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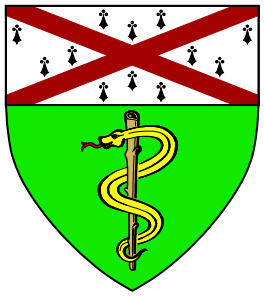

PROJECT ED HEALTH III

BNI Training Manual

Opioid Dependent Patients in the Emergency Department

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BNI Training Manual For Opioid Dependent Patients in the ED

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I. Overview of the Manual

This manual is adapted from an earlier manual on Emergency Department (ED) clinician administered brief intervention for harmful and hazardous alcohol use. The current manual is designed to provide the ED Research Interventionist with the necessary skills to easily and effectively perform a brief intervention, the Brief Negotiation Interview (BNI), with ED patients who have been identified as opioid (heroin or prescription opioid) dependent. These patients will be enrolled in a federally-funded randomized clinical trial testing the efficacy of 3 treatments: 1) Screening, Brief Intervention (BNI) and Facilitated Referral to Treatment (SBIRT), 2) Screening, Brief Intervention and ED initiated Treatment with Buprenorphine (SBI+Bup) and 3) Standard Care (SC). All subjects will have consented to participate in the study. The following sections provide background information and the goals of the study, and describe the critical components of the BNI. An easy to follow, step-by-step approach to performing the BNI is also included. The study protocol to be followed by a Research Interventionist administering the BNI to subjects is provided along with additional motivational and troubleshooting strategies. While the manual gives the reader a critical overview of the BNI, participation in 2 half-day training sessions, followed by successful completion of a test case for SBIRT and SBI+Bup treatments is required to be certified to begin performing interventions with subjects enrolled in the trial. Weekly feedback and booster sessions will be offered during the course of enrollment to ensure effective and consistent performance.

II. Background Information

Introduction

Opioid dependence is a major public health concern and remains primarily an untreated medical condition in the United States. There are approximately 1 million heroin dependent individuals and 2.5 million prescription opioid dependent individuals in the U.S.[1] Economic costs are estimated at greater than $21 billion/year and have far reaching implications for the individual, workplace, society and the healthcare system.[2] Opioid agonist treatment, including methadone and buprenorphine, has been demonstrated to be the most effective treatment. However, opioid dependent patients do not often seek help through specialized treatment centers, but do frequently visit Emergency Department (ED) of hospitals, either for their addictive disorder or for associated medical and psychiatric comorbid conditions.[3] Many, particularly young adults, have few if any other interactions with the health care system. Therefore, the ED visit is often their only contact with a treatment system and represents an ideal opportunity for detection, referral and treatment.

Brief Interventions Work

Brief interventions are short counseling session, ranging from 5-60 minutes that incorporate feedback, advice, and motivational enhancement techniques to assist the patient in reducing their alcohol consumption to low-risk guidelines thereby reducing their risk of illness/injury.

There is compelling evidence in the literature that brief interventions for alcohol problems are effective [4,5] in a variety of settings including primary care[6,7] and inpatient trauma settings.[8] ED-based randomized controlled trial testing the effectiveness of screening, brief intervention and referral to treatment have had mixed results. Researchers in Germany studies a computer-generated intervention in injured patients presenting to an ED and found a significant decrease in alcohol consumption in the intervention group,[9] while two other studies reported a similar decrease in alcohol consumption in the intervention and control groups but demonstrated significant reductions in negative consequences after the initial brief intervention session[10] or a booster session[11] in the intervention group. One study detected no difference in consumption between the intervention and control groups.[12] In our own study, where we enrolled both injured and non-injured patients with harmful and hazardous drinking, showed similar significant reductions in both groups, without a treatment effect.[13] Other cohort studies without control groups have shown a significant reduction in alcohol use.[14] A recently published study conducted at 14 ED sites that used a quasi-experimental comparison group design that we also participated in revealed that screening, brief intervention and referral for treatment on patients with all degrees of unhealthy alcohol use was effective. A total of 1,132 patients were enrolled (581 control, and 551 intervention (BNI)). At 3-month follow-up, the BNI group reported consuming 3.25 fewer drinks per week than controls. Of the at risk drinkers, 37% no longer exceeded NIAAA low-risk guidelines compared with 18.6% in the control group, 95% CI 11.5% to 25.6%. A very recent meta-analysis of strategies targeting alcohol problems in the ED examined the extent to which interventions were effective in reducing alcohol consumption and related harm.[15] Thirteen studies were included, 10 randomized control trials and 3 cohort studies. The results revealed that interventions did not significantly reduce subsequent alcohol consumption, but were associated with

approximately half the odds of experiencing an alcohol-related injury (OR=0.59, CI 0.42-0.84).

Additionally, brief interventions have long been shown to be effective in treating tobacco use and dependence in all populations including adolescents, pregnant women, older adults and racial and ethnic minorities.[16],[17].[18],[19] Recently Brown reported success in identifying patients in a primary care setting that subsequently had an intervention by telephone. As a result formal clinical practice guidelines have been developed for treating tobacco use by a US public Health Panel and Consortium.[20] Other studies have documented the benefits of brief for those at risk for HIV/AIDS and other health-risk behaviors.[21],[22]

Despite the above, few studies have investigated the efficacy of brief interventions for drug dependence. Bernstein and colleagues reported their experience with Project ASSERT in Boston, which used Health Promotion Advocates to screen for alcohol and other drug use in an urban ED.[23] This cohort study showed that during a one year period of time, 2,931(41%) patients screened positively for substance abuse. Of the 1,096 enrolled in a follow up program, 245 kept the appointment and demonstrated a significant 45% reduction in severity of drug problems and a 56% reduction in alcohol use. More recently Bernstein and colleagues tested the impact of a single, structured encounter by similar peer educators that targeted cessation of dug use in the same hospital in Boston's walk-In Clinics.[24] Of the 1175 patients enrolled, the intervention group was more likely to be abstinent than the control group for cocaine (22.3% versus 16.9%), heroin (40.2% versus 30.6%), and both drugs (17.4% versus 12.8%). These findings support further investigation of brief intervention for drug use in the ED.

The ED Visit is an Opportunity for Intervention

Patients with opioid dependence may have more frequent contact with emergency departments (EDs) than with primary care or other treatment services. This level of contact with EDs raises the important question of the role of screening, brief Intervention, and referral to treatment in EDs. A statewide hospital ED study of adult patients in Tennessee[25] revealed a high prevalence of undetected substance abuse and need for treatment. Between 4 and 27% of patients were determined to need treatment according to strict DSM-IV criteria or through more comprehensive criteria, including self-reported addiction. Fewer than10% of these patients who were identified as needing substance abuse treatment were engaged in substance abuse treatment. Treatment need was found to be greater among patients who 1) reported 1 or more prior ED visits in the past year (adjusted OR 1.622; 95% CI 1.13 to 2.31) and 2) were on Medicaid (OR 1.63; 95% CI 1.30-2.05) and Medicare (2.50 95% CI 1.34-4.65) than those privately insured. Unfortunately only 1% of these patients were identified by the practitioner as having a diagnosis of substance abuse at the time of their ED visit. Of note, ED patients with unmet substance abuse treatment need generated much higher hospital and ED charges than patients without such need.[26]

While a considerable part of emergency care is occupied with treating medical consequences of substance use, and it is well known that medical and psychiatric disorders are frequent among populations with alcohol and/or drug disorders,[27] the drug use is often not addressed at the time of the ED visit. Therefore an important opportunity is missed. Our own experience with Project ASSERT, an innovative program that uses Heath Promotion Advocates to assist with identification and referral

of ED patients with drug and alcohol problems highlights the fact that many heroin/prescription opioid users use the ED as their primary source of care. Our 5-year program evaluation revealed that 22,500 patients were screened for alcohol and other drug use. Of the 1293 who reported heroin use in the past 30 days, 25% had no health insurance, 49% had no regular doctor and 29% used the ED for the regular source of care. Of the 310 patients who used prescription opioids, 22% reported having no health insurance, 35% had no regular doctor and 27% used the ED as their regular source of care.

III. Overview of the BNI

The Brief Negotiation Interview (BNI) described in this grant was first developed in 1994 by Drs Edward Bernstein, Judith Bernstein and Gail D'Onofrio in consultation with Dr. Stephen Rollnick for Project ASSERT in the ED.[28,29] It was later refined and tested for hazardous and harmful drinkers in the ED by the current investigator group.[30]

The BNI is a brief counseling method that incorporates brief feedback and advice with motivational enhancement techniques to assist the patient in changing behaviors and in this case, following up with a referral to either a specialized treatment center, or accepting immediate treatment and following up with our Primary Care Center for office-based Buprenorphine treatment.[31] The BNI procedure is patient-centered and the skills used are based in large part on the patient's motivation and readiness to change. The primary outcome of the BNI procedure is the patient's agreement to accept a referral to a formal specialized treatment center or continue with ED initiated treatment and to decrease harm by reducing drug use and HIV risk. The interventionist and patient come to this agreement through a process of negotiation described in the following sections.

IV. Components of the BNI

The BNI procedure consists of 4 major steps:

1) Raise The Subject/Establish Rapport

- Raise the subject of drug use
- Ask Permission to discuss opioid dependence
- Assess level of physical discomfort

2) Provide Feedback

- Review patient's drug use and patterns
- Ask the patient about and discuss drug use and its negative consequences
- Make a connection (if possible) between drug use and ED visit or any medical issues
- Provide Feedback on Study Assignment
    i. ***For SBIRT…*** Inform patient that they will receive a Facilitated Referral and that a variety of treatments work for opioid dependence
    ii. ***For SBI+Bup…*** Inform patient that they will receive buprenorphine maintenance starting in the ED and continuing in the YNHH-PCC, and that it is an effective treatment for opioid dependence

3) Enhance Motivation

- Assess Readiness to Change
    For SBIRT… Assess readiness to formally agree to enroll in a drug treatment program
    For SBI+Bup… Assess readiness to formally agree to enroll in buprenorphine treatment
- Enhance Motivation
    - Ask a series of open-ended questions designed to evoke "Change Talk" (or self-motivational statements) about entering treatment from the patient.
    - Reflect or reiterate the patient's motivational statements regarding entering treatment.

