ASSIST-Lite

in the Emergency Department

Screening and brief intervention for substance use in emergency care settings using the ASSIST-Lite

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FOREWARD

A Fast Effective Way for Emergency Department Clinicians to Help

Almost every shift I work I see people's lives harmed though alcohol and drug use. If you put each one of the tragic anecdotes that emergency clinicians see every day in Australia in a matchbox, they might fill the Melbourne Cricket Ground. Many of these presentations could be prevented. While emergency clinicians are keen to intervene, my research suggests they lack time and resources.

Alcohol related harm is a major contributor to the workload of Emergency Departments with almost one in ten of all presentations and one in three injury presentations being alcohol related. That's half a million presentations every year from alcohol alone. When harm due to tobacco, illicit drugs and the non-medical use of pharmaceutical drugs is added, the burden is even greater. People whose problems are related to their alcohol and other drug use are more likely to return to the Emergency Department without interventions to address their risky substance use.

Screening, brief intervention and referral to treatment (SBIRT) can help to identify and reduce the health risks associated with substance use and lead to reductions in future presentations to the Emergency Department. Barriers to SBIRT such as time pressures and competing priorities are outweighed by improved patient outcomes.

The ASSIST-Lite is an ultra-rapid screening tool that can be easily administered in time pressured environments as part of routine assessment and care. The questionnaire and associated brief intervention can be delivered via a computer or in person and patients whose scores indicate risky substance use can be given printed information and self-help materials to take home.

This resource provides a clear and comprehensive overview of how the ASSIST-Lite can be part of routine care in an Emergency Department as well as providing realistic scenarios and case studies demonstrating how to deliver the ASSIST-Lite and Brief Intervention. It will allow emergency clinicians to become part of the solution rather than simply band-aiding the problem.

Congratulations to Jen Harland, Robert Ali and the team for developing this excellent resource. I commend it to all Emergency Department staff and encourage you to use it as the basis to develop your own protocols for SBIRT for drug misuse in your setting.

Professor Diana Egerton-Warburton
Emergency Physician

ACKNOWLEDGEMENTS

The *ASSIST-Lite in the Emergency Department* resource was developed by the DASSA-WHO Collaborating Centre for Research in the Treatment of Drug and Alcohol Problems. The centre is a collaboration between the Drug and Alcohol Services South Australia (DASSA) and the University of Adelaide. The DASSA-WHO Collaborating Centre assists the World Health Organization in undertaking and coordinating major research activities in the area of prevention and treatment interventions for drug and alcohol misuse throughout the world, particularly in the Asia-Pacific region.

This project is supported by a dedicated team and contributors: Robert Ali (DASSA-WHO Collaborating Centre), John Marsden (King's College London), Jennifer Harland (DASSA-WHO Collaborating Centre), Susan Henry-Edwards (DASSA-WHO Collaborating Centre), Linda Gowing (DASSA-WHO Collaborating Centre).

This manual is based on material included in the ASSIST with Substance — *Screening and Brief Intervention for Nurses manual* (Harland & Curtis, 2014) *ASSIST on Ice – The Alcohol Smoking and Substance Involvement Screening Test (ASSIST) and Brief Intervention for Methamphetamine Use* (Harland and Ali 2017) and *ASSIST with Corrections (Henry-Edwards*, Harland and Ali, 2019)

All resources shown in this manual are available on the ASSIST Portal (assistportal.com.au). The portal has been developed by the DASSA-WHO Collaborating Centre, University of Adelaide, as a repository for ASSIST tools, training resources, research articles and publications. The ASSIST Portal is freely accessible to all.

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The ASSIST-Lite is a screening tool which rapidly and efficiently identifies those who use substances at hazardous or harmful levels and are at risk of harm because of their substance use.

ASSIST-Lite

IN THE EMERGENCY DEPARTMENT

OVERVIEW

Psychoactive substance use is prevalent and widespread throughout the world and is associated with significant morbidity and mortality. The World Health Organization (WHO) has identified alcohol, tobacco, and illicit drugs as among the top 20 risk factors for ill-health and has adopted a public health approach to screening for alcohol and other drug use, and early intervention for such problems.[1] Front-line health care professionals can play a key role in the detection and prevention of hazardous alcohol consumption, smoking and substance-related problems.[2]

The *ASSIST-Lite* is a screening tool which rapidly and efficiently identifies those who use substances at hazardous or harmful levels and are at risk of harm because of their substance use. It can be used as a stand-alone screening tool, as the first part of a comprehensive drug and alcohol assessment, or to monitor an individual's progress.[3]

Why use the ASSIST-Lite and linked brief intervention?

The *ASSIST-Lite* is an ultra-rapid screener which has been optimised for medical settings which rapidly identifies those at risk of harm because of their substance use. It can be used as a stand-alone screening tool, as the first part of a comprehensive drug and alcohol assessment, or to monitor an individual's progress.

The ASSIST-Lite Brief Intervention presented in this package can be delivered in a few minutes. The principles and practice suggestions can also be used for longer or recurrent intervention sessions as needed.

Many health care professionals avoid screening and brief intervention for substance use. Reasons for not implementing screening and brief intervention in Emergency Departments include:

- a lack of time
- feeling that they are not competent or capable of giving an intervention or do not have specialist knowledge about substance misuse and addiction
- concerns regarding how screening and brief intervention fit with other assessment and intervention
- concern that they will experience resistance and defensiveness from patients

This resource addresses these barriers using a simple step-by-step approach. Screening and brief interventions have been shown to be acceptable and motivating for many people with hazardous or harmful substance use.[4] In Emergency Departments, screening and brief intervention offers an opportunity to provide assistance to people at risk from their substance use who may not have otherwise sought help. It provides Emergency Department staff with a simple, valid method of providing timely support and brief intervention to patients in their care.

[1] World Health Organization, 2010, ATLAS on Substance use: Resource for the Prevention and Treatment of Substance Use Disorders. World Health Organization, Geneva

[2] Madras, B.K., Compton, W.M., Avula, D., Stegbauer, T., Stein, J.B., Clark, H.W., 2009. Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare.

