3 of every 100 women drink like this five or more times per month.

Pregnant women are even less likely to drink this much.



Feedback – Marijuana

You reported using marijuana in the past month. Only 4 of every 100 women smoke marijuana each month. Pregnant women are even less likely to smoke marijuana.



Feedback – Drugs

You reported using [primary drug] in the past month. Only 1-2 of every 100 women uses an illicit drug other than marijuana each month. Pregnant women are even less likely to use drugs.



Feedback - Cost of Use

Looking at the chart, if you use [primary substance] _____ days per week and spend on average \$_____ per day on it, then you are spending \$ _____ per year.

		Number of Days Primary Substance Used Per Week						
		1	2	3	4	5	6	7
Average Amount Spent Per Day (\$) on Primary Substance	1	52	104	156	208	260	312	364
	2	104	208	312	416	520	624	728
	3	156	312	468	624	780	936	1092
	4	208	416	624	832	1040	1248	1456
	5	260	520	780	1040	1300	1560	1820
	6	312	624	936	1248	1560	1872	2184
	7	364	728	1092	1456	1820	2184	2548
	8	416	832	1248	1664	2080	2496	2912
	9	468	936	1404	1872	2340	2808	3276
	10	520	1040	1560	2080	2600	3120	3640
	11	572	1144	1716	2288	2860	3432	4004
	12	624	1248	1872	2496	3120	3744	4368
	13	676	1352	2028	2704	3380	4056	4732
	14	728	1456	2184	2912	3640	4368	5096
	15	780	1560	2340	3120	3900	4680	5460
	16	832	1664	2496	3328	4160	4992	5824
	17	884	1768	2652	3536	4420	5304	6188
	18	936	1872	2808	3744	5680	5616	6552
	19	988	1976	2964	3952	4940	5928	6916
	20	1040	2080	3120	4160	5200	6240	7280
25	1300	2600	3900	5200	6500	7800	9100	
30	1560	3120	4680	6240	7800	9360	10920	
35	1820	3640	5460	7280	9100	10920	12740	
40	2080	4160	6240	8320	10400	12480	14560	
45	2340	4680	7020	9360	11700	14040	16380	
50	2600	5200	7800	10400	13000	15600	18200	
75	3900	7800	11700	15600	19500	23400	27300	
100	5200	10400	15600	20800	26000	31200	36400	

Your Risk Level

Your ASSIST score is: _____

You reported that you had the following problems as a result of your use:

	You had a strong desire or urge to use.
	Your use led to health, social, legal or financial problems.
	You failed to do what was normally expected of you because of your use.
	A friend, relative or someone else ever expressed concern about your use.
	You tried and failed to control, cut down or stop using.
	You used a drug by injection for nonmedical purposes.

This places you at a **MODERATE** level of risk. In other words, if you continue to use like you have been, you are likely to continue to have these problems and you may start to develop others.

Your Risk Level

Your ASSIST score is: _____

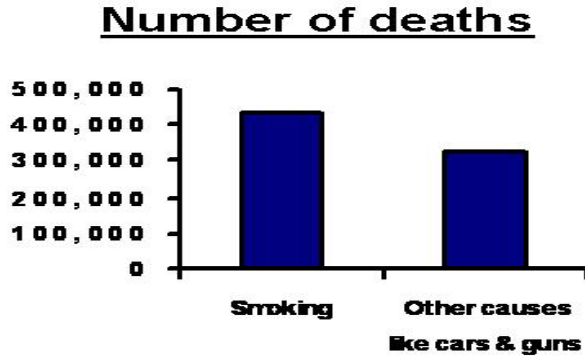
You reported that you had the following problems as a result of your use:

	You had a strong desire or urge to use.
	Your use led to health, social, legal or financial problems.
	You failed to do what was normally expected of you because of your use.
	A friend, relative or someone else ever expressed concern about your use.
	You tried and failed to control, cut down or stop using.
	You used a drug by injection for non medical purposes.