4) Negotiate And Advise

- Negotiate goal regarding treatment engagement
- Give advice
- Complete referral/treatment agreement and Secure & Provide Referral for treatment (Buprenorphine/Suboxone or other)

Each step has critical components, specific objectives, actions and necessary preparations to be successful. Details of each step for SBIRT are provided on pages 11 through 20 and for SBI+Bup on pages 21 through 32. Prior to detailing the actual BNI procedure, it is important for the Interventionist to know how the administration of the BNI coincides with the overall study protocol. A sample of the BNI dialogue for each condition appears in Tables 8 and 9.

V. Study Protocol

Study Period and Target Population
This study will be conducted in the ED at Yale-New Haven Hospital (YNHH) for an estimated 4 years, beginning February 20, 2009.

Inclusion Criteria
ED patients aged 18 and above who meet DSM-IV-TR criteria for opioid dependence are eligible for inclusion.

Exclusion Criteria
Excluded from the study will be patients who fall into any of the following categories:

- Inability to read and understand English
- currently enrolled in a formal substance abuse treatment program
- Current, active suicidality or homicidal risk
- Current psychotic disorder
- condition that precludes interview i.e., life threatening injury/illness
- in police custody
- unable to provide to 2 alternate contact numbers for follow-up
- Unwilling to be randomized to one of the three study conditions
- Requiring opioid agonist medication for a pain-related diagnosis

Research Plan
Patient eligibility will be determined by the study Research Associate (RA) through a series of steps, based on the criteria listed above. 360 eligible and consenting patients who have completed their baseline assessment by the RA will be randomized to one of three study conditions by the Research Interventionist (RI). One group will receive a written hand out from an ED staff member (SC). Another group will receive a BI, namely the BNI from the interventionist and a referral that will link the patient directly to a specialized treatment center. The third group will receive a BNI and will have treatment with Buprenorphine initiated in the ED.

Every SBIRT and SBI+Bup intervention will be audio-taped with subject consent. The RI will assist with recorder set-up and will be provided with intervention aids (e.g., the BNI laminated reference card, BNI showcards, drug/referral agreement and patient health information handout).

VI. Research Interventionist Roles and Expectations

Once the patient has been consented and enrolled into the study, the Research Interventionist (RI) will randomize the patient and perform the necessary condition. They will need to review the patient's record prior to beginning the BNI to determine reason for the ED visit. They may discuss medical conditions with the treating physician. Should the patient be randomized to the SBI+Bup group, they will discuss treatment with the on-call study physician. The RI should also review all research assessments prior to conducting the intervention. Finally, the intervention should be conducted in a timely manner in a climate as quiet and private as possible.

- **SBIRT Group**

  The BNI should be performed exactly as outlined in the procedural steps. (REFER to the 4 steps on pages 11 through 20) It is designed to take approximately 20 minutes to complete. The intervention should conclude with the patient receiving a copy of the referral agreement they have completed with you and an information sheet.

- **SBI+Bup Group**

  The BNI should be performed exactly as outlined in the procedural steps. (REFER to the 4 steps on pages 21 though 32. It is designed to take approximately 20 minutes to complete. The intervention should conclude with the patient receiving their initial dose of buprenorphine, as detailed in the "Buprenorphine: Beginning Treatment" handout" in Table 4 of this manual, as well as receiving a copy of the referral agreement they have completed with you and an information sheet with step-by-step instructions for following up at the YNHH-Primary Care Center for continued buprenorphine maintenance treatment.

SUMMARY

- Review ED record, and ALL research assessments, including the Health Quiz (HQ), Structured Clinical Interview for the DSM-IV-TR (SCID), HIV/AIDS Risk Behavior Scale (HRBS), Clinical Opioid Withdrawal Scale (COWS), Objective Opioid Withdrawal Scale (OOWS) and Insurance Information before seeing the study patient
- Perform the BNI in a timely fashion, aware of patient discharge plans
- Adhere to the BNI script
- Ensure quality audio-taping of BNI; keep recorder near conversation area
- Discuss any operational problems with Principal Investigator/Project Director

The Brief Negotiation Interview (BNI) for the SBIRT study condition

STEP1: Raise the Subject/ Establish Rapport

Critical considerations:

1. Be respectful
2. Remember that asking the patient's permission to discuss his/her drug use is an important aspect of the intervention
3. Avoid arguing or being confrontational
4. Be mindful of the patient's possible physical discomfort

PREPARATION:

- Review ED record, SCID (Table 1), HQ (Table 13), HRBS (Table 14), COWS (Table 10), OOWS (Table 11) and Insurance Information, and discuss with treating MD, if necessary

OBJECTIVES	ACTION(S)	QUESTIONS/COMMENTS
Raise the subject	• Introduction and explanation of your role • Avoid a judgmental stance • Acknowledge the patients situation • Set a comfortable climate	*"Hello, I am ____with Project ED Health"*
Establish Rapport	• Ask permission (see Health Quiz for drug of abuse) • Engage the patient	*"Would you mind if we spend a few minutes talking about your use of_____(fill in with patient's drugs of abuse)?"* ***<PAUSE>*** *"I want to talk about how it's affected you and how we might be able to help."*
Assess discomfort	• Ask about symptoms of withdrawal (see SCID for physical dependence symptoms endorsed by patient) • Reflective listening	*"Tell me about how you are feeling right now?"* OR *"How much physical discomfort is your drug use causing you at the moment?* REFLECT on any stated connection between pattern of use & discomfort/withdrawal symptoms

		EXAMPLE: It sounds like your use has caused you a lot of physical problems and discomfort.

STEP 1 SUMMARY

This first step sets the climate for a successful BNI. Asking permission to discuss the subject of drug use formally lets the patient know that their wishes and perceptions are central to the treatment, which later enhances the chance that the patient will accept a referral for treatment. Further, reflecting on patient-acknowledged problems and discomfort related to their drug use motivates the patient to start considering compelling reasons for change, but without being confronted with this information in a threatening or harsh (i.e., non-motivational) manner.

STEP2: Provide Feedback

Critical components:

1. Review current drug use and opioid dependence symptoms
2. Discuss the role of opioid dependence in contributing to negative life consequences (financial, family, employment, health, legal)
3. Ask about and/or make connection between drug use and reason for ED visit (if applicable) and risk of HIV/AIDS
4. Inform patient that a variety of treatments work to effectively reduce and stop drug use, and ask for patient's positive treatment experiences

PREPARATION:

- Review Health Quiz, SCID, HRBS
- Handouts: Treatment Referral List (Table 7)

OBJECTIVES	ACTION(S)	QUESTIONS/COMMENTS
Review patient's drug use & patterns	• Review screening data (see Health Quiz & SCID)	*"From what I understand you are using… (fill in amounts from screening)." BUT DO NOT RE-SCREEN**.***
Ask the patient about and discuss drug use and its negative consequences	• Ask for patient's feedback regarding negative consequences	*"Besides physical discomfort, how bothered are you by your drug use, if at all?" OR "What problems has it caused you, if any?"* ***<PAUSE>***
	Give SCID feedback • Be non-judgmental	*ONLY IF PT NOT BOTHERED… "We know that drug use can cause serious problems in your life. Based on what you told us in the screening, drugs have…(LIST SCID SYMPTOMS ENDORSED BY PT.)*
	• Express concern	***"I am concerned about your drug use and how it seems to be affecting other things that are important to you."*** ***<PAUSE>***
	• Assess Drug use & HIV-risk connection (see HRBS)	*"What connections might you see between the way you use drugs and HIV/AIDS risk?"*

		IF PATIENT STATES ANY ACCURATE & RELEVANT CONNECTION(S) reiterate them, acknowledge the patient's good insight and give additional relevant facts on HIV/AIDS risk. IF PATIENT DOES NOT STATE ANY ACCURATE & RELEVANT CONNECTIONS, MAKE the connection based on HRBS or general caution about drug use and HIV risk *SAMPLE: Any drug use compromises good judgment. Without good judgment anyone can engage in HIV-risky behavior.*
Make connection between drug use & the ED visit (if applicable)	• Discussion of specific patient medical issues, e.g., withdrawal, overdose, MVC or injury, infection, or any indirect consequence, treatment-seeking, etc.	*"What (if any) connection is there between your drug use and this ED visit?"* ***<PAUSE>*** IF PATIENT SEES ANY ACCURATE & RELEVANT CONNECTION, reiterate what they have said. *SAMPLE: You're right...[reiterate pt's connection]…that's a good connection to make.* IF PATIENT DOES NOT SEE AN ACCURATE CONNECTION, then make one using facts (if applicable)(see ED Record, Health Quiz & SCID) *SAMPLE: One of the things that we see as a connection is that your pattern of drug use may have contributed to your fall, physical discomfort, or whatever they're in the ED for (if relevant).* IF THERE ACTUALLY IS NO CONNECTION between today's visit and drug use, ask about any potential connections between drug use & overall health issues.

Feedback on Study Assignment	• Tell the patient that he/she has been selected to receive a BI and a facilitated referral	*"So, in order to help you with all of this, you will be receiving a Facilitated Referral in the ED today* (hand patient the Referral List)*, which means that I will help you choose from a variety of local treatment centers listed in this pamphlet."*
	• Tell the patient that a variety of different treatments work and that they have a choice of treatment center.	*"If you decide to accept our recommendation, treatment would help you with your withdrawal and also those problems you mentioned above."*

STEP 2 SUMMARY

This step provides the opportunity to offer feedback and education related to patient issues. In fact, four different levels of feedback have been offered in this step, all of which can be used in the next step of enhancing motivation, i.e., (1) Linking drug use to negative consequences or problems that they acknowledge they are feeling in their life such as financial, family, employment, health, and legal problems and; (2) Connecting the ED visit to the drug use if possible, such as overdose, withdrawal, injury, lack of follow-up etc; and (3) Connecting drug use and HIV/AIDS risk and ending with perhaps the most important piece of feedback, which is (4) that treatment CAN help to ameliorate all of the above problems and risky behaviors.