[3] Ali, R., Meena, S., Eastwood, B., Richards, I. & Marsden, J. (2013) Ultra-rapid screening for substance use disorders: The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST-Lite) Drug and Alcohol Dependence 132 352-361

[4] Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V and Monteiro M (2010). The ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care. Geneva, World Health Organization.

How to use this resource

This manual has been designed to complement the *ASSIST-Lite in the Emergency Department* instructional video and includes a number of '*spotlights*', '*tips*' and *'notes'* to help translate the evidence into practice. This resource can be used in a number of ways. These include:

- personal learning and professional development
- face-to-face group setting
- in-service session
- on-line
- Flipped classroom model (recommended for students)

See Chapter 9 Training and education session options for more information.

The package can be delivered in a short session (one to two hours), as a longer workshop, or online. The scenarios in the instructional video highlight different presenting issues and how the ASSIST-Lite can be easily introduced as part of routine clinical care. Facilitators can tailor the training depending on the needs of the participants and the purpose of the workshop or training.

It is recommended that facilitators read all of this manual to gain a better understanding of the ASSIST-Lite and of the various ways in which it can be delivered and implemented in practice.

We are delighted you are using this resource and would be keen to hear your feedback. If you have any suggestions or comments, or would like further copies please contact: dassawhocentre@adelaide.edu.au.

You can also obtain free online access to this resource through the ASSIST Portal: www.assistportal.com.au

Contributors

Jennifer Harland RN MA MSc CDAN
DASSA-WHO Collaborating Centre
University of Adelaide, Australia

Associate Professor Robert Ali MBBS FAFPHM FAChAM
DASSA-WHO Collaborating Centre
University of Adelaide, Australia

Susan Henry-Edwards B. Ed. M. Soc. Sci (App Soc Res)
DASSA-WHO Collaborating Centre
University of Adelaide, Australia

Associate Professor Linda Gowing PhD
DASSA-WHO Collaborating Centre
University of Adelaide, Australia

It is recommended that facilitators read all of this manual to gain a better understanding of the ASSIST-Lite and of the various ways in which it can be delivered and implemented in practice.

PART 1

CHAPTER 1

Why consider Screening, Brief Intervention and Referral to Treatment in emergency care settings?

OVERVIEW

This chapter provides an overview of the evidence related to screening and brief intervention in emergency care settings.

Substance use, primarily alcohol, is a factor in a substantial proportion of presentations to hospital emergency departments.[5] It has been estimated that intoxicated trauma patients are two and a half times more likely to re-present to an emergency department within two years, compared to sober patients.[6] In one study[7], the rate of repeat visits to emergency departments was double for people with a substance problem compared to those without a substance problem.

Estimates of the proportion of emergency department presentations that are alcohol-related vary widely. Almost one in ten of all emergency department presentations are alcohol related[8] while around a third of injury presentations have been reported to involve alcohol consumption[9] and even higher proportions have been reported for injuries related to

[5] Forsythe, M., & Lee, G. A. (2012). The evidence for implementing alcohol screening and intervention in the emergency department - time to act. International Emergency Nursing, 20(3), 167172. doi: http://dx.doi.org/10.1016/j.ienj.2011.09.006

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[7] Brubacher, J. R., Mabie, A., Ngo, M., Abu-Laban, R. B., Buchanan, J., Shenton, T., & Purssell, R. (2008). Substance-related problems in patients visiting an urban Canadian emergency department. CJEM Canadian Journal of Emergency Medical Care, 10(3), 198-204.

[8] Egerton-Warburton, D., Gosbell, A., Moore, K., Wadsworth, A., Richardson, D., & Fatovich, D. M. (2017). Alcohol-related harm in emergency departments: a prospective, multicentre study. Addiction. doi: 10.1111/add.14109

[9] Browne, A. L., Newton, M., Gope, M., Schug, S. A., Wood, F., & Allsop, S. (2013). Screening for harmful alcohol use in Australian trauma settings. Injury, 44, 110-117.

interpersonal violence.[10] The Designer Drug Early Warning System (D2EWS) project at the Royal Adelaide Hospital found that alcohol was predominant in presentations with clinical intoxication (61% of cases) but the use of other drugs, and polydrug use, was nonetheless substantial.

A recent Australian study[11] found that two-thirds of people with amphetamine-related psychosis had health service contact in the two years prior to their first admission for psychosis. Of these, 45% had emergency department contacts, and 30% had prior general hospital admissions. The likelihood of contact escalated over the two years prior to admission for psychosis. Screening and brief intervention in this group may have the potential to prevent at least some cases of amphetamine-related psychosis.

Attendance at an emergency department is often a time of crisis when patients may be more willing to accept help and advice.[12] A brief intervention delivered in the context of presentation to a hospital emergency department can be used to help the patient gain insight into the consequences of their substance use and may be a motivating factor to encourage behavioural change[13] or engagement in structured treatment. Interventions in the emergency setting would have a public health aim[14] with those presenting in emergency department comprising a higher risk population.[15]

Providing brief interventions for substance use to people presenting to hospital emergency departments has the potential to facilitate management and discharge of some patients and may reduce the likelihood of repeat presentations.[16]

Potential target population for Screening, Brief Intervention and Referral to Treatment (SBIRT)

Considerable attention has been paid to detection and intervention with adolescents and young adults presenting to emergency departments and trauma centres because prevention and early intervention in this population is considered to have the greatest potential to impact on alcohol use and its consequences.[17] Adolescents and young adults are also less likely to have entrenched drinking behaviours, and hence may potentially be more responsive to brief interventions.

At the other extreme, patients aged over 60 years are more likely to attend an emergency department as a result of falling while intoxicated.[18] This population are very likely to attend the emergency department repeatedly, thus imposing a significant burden on resources.

