SBIRT Checklist for Observation in Real-time (SCORe) Protocol

Adapted from:Vendetti, J., McRee, B. & Del Boca, F. Development of the SBIRT Checklist for Observation in Real-time (SCORe). *Addiction* 2017; 112(S2): 34-42.

# Introduction

The SCORe instrument is an observation form used to structure the recording of information gleaned from practitioners as their SBIRT activities are shadowed during the course of a typical workday. To increase their relevance and to enhance observer efficiency, data collection forms may be tailored to the specific performance sites where observations occur.

Structured observations are conducted using standardized observation forms specific to each service component (screening, brief intervention and referral to treatment) where necessary. In addition to capturing information on the service delivery process, observers also record data on practitioners’ level of adherence to an evidence-based protocol in performing those activities. This document provides instructions for completing the SBIRT Checklist for Observation in Real-time (SCORe).

The primary purpose in collecting SBIRT session data is to record whether practitioners adhere to the evidence-based protocol on which the SBIRT process is based. For each patient/practitioner direct service observation, the observer should document the practitioner’s adherence to a checklist of service delivery activities. The form used to collect these data should be completed once for each patient/practitioner interaction. The method for collecting the observation data is via direct observation or indirect, taped interactions, if necessary.

## Item-by-Item Instructions

### Practitioner Adherence: Screening Components

The Screening Component section described below follows the elements of the full ASSIST tool, however it may be used for the observation of other screening tools or pre-screening instruments although not all components will be relevant.

1. *Establishes rapport and introduces the screening:* Did the practitioner attempt to establish a relationship with the patient to build trust and make the patient feel comfortable; such as greet the patient in a friendly way, smile, introduce him or herself as part of the medical team, express concern about the patient’s condition, ensure confidentiality, etc.?
2. *Provides a rationale for asking the questions:* Did the practitioner introduce the ASSIST (or other tool) by telling the patient *why* the questions are being asked and how the answers may relate to his or her current health status?
3. *Addresses confidentiality:* Did the practitioner assure the patient that the answers that he or she provides will be kept as strictly confidential and that his or her answers would be shared only with their doctor, for example. (Note: the people who have access to the screening assessment may change from state to state or from site to site). If applicable, the practitioner should assure the patient that law enforcement and insurance companies, for example, cannot access this information. Note: if the standardized introduction to the ASSIST is used, confidentiality is addressed.
4. *Provides a standardized introduction to screening:* Did the practitioner read (or very closely paraphrase) the same introduction to all patients? If the standardized instruction is printed at the beginning of the assessment, did the practitioner read or paraphrase it?
5. *Defines time window of interest:* Did the practitioner tell the patient what the time-frame of interest is (e.g., past 30 days, 3 months, lifetime)? Note: if the standardized introduction to the ASSIST is used, this is addressed.
6. *Asks questions as written:* Did the practitioner ask the questions verbatim (or paraphrase closely if the patient did not understand the first time)? Did he or she repeat the stem frequently enough for the patient to keep track of the question being asked?
7. *Provides Response Card and Drug List to patient:* Did the practitioner hand or show the patient a card that lists all the categories of substances (along with the specific drug names) that he or she will be asking about? This can help the patient to identify the substances that he uses even if he were unsure of the category they belong to. Does this card also include a set of responses that the patient can choose from or refer to in answering each of the questions?
8. *Accurately follows skip patterns:* Did the practitioner ask question 2 only for those substances endorsed in question 1, and ask question 3-5 only for those substances used in the past 3 months? Did the practitioner ask questions 6-7 for all substances endorsed in question 1? In general, errors where the practitioner asks too many questions (i.e., asking question 3 for drugs not recently used) is less serious than forgetting to ask questions about drugs identified by the patient. However, asking too many questions can cause frustration for the patient.
9. *Accurately classifies drugs or standard drinks:* Did the practitioner record the substances that the patient used in the correct category? For example, although Ecstasy has stimulant properties, it should be categorized under Hallucinogens (as indicated by the US Drug Enforcement Administration). If the practitioner is using a standardized drug card, you can assume that the drugs are being accurately categorized. In some cases patients will use slang names for street drugs and practitioners must probe to determine which drug category should be coded. When asking the alcohol questions, did the practitioner clarify what constitutes a “drink”? For example, did the practitioner ask the patient what they drank in order to determine whether the patient’s understanding of a “drink” (e.g., 2 Long Island iced teas) was consistent with the practitioner’s calculation of the number of “standard drinks” (2 LI iced teas equals about 4 standard drinks).
10. *Uses probing techniques to clarify ambiguities:* When the patient’s answers to questions are not easily scored or when the patient contradicts what he or she said in an earlier answer, does the practitioner ask for clarification from the patient or remind the patient of the previous answer in order to obtain accurate information? This sometimes requires the practitioner to give the patient some parameters, such as “did you go out of the house in search of cocaine because you were craving it or did you snort it just because someone presented it to you?” Probes are often used to make certain that the patient meets the threshold of the screening criterion.
11. *Scores the assessment accurately:* Did the practitioner add the individual item scores for each substance category correctly?
12. *Accurately categorizes patient risk:* Did the practitioner accurately transfer the scores to the correct risk category (0-3, [0-10 for alcohol]=low, 4-26, [11-26 for alcohol]=moderate, >26=high)?