STEP3: Enhance Motivation

Critical components:
1. Assess readiness to engage in treatment
2. Enhance motivation
3. Use of Open-ended Questions
4. Use of Reflective Listening

PREPARATION:
- "Readiness to Change Ruler" (Table 2)
- Handouts: Pros/Cons of Treatment (Table 5)

OBJECTIVES	ACTION(S)	QUESTIONS/COMMENTS
Assess readiness to change	• Have patient self-identify readiness to change, on a scale of 1-10	**[Show Readiness Ruler]** *"On a scale from 1-10, how ready are you to enroll in a drug treatment program?"* *"1 is not at all, 10 is completely"*
Enhance motivation	• Ask motivational questions	IF PATIENT SAYS: - **≥ 2, ask "***Why did you choose that number and not a lower one?" (i.e., "What are some reasons you would engage in treatment?") "What else?"* repeatedly OR *"How has treatment been helpful to you in the past?"*
	• Reflect motivational answers	Then REFLECT on their reasons and reinforce with clinical information (e.g., "Treatment does in fact work to help reduce and eliminate use, as well as the problems connected with it." Take the patient's answer from the above question and ask:
	• Ask about their initial reason to get a more motivating answer	*"Why is that reason important to you?"*
	• What if the pt picks a "1"?	- **1 or unwilling, ask "***What would it take for that "1" turn into a "2"?* OR *"Imagine you did sign up, how could that be helpful to you?" OR "What would have to happen for you to be*

		ready? and "*How important would it be for you to prevent that from happening?"* - Reflect/reiterate positive reasons for change
	• Additional Motivational Strategies (ONLY if above does NOT lead to readiness to attend treatment) **(OPTIONAL)**	To explore possible positive thoughts about treatment ask *"Why might you ever go? Have you ever thought about going before? What were some of the reasons why? Why is it important to have this conversation now?"* *Would you mind if I gave you some possible reasons based on your screening?* *If pt says, "Yes," reflect on the possible positive consequences of treatment (i.e., reversing the symptoms endorsed on the SCID.* *If pt says, "No,"* discuss possible benefits of treatment (e.g., reversing the negative effects of opioid dependence discussed in Steps 1 & 2)
	• Summarize	Offer summary reflection of patient's reasons for starting or considering treatment, ending with a reinforcement of the patient's autonomy… "Ultimately, the decision to seek treatment is up to you."

STEP 3 SUMMARY

Opioid dependent patients spend much of their time justifying their drug use by rehearsing reasons to continue using. However, in Step 3 of the BNI, specific motivational enhancement techniques are utilized to reverse this so that the patient begins to clarify and, through RI-reflections, reinforce highly personal reasons in favor of *engaging in treatment* for their opioid dependence (vs. continued use). The primary tools to promote such a discussion of reasons or motives for treatment engagement are 1) the readiness ruler question (1-10), 2) asking why they did not select a lower number and other questions about positive reasons offered, and 3) selectively reflecting on reasons that promote treatment-seeking. Exploring this gap between the patient's current situation and how their life might be if engaged in treatment is what often tips the scale in terms of changing behavior.

STEP4: Negotiate and Advise

Critical components:

1. Negotiate a plan on how to engage in treatment and reduce HIV risk
2. Direct advice
3. Referral agreement and provide an information handout

Preparation:

- Treatment Referral List
- Agreement form
- Handouts: Information specific to selected treatment agency; Appointment Card (Table 12)

OBJECTIVES	ACTION(S)	QUESTIONS/COMMENTS
Negotiate goal	• Assist patient's selection of a next step goal • Avoid being argumentative	*"What's the next step, if any?"* ***<PAUSE>*** IF YES TO TREATMENT, ***skip*** to bottom, "Secure Referral." IF NO, reiterate reasons patient gave above and ***<PAUSE>*** IF STILL NO, then ask if the patient might consider it and give advice below for patient to have, even if s/he does NOT want to consider it, and then SKIP TO "Provide Handouts."
Give advice	• Deliver treatment advice/education • Harm reduction	*"If you enter a treatment program or referral from here you will be on the road to recovery.* *Specifically, treatment can help you take care of* (SCID listing of negative consequences of patient's opioid use), including reducing the risk of contracting HIV, but it is up to you*."*
Complete Treatment Agreement & Secure Referral	• Select a treatment agency with patient's input	*"Which of these programs might you be interested in?" [SHOW LIST]*

		"Ok, based on your preferences, your insurance information and availability of program slots, I will make an appointment for you. I will be back to tell you about it as soon as possible."
	• Review Treatment Agreement	*"But, before I go, I would like you to complete this referral agreement, which will reinforce your decision to seek formal drug treatment. This is really an agreement between you and yourself"*
	• Step out of interaction (take recorder) to make an appointment for the patient	*[Pt waits for RI to return]*
	• Provide a referral	*Here is your referral. It is for…[GIVE ALL DETAILS] "How does this sound to you?"* *IF PATIENT UNWILLING TO ATTEND, remind them that that is up to them, but that you would like them to have the referral and additional information (see below) should they change their mind.*
	• Provide Handouts	Provide: - Agreement (Add Appointment Specifics, i.e., date, time, address, etc.) Pt keeps 1 copy; 1 copy for study - ED Health Referral Pamphlet
	• Wrap-up	- Ask the patient if s/he has any questions. ***<PAUSE>*** **-** Thank patient for his/her time.

STEP 4 SUMMARY

In this step, the RI has negotiated a referral to specialized drug treatment program that the patient is willing to attend. If the patient is not ready, then additional advice is given and options discussed in another attempt to negotiate and motivate the patient. While the patient is the decision-maker and should ultimately be responsible for his/her plan, the RI should provide the referral secured, as well as all of the other handouts, stating that this is the information the patient would consult should they change their mind. End by asking if the patient has any questions about the information or instructions and by thanking them for their time.

The Brief Negotiation Interview (BNI) for SBI+Bup study condition

STEP1: Raise the Subject/ Establish Rapport

PREPARATION:

- Review ED record, Health Quiz, SCID, HRBS, COWS & OOWS and Insurance Information, and discuss with treating MD if necessary

OBJECTIVES	ACTION(S)	QUESTIONS/COMMENTS
Raise the subject	• Introduction and explanation of your role • Avoid a judgmental stance • Acknowledge the patients situation • Set a comfortable climate	*"Hello, I am ____with Project ED Health"*
Establish Rapport	• Ask permission (see Health Quiz for drug of abuse) • Engage the patient	*Would you mind if we spend a few minutes talking about your use of_____(fill in with patient's drugs of abuse)?"* ***<PAUSE>*** *"I mainly want to talk about how it's affected you and how we might be able to help."*
Assess comfort	• Ask about symptoms of withdrawal (see SCID for physical dependence symptoms endorsed by patient) • Reflective listening	*"Tell me about how you are feeling right now?* OR *"How much physical discomfort is your drug use causing you at the moment?* REFLECT on any stated connection between pattern of use & discomfort/withdrawal symptoms *EXAMPLE: It sounds like your use has caused you a lot of physical problems and discomfort.*

STEP 1 SUMMARY

This first step sets the climate for a successful BNI. Asking permission to discuss the subject of drug use formally lets the patient know that their wishes and perceptions are central to the treatment, which later enhances the chance that the patient will accept a referral for treatment. Further, reflecting on patient-acknowledged problems and

discomfort related to their drug use motivates the patient to start considering compelling reasons for change, but without being confronted with this information in a threatening or harsh (i.e., non-motivational) manner.

STEP2: Provide Feedback

Critical components:

1. Review current drug use and opioid dependence symptoms
2. Discuss the role of opioid dependence in contributing to negative life consequences (financial, family, employment, health, legal)
3. Ask about and/or make connection between drug use and reason for ED visit (if applicable) and risk of HIV/AIDS
4. Inform patient that a variety of treatments work to effectively reduce and stop drug use, and ask for patient's positive treatment experiences

PREPARATION:

- Review Health Quiz, SCID, HRBS
- Handouts: Benefits of Buprenorphine & Buprenorphine: Beginning Treatment handouts (Tables 3 & 4)

OBJECTIVES	ACTION(S)	QUESTIONS/COMMENTS
Review patient's drug use & patterns	• Review screening data (see Health Quiz)	*"From what I understand you are using… (fill in amounts from screening)." BUT DO NOT RE-SCREEN.*
Ask the patient about and discuss drug use and its negative consequences	• Ask for patient's feedback on consequences	*"Besides physical discomfort, how bothered are you by your drug use, if at all?" OR "What problems has it caused you, if any?"* ***<PAUSE>***
	Give SCID feedback • Be non-judgmental	*ONLY IF PT NOT BOTHERED… "We know that drug use can cause serious problems in your life. Based on what you told us in the screening, drugs have…(LIST SCID SYMPTOMS ENDORSED BY PT.)*
	• Express concern	***"I am concerned about your drug use and how it seems to be affecting other things that are important to you."*** ***<PAUSE>***

	• Assess Drug use & HIV-risk connection (see HRBS)	*"What connections might you see between the way you use drugs and HIV/AIDS risk?"* IF PATIENT STATES ANY ACCURATE & RELEVANT CONNECTION(S) reiterate them, acknowledge the patient's good insight and give additional relevant facts on HIV/AIDS risk IF PATIENT DOES NOT STATE ANY ACCURATE & RELEVANT CONNECTIONS, MAKE the connection based on HRBS or general caution about drug use and HIV risk *SAMPLE: Any drug use compromises good judgment. Without good judgment anyone can engage in HIV-risky behavior.*
Make a connection between drug use & the ED visit (if applicable)	• Discussion of specific patient medical issues e.g., withdrawal, overdose, MVC or injury, infection, or any indirect consequence, treatment-seeking, etc.	*"What (if any) connection is there between your drug use and this ED visit?"* ***<PAUSE>*** IF PATIENT SEES ANY ACCURATE & RELEVANT CONNECTION, reiterate what they have said. *SAMPLE: You're right...[reiterate pt's connection]…that's a good connection to make.* IF PATIENT DOES NOT SEE A CONNECTION, then make one using facts (if applicable)(see ED Record, Health Quiz & SCID) *SAMPLE: One of the things that we see as a connection is that your pattern of drug use may have contributed to your fall, physical discomfort, or whatever they're in the ED for (if relevant).*

		IF THERE ACTUALLY IS NO CONNECTION between today's visit and drug use, ask about any potential connections between drug use & overall health issues.
Feedback on Study Assignment	• Tell the patient that he/she has been selected to receive a BI+Buprenorphine/ Suboxone	*"So, in order to help you with this, we would like to offer you a medicine called Buprenorphine or Suboxone, as it is commonly known, in the ED today* (hand patient the Buprenorphine/ Suboxone Information Handout)*, which means that I will help you start suboxone in the ER today and follow up for suboxone maintenance at the YNHH-Primary Care Center on a pretty frequent basis (about 3x/week to start.."*
	• Tell the patient that Buprenorphine/ Suboxone works for opioid dependence.	*"If you decide to accept our recommendation, treatment would help you with all of the problems we've been talking about, but especially the physical discomfort caused by withdrawal."*

STEP 2 SUMMARY

This step provides the opportunity to offer feedback and education related to patient issues. In fact, four different levels of feedback have been offered in this step, all of which can be used in the next step of enhancing motivation, i.e., (1) Linking drug use to negative consequences or problems that they acknowledge they are feeling in their life such as financial, family, employment, health, and legal problems and; (2) Connecting the ED visit to the drug use if possible, such as overdose, withdrawal, injury, lack of follow-up etc; and (3) Connecting drug use and HIV/AIDS risk and ending with perhaps the most important piece of feedback, which is (4) that buprenorphine treatment CAN help to ameliorate all of the above problems and risky behaviors.