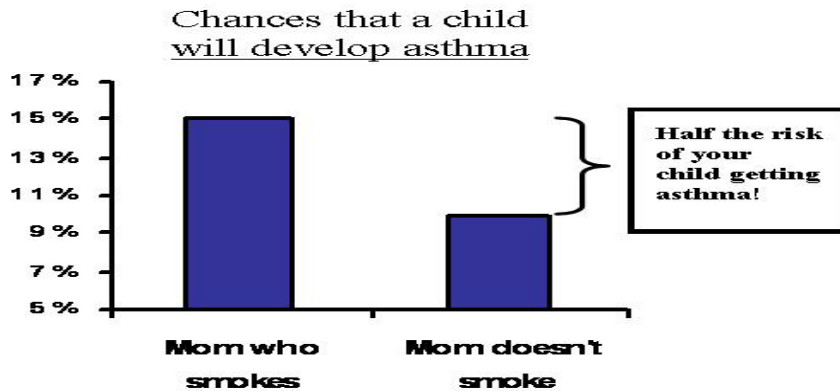
This places you at a **HIGH** level of risk. In other words, if you continue to use like you have been, you are very likely to continue to have these problems and you are likely to develop others.

How Tobacco Use Affects Kids

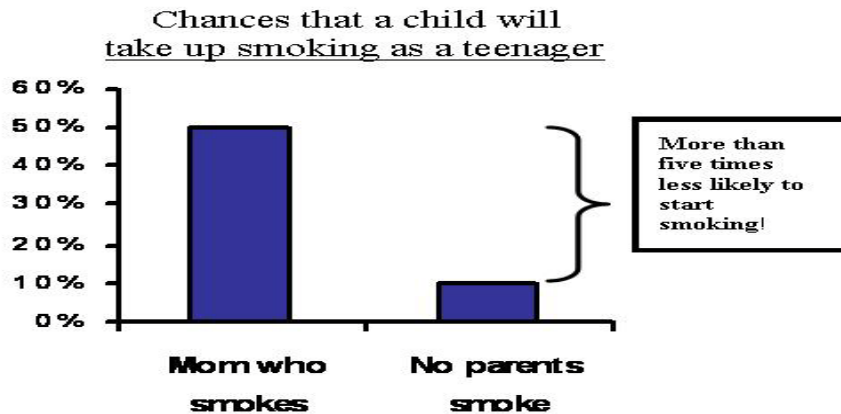
1. Parents are more likely to die from smoking cigarettes than they are from all other causes like car accidents, guns, alcohol-related problems, and HIV.



2. Children of mothers who don't smoke cigarettes are two times less likely to develop asthma.

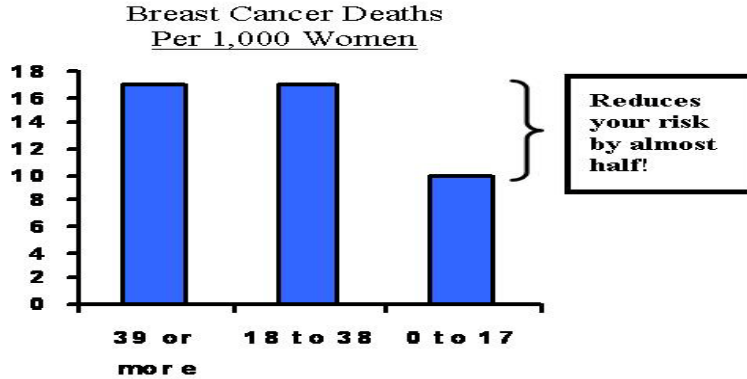


3. Teenagers of mothers who don't smoke cigarettes are five times less likely to start smoking.

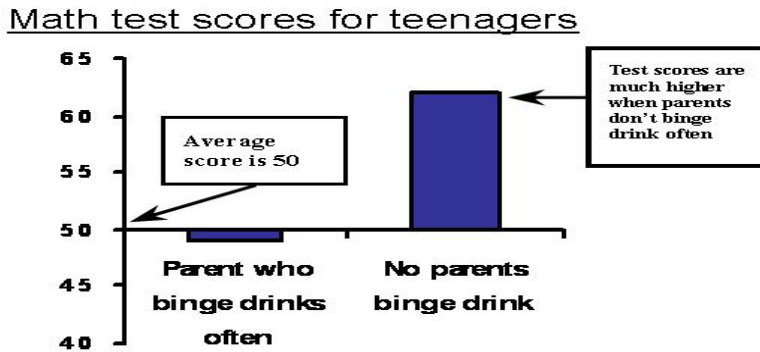


How Alcohol Use Affects Kids

1. Women who drink no more than 2 drinks per day are less likely to die from breast cancer.



2. Standardized test scores of kids are much higher when parents don't drink heavily. These kids seem more able to learn and do better in school.