Challenges to delivery of SBIRT in emergency department settings

Providing brief interventions in a hospital setting, particularly the emergency department, is associated with a number of challenges, including time pressures and the short duration of patient provider relationships that limit the possible degree of therapeutic engagement.

The majority of studies of brief interventions in the emergency department setting have used additional personnel to undertake screening or deliver interventions or both.[19] Where regular emergency department personnel are used, it tends to be for screening only. Screening is either computerised or

[10] Poynton, S., Donnelly, N., Weatherburn, D., Fulde, G., & Scott, L. (2005) The role of alcohol in injuries presenting to St Vincent's Hospital Emergency Department and the associated short-term costs. Vol. 6. Alcohol Studies Bulletin: NSW Bureau of Crime Statistics and Research.

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the relevant questions were embedded in routine computer systems. These interventions are minimal in nature, largely involving the provision of written information and referral to additional services.

Sise et al.[20] found that rates of screening in the emergency department and trauma service of a hospital in California, USA, were low (12% of eligible patients) until health educators were made available which increased the capture rate to 71%.

The screening methods and brief interventions to be delivered need to be quick and simple so that they can be provided even at times of high demand in the emergency department. The time factor has led to interest in brief, sometimes single item[21], screening tools that are readily integrated into emergency department processes.[22] However, most attention has been given to screening for risky alcohol consumption — the literature on brief screening tools for other substances is scant.

Studies of brief interventions delivered in hospital emergency departments have used diverse approaches for initial screening, ranging from saliva tests[23] to general health surveys in which questions about quantity and frequency of substance use were embedded[24], and specific instruments such as CAGE, DrinC, DAST-10, ASSIST, AUDIT and CRAFFT.[25] In some studies, a very brief approach to screening was followed by more detailed assessment, and then by intervention. One reason for embedding questions about alcohol in a general health questionnaire is to increase acceptability to patients, but one study[26] found a straight alcohol questionnaire to be equally accepted as a general health questionnaire incorporating alcohol questions.

Blow et al.[27] note that computer technologies offer a way to overcome both time and personnel barriers to screening and brief intervention in emergency department settings, either by completely delivering a brief intervention or to aid a therapist by facilitating the process. An increasing number of studies have been undertaken to determine the acceptability of computer-based approaches to patients and staff in emergency departments[28 29 30], and to validate the computer-based processes.[31] Even video conferencing has been considered as a technology that might help overcome barriers in emergency department settings.[32]

The acceptance of computer-based screening for alcohol and other drug use, as well as other personal behaviours, is dependent on perceptions of confidentiality. One systematic review assessed the use of computer technologies to assess and reduce high-risk behaviours, including substance use. The studies included were highly variable, but the authors concluded that the use of computer technologies for

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behavioural health screening in emergency departments was both feasible and acceptable to patients and staff.[33]

A recent study in the US[34] screened patients in the emergency department waiting room by in-person survey, computer kiosk or both. Nearly three quarters of participants expressed a preference for the in-person survey, but disclosure of at-risk alcohol and substance use was more likely with the computer kiosk.

Effectiveness of SBIRT in hospital settings

Much of the research on the effectiveness of brief interventions for substance use relates to primary health care settings. In general, primary care settings, screening and brief interventions have been shown to reduce alcohol consumption.[35][36] There is also evidence for significant reductions in alcohol consumption and alcohol-related problems among adolescents following brief alcohol interventions delivered in a range of settings.[37]

There is evidence[38] that brief interventions provided in the general hospital setting, including to heavy alcohol users admitted to inpatient units,[39] may be effective in reducing alcohol consumption. Emmen et al.[40] considered the effectiveness of an opportunistic brief intervention for problem drinking in a general hospital setting, in terms of reduction of alcohol consumption. Two of the eight studies included in the review were undertaken in outpatient clinics. Emmen et al. noted that most studies had methodological weaknesses; only one study, with a relatively intensive intervention and a short follow-up period, showed a significantly large reduction in alcohol consumption in the intervention group.

In general, primary care settings, screening and brief interventions have been shown to reduce alcohol consumption.

[33] Choo, E. K., Ranney, M. L., Wong, Z., & Mello, M. J. (2012). Attitudes toward technology-based health information among adult emergency department patients with drug or alcohol misuse. Journal of Substance Abuse Treatment, 43(4), 397-401. doi: http://dx.doi.org/10.1016/j.jsat.2012.09.005

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[39] McQueen, J., Howe, T. E., Allan, L., Mains, D., & Hardy, V. (2011). Brief interventions for heavy alcohol users admitted to general hospital wards. Cochrane Database of Systematic Reviews, (8). doi: 10.1002/14651858.CD005191.pub3.

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Spotlight on the acceptability of the ASSIST-Lite

A Feasibility Study of the ASSIST-Lite with Brief Advice in Hospital Emergency Departments was conducted at the Royal Adelaide Hospital Emergency Department. The study aimed to assess the feasibility and acceptability of a web-based application on a computer tablet to screen patients in the emergency department for use of alcohol and other drugs, and to provide brief advice on the levels of risk associated with their use.