STEP3: Enhance Motivation

Critical components:
1. Assess readiness to engage in treatment
2. Enhance motivation
3. Use of Open-ended Questions
4. Use of Reflective Listening

PREPARATION:
- "Readiness to Change Ruler"
- Handouts: Benefits of Buprenorphine Treatment (Table 3)

OBJECTIVES	ACTION(S)	QUESTIONS/COMMENTS
Assess readiness to change	• Have patient self-identify readiness to change, on a scale of 1-10	**[Show Readiness Ruler] (See Table 2)** *"On a scale from 1-10, how ready are you to start Buprenorphine/ Suboxone treatment in the ER today and to continue it in the PCC after today?"* *"1 is not at all, 10 is completely"*
Enhance motivation	• Ask motivational questions • Reflect motivational answers • Ask about their initial reason to get a more motivating answer	IF PATIENT SAYS: - **≥ 2, ask "***Why did you choose that number and not a lower one?" (i.e., "What are some reasons you would engage in treatment?") "What else?"* repeatedly OR *"How has treatment been helpful to you in the past?"* Then REFLECT on their reasons and reinforce with clinical information (e.g., "Buprenorphine/Suboxone does in fact work to help reduce and eliminate use, as well as the problems connected with it, especially all of the physical discomfort caused by withdrawal." Take the patient's answer from the above question and ask: *"Why is that reason important to you?"*

	• What if the pt picks a "1"?	- **1 or unwilling, ask "***What would it take for that "1" turn into a "2"?* OR *"Imagine you did sign up, how could that be helpful to you?" OR "What would have to happen for you to be* ready? and "*How important would it be for you to prevent that from happening?"* - Reflect/reiterate positive reasons for change
	• Additional Motivational Strategies (ONLY if above does NOT lead to readiness to attend treatment) **(OPTIONAL)**	To explore possible positive thoughts about treatment ask *"Why might you ever go? Have you ever thought about going before? What were some of the reasons why? Why is it important to have this conversation now?"* *Would you mind if I gave you some possible reasons based on your screening?* *If pt says, "Yes," reflect on the possible positive consequences of treatment (i.e., reversing the symptoms endorsed on the SCID.* *If pt says, "No,"* discuss possible benefits of buprenorphine (See Appendix 3)
	• Summarize	*Offer summary reflection of patient's reasons for starting or considering treatment,* ending with a reinforcement of the patient's autonomy… *"Ultimately, the decision to seek Suboxone treatment is up to you."*

STEP 3 SUMMARY

Opioid dependent patients spend much of their time justifying their drug use by rehearsing reasons to continue using. However, in Step 3 of the BNI, specific motivational enhancement techniques are utilized to reverse this so that the patient begins to clarify and, through RI-reflections, reinforce highly personal reasons in favor of *engaging in buprenorphine treatment* for their opioid dependence (vs. continued use). The primary tools to promote such a discussion of reasons or motives for treatment engagement are 1) the readiness ruler question (1-10), 2) asking why they did not select a lower number and other questions about positive reasons offered, and 3) selectively reflecting on reasons that promote buprenorphine treatment-seeking.

Exploring this gap between the patient's current situation and how their life might be if engaged in buprenorphine treatment is what often tips the scale in terms of changing behavior.

STEP4: Negotiate and Advise

Critical components:

1. Negotiate a plan on how to engage in treatment and reduce HIV risk
2. Direct advice
3. Referral agreement and provide an information handout

Preparation:

- Agreement forms
- Handouts: Buprenorphine: Beginning Treatment handout Information (Table 4), Appointment Cards (Table 12)

OBJECTIVES	ACTION(S)	QUESTIONS/COMMENTS
Negotiate goal	• Assist patient's selection of a next step goal • Avoid being argumentative	*"What's the next step, if any?"* ***<PAUSE>*** IF YES TO TREATMENT, ***skip*** to bottom, "Secure Buprenorphine/ Suboxone Treatment." IF NO, reiterate reasons patient gave above and ***<PAUSE>*** IF STILL NO, then ask if the patient might consider it and give advice below for patient to have, even if s/he does NOT want to consider it, and then SKIP TO "Provide Handouts."
Give advice	• Deliver treatment advice/education • Harm reduction	*"If you start Suboxone treatment today and follow-up in the PCC, you will be on the road to recovery.* *Specifically, treatment can help you take care of* (SCID listing of negative consequences of patient's opioid use), including reducing the risk of contracting HIV, but it is up to you*."*

Review Treatment Agreement & Secure Suboxone Treatment	• Review Treatment Agreement	*"In a moment, I will be stepping out to ask the doctor about your Suboxone treatment plan and I will be back to tell you about it as soon as possible. But before I go, I would like you to complete this treatment agreement, which reinforces your decision to sign up for a formal Suboxone treatment. This is really an agreement between you and yourself."*
	• Step out of interaction (take recorder) to develop Suboxone Treatment Plan with MD	*[Pt waits for RI to return]*
	• Provide a Treatment Plan	*"Here is the doctor that will give you your initial Buprenorphine/Suboxone treatment plan [Introduce MD]."* *Here are your instructions for following up at the PCC, which are very important to stick to if you want to get the most out of treatment [GIVE ALL DETAILS]* *IF PATIENT UNWILLING TO ATTEND, remind them that that is up to them, but that you would like them to have the referral and additional information (see below) should they change their mind.*
	• Provide Handouts	Provide: - Agreement (Pt keeps 1 copy; 1 copy for study) - ED Health Study Referral Pamphlet - Buprenorphine Information Handouts - Appointment Cards
	• Wrap-up	- Ask the patient if s/he has any questions. ***<PAUSE>*** - Thank patient for his/her time.

STEP 4 SUMMARY

In this step, the RI has negotiated a referral to a Suboxone treatment program. If, however, the patient is not ready, then additional advice is given and options discussed in another attempt to negotiate and motivate the patient. While the patient is the decision-maker and should ultimately be responsible for his/her plan, the RI should provide the referral secured, as well as all of the other handouts, stating that this is the information the patient would consult should they change their mind. End by asking if the patient has any questions about the information or instructions and by thanking them for their time.

VII. Additional Motivational Strategies

- **Refrain From Directly Countering Resistance Statements**

  For example, the patient may say “How can I have a drug problem when I use less than all my buddies?” You can reply noting that dependence can vary between patients and that it is worthy of further assessment and discussion, within the context of this brief interview and advice from treatment professionals.

- **Focus On The Less Resistant Aspects Of The Statement**

  For example, the above patient may be wondering about how much their drug use is a problem. The response might be to restate his concern and ask about his level of drug use, which is the less resistant part of the statement. “It sounds like you’re confused about how you could have an issue with your drug use if you use less than all your friends. I’d like to explain this to you.” (*And remember, this is a statement NOT a question, so the intonation should turn down at the end of the remark*).

- **Restate Positive or Motivational Statements**

  For example, if a patient says: “You know, now that you mention it, I feel like I have been using more than I wanted to lately,” the RI could say, “It sounds like you realize that your use is out of your control.”). This serves to reinforce the patient’s motivation-even if the motivational statement is a relatively weak one. If the patient says, “I guess I might have to change my use” this could be restated as “It sounds like you’ve been thinking about stopping your use”.

- **Other Helpful Hints**

  Encourage patients to think about previous times they have been abstinent, even for a few days.

  Praise patients for their willingness to discuss such a sensitive topic, their willingness to consider change, and their courage for considering treatment. Acknowledge how hard it is to find treatment options.

  View the patient as an active participant in the intervention.

VIII. Common Problems

Certain problems may occur during the course of the intervention steps….

- **Refusal To Engage In The Discussion Of The Topic Of Drug Use**

Most patients will agree to discuss the topic, because they have already consented to be in the study, but in the unlikely event that someone outright refuses to discuss it at all, tell the patient that you will respect their wishes and that all you will be doing is giving him 3 pieces of information:

1. His/her drug use meets criteria for treatment
2. There is no safe level of opioid use
3. You are concerned and that s/he should cut down and stop to avoid future Harm (Steps 2 and 4 only).

- **Refusal To Self-Identify Along The Readiness Ruler**

When this happens, it is usually a problem with understanding the numbers. There are several ways of dealing with this:

1. Anchor the numbers with descriptors, such as “1” means not ready at all or 0 per cent ready, and 10 means completely ready or 100% ready to change.
2. Ask “What would make this a problem for you?” Or, “How important is it for you to change any aspect of your drug use?”
3. Discussion of Pros and Cons (refer to list).

- **Unwilling To Associate Visit With Opioid or Drug Use**

Don’t force the patient to make the connection, but be sure that he/she hears that in your medical opinion there is a connection. However, this connection may not be the thing that ultimately motivates the patient to change. If this happens try to find some other negative consequence of drug use that the patient <u>can</u> agree bothersome enough to consider decreasing or stopping their drug use.

TABLE 1: Mini-SCID Symptoms

(Referred to in Steps 1 and 2 of BOTH SBIRT & SBI+Bup)

a. Needing to use more (name the drug/drug class selected) to get the same effect that you did when you first started taking it
b. When you reduced or stopped using (name the drug/drug class selected), having withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feel agitated, anxious, irritable, or depressed), or using any drug(s) to keep yourself from getting sick (withdrawal symptoms) or so that you would feel better.
c. Finding that when you used (name the drug selected), you end up taking more than you thought you would.
d. Trying to reduce or stop taking (name the drug selected) but failed.
e. On the days that you used (name the drug/drug class selected), spending substantial time (>2 hours) obtaining, using, or in recovering from the drug, or thinking about the drug.
f. Spending less time working, enjoying hobbies, or being with others because of your drug use.
g. Continuing to use (name the drug selected), even though you knew that the drug caused you health or mental problems.