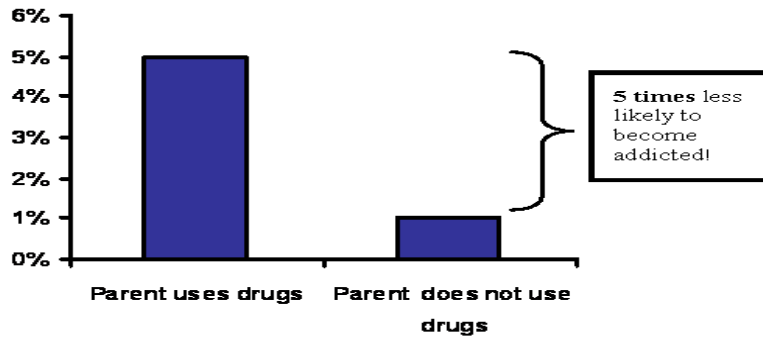
3. Children are 3 less more likely to be physically or sexually abused in a household in which parents don't abuse alcohol. In fact, the chance is 60% that kids who live in households where a parent abuses alcohol will experience some form of physical or sexual assault during childhood.



How Drug Use Affects Kids

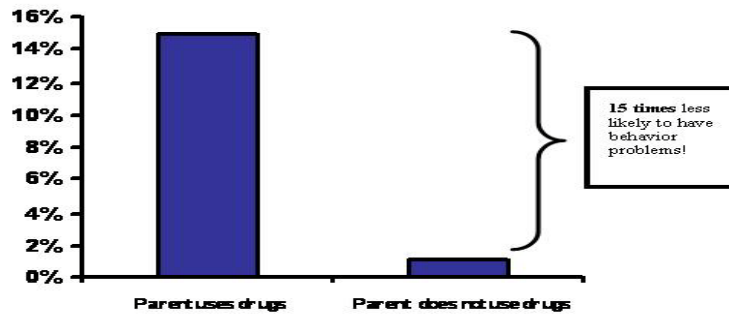
1. Teenagers are 5 times less likely to become addicted to drugs if their parents do not use drugs.

Chances that a teenager will become addicted to cocaine, speed, or heroin



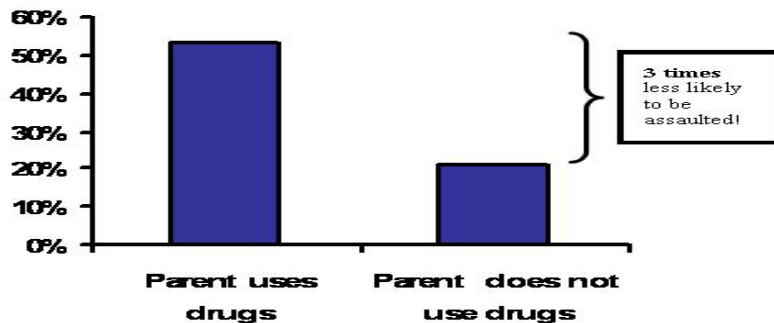
2. Kids of parents who don't use drugs are 15 times less likely to have a serious behavior problem at school.