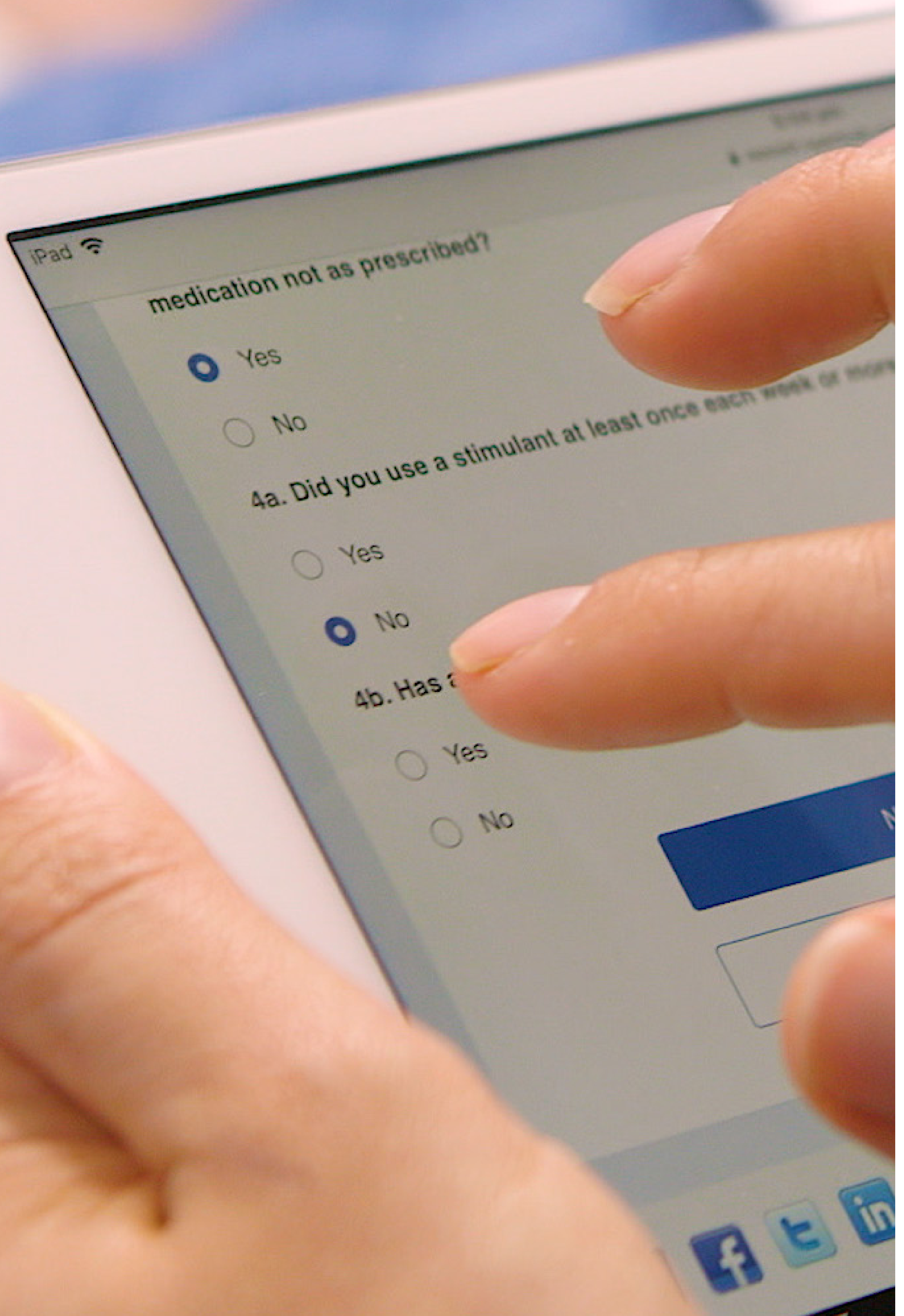
Recruitment was conducted through May and June 2017 on Thursday, Friday, Saturday and Sunday evenings between 6pm and midnight. Potential participants (people aged between 18 and 60 years who were deemed well enough to participate) were identified by ED staff. Research assistants, who were medical students, provided information about the study and invited participation in the study. The ASSIST-Lite was completed on tablet computers (iPad mini).

The ASSIST-Lite application took the participant through the assessment process. Results of their assessment were stratified based upon the risk severity for each substance and the substance appropriate advice was then displayed on the screen. For those in the moderate risk range, brief advice on strategies to reduce the risk for each substance were given. For those with high risk substance scores, the advice included the need to seek help and the Alcohol and Drug Information Service (ADIS) phone number was provided as a source of referral to treatment after they left hospital.

Acceptability of the intervention:

- Overall 632 patients were invited to complete the ASSIST-Lite which was all the eligible presentations to the ED in the period of recruitment. Of those, three-quarters (479, 75.8%) agreed to participate (241 male, 238 female).
- Of the 479 who agreed to participate, all completed the ASSIST-Lite.
- Feedback from emergency department staff was strongly positive about the self-assessment process while waiting in the ED. Staff were grateful that something was being done to address substance use that may reduce the likelihood of representation to hospital.
- The medical students who worked as research assistants found it easy to approach potential participants. They also reported that most participants were interested in their scores with many wanting to further discuss their results.
- Interestingly, the research assistants reported they spent most time with those individuals who admitted using methamphetamine in the prior three months. In those cases, the individuals expressed gratitude for information about the risks and harms of methamphetamine use as well as the strategies to reduce risk. They claimed it was difficult to access such detailed personalised information.

1



CHAPTER 2

Overview of the ASSIST-Lite

Background

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed for the World Health Organization (WHO) in 1997 by an international group of addiction researchers to screen for risky use of tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, sedatives, hallucinogens, inhalants, opioids and 'other drugs' that do not fall into the previous nine categories. The ASSIST is a validated screening tool that is currently used across a range of countries and cultures. The ASSIST was originally designed for primary care settings as they have the potential to identify patients with problems associated with drug use, and to provide an intervention, albeit brief, to at-risk patients.[41]

Translating the ASSIST into routine use in health services has proved problematic. Substance use disorders are not systematically screened, diagnosed or treated in general medical settings, and time constraints on staff appear to be the main barrier.[42]

In 2008, an American Preventive Service Task Force called for a research and development initiative to '*provide questionnaires short enough to be potentially useful in the practice setting with acceptable accuracy and reliability'. The ASSIST-Lite was developed to address this need and is ideally suited for opportunistic and routine screening for substance use in primary, general medical and welfare service settings.*

What is the ASSIST-Lite?

The ASSIST-Lite is a short form of the ASSIST. The ASSIST-Lite screens for risk of harm from substance use; specifically, tobacco, alcohol, cannabis, amphetamine type stimulants and cocaine, sedatives and opioids. There is also the opportunity to ask about any other psychoactive substance not listed. The ASSIST-Lite identifies which substances are of concern, and gives an indication of the severity of substance related risks and harms. Consequently, it can form a valuable part of a comprehensive health assessment.