TABLE 2: READINESS RULER

(Referred to in Step 3 of BOTH SBIRT & SBI+Bup)

READINESS RULER

Not ready at all — Completely ready

1	2	3	4	5	6	7	8	9	10

TABLE 3: Benefits of Buprenorphine Treatment

(Referred to in Step 3 of SBI+Bup)

Benefits of Buprenorphine:

- **Patients do not need to go to a methadone clinic to receive Buprenorphine.** Buprenorphine is prescribed in a doctor's office, is dispensed in local pharmacies, and can be taken at home as a sublingual pill.
- **Reduces cravings and prevents withdrawal symptoms** such as pain and nausea by blocking the effects of other opiates.
- **Long lasting**. Taken once a day
- **Safer** than heroin or traditional prescription opiates; buprenorphine alone is unlikely to result in an overdose. Like methadone, buprenorphine reduces the craving for opiates and permits productive living. But buprenorphine has a ceiling effect, which means there is less likelihood of abuse or of an overdose.
- **Reduced health risks**, especially those related to IV drug use, such as HIV and hepatitis B and hepatitis C viruses, skin infections and vein problems.
- **Opioid Agonist Maintenance** allows patients to focus on and address psychosocial problems

Excerpted from: http://rehabdrchester.com/html/Buprenorphine%20Treatment.htm

TABLE 4: **Buprenorphine- Beginning Treatment**

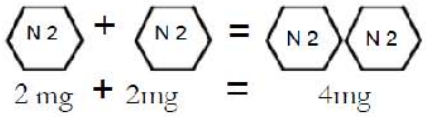
Buprenorphine- Beginning Treatment

Day One: Before taking a buprenorphine tablet you want to feel lousy from your withdrawal symptoms. Very lousy. It should be at least 12 hours since you used heroin or pain pills [oxycontin (snorted), vicodin, etc…), 16 hours since oxycontin (swallowed) and at least 48 hours since you used methadone.

Wait it out as long as you can. The worse you feel when you begin the medication the more satisfied you will be with the whole experience. If you take the buprenorphine too soon, it can make you feel worse rather than better.

You should have at least 3 of the following feelings: • Twitching, tremors or shaking • Joint and bone aches • Bad chills or sweating • Anxious or irritable • Goose pimples

				
Very restless, can't sit still	Heavy yawning	Enlarged pupils	Runny nose, tears in eyes	Stomach cramps, nausea, vomiting, or diarrhea

First dose: 4 mg of Buprenorphine (Bup) under the tongue. This is two 2mg tablets:	
	
	Put the tablets under your tongue. Keep it there. If you swallow Bup tablets they will not work, the medicine is best absorbed through the thin skin on the bottom of your tongue.

It takes about 20-45 minutes for the medication to be absorbed and have an effect. Feel better? Good, the medicine is working. Still feel lousy after 45 minutes? Don't worry, you may need more medication.

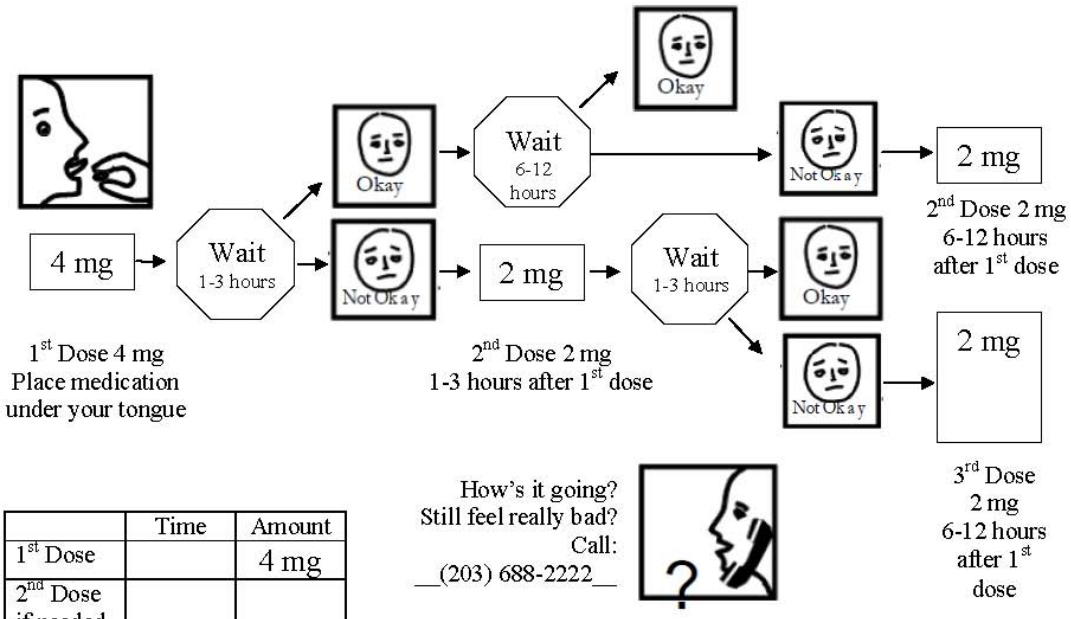
At 1-3 hours (60-180 minutes) after your first dose, see how you feel. If you feel fine after the first 4 mg, don't take any more, this may be all you need. If you have withdrawal feelings, take another 2 mg dose under your tongue.

Later in the day (6-12 hours after the first dose), see how you feel again. If you feel fine, don't take any more. If you have withdrawal feelings, take another 2 mg dose under your tongue.

Do not take more than 8 mg of Bup on the first day.

Most people feel better after the 4-8 mg on the first day. Still feel really bad, like a bad withdrawal? Call the study doctor right away. You can call or page any time during the day if you are having difficulty.

Day One Summary: **No medication until you feel significant withdrawal.** 4 mg under your tongue, wait 1-3 hours. If still feel sick, take 2 mg. Wait 1-3 hours. If still sick, take 2 mg again. Do not take more than 8 mg on Day 1.



	Time	Amount
1st Dose		4 mg
2nd Dose if needed		
3rd Dose if needed		

= Total mg taken on Day One

★ No more than 8 mg on Day One

Day Two: The right dose depends on how you felt on Day One	
If the total on Day One was **4 mg**	If you took <u>4 mg on Day 1 and feel fine the next morning</u>, then take 4 mg again on Day 2. This will be your new daily dose. If you took <u>4 mg on Day 1 and feel some withdrawal the next morning</u>, then try starting with 8 mg on the morning of Day 2. Later in the day on Day 2, see how you feel. If you feel fine , there is no need to take more. If you still feel withdrawal, you can try taking another 4 mg dose.
If the total on Day One was **8 mg**	If you took <u>8 mg on Day 1 and feel fine the next morning</u>, then take 8 mg again on Day 2. This will be your new daily dose. If you took <u>8 mg on Day 1 and feel some withdrawal the next morning</u>, then try starting with 16 mg on the morning of Day 2.

Day Two Summary: 8-16 mg total, depending on how much you took on Day 1.

<table>
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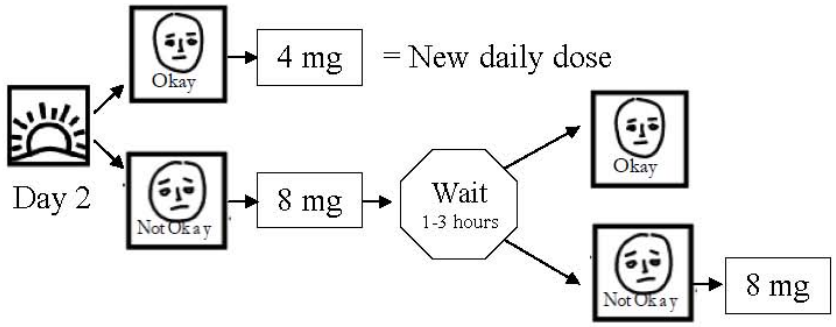
<td>If the total on Day One was 4 mg</td>
<td> 
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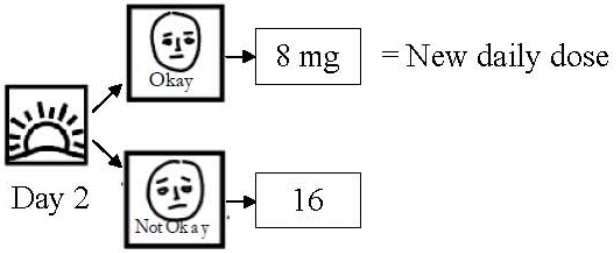
<tr>
<td>If the total on Day One was 8 mg</td>
<td> 
</td>
</tr>
</table>

	Time	Amount
1st Dose		
2nd Dose if needed		

= Total mg taken on Day One

= Total mg taken on Day Two

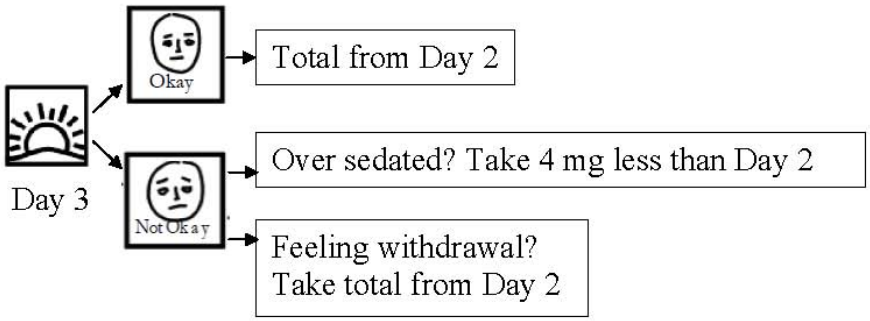
Day Three:

The right dose for you on Day 3 depends on how you felt on Day 2. Did you still feel unwell, like you were in some withdrawal by the evening or night of Day 2? Or did you feel like the medication was too strong, leaving you too groggy or sedated? Different people need different doses of Bup.

If you felt comfortable at the end of Day 2, repeat the dose you took on Day 2. This is your new daily dose.

If felt too tired, groggy, or over sedated on Day 2, try taking a lower dose on Day 3. Take 4 mg less on Day 3 than you took on Day 2.

Day Three Summary: Take the total Day 2 dose under your tongue in the morning. You can try a little less if the Day 2 dose felt too strong.



	Time	Amount
1st Dose		
2nd Dose if needed		

= Total mg taken on Day Three.
This is your new daily dose

Follow up:

- ★ Come to the Primary Care Center at 789 Howard Avenue on: _____ at _____. You must bring a valid, government-issued photo identification card to this visit.
- ★ You can reach a nurse to discuss this appointment during the day, Monday, Wednesday and Friday at (203) 688-9222.
- ★ If you have an urgent medication related problem BEFORE your PCC visit you may speak with a study physician by calling (203) 688-2222 and asking for the Project ED Health physician on call.

