Welcome to the third module of the “Screening, Brief Intervention, and Referral to Treatment Core Curriculum.” In this module, we’ll review the Brief Intervention.
The goal of this session is to provide you with the information, tools, skills, and resources to successfully conduct a brief intervention with your patients. You will learn how this is done through the use of the Brief Negotiated Interview.
The Brief Intervention is intended to raise awareness of problematic behaviors and increase motivation to change. Because Motivational Interviewing strategies are used in the Brief Intervention, let’s take a few minutes to review some of the strategies that the Brief Intervention builds on.
Motivational Interviewing strategies that are most commonly used in the Brief Intervention are listed on the slide. After reviewing these strategies, we will incorporate them into the specific steps of the Brief Intervention. Let’s look at “change talk” first.
“Change talk” is at the heart of MI. As the amount of patients’ “change talk” increases, so does their commitment to change. Through our conversations, we can evoke and affirm desire, ability, reasons, and need. To remember those, use the acronym DARN.
You may remember the acronym “OARS” from the Motivational Interviewing training modules. “O” stands for “open-ended questions”; “A” for “affirmation”; “R” for “reflective listening”; and “S” for “summaries.”

The A from OARS – Affirmation – is critical in change talk. Gently reflect and summarize consequences of the behavior, focusing on those that have been identified by the patient.
Another key strategy is decisional balance. The point is to help the person look at factors that may support staying the same versus changing a behavior. In some ways, it’s a cost versus benefit assessment based on the person’s concerns that aims to leverage benefits of change against the status quo.
When conducting a decisional balance discussion, accept all answers given by the patient. Avoid the urge to disagree or argue with their views; instead, explore them. Be sure to note both the benefits and costs of current behavior and of change. This exploration should include your patient’s goals and values. What is important to them?
Another MI strategy in the Brief Intervention is the readiness ruler. Readiness rulers can measure three things: Importance, or the priority to change; Confidence in one’s own ability to change; and Readiness, which is a willingness to change.
Using the readiness ruler is a great way to gauge how ready they are to change.
Personalized reflective discussion is also key to the Brief Intervention. In SBIRT, we use the AUDIT and/or DAST scores – and other health-related information – to explore the person’s readiness and commitment to change.
Remember, there are five steps in the personalized reflective discussion, beginning with initiating a reflective discussion.
Reflective discussion between a clinician and patient usually follows other conversation. As noted earlier, the relationship and rapport with the person is critical. The first step is to ask for the person’s permission to have the conversation. Asking permission shows respect for the person’s autonomy.
After being invited to discuss findings, the clinician can review the results of related health assessment data. The example shown on this slide is for the Alcohol Use Disorders Identification Test, or AUDIT.
The Brief Intervention is a fluid process; there is no one right or wrong way. It all depends on the person and the situation. Staying focused on the person’s perceptions, values, and needs throughout the discussion is the main goal.
Our training focuses on the Brief Negotiated Interview (or BNI) developed by Miller and Rollnick, the authors of Motivational Interviewing. The approach is attractive to busy clinicians since it can be completed in 5 to 15 minutes and it follows a semi-structured format that is easy to remember and use.

The five main steps in the Brief Negotiated Interview are listed on the slide, and we’ll review each one in a few minutes.
This is the Brief Negotiated Interview form, developed by Rollnick and colleagues, that includes language that is specific to substance use.
It’s important to know that in our Motivational Interviewing modules, we talked about both substance use and other behavioral health problems that MI is useful in addressing. This adapted version of the BNI form uses “health condition” as opposed to “substance use.”
The first step in the BNI is to build rapport with the patient. This often starts with general conversation. At the point where the patient appears to be gaining comfort, show respect by asking permission to talk about alcohol and/or drugs. For example, you could say:

“Would you mind taking a few minutes to talk with me about your alcohol and drug use? What's a normal day look like for you, and where and how do alcohol and drugs fit in?”

Although very few refuse the invitation, that’s their choice. Keeping the discussion open is the main goal. Here is an example of how you could respond:

“That's absolutely your choice. But part of my job is to ask everyone these questions. I think it’s also important that you know I am concerned about health risks related to your drinking. If you change your mind, I’m here to listen and talk.”
It’s best to start by discussing the positives about substance use. This often is experienced by the patient as novel and disarming. It also provides the clinician a better understanding of why the patient uses substances.

The second part of this discussion is to talk about the down side of use. Generally, it’s better to ask about the “not-so-good” things about use, rather than asking about the “bad” things about use.
Going back to the OARS, use open-ended questions to clarify and to elicit information. You might also want to reflect back to the patient what he or she has said so that they know you’re listening and understand what they’re saying.
Periodically summarizing what has occurred in the counseling session reinforces what has been said, shows that you have been listening carefully, and prepares the patient to move on.
A double-sided reflection is often useful. For example, “So, on the one hand, the pros of use are.... And on the other hand....”
In this discussion, it’s important to think about the person’s reaction, and use it to decide next steps. If it’s a negative reaction, go back to the pros and cons. Remind the person that your responsibility, as a clinician, is to provide feedback so that they can make informed decisions. However, also convey that decisions and choices are theirs to make.
The third step in the BNI is to provide feedback. Start by asking permission to provide information. Feedback should include a discussion of screening findings, known consequences that are linked to use behaviors, and a description of healthier behaviors regarding the use of substances. For example:

“I have some information about low-risk drinking guidelines. Would you mind if I share them with you?”