Repeat screening (at 3-month intervals) with the ASSIST-Lite can also be used to monitor progress and changes over time. Interventions can be stepped up if the score has increased and the Brief Intervention can be used to intervene early if it appears that other issues are developing.

The Brief Intervention is an important part of the process when using the ASSIST-Lite and adds to the benefits of screening. While screening alone has been shown to lead to reductions in substance misuse, the addition of the brief intervention enhances this effect.[43] The ASSIST-Lite BI provides an opportunity to explore risk factors and to increase awareness and confidence through the use of motivational interviewing and a supportive non-judgemental approach.

The ASSIST-Lite risk score refers to risk of harm from current patterns of substance use. Harm is broadly defined and includes health, legal, social, financial, work and family issues.

The risk of harm score for each substance helps to initiate and frame a brief discussion with individuals about their substance use. The score obtained for each substance falls into a '*low', 'moderate' or 'high'* risk category which determines the most appropriate intervention for that level of use.

As outlined in figure 1, ASSIST-Lite scores are linked to risk categories and recommended interventions.

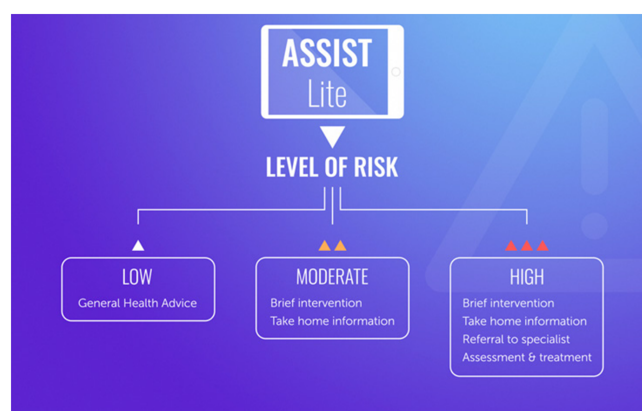


Figure 1 ASSIST-Lite Risk Categories

[41] Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V and Monteiro M (2010). The ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care. Geneva, World Health Organization.

[42] Ali, R., Meena, S., Eastwood, B., Richards, I. & Marsden, J. (2013) Ultra-rapid screening for substance use disorders: The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST-Lite) Drug and Alcohol Dependence 132 352-361

[43] Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V and Monteiro M (2010). The ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care. Geneva, World Health Organization.

How to administer the ASSIST-Lite

The ASSIST-Lite can be administered by health professionals or community care workers in a range of settings or self-completed on a computer tablet. This section provides a step-by-step guide to conducting screening and brief intervention using the ASSIST-Lite in an emergency care setting.

NOTE: The questions contained in the hard copy and the electronic version are the same. When completing the electronic version, the person is given on-screen instructions, information and tailored feedback based on their responses and risk category.

Step 1: The introduction

The ASSIST-Lite Questionnaire (Appendix A) requires an introduction which may be modified to suit the circumstances. It must include a number of key elements:

- the limits of confidentiality as specified by the organisation
- that you are only interested in non-medical use of drugs (using prescription medications that were not prescribed for the person or using them in ways that were not intended)
- clarification that the ASSIST-Lite focuses on use in the last three months

Introduce yourself and explain what you would like the patient to do. You will need to provide specific information on how the results will be used in your Service. If using a computer tablet, ensure the patient is able to use it and assist where necessary. Here is a basic example of an introduction:

'Would you be interested in completing a short questionnaire on lifestyle choices? It asks questions about your alcohol and other drug use in the past three months. We are only interested in non-medical use of drugs. Your responses will help identify any risks or harms associated with your substance use. It is entirely voluntary and your results are confidential."

Depending on the situation, either hand the patient a computer tablet for self-completion or read out the questions and score the responses.

Step 2: The ASSIST-Lite Questions

The questions ask about psychoactive substance use in the **PAST THREE MONTHS ONLY**. Ask the stem question and only ask the supplementary questions if the person answers '*yes*'.

Question 1 refers to tobacco use and scores 1 point for every '*yes*' response:

1. Did you smoke a cigarette containing tobacco?

If the person answers no, go to question 2. If yes, ask the following two supplementary questions:

1a. Did you usually smoke more than 10 cigarettes a day?

1b. Did you usually smoke within 30 minutes of waking?

The supplementary questions are designed to assess the level of tobacco use disorder and severity of dependence to identify the relevant risk category.

Question 2 refers to alcohol use in the past three months and scores 1 point for every yes response.

2. Did you have a drink containing alcohol?

If 'no' go to the next question, if yes ask the following three supplementary questions:

2a. On any occasion, did you drink more than 4 standard drinks of alcohol?

TIP: If a person is unsure of a standard drink, explain or show them a Standard Drink Chart (Appendix B)

2b. Have you tried and failed to control, cut down or stop drinking?

TIP: You may need to break the question into parts to make it clearer. For example:

- ***Have you tried to cut down on your use?***
- ***Were you successful?***
- ***When was the last time you tried and were not successful?***

2c. Has anyone expressed concern about your drinking?

Tip: This question refers to ANYONE who has expressed concern. This could include a family member, friend, employer, health professional, magistrate, judge, police, teacher or anyone else.

Question 3 refers to cannabis use in the past 3 months:

3. Did you use cannabis?

If the person answers 'no', go to question 4. If 'yes' ask the following two supplementary questions:

3a. Have you had a strong desire or urge to use cannabis at least once a week or more often?

Tip: Emphasise that a strong desire or urge is a craving and not just a mild or transient desire.

3b. Has anyone raised concern about your use of cannabis?

Question 4 asks about stimulant use in the past 3 months:

4. Did you use an amphetamine-type stimulant, or cocaine, or a stimulant medication not as prescribed?

Tip: Some common examples of amphetamines and amphetamine type stimulants are speed, Ice/crystal and Ecstasy.