TABLE 5: PROS AND CONS

(Referred to in Step 3 of BOTH SBIRT & SBI+Bup)

Reasons to enter drug treatment

To spend less money
To avoid constantly seeking drugs
To do a better job at home
To do a better job at work
To live longer, and feel better
To sleep better
To be able to care for myself longer
To be able to care for my children better
To be a better son/daughter, wife/husband, parent or grandparent
To reduce the possibility that I will die
Other reasons:_____

Reasons for ongoing drug use

Boredom
Habit
I enjoy the taste or the way that it feels
For pleasure in social situations
To more easily socialize
Other people expect that I will use when I am with them
To relax or relieve stress
To cope with feelings of anger
To cope with feelings of anxiety
To cope with feelings of boredom
To deal with momentary feelings of depression
To deal with momentary feelings of loneliness
To deal with feelings of frustration
To relieve the stress of arguments with family members or friends
It's something I do when I'm watching T.V.
It's something I do with certain friends or relatives
To help me sleep
To relieve pain
To make me feel better
Other

TABLE 6: TREATMENT AGREEMENT

(Referred to in Step 4 of BOTH SBIRT & SBI+Bup)

TREATMENT AGREEMENT

Date:_____

I, _____, agree to enroll in the following drug treatment program:

Program Name, Address & Tele #:_____

Date of Appt & Contact Person: _____

Patient Signature: _____

TABLE 7: PROJECT ED HEALTH TREATMENT REFERRAL LIST

(Referred to in Step 4 of BOTH SBIRT & SBI+Bup)

Local Alcohol and Drug Treatment Resources

APT Foundation-Access Center
One Long Wharf Dr, Suite 10, New Haven
(203) 781-4357
Walk-in Screening available: M-F: 7:30am-12pm
Methadone maintenance: *495 Congress Ave and 540 Ella Grasso Blvd*
Outpatient, methadone, and residential treatment for adolescents, men, women, including pregnant women, and women with children, Spanish-speakers, and HIV+ individuals.

Crossroads Inc.
42 Howe St and 54 East Ramsdell St, New Haven
(203) 387-0094, Dial "O"
M-F: 9am-5pm; Outpatient services and residential treatment facility for 18+ men, women, Spanish-speakers, dual-diagnosed, and HIV+ individuals.

Crossroads Inc.-Amethyst House
48 Howe St, 3rd flr, New Haven
(203) 821-3040
M-F: 9am-5pm; Residential treatment facility for women 18+ who are pregnant or have children, dual-diagnosed, and HIV+ individuals.

Grant Street Partnership
62 Grant St, New Haven
(203) 503-3350
M-F; 9am-5pm; Outpatient services (18+ men and women) and residential treatment facility (men only).

Hispanic Clinic Substance Abuse Unit (CMHC)
34 Park St, New Haven
(203) 974-5800; M, T, Th & F 9am-4:30pm, W: 11am-6:30pm; Outpatient services for Latino clients who primarily use alcohol (No IV drug users).

Hospital of St. Raphael Chemical Dependency
Chapel St, New Haven
(203)784-8790
M-F: 12:30-9pm. Outpatient services, including evening programs for men and women 16+.

Multicultural Ambulatory Addiction Services (MAAS)
426 East St, New Haven
(203) 495-7710
M-F 9am-5pm; Walk-ins: 8:30am-11:30am
Outpatient services, including methadone, for men and women 18+, especially African American and Latinos.

South Central Rehabilitation Center (SCRC)
232 Cedar St, New Haven
(203) 503-3300
24 hours a day, 7 days a week. Walk-ins: 5:30am-12:30pm. Detox, methadone, and triage facility for men and women 18+, including dual-diagnosed individuals.

Substance Abuse Treatment (SATU)
One Long Wharf Drive, New Haven
(203) 974-5777
M-F: 8:30am-5:30pm, walk-ins accepted; Central evaluation, referral, and outpatient services for men and women 17+, Spanish-speakers, those who are dual-diagnosed, and HIV+ individuals.

Taking Initiative Center (TIC)
514-516 Whalley Ave, New Haven
(203) 389-2970 ext 1317, M-F 8am-4:30pm
Drop-in center and outpatient services and referral for homeless of New Haven.

VA Research Programs
950 Campbell Ave, West Haven
(203) 937-4804
M-F: 7am-2pm
Opiates (including heroin)

(203) 937-4833
M-S: 7am-3pm
Opiates (including heroin) + cocaine/crack

Project

ED Health

Identifying health risks and providing access to treatment services

Project ED Health is a federally-funded research project operating in the Yale New Haven Hospital Adult Emergency Department. Study researchers identify eligible patients and offer them enrollment in a study which offers access to treatment services for opioid dependence.

Drug dependence affects people from all walks of life and backgrounds. Family, friends, coworkers or neighbors may be dependent on opioid drugs which could lead to problems including injuries, domestic violence or illnesses such as heart disease and cancer. Early intervention can help and is often cost effective. Like other chronic diseases, drug problems can be successfully treated.

Project ED Health researchers can provide you with information on new treatment options to help you feel better starting today!

The following services and/or community programs are available:

Infoline (referrals to all types of community services)	211

Alcohol and Drug Use:

Alcoholics Anonymous (AA)	(866) 783-7712
Narcotics Anonymous (NA)	(800) 627-3543
ADRC (residential)	(860) 714-3700
Alliance (residential)	(866) 234-3433
Columbus House -Recovery House (walk-ins, residential)	(203) 772-2658
Connecticut Valley	(860) 262-5000
Continuum crisis/Respite	(203) 784-1161
Hall-Brooke (outpatient, residential)	(800) 543-3669
Merritt Hall (residential)	(800) 828-3396
Rushford Treatment Center (walk-ins, outpatient, residential)	(800) 542-4791
Salvation Army (walk-ins, residential) -New Haven	(203) 865-0511
-Hartford	(860) 527-8106
-Bridgeport	(203) 367-8621
Silver Hill	(866) 542-4455
Stonington (outpatient, residential)	(800) 832-1022
Buprenorphine Physician Locator: http://buprenorphine.samhsa.gov/	

HIV/AIDS:

AIDS Interfaith Network, Inc.	(203) 624-4350
AIDS Project New Haven	(203) 624-0947
Hispanos Unidos Contra el SIDA/AIDS, Inc.	(203) 781-0226

Primary Health Care/Other:

CT Breast and Cervical Cancer Detection Program (M & Th only)	(203) 688-4562
Depression Clinic (CMHC)	(203) 974-7300
Dept of Social Services (194 Bassett St)	(203) 974-8000
Elderly Services (DSS)	(203) 974-8027
Fair Haven Community Health Center	(203) 777-7411
Gamblers Anonymous	(800) 266-1908
Healthy Start (prenatal care)	(203) 946-8187
Hill Health Care Center	(203) 503-3000
	(203) 776-9594
Husky Infoline	(800) 434-7869
Logisticare transportation (24 hrs, non-substance abuse, Title 19, Husky)	(888) 248-9895
Project ED Health	(203) 785-2946
YNHH Primary Care Center	(203) 688-2471
YNHH Women's Center	(203) 688-4101
Yale Physician Referral Service	(203) 688-2000

TABLE 8: CASE EXAMPLE OF BNI DIALOGUE FOR SBIRT CONDITION

SPEAKER	DIALOGUE	PROCEDURE
Clinician	Hello, I am one of the ED Health Study RAs. I understand that you have discussed some issues related to your use of opioids with one of our other RAs.**<PAUSE>** This must be a tough time for you." **<PAUSE>** Would you mind spending a few minutes talking about your use of opioids?	**RAISE THE SUBJECT**
Patient	Ok, like what?	
Clinician	"I would like to take some time to talk with you about the issues related to your use and then to explore how we might be able to help with that." How are you feeling right now?	
Patient	Not great at all. I like it; it makes me feel good, but it would be great to slow down a little or take a break on some days without getting sick. I'm feeling really bad right now.	
Clinician	Sounds like you're in a lot of physical discomfort and that using less would really be something you'd like to do. We'd be happy to help you with that.	
Patient	Alright…well…	**PROVIDE FEEDBACK**
Clinician	From what I understand you use heroin intravenously everyday, about 4-5 bags a day throughout the day, and that it's caused you some problems. Tell me more about those problems.	Make Connection
Patient	Well, I mean…nothing I can't handle, but life does seem to suck right now. People can't take my crap anymore, especially my boss.	
Clinician	So, it sounds like heroin has caused some relationship and work problems for you. Although you are able to keep your job it's getting tougher.	Review Mini-SCID
Patient	Yes, I spend more and more time trying to get heroin and it's hard to find clean needles. Sometimes I have to share needles.	
Clinician	So sharing needles can lead to real health problems and spending more time trying to find the drug certainly takes you away from your work. How does it affect other parts of your life?	
Patient	Well I had to drop out of my adult ed classes. And I lost my friends ad girlfriend because I have no time to hang with them.	
Clinician	This must be a very hard time for you. So you're telling me that both your work and personal life are in a mess and the fact that you're sharing needles is putting your health at even greater risk. What connection do you see between your drug use and this ED visit?	