*Comments*: Use the “*Comments”* section to describe any other components used in the screening assessment. For example, if the observation is of a pre-screen or the ASSIST-FC vs. full ASSIST screen, please indicate it in the comments section.

### Practitioner Adherence: Brief Intervention (BI) Components

The SCORe follows the ASSIST-linked brief intervention that incorporates a FRAMES approach using Motivational Interviewing style elements. Therefore, there are two primary groupings of elements that should be coded for adherence to the BI protocols. The first group contains the more objective components of the intervention (1-11) on the left-hand side of the Checklist. The second group of elements on the right-hand side of the form (12-20) is used to judge the more stylistic aspects of motivational interviewing (MI) which can be subjective, have a tendency to overlap and are more difficult to identify. Unlike the objective components of the intervention, the stylistic elements, by definition, should have a higher threshold for being marked as present. Ideally, the more widely accepted elements of MI delivery should be used at least 2 times by the practitioner to be coded as “yes.” The observer should jot down phrases or use hash marks to keep a running count of these items.

If a combined BI is conducted for two or more substances (i.e., alcohol and cocaine) the observer should use one Patient Session form only and code the adherence elements as a single BI (rather than using two forms, one for each substance).

Usually, the observer will watch the screening and brief intervention (SBI) activities in succession. In these cases, the observer should begin coding any of the MI style elements (e.g., supporting self efficacy, utilizing open-ended questions, utilizing affirmations, utilizing reflective listening, etc.) that is heard during the screening process. When SBI is delivered sequentially, the practitioner will likely use their MI techniques throughout the session as the elements are closely linked.