If the person answers no, go to question 5. If yes, ask the two supplementary questions:

4a. Did you use a stimulant at least once a week or more often?

4b. Has anyone expressed concern about your use of a stimulant?

Question 5 refers to sedative use in the past three months

5. Did you use a sedative or sleep medication not as prescribed?

Tip: A common example are benzodiazepines such as diazepam, alprazolam and lorazepam.

If no, go to question 6. If 'yes' ask the following 2 supplementary questions:

5a. Have you had a strong desire or urge to use a sedative or sleeping medication at least once a week or more often?

5b. Has anyone expressed concern about your use of a sedative or sleeping medication?

Question 6 refers to opioid use in the past three months:

6. Did you use a street opioid (e.g. heroin), or an opioid-containing medication not as prescribed?

If no, go to question 7. If yes, ask the supplementary questions:

6a. Have you tried and failed to control, cut down or stop using an opioid?

6b. Has anyone expressed concern about your use of an opioid?

The final question asks about any other substances used that have not been asked about:

7. Did you use any other psychoactive substance?

If yes, ask and record the substance(s) used in the space provided.

Tip: When asking about other substances, give some examples of other drugs that may be used by the target group. Examples could include anabolic steroids, GHB, Kava, and synthetic cannabis.

Note that this question is not scored, but prompts further assessment.

Step 3: Scoring

An individual can score between 0 and 3 for all substances except alcohol where the range is 0-4. For tobacco, cannabis, stimulants, sedatives and opioids low risk is a score of zero, moderate risk a score of one or two, and high risk a score of three. For alcohol, low risk is a score of zero or one, moderate risk is a score of two and high risk is a score of three or four.

Substance	Low risk score	Moderate risk score	High risk score
Tobacco	0	1-2	3
Alcohol	0-1	2	3-4
Cannabis	0	1-2	3
Amphetamine type stimulants	0	1-2	3
Sedatives	0	1-2	3
Opioids	0	1-2	3
Other	0	1-2	3

Step 4: Provide a brief intervention

The ASSIST-Lite Brief Intervention is delivered in the spirit of Motivational Interviewing (Chapter 3), and is based on the FRAMES Model (Chapter 4) and the Trans Theoretical Model (TTM) of behaviour change or Stages of Change (Chapter 5).

The aim of the brief intervention is to help the person understand that their substance use is putting them at risk of harm which may serve as a motivation for them to reduce or cease their substance use. Brief interventions should be personalised and offered in a supportive, non-judgmental manner.

Individuals whose ASSIST-Lite scores are all in the **low risk range** do not need any intervention to change their substance use. It is good practice to reinforce that what they are doing is responsible and encourage them to continue their current low risk substance use patterns. If time permits, provision of general information about alcohol and other drugs to low risk users may be appropriate for several reasons:

- It increases the level of knowledge in the community about alcohol and other substance use and risks
- It may act as a preventive measure by encouraging low risk substance users to continue their low risk substance use behaviour
- It may remind those with a past history of risky substance use about the risks of returning to hazardous substance use
- Information they are given may be passed onto friends or family who do have substance use issues

People in the **moderate risk range** are at risk of, or may already be experiencing health, legal, social, relationship, occupational or financial harms or have the potential for these problems should their substance use continue in the same way. The aim of the Brief Intervention is to raise awareness of the risks and harms associated with their current pattern of use and be made aware of options available to support behaviour change.

Note: Practical skills and techniques required to deliver a brief intervention to people at moderate risk is covered in Chapter 3 and a comprehensive step-by-step approach to providing an effective ASSIST-Lite Brief Intervention is provided in Chapter 6.

The ASSIST-Lite Brief Intervention lasts only a few minutes and is not intended as a stand-alone treatment for people who are dependent or at '**high risk**' from their substance use. A brief intervention should be used to encourage such individuals to accept a referral to specialised drug and alcohol assessment and treatment.

At a minimum, high risk individuals need referral for further substance use assessment and treatment. Depending on the needs of the client, treatment can include:

- sessions with a primary care or other suitable worker
- specialist drug and alcohol treatment or counselling
- cognitive behavioural therapy
- group program
- medication to treat dependence and prevent relapse
- inpatient or ambulatory withdrawal
- residential rehabilitation/therapeutic community
- a 12-step, SMART Recovery or similar self-help or peer support program

There may be other treatment options depending on availability in the individual's region, country or culture. There may also be underlying reasons associated with an individual's substance use that need to be addressed such as mental health issues, trauma, chronic pain, relationship difficulties, social issues, or homelessness.

It is also very important that high risk and injecting individuals are referred to health services for appropriate physical health checks including blood and other biological screening. For example, heavy drinking individuals should have their liver enzymes checked, and people who inject drugs should be screened for blood borne viruses.

Individuals should be made aware that injecting drugs is associated with an increased likelihood of dependence, overdose (particularly if injecting opioids), psychosis (particularly if injecting stimulants), local and systemic infections and communicable diseases such as Hepatitis B/C and HIV.

Those who choose to continue to inject should be informed of appropriate harm reduction strategies. These may include:

- not injecting alone
- not sharing injecting equipment and drug paraphernalia
- hygiene around injecting
- avoiding the use of other substances at the same time, especially alcohol and sedatives
- learning first aid and resuscitation techniques
- having test dose to check the potency of the substance being used
- being informed of where they can access sterile injecting equipment (or how to clean existing equipment if unavailable) and how to safely dispose of their used injecting equipment
- have Narcan available to reverse an opioid overdose

Those who choose to continue to inject should be informed of appropriate harm reduction strategies.

1

Spotlight on screening versus assessment

Screening is the first step in assessment. Screening tools such as the ASSIST-Lite are quick and easy to administer and can be used with everyone.

Screening is part of a population approach to substance use problems. It aims to reduce the overall burden of substance related harms in the community by identifying and responding to individuals with low to moderate level problems. Generally, screening is undertaken routinely even if the person has not reported having alcohol or other drug problems. Screening provides an indication of whether the person is at risk of or is experiencing alcohol and other drug related harms and, therefore, in need of more detailed assessment. Screening can also identify those who have more intense harms and require further assessment and intervention enabling the targeting of resources to those at higher need.