SPEAKER	DIALOGUE	PROCEDURE
Patient	I'm dope sick and I don't know what to do anymore. I thought you could help me out. Look, at least I'm being straight with you and not giving you a whole story about fake pain.	
Clinician	We *can* help you with this by getting you a referral to a drug treatment center **right now.** Treatment works – it can help you reduce and stop your heroin use, which is escalating to a point where you're always in some degree of withdrawal. So, let's next talk about how ready you might be to do engage in treatment. On a scale from 1-10, how ready are you to go to the appointment we arrange for you, where 1 means not ready at all and 10 means totally ready?	**ENHANCE MOTIVATION** Readiness to change
Patient	I don't know, maybe a 5	
Clinician	OK, so that is good, you are halfway or 50% there. Why not less? In other words why did you not pick a 1 or 2? What are some reasons why you think starting this treatment would be good for you?	Evoke "Change Talk"
Patient	Well, I am here because I have no place left to get my stuff and I'll just get more and more sick. I'm also tired of this pattern and miss my girlfriend.	Beginning "Change Talk"
Clinician	Those are 2 good reasons, anything else?	Open Question to elicit more "Change Talk"
Patient	My girlfriend did say that she'd consider taking me back if I ever got into treatment.	More "Change Talk"
Clinician	So, even though the answer to this question should be obvious, tell me in your own words why it would be important to you to start treatment and get your girlfriend back?	
Patient	Because she's the only person that has ever gotten me and really understood why I am this way. And she's totally drug-free – she's never even touched the stuff. I know I can get her back.	Deeper "Change Talk"
Clinician	So it sounds like starting treatment would give you a number of things that are very important to you. In the short-run, it would make you much more physically comfortable and you wouldn't have to be running around anymore. It could also help things between you and your boss, because you wouldn't have to be running around anymore and you might even re-connect with your friends. But most importantly, it would help you get back together with your girlfriend. Now, if you don't mind, I'd like to add one more thing to the list (wait for permission). You would also reduce the risk of contracting HIV/AIDS.	Reflection of "Change Talk"

SPEAKER	DIALOGUE	PROCEDURE
Patient	I've always thought about all the bad stuff heroin was doing to me, which only made me want to use more. Now, you make it sound like I could *get* a lot of good stuff from doing this treatment.	Commitment Talk
Clinician	So, what's the next step, if any?	**NEGOTIATE & ADVISE**
Patient	I want to try it. How do I start?	Summarize
Clinician	Well I'm going to review this list with you so we can identify the best place for you to get help and I will call to try to get an appointment with you today. Because it is sometimes helpful to write down our goals and plans, I'm going to ask you to fill out this agreement sheet. It is an agreement between you and your self and is not a part of your medical records. I think you've made an excellent decision and I wish you all the best. Thank you for your time.	Negotiate goal Follow-up Thank patient

TABLE 9: CASE EXAMPLE OF BNI DIALOGUE FOR SBI+Bup CONDITION

SPEAKER	DIALOGUE	PROCEDURE
Clinician	Hello, I am one of the ED Health Study RAs. I understand that you have discussed some issues related to your use of opioids with one of our other RAs.**<PAUSE>** This must be a tough time for you." **<PAUSE>** Would you mind spending a few minutes talking about your use of opioids?	**RAISE THE SUBJECT**
Patient	Ok, like what?	
Clinician	"I would like to take some time to talk with you about the issues related to your use and then to explore how we might be able to help with that." How are you feeling right now?	
Patient	Not great at all. I like it; it makes me feel good, but it would be great to slow down a little or take a break on some days without getting sick. I'm feeling really bad right now.	
Clinician	Sounds like you're in a lot of physical discomfort and that using less would really be something you'd like to do. We'd be happy to help you with that.	
Patient	Alright…well…	**PROVIDE FEEDBACK**
Clinician	From what I understand you use heroin intravenously everyday, about 4-5 bags a day throughout the day, and that it's caused you some problems. Tell me more about those problems.	Make Connection
Patient	Well, I mean…nothing I can't handle, but life does seem to suck right now. People can't take my crap anymore, especially my boss.	
Clinician	So, it sounds like heroin has caused some relationship and work problems for you. Although you are able to keep your job it's getting tougher.	Review Mini-SCID
Patient	Yes, I spend more and more time trying to get heroin and it's hard to find clean needles. Sometimes I have to share needles.	
Clinician	So sharing needles can lead to real health problems and spending more time trying to find the drug certainly takes you away from your work. How does it affect other parts of your life?	
Patient	Well I had to drop out of my adult ed classes. And I lost my friends ad girlfriend because I have no time to hang with them.	
Clinician	This must be a very hard time for you. So you're telling me that both your work and personal life are in a mess and the fact that you're sharing needles is putting your health at even greater risk. What connection do you see between your drug use and this ED visit?	

SPEAKER	DIALOGUE	PROCEDURE
Patient	I'm dope sick and I don't know what to do anymore. I thought you could help me out. Look, at least I'm being straight with you and not giving you a whole story about fake pain.	
Clinician	We *can* help you with that, because you have been assigned to receive Suboxone. Suboxone can help you reduce and stop your heroin use, which is getting you to the point of withdrawal sooner and sooner. (REVIEW SUBOXONE FACTS) So, let's next talk about how ready you might be to do something different about this. On a scale from 1-10, how ready are you to accept suboxone treatment in the ER tonight and to follow-up at YNHH's Primary Care Center next week, where 1 means not ready at all and 10 means totally ready?	**ENHANCE MOTIVATION** Readiness to change
Patient	I don't know, maybe a 5	
Clinician	OK, so that is good, you are halfway or 50% there. Why not less? In other words why did you not pick a 1 or 2? What are some reasons why you think starting this treatment would be good for you?	Evoke "Change Talk"
Patient	Well, I am here because I have no place left to get my stuff and I'll just get more and more sick. I'm also tired of this pattern and miss my girlfriend.	Beginning "Change Talk"
Clinician	Those are 2 good reasons, anything else?	Open Question to elicit more "Change Talk"
Patient	My girlfriend did say that she'd consider taking me back if I ever got into treatment.	More "Change Talk"
Clinician	So, even though the answer to this question should be obvious, tell me in your own words why it would be important to you to start treatment and get your girlfriend back?	
Patient	Because she's the only person that has ever gotten me and really understood why I am this way. And she's totally drug-free – she's never even touched the stuff. I know I can get her back.	Deeper "Change Talk"
Clinician	So it sounds like starting treatment would give you a number of things that are very important to you. In the short-run, it would make you much more physically comfortable and you wouldn't have to be running around anymore. It could also help things between you and your boss, because you wouldn't have to be running around anymore and you might even re-connect with your friends. But most importantly, it would help you get back together with your girlfriend. Now, if you don't mind, I'd like to add one more thing to the list (wait for permission). You would also reduce the risk of contracting HIV/AIDS.	Reflection of "Change Talk"

SPEAKER	DIALOGUE	PROCEDURE
Patient	I've always thought about all the bad stuff heroin was doing to me, which only made me want to use more. Now, you make it sound like I could *get* a lot of good stuff from doing this treatment.	Commitment Talk
Clinician	So, what's the next step, if any?	**NEGOTIATE & ADVISE** Summarize
Patient	I want to try it. How do I start?	
Clinician	Explain process as per Dr. Fiellin's protocol and ask the patient to sign prepared agreement sheet. I think you've made an excellent decision and I wish you all the best. Thank you for your time.	Negotiate goal Follow-up Thank patient

TABLE 10: **Clinical Opiate Withdrawal Scale**

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score…

Project #: 1☐☐☐ Date:☐☐-☐☐-☐☐ RA:☐☐☐ Time (military) ☐☐☐☐

Reason for this assessment:_____

Resting Pulse Rate: ____beats/minute *Measured after patient is sitting or lying for 1 minute* ☐ 0… pulse rate 80 or below ☐ 1… pulse rate 81-100 ☐ 2…pulse rate 101-120 ☐ 4… pulse rate greater than 120	**GI Upset**: *Over last ½ hour* ☐ 0…no GI symptoms ☐ 1…stomach cramps ☐ 2…nausea or loose stool ☐ 3…vomiting or diarrhea ☐ 5…multiple episodes of diarrhea or vomiting
Sweating: *Over past ½ hour not accounted for by room temperature or patient activity.* ☐ 0…no report of chills or flushing ☐ 1…subjective report of chills or flushing ☐ 2…flushed or observable moistness on face ☐ 3…beads of sweat on brow or face ☐ 4…sweat streaming off face	**Tremor:** *Observation of outstretched hands* ☐ 0…No tremor ☐ 1…tremor can be felt, but not observed ☐ 2…slight tremor observable ☐ 4…gross tremor or muscle twitching
Restlessness: *Observation during assessmen*t ☐ 0…able to sit still ☐ 1…reports difficulty sitting still, but is able to do so ☐ 3…frequent shifting or extraneous movements of legs/arms ☐ 5…Unable to sit still for more than a few seconds	**Yawning:** *Observation during assessment* ☐ 0…no yawning ☐ 1…yawning once or twice during assessment ☐ 2…yawning three or more times during assessment ☐ 4…yawning several times/minute
Pupil size: ☐ 0…pupils pinned or normal size for room light ☐ 1…pupils possibly larger than normal for room light ☐ 2…pupils moderately dilated ☐ 5…pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability:** ☐ 0…none ☐ 1…patient reports increasing irritability or anxiousness ☐ 2…patient obviously irritable anxious ☐ 4…patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches: *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* ☐ 0…not present ☐ 1…mild diffuse discomfort ☐ 2…patient reports severe diffuse aching of joints/muscles ☐ 4…patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin:** ☐ 0…skin is smooth ☐ 3…piloerrection of skin can be felt or hairs standing up on arms ☐ 5…prominent piloerrection
Runny nose or tearing: *Not accounted for by cold symptoms or allergies* ☐ 0…not present ☐ 1…nasal stuffiness or unusually moist eyes ☐ 2…nose running or tearing ☐ 4…nose constantly running or tears streaming down cheeks	*The total score is the sum of all 11 items…* Total Score: ☐☐

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

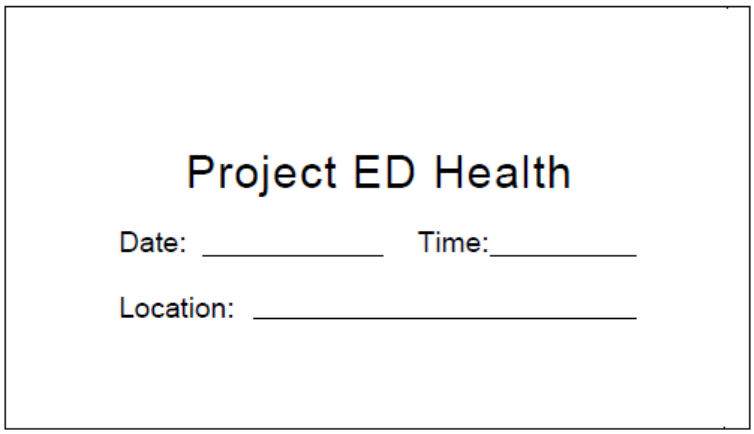
TABLE 11: OBJECTIVE OPIOID WITHDRAWAL SCALE (OOWS)

Observe the patient during a 5 minute observation period then indicate a score for each of the opioid withdrawal signs listed below (items 1-13). Add the scores for each item to obtain the total score