Chances that a child will have serious behavior problems in school



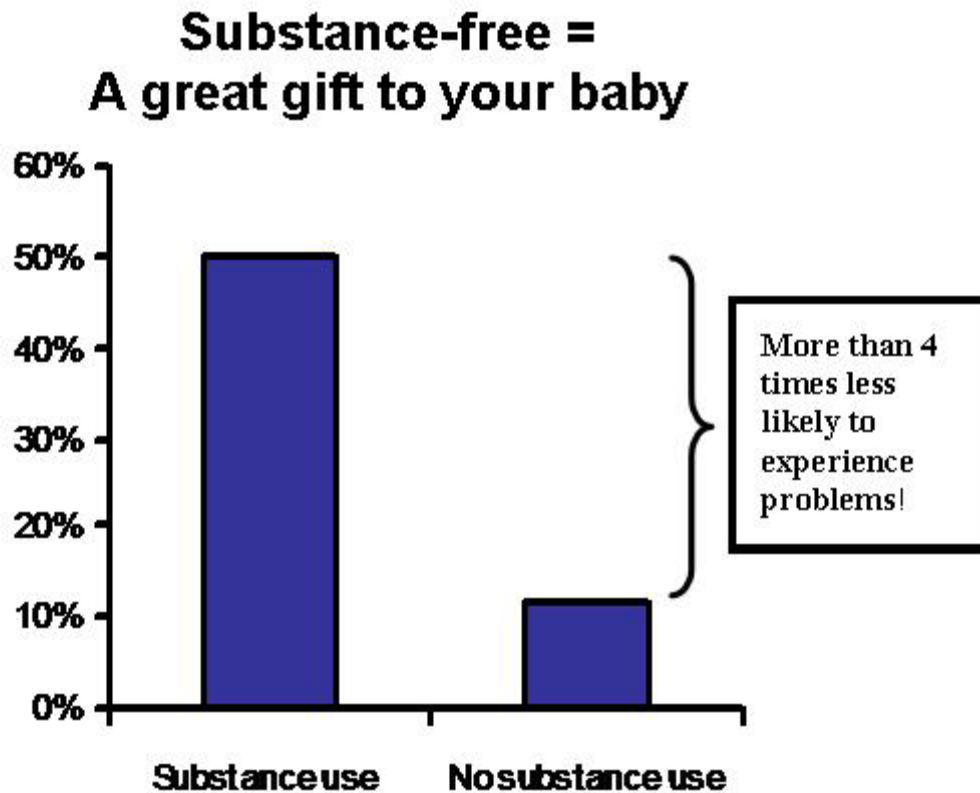
3. Children are 3 times less likely to be physically or sexually abused in a household in which parents don't use drugs. In fact, there is a 50-50 chance that kids who live in households where a parent uses drugs will experience some form of physical or sexual assault during childhood.

Chances that a child will be physically or sexually assaulted



Benefits of Not Using Substances during Pregnancy

1. Women who do not use substances during her pregnancy are more than 4 times less likely to have children who experience problems such as birth defects, difficulties learning in school, or behavioral problems.



Change Plan Contract

Date: _____

Primary Substance: tobacco alcohol marijuana drug (specify): _____

I agree to the following goal:

- I will quit completely.
- I will cut down.
- I will take my prescription medications only as prescribed.
- I will continue to stay quit.
- I will continue to use less.

To achieve my goal, I plan to:

- Change by myself
- Follow-up with a referral for: Counseling Self-Help Social Worker Medication

The specific referral(s) will be to: _____

Patient Signature

Nurse Signature

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Glossary

Affirmations - acknowledgment of a person's strengths, attitudes, and efforts that promote change

ASSIST - Alcohol, Smoking and Substance Involvement Screening Test was developed by the World Health Organization to screen people for substance use and to provide an indication of the level of risk based on the level of use in the past 3 months

Change planning – a formal strategy used in motivational interviewing in which practitioners help people who have expressed an intention to change develop a plan for how to achieve it

Change talk – a category of language in motivational interviewing in which a person expresses his or her motives for change (e.g., “If I keep using cocaine, it will destroy my marriage”)

Closed questions – questions that call for a “yes” or “no” response or that seek specific information or details (e.g., “Have you had more than four drinks on any one occasion in the past three months?”)

Commitment language – the way people speak about their commitment to change (e.g., expressed intentions to change, plans and steps taken toward change)

Complex reflection - a reflection in which a practitioner paraphrases what someone has said in a manner that adds meaning to it, often based on implications within the person's spoken words (e.g., “You sound frustrated by your predicament”)

DARN-CAT – an acronym used in motivational interviewing that describes different categories of change talk (desire, ability, reasons, need, commitment, activation, taking steps)

Decisional balance – an approach used to help people consider the costs and benefits of making changes versus not changing something

Developing discrepancy – a strategy used in motivational interviewing in which a practitioner has someone consider the way in which his or her current behavior conflicts with important values or goals (e.g., drinking with parenting) and how behavior change (e.g., not drinking) might resolve the discordance