Screening tools such as the ASSIST and ASSIST-Lite are not designed to be used alone to diagnose alcohol or drug dependence or to make decisions about specific treatments although they can contribute to these decisions.

If a person scores moderate risk on a screening tool this should be followed by a brief intervention, and further support and services if required. If a person scores high risk on a screening tool then they need referral to treatment for a more detailed assessment and intervention.

Assessment is conducted with individuals whose screening results have indicated risky or harmful substance misuse or who present with drug and alcohol related problems. Assessment is more detailed and individualised than screening.

All of the information gathered from both screening and assessment can then be used in case formulation and decisions about intervention and treatment.

Assessment is conducted with individuals whose screening results have indicated risky or harmful substance misuse or who present with drug and alcohol related problems.

CHAPTER 3

Using Motivational Interviewing in an ASSIST-Lite Brief Intervention

When conducting the ASSIST-Lite and Brief Intervention, it is likely that the screener will have a relatively short time to spend with individuals. This chapter focuses predominantly on the practical skills and techniques required to deliver a brief intervention to people at moderate risk, rather than detailing the underlying theory or providing training on delivering lengthy or on-going sessions with clients.

The brief intervention approach adopted in this manual is based on the motivational interviewing (MI) principles developed by William R. Miller in the USA and further elaborated by Miller and Stephen Rollnick.[44] It is based on the assumption that people are most likely to change when motivation comes internally, rather than externally from another source.

Brief interventions are delivered within the Spirit of Motivational Interviewing. That is, there is a collaborative approach based on compassion and acceptance of the individual's circumstances. The screener aims to evoke answers that will provide the individual with insight into their current situation and options for change.

Motivational interviewing techniques are designed to promote behaviour change by helping people to explore and resolve ambivalence. This is especially useful when working with people in the pre-contemplation (happy to continue using) and contemplation (some uncertainty about use but not enough to change) stages, but the principles and skills are important at all stages. Motivational interviewing is based on the understanding that effective intervention assists a natural process of change.[45] It is important to note that motivational interviewing is done for or with someone, not on or to them.

This section outlines the key motivational interviewing skills required to deliver an effective brief intervention.

[44] Miller W and Rollnick S (2013) Motivational Interviewing Helping People Change (3rd ed). New York and London, Guildford Press

[45] Miller W and Rollnick S (2013) Motivational Interviewing Helping People Change (3rd ed). New York and London, Guildford Press

Feedback

Providing feedback to individuals is an important part of the brief intervention process. The way that feedback is provided can affect what the client really hears and takes in. Feedback should be given in a way that takes account of what the client is ready to hear and what they already know. A simple and effective way of giving feedback involves three steps[46]. It takes account of the client's existing knowledge and interest, and is respectful of their right to choose what to do with the information.

Feedback
Elicit
Provide
Elicit

Elicit the client's readiness or interest for information. That is, ask the client what they already know and what they are interested in knowing. It may also be helpful to remind the client that what they do with the information is their responsibility. For example:

> *"Would you like to see the results of the questionnaire you completed?"*
>
> *"What do you know about the effects of (substance)?"*

Provide feedback in a neutral and non-judgmental manner. For example:

> *"Your score for (substance) was in the moderate risk range. This means that your current level of use puts you at risk of experiencing health, social, legal, financial and other problems, either now or in the future."*

Elicit their personal interpretation. That is, ask the person what they think about the information and what they would like to do. You can do this by asking key questions, for example:

> *"How concerned are you by your score for (substance)?"*
>
> *"How do you feel about that?"*
>
> *"What do you see as your options?"*
>
> *"How surprised are you by your score?"*
>
> *"What concerns you most?"*

Create discrepancy and reduce ambivalence

People are more likely to be motivated to change their substance use behaviour when they see a difference or discrepancy between their current substance use and related problems and the way they would like their life to be. Motivational Interviewing aims to create and amplify a discrepancy between current behaviour and broader goals and values from the individual's point of view. It is important for the person to identify their own goals and values and to express their own reasons for change.

Ambivalence refers to the contradictory feelings people have about their substance use. Some feelings are positive, such as the pleasure associated with using. Other feelings are negative, such as the risks involved or problems it creates. By creating discrepancy, you can reduce their ambivalence to change.

Using basic counselling techniques assists in building rapport and establishing a therapeutic relationship that is consistent with the spirit of Motivational Interviewing. The four key techniques are:

OARS
Open questions
Affirming
Reflecting
Summarising

Open questions

Asking open-ended questions encourages the individual to start thinking about their substance use and allows the person to do most of the talking. Open ended questions provide the opportunity to explore their reasons for change, without being limited to '*yes*' or '*no*' responses.

Within the context of the ASSIST-Lite Brief Intervention examples of the types of questions asked include:

> *"What are some of the good things about using (substance)?"*
>
> *and*
>
> *"What are the less good things for you about using?"*

This approach is termed a *decisional balance* and encourages the individual to explore the pros and cons of their use in a balanced way.[47]

[46] Miller W and Rollnick S (2013) Motivational Interviewing Helping People Change (3rd ed). New York and London, Guildford Press

[47] Miller W and Rollnick S (2002). Motivational Interviewing (2nd ed) New York and London, Guilford Press

Open-ended questions also help to explore the relationship between substance use and their presenting problem. For example:

> *"How do you think your substance use contributed to your being in this situation?"*

Asking open-ended questions of individuals also reinforces the notion that the individual is responsible for the direction of the intervention and of their substance use choices.