“For a female, we know that 4 or more drinks in one sitting or more than 7 drinks in a week and/or the use of illicit drugs can put a person at risk for illness or injury and other problems. For a male, we know that 5 or more drinks in a sitting or more than 14 drinks in a week can put a person at higher risk for illness or injury and other problems.”
Looking at the BNI form we’re providing, note that offering feedback starts with asking permission to discuss the issue, followed by information-sharing about the results of the screening scales or other related health information.

At this point, sharing brief educational materials can be useful. We advise using handouts only if you are discussing the points included in the materials.
As you discuss the results of the AUDIT, DAST, or other finding, link the information to the person and their life. The most important and powerful element of providing feedback is to make it real, so feedback must be personalized.

Help the person make the connections by asking questions like, “What are your thoughts (or feelings) about this information?”
Step 4 in the BNI is Build Readiness to Change. This is when you will discuss the person’s potential interest in making a change. The Readiness Ruler is an effective tool for focusing this conversation.
Start with: “Could we talk for a few minutes about your interest in making a change?”

Offer a brief summary to help frame the question of readiness. Then ask the question, “On a scale from 1 to 10, with 1 being ‘not ready at all’ and 10 being ‘completely ready,’ how ready are you to make any changes in your substance use?” Show the person the laminated Readiness Ruler that is provided in our Pocket Card Tool Kit to make it visual.
If the patient says, “I am at a 5,” rather than asking why not a higher number, you should respond with affirmation. For example, “You marked 5. That’s great! That means you’re 50% ready.”

Next, you can ask why they didn’t choose a lower number. Asking why the number isn't lower invites the patient to articulate reasons and motives for considering change.

If you ask why the number is not higher, it can elicit barriers and reasons for staying the same. In effect, it showcases resistance talk rather than change.
The final step in the BNI is to negotiate a plan for change. Start the discussion by focusing on what the patient is willing and able to do. For example, “What are some steps that will work for you to stay healthy and safe?”

Remember! The person may have marked a 1 or 2 on the Readiness Ruler, meaning they are not really at the point of making changes. In the change model, that means they are in the “precontemplation” stage.

As before, keeping the discussion open is the main goal. This is another place you may want to reinforce that the choice is theirs, but that you are concerned and hope to talk about it again later.
Remember that this is the patient’s plan, not yours. Work toward concrete steps the person is willing and able to take. For example, “What specifically will you do to reduce use? How will that help you in reducing risk?”

Pointing out strengths that the person may have to make changes is also important. Think about the conversation and use affirmations to reinforce abilities, then reflect that back to the person.
Considering supports that can help the person be successful is also important. Who or what has helped the person overcome problems in the past?

Whatever is decided, the plan is written down and the patient takes it with them as their personal plan for change. To the extent possible, the plan should be simple and measurable – meaning the person knows if he or she is achieving the goals. It shouldn’t be complicated, or “perfect”; as before, keep it simple and focused on steps the person is willing to take.
Offering information or ideas is also acceptable at this point. But ask first, so the person doesn’t feel like they are being “told what to do.” And at the end, be sure to thank the person for talking about an issue that can be difficult. Also thank them for their time and interest and for their willingness to explore options to improve their health and well-being.
Example: At-Risk Drinking Plan

- I will drink no more than 4 times per week and no more than 3 bottles of beer or glasses of wine per day.
- If I am out, I will not drink any alcoholic beverage and get behind the wheel of my car. I will either ride home with someone who has not been drinking or take another mode of transportation.
- If by the end of 30 days I have not been able to sustain this change, then I will schedule an appointment with an alcohol counselor to complete a full assessment and get counseling.
- I will follow up with my healthcare provider about the results of my actions, either in person or by telephone, by the end of 30 days.

Here is an example of an action plan for a patient who is at-risk. It includes specific actions that the patient will take to help them change their substance use behavior, prevent negative consequences, and ensure they stay in touch with their healthcare provider.
This is an example of an action plan for a patient who is dependent on alcohol.

Remember, these are JUST examples. The agreements you reach with your patients may be far more simple, like making one change and reporting back to you on the next visit. As before, the Brief Intervention is fluid, and it depends on the person, the situation, and their readiness to make changes.
Remember: the Brief Negotiated Interview is based on Motivational Interviewing – so keep the OARS clearly in mind!
In summary, the Brief Intervention and, more specifically, the 5- to 15-minute Brief Negotiated Interview, follows a structure, but there is no single right way. It all depends on the person, their problem, and the situation!

And as we said in Motivational Interviewing, the skills are not easy to learn – they do take practice! The more often you use the BNI, the easier and more comfortable it will be!
In the next session, which is the last of the core modules, you will learn about referring patients to treatment.
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