Direct methods – strategies used in motivational interviewing for identifying and reinforcing people's motives for positive behavior change

EPE – an acronym used in motivational interviewing that stands for Elicit, Provide, Elicit, which is a technique for collaboratively sharing information or giving advice

Equipoise – a stance in which someone is indifferent or has no clear attachment to a position or recommendation for another person

Evocation – the general practitioner stance in motivational interviewing that presumes all people have motivations for change and that underpins the direct methods of this approach for drawing out these motivations

Key question – a question used in motivational interviewing when someone has shown signs of readiness to change and is poised to make a commitment to change (e.g., What do you think you want to do at this point?)

Microskills – fundamental or basic strategies used in motivational interview (open questions, affirmations, reflections, and summaries) that underpin the person-centered aspect of the approach

MINT – an acronym for an international training group called the Motivational Interviewing Network of Trainers

MI Spirit – the style in which practitioners interact with people when they are using motivational interviewing, incorporating the elements of collaboration, evocation, and supporting autonomy

Motivational enhancement therapy – a manualized version of motivational interviewing, which includes a personalized feedback intervention that was developed for a large scale, multi-site study conducted in the U.S.A. called Project MATCH.

Motivational interviewing - a person-centered counseling method developed by William Miller and Stephen Rollnick that aims to elicit and strengthen personal motivation for change

OARS – an acronym used in motivational interviewing to describe fundamental or basic strategies of the approach (Open questions, Affirmations, Reflections, and Summaries)

Open questions – questions or requests that invite discussion, exploration, or elaboration about a topic and are phrased in a manner that cannot be answered with a “yes” or “no” response (e.g., “What do you think about that?” “Tell me more about that”)

Personalized feedback – a strategy in which a practitioner gives someone information from an assessment about his or her behavior relative to norms (e.g., describes how much the person is drinking compared to peers) or other important factors (e.g., “Your boss said you can keep your job if you do something about your drinking”) to cause the person to consider changing

Person-centered counseling – a nondirective humanistic psychotherapeutic approach based largely on the work of Carl Rogers

Preparatory language - the way people speak about what motivates them to change, often involving statements about their desire, ability, reasons, and need for change, often as a prelude to making a commitment to change.

Project MATCH - a large scale, multi-site study conducted in the U.S.A. in which the efficacy of motivational interviewing, cognitive behavior therapy, and twelve-step facilitation for alcohol dependent adults was compared

REDS – an acronym used in motivational interviewing that details the basic principles of the approach (Rolling with resistance, Express empathy, Develop discrepancy, Support self-efficacy)

Reflection – a statement about what a person said to indicate one’s understanding about what that person meant

Resistance – the interpersonal style in which a person interacts with someone in a manner that indicates tension or trouble in the relationship (e.g., arguing, interrupting, negating, dismissing, ignoring)

Righting reflex – the natural tendency of others to try to fix people’s problems when they are told about them

SBIRT – Screening, Brief Intervention, and Referral to Treatment is an approach used to identify people who use tobacco, alcohol, or illicit drugs or who misuse prescribed medications, provide them with a brief intervention that causes them to consider changing their use, and refer them to treatment or other support services, as needed.

Simple reflection – a reflection in which a practitioner repeats or rephrases what someone has said without adding any meaning to it

Solicited advice – advice that is given only when someone has specifically sought or requested it or granted permission for it to be shared

Stages of change – a transtheoretical model of behavior change developed by James Prochaska and Carlo DiClemente that posits that behavior change occurs sequentially across recurring stages (precontemplation, contemplation, preparation, action, and maintenance)

Summaries – a technique used in motivational interviewing to reflect back to people multiple things that they had said for the purpose of: 1) collecting ideas to convey the bigger picture or to reinforce a person’s motives for change; 2) linking statements to fully capture both sides of a person’s ambivalence; or 3) capturing a common understanding of what has been said before transitioning to another topic

Sustain talk – a category of language used in motivational interviewing in which a person expresses his or her motives to not change one’s behavior (e.g., “I like the way drinking makes me feel”)

Unsolicited advice – advice that is given to someone when they have not requested it or granted permission for it to be shared