Project #: 1☐☐☐ Date:☐☐-☐☐-☐☐ RA:☐☐☐ Time (military) ☐☐☐☐

	Date							
	Time							
1	**Yawning** 0 = no yawns 1 = ≥ 1 yawn							
2	**Rhinorrhoea** 0 = < 3 sniffs 1 = ≥ 3 sniffs							
3	**Piloerection** (observe arm) 0 = absent 1 = present							
4	**Perspiration** 0 = absent 1 = present							
5	**Lacrimation** 0 = absent 1 = present							
6	**Tremor** (hands) 0 = absent 1 = present							
7	**Mydriasis** 0 = absent 1 = ≥ 3 mm							
8	**Hot and cold flushes** 0 = absent 1 = shivering / huddling for warmth							
9	**Restlessness** 0 = absent 1 = frequent shifts of position							
10	**Vomiting** 0 = absent 1 = present							
11	**Muscle twitches** 0 = absent 1 = present							
12	**Abdominal cramps** 0 = absent 1 = Holding stomach							
13	**Anxiety** 0 = absent 1 = mild – severe							
	TOTAL SCORE							

TABLE 12: Appointment Cards



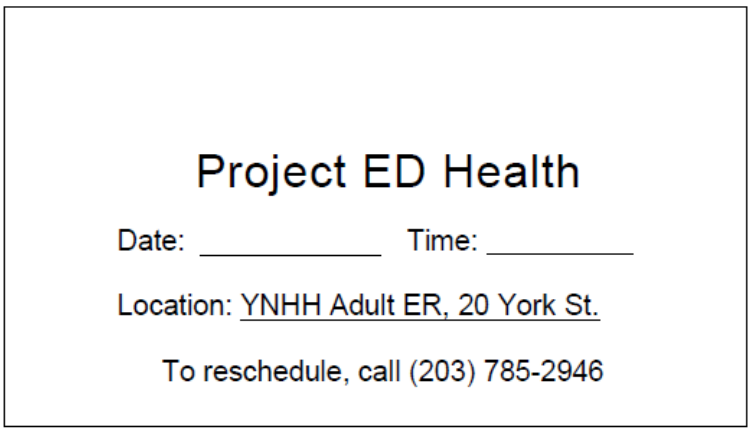


TABLE 13: PROJECT ED HEALTH III – HEALTH QUIZ

Project ED Health III
HEALTH QUIZ

Project #:..... 1☐☐☐
Date: ☐☐-☐☐-☐☐ RA:... ☐☐☐

1. Are you……
   ☐ 1…male
   ☐ 2…female

2. What is your age? ☐☐

3. Which race/ethnicity do you consider yourself?
   ☐ 1…white, of Hispanic origin
   ☐ 2…white, not of Hispanic origin
   ☐ 3…black, of Hispanic origin
   ☐ 4…black, not of Hispanic origin
   ☐ 5…Asian or Pacific Islander
   ☐ 6…American Indian or Alaskan Native
   ☐ 7…other

4. Do you currently smoke cigarettes?
   ☐ 0…not at all [Skip to Q6]
   ☐ 1…every day
   ☐ 2…some days

5. On average, about how many cigarettes do you smoke per day? ☐☐

6. Do you ever drink beer, wine, liquor or any drink containing alcohol?
   ☐ 0…no [Skip to Q11]
   ☐ 1…yes

Say: "For the next questions, 1 drink equals a 12oz. beer; 5oz. glass of wine; 12oz. wine cooler; 1½ oz. shot of liquor; or a mixed drink made with 1 shot."
Ask: "What do you usually drink?" **Calculate: #** of drinks in what they say

7. On average, how many days per week do you drink alcohol? ☐

8. On a typical day when you drink, how many drinks do you have? ☐☐
   [Do NOT accept word response or range]

9. What is the maximum number of drinks you had on any given day in the past 28 days? ☐☐

10. **[Ask ALL drinkers]** How many times in the past year have you had…
    [For men] 5 or more drinks ☐☐☐
    [For women] 4 or more drinks ☐☐☐

11. Are you in the ED today for treatment of an injury?
    ☐ 0…no
    ☐ 1…yes

12. In the PAST 30 days have you used any of the following pain relievers?		
a) Codeine	☐ 0…No	☐ 1…Yes
b) Fentanyl (Duragesic, Actiq, Sublimaze)	☐ 0…No	☐ 1…Yes
c) Hydrocodone (Vicodin, Lorcet, Lortab, Hycodan, Norco, Vicoprofen)	☐ 0…No	☐ 1…Yes
d) Hydromorphone (Dilaudid, Palladone)	☐ 0…No	☐ 1…Yes
e) Meperidine (Demerol)	☐ 0…No	☐ 1…Yes
f) Methadone (Dolophine, Methadose)	☐ 0…No	☐ 1…Yes
g) Buprenorphine (Subutex, Suboxone)	☐ 0…No	☐ 1…Yes
h) Morphine (MS Contin, Kadian, Duramorph)	☐ 0…No	☐ 1…Yes
i) Oxycodone (Percocet, Percodan, Roxicet, Oxycontin, Roxicodone, Endocet, Tylox)	☐ 0…No	☐ 1…Yes
j) Oxymorphone	☐ 0…No	☐ 1…Yes
k) Pentzocine (Talwin)	☐ 0…No	☐ 1…Yes
l) Propoxyphene (Darvocet, Darvon, Wygesic)	☐ 0…No	☐ 1…Yes
m) Other (specify)_____	☐ 0…No	☐ 1…Yes
IF ALL 'NO', SKIP to Q15		

13. Were these drugs prescribed for you?
    ☐ 0…no
    ☐ 1…yes

14. Have you ever taken the drug(s) for the experience or feeling it caused?
    ☐ 0…no
    ☐ 1…yes

15. In the PAST 30 days have you used heroin?
    ☐ 0…no
    ☐ 1…yes
    [IF Q12 AND Q15 'No', SKIP to Q19]

16. How often do you use heroin or [insert name of drug(s) reported in Q12]?
    ☐☐ days/week*
    ☐☐ days/month [Probe→recalculate in wks]→☐☐ days/week*

*NOTE:
- IF ≥3 days/week ask Q17-Q18
- IF <3 SKIP to Q19

[IF ≥3days/week in Q16] SAY: "I have just a few more questions to determine if you're eligible for a public health project we're doing. I need to review how often you used heroin or [insert name of other drug(s) reported in Q12] in the past 7 days. If you haven't used 3 or more days in the past 7 days due to something unusual, such as illness, etc…, we'll start on the last day you used and go back 6 days from then, but all within the last 30 days.

17. When was the last day you used heroin or [insert name of drugs reported in Q12]? _____

18. You said that you last used [Insert last day of use reported in Q17], did you use the day before that? [repeat, going back for a **total of 7 consecutive days only**; mark 'X' to indicate day of use]

7-day period of use	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Last day of use (from Q16)
'X'= Day of Use							X

NOTE:
- IF ≥3 days→Q19→SCID
- IF <3 days→Q19→inform patient that they are not eligible and thank them for their time

19. Have you had unprotected sex (sex without using a condom) with a new or not a steady partner in the past 90 days?
    - ☐ 0…no
    - ☐ 1…yes
    - ☐ 9…refused

TABLE 14: PROJECT ED HEALTH III - HRBS

HRBS

The following questions are about your sexual and drug use behaviors, things that happened, or that you have done in the past 30 days. Think back over this time about the places you have been, the things that you have done, and the people that you have been with. The most important thing is that you respond HONESTLY and ACCURATELY. OK, let's start…

Drug Use Section:

10.1 How many times have you hit up (i.e. injected any drugs) IN THE PAST 30 DAYS?

- ☐ 0…Hasn't hit up [SKIP to question 10.7]
- ☐ 1…Once a week or less
- ☐ 2… More than once a week (but less than once a day)
- ☐ 3…Once a day
- ☐ 4…2-3 times a day
- ☐ 5…More than 3 times a day

10.2 How many times IN THE PAST 30 DAYS have you used a needle after someone else had already used it?

- ☐ 0…No times
- ☐ 1…One time
- ☐ 2…Two times
- ☐ 3…3-5 times
- ☐ 4…6-10 times
- ☐ 5…More than 10 times

10.3 How many people have used a needle **before** you IN THE PAST 30 DAYS?

- ☐ 0…None
- ☐ 1…One person
- ☐ 2…Two people
- ☐ 3…3-5 people
- ☐ 4…6-10 people
- ☐ 5…More than 10 people

10.4 How many times IN THE PAST 30 DAYS has someone used a needle **after** you have used it?

- ☐ 0…No times
- ☐ 1…One time
- ☐ 2…Two times
- ☐ 3…3-5 times
- ☐ 4…6-10 times
- ☐ 5…More than 10 times

1

SECTION 10. HRBS (cont.)

10.5 How often, IN THE PAST 30 DAYS, have you cleaned needles before re-using them?

- ☐ 0…Doesn't re-use
- ☐ 1…Every time
- ☐ 2…Often
- ☐ 3…Sometimes
- ☐ 4…Rarely
- ☐ 5…Never

10.6 Before using needles again, how often IN THE PAST 30 DAYS did you use bleach to clean them?

- ☐ 0…Doesn't re-use
- ☐ 1…Every time
- ☐ 2…Often
- ☐ 3…Sometimes
- ☐ 4…Rarely
- ☐ 5…Never

Sexual Behavior Section:

10.7 IN THE PAST 30 DAYS, how many people, including clients, have you had sex with (i.e. vaginal/anal sex)?

- ☐ 0…None [SKIP to next Section]
- ☐ 1…One person
- ☐ 2…Two people
- ☐ 3…3-5 people
- ☐ 4…6-10 people
- ☐ 5…More than 10 people

10.8 IN THE PAST 30 DAYS, how often have you used condoms when having sex with your regular partner(s)?

- ☐ 0…No regular partner
- ☐ 1…Every time
- ☐ 2…Often
- ☐ 3…Sometimes
- ☐ 4…Rarely
- ☐ 5…Never

2

SECTION 10. HRBS (cont.)

10.9 IN THE PAST 30 DAYS, how often have you used condoms when you had sex with casual partners?

- ☐ 0...No casual partners
- ☐ 1...Every time
- ☐ 2...Often
- ☐ 3...Sometimes
- ☐ 4...Rarely
- ☐ 5...Never

10.10 IN THE PAST 30 DAYS how often have you used condoms when you have been paid for sex or paid someone else for sex?

- ☐ 0...No paid sex
- ☐ 1...Every time
- ☐ 2...Often
- ☐ 3...Sometimes
- ☐ 4...Rarely
- ☐ 5...Never

10.11 IN THE PAST 30 DAYS how many times did you have anal sex?

- ☐ 0...No times
- ☐ 1...One time
- ☐ 2...Two times
- ☐ 3...3-5 times
- ☐ 4...6-10 times
- ☐ 5...More than 10 times

3

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