1. *Asks permission to show the screening scores:* The start of the BI should include a question posed to the patient that requests permission to share the results of the screening assessment and associated risk scores.
2. *Describes the risk levels associated with the scores:* Next, the practitioner should explain to the patient the risk level associated with each score and what that means (i.e., low, moderate or high). For example, “You scored a 17 – which places you in the moderate risk range for your marijuana use. That means that you are at risk for health, social and other problems related to your current level of marijuana use.”
3. *Describes the risks associated with the substance: health, legal, financial, social, etc.:* The practitioner should tell the patient (and perhaps use a handout) about the health, legal, financial and social problems related to the substance that the patient is using (e.g., heart disease, COPD, cancer for tobacco). The practitioner should link any of the problems that the patient mentioned during the interview to the patient’s presenting problem when possible.
4. *Describes lower-risk drinking guidelines:* If applicable, the practitioner should give the patient information that will help him or her make better decisions, including information about lower-risk drinking guidelines and the definition of a standard drink (if applicable). This item is for those scoring in a risk range for alcohol use. If the patient does not use alcohol, check NA for this item.
5. *Promotes personal responsibility/choice:* The practitioner should let the patient know that what he or she does with the information provided, as well as whether he or she would like to make changes in their substance use, is his or her own decision.
6. *Provides advice related to limits of consumption: maintain, reduce, abstain:* The practitioner should give the patient tailored advice, based on the screening scores, including the advice to abstain if necessary (e.g., if the patient is pregnant or taking prescribed medications that interact with alcohol). The practitioner should also let the patient know that he or she is there to help assist the patient in getting the care needed.
7. *Provides a menu or variety of change options:*  The practitioner’s advice to the patient should include more than one option to help the patient make changes. For example, depending on the patient’s resources and beliefs, the practitioner should allow the patient to choose the type of change that he or she is comfortable with, for example, not changing at all, cutting back, or quitting. The practitioner can then provide a menu of ways to make that change from which the patient might choose. For quitting smoking menu options might include use of nicotine replacement therapy, non-nicotine medication, Quitline telephone services, brief counseling, cold turkey, etc.
8. *Utilizes importance/readiness/confidence rulers, decisional balance, pros/cons:* When conducting brief interventions, practitioners can utilize several tools that assist patients in expressing their ambivalence. Practitioners should attempt to use at least one of these tools to help the patient develop an internal motivation to change. The decisional balance is a form which allows the patient to record the good things and the not so good things about using the target substance. The balance also covers the good things and the not so good things about not using (or using less) of the substance. Note that the patient may not wish to write their thoughts on paper; however, the practitioner should still review the form with the patient. Check “yes” to this item if any one of these tools is used. Circle the specific tool utilized.
9. *Helps patient sets goals/develop a plan of action:* The practitioner should, toward the end of the BI, establish whether the patient is agreeable to making some changes in his or her substance use. If the patient is willing to make some changes, the practitioner should develop a plan with the patient that includes setting a quit/cutting back date and tangible short term goals. This may include attending additional BI or BT sessions within the setting, attending peer counseling groups, keeping a drinking diary, etc.
10. *Provides take-home/resource materials:* The practitioner should end the BI by asking the patient if he would like some additional resource materials, such as local treatment options, self-help groups or educational materials.
11. *Informs patient about additional BIs/BT and makes appointment, if applicable:* The practitioner should inform the patient about the availability of additional sessions of BI or BT. If the patient is interested, the practitioner should provide the patient with an appointment card or make a future appointment at the time of the session.
12. *Avoids lecturing, warning, convincing – asks permission to educate, suggest or advise:* One of the tenants of MI is to listen to patients more than tell them what to do. Practitioners should always *ask* before giving advice or making suggestions to patients. It is important that practitioners elicit ideas and solutions from their patients rather than providing them with what they think the answer to the problem might be. On the other hand, if the patient *asks* for advice or information, the practitioner is in a position to give the patient what they are looking for.
13. *Expresses empathy:* Empathy communicates respect for and acceptance of patients and their feelings. It encourages a nonjudgmental, collaborative relationship, where the practitioner listens rather than tells, gently persuades with the understanding that the decision to change is the patient’s. The clinician uses reflective listening to express empathy regarding the patient's ambivalence rather than confront him or her with the need to change. The assumptions are that acceptance facilitates change and that ambivalence is normal. Empathy is expressed non-verbally by eye contact, body position and facial expression. It is conveyed verbally through the practitioner reflections on what the patient expresses.
14. *Reduces resistance:* Patients are likely to be resistant to change and may argue with the practitioner or say things contrary to change. The practitioner should treat ambivalence (mixed feelings) as normal, use double-sided reflections and see the resistance as a cue to change tactics with the patient. If the practitioner encounters no resistance from the patient during the session, check NA for this item.
15. *Supports self-efficacy:* Many patients find it difficult to believe that they can begin or maintain behavioral change. Education can increase patients’ sense of self-efficacy. Credible, understandable and accurate information helps patients understand how substance use progresses to abuse or dependency. It is important for the practitioner to make the connection between previous successful changes and the potential to change the current use pattern. The practitioner should reinforce any willingness to hear information, acknowledge a problem or take steps toward change. Ideally, the observer should hear at least 2 examples of supporting self-efficacy before checking “yes” to this item.
16. *Utilizes open-ended questions:* Open ended questions facilitate dialogue and are a means to solicit information in a neutral way. The questions cannot be answered with a single word or phrase. For example, “Why don’t you tell me about your alcohol use on a typical day” vs. “How many drinks do you drink on a typical day.” Ideally, the observer should hear at least 2 examples of open-ended questions before checking “yes” to this item.
17. *Utilizes affirmations:* When done sincerely, affirming a patient supports and promotes self-efficacy. More broadly, affirmation acknowledges the difficulties the patient has experienced. Affirming helps the patient feel confident about marshaling their inner resources to take action and change behavior. For example, “That must have been very difficult for you.” “That’s a good suggestion,” “You’re certainly a resourceful person to have been able to live with the problem this long and not fall apart.” Ideally, the observer should hear at least 2 examples of utilizing affirmations before checking “yes” to this item.
18. *Utilizes reflective listening:* Reflective listening is a challenging skill in which the practitioner demonstrates that he or she has accurately heard and understood a patient’s communication by restating its meaning. That is, the practitioner hazards a guess about what the patient intended to convey and expresses this in a responsive statement, not a question. Reflective listening is a way of checking rather than assuming that one knows what is meant. Reflective listening strengthens the empathetic relationship between the practitioner and the patient and encourages further exploration of problems and feelings. This form of communication is particularly appropriate for brief interventions when used selectively to reinforce certain processes. It reduces the likelihood of resistance, encourages the patient to keep talking, communicates respect, cements the therapeutic alliance, clarifies what the patient means and reinforces motivation. Ideally, the observer should hear at least 2 examples of reflective listening before checking “yes” to this item. Examples include:

| ***Reflection Type*** | ***Patient*** | ***Practitioner*** |
| --- | --- | --- |
| *Simple* | *I don’t plan to quit smoking anytime soon* | *You don’t think that abstinence would work for you right now* |
| *Amplified* | *I don’t know why my wife is worried about this. I don’t drink any more than any of my friends* | *So your wife is worrying needlessly* |
| *Reframing* | *My husband is always nagging me about my cigarette smoking – calling me an addict. It really bugs me* | *It sounds like he really cares about you and is concerned, although he expresses it in a way that makes you angry* |
| *Double -sided* | *I know you want me to give up cigarettes completely but I’m not going to do that* | *You can see that there are some real problems because of your smoking, but you’re not willing to think about quitting altogether* |

1. *Generates change talk:* Understanding how to listen for and generate “change talk” is an essential component of MI. It is hypothesized that commitment talk leads to the most immediate change. For the purposes of the observation, any change talk that is heard is assumed to be generated by the practitioner. Ideally, the observer should hear at least 2 examples of change talk from the patient before checking “yes” to this item. There are 5 types of change talk: (DARN-C)
   1. Desire “I want to…”
   2. Ability “I could…”
   3. Reasons “I should because…”
   4. Need “I need to…”
   5. Commitment “I will…”
2. *Closes with summary of session:* All sessions should end with a recap of the session. Practitioners should review, with the patient, any progress or decisions made, “check in” with the patient by asking how he or she thought the session went and if the session met the patient’s expectations.

*Comments:* If any other BI components are used, please note them in the *“Comments”* section.

### Practitioner Adherence: Referral to Treatment Components

*The Referral to Treatment components are self-explanatory and do not need additional instructions. MI techniques have been previously described in this document.*

1. *Uses MI techniques to determine patient’s interest in additional treatment*
2. *Collaborates with patient to assess preferences for treatment options (e.g., modality, gender specific, schedule, location)*
3. *Determines logistical barriers (e.g., insurance, transportation, child care, employment)*
4. *Offers on-site SA assessment and treatment, if available (e.g., co-located within medical setting)*
5. *Facilitates warm handoff to therapist (e.g., sends therapist to patient’s room, walks patient to therapist’s office)*
6. *Facilitates telephone conversation between patient and therapist (either in-house or at outside agency) for assessment and treatment*
7. *Facilitates telephone conversation between patient and outside agency for assessment and treatment (i.e., no specific therapist contact)*
8. *Makes appointment for patient for further assessment and treatment at in-house department or outside agency*
9. *Provides patient agency contact information (where and when to go for assessment, but no set appointment)*
10. *Provides patient with list of available treatment options and contact information in catchment area*
11. *Provides transportation to treatment agency directly from medical setting (e.g., sends patient to treatment agency in taxi or van)*
12. *Conducts follow-up with patient, therapist, or agency to determine treatment initiation*
13. *Links patient to peer support to facilitate treatment engagement*

*Comments:* If any other referral strategies are used, please note them in the *“Comments”* section.