Affirming

Affirming the individual's strengths and efforts to change helps build confidence, while affirming self-motivating statements (or change talk) encourages readiness to change. Affirming can take the form of compliments or statements of appreciation and an understanding of the difficulties the choice poses. This helps build rapport and validates and supports the client during the process of change. This is most effective when the client's strengths and efforts for change are noticed and affirmed.[48]

Reflecting

Reflecting involves rephrasing a statement to capture the implicit meaning and feeling of an individual's statement. It encourages continual personal exploration and helps people understand their motivations more fully. Reflections can be used to amplify or reinforce the desire for change.[49]

It is important to reflect back the underlying meanings and feelings the person has expressed as well as the words they have used. Using reflections is like being a mirror for the person so that they can hear the screener say what they have communicated. Reflecting shows the person that the screener understands what has been said and can be used to clarify what the person means.

Summarising

Summarising is an important way of gathering together what has already been said and '*checks in*' with the individual to ensure mutual understanding of the discussion. Summarising adds to the power of reflecting, particularly in relation to concerns and change talk. First, individuals hear themselves say it, then they hear the screener reflect it, and then they hear it again in the summary. The screener can then choose what to include in the summary to help emphasize the individual's identified reasons for change.

Within the context of the ASSIST-Lite Brief Intervention, reflecting and summarising are used to highlight the individual's ambivalence about their substance use and to steer the person towards a greater recognition of their problems and concerns.

Here are some examples of OARS in practice for drug use:

Technique	Examples
Open-ended questions	What do think are some of the benefits of addressing your drug use? You mentioned that you would like to stop using again, what has worked for you in the past?
Affirming	It sounds as though you are very resourceful to have coped with the challenges over the past few years. I appreciate that it has taken a lot of courage to discuss your drug use with me today.
Reflecting	You enjoy using (substance), though it sounds as if it gets you into trouble and you have had a few injuries. You are worried about your children and you don't want them growing up without you in their lives.
Summarising	So just to make sure I understand, you enjoy using, though it is causing some problems in your life. You have been to detox before, but you left because of the no-smoking policy. You are keen to stop, but are not sure what other options are available. Am I on the right track?

[48] Miller W and Rollnick S (2013) Motivational Interviewing Helping People Change (3rd ed). New York and London, Guildford Press

[49] Miller W and Rollnick S (2013) Motivational Interviewing Helping People Change (3rd ed). New York and London, Guildford Press

1

Eliciting change talk

As outlined by Miller and Rollnick (2012), eliciting change talk is a strategy for helping the person to resolve ambivalence and is aimed at enabling the individual to present the arguments for change. There are four main categories of change talk:

- Recognising the disadvantages of staying the same
- Recognising the advantages of change
- Expressing optimism about change
- Expressing an intention to change

There are a number of ways of drawing out change talk from the client. Asking direct open questions is a good example:

> *"What worries you about your substance use?"*
>
> *"What do you think will happen if you don't make any changes?"*
>
> *"How would you like your life to be in 12 months' time?"*
>
> *"What do you think would work for you if you decided to change?"*
>
> *"How confident are you that you can make this change?"*
>
> *"How important is it to you to cut down your substance use?"*
>
> *"What are you thinking about your substance use now?"*

Important tips

In brief, the person conducting the ASSIST-Lite Brief Intervention can be most effective if they adopt the principles of motivational interviewing and are:

- objective
- a conduit for the delivery of information pertinent to that individual
- empathetic and non-judgemental
- respectful of the individual's choices
- open and not dismissive of the individual's responses
- respectful toward the individual
- competent in using open-ended questions, affirmations, reflections and summaries to guide the conversation in the direction of self-discovery for the individual and ultimately towards change

The person conducting the ASSIST-Lite Brief Intervention can be most effective if they adopt the principles of motivational interviewing.

Recommended further reading

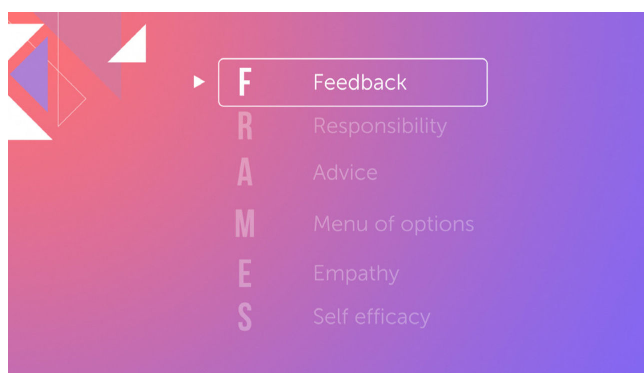
Miller W and Rollnick S (2013) Motivational Interviewing Helping People Change (3rd ed). New York and London, Guildford Press

CHAPTER 4

The FRAMES Model

Experience and research into brief interventions for substance use have found that effective brief interventions comprise a number of consistent and recurring features. These features have been summarised using the acronym FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy.[50, 51]

Feedback



The provision of personally relevant **feedback** (as opposed to general feedback) is a key component of a brief intervention. This includes information about the individual's substance use obtained from the ASSIST-Lite and the level of risk associated with those scores. It is worth noting that most people are interested in knowing their questionnaire scores and what they mean.

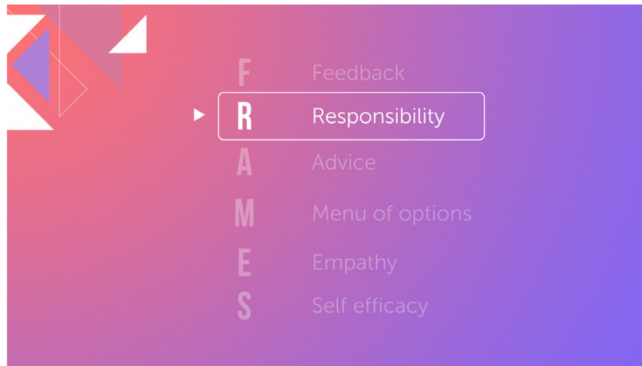
Information about personal risks associated with a person's current alcohol and drug use patterns that have been reported during the screening (e.g. low mood, anxiety, relationship problems, health problems) combined with general information about substance related risks and harms also comprises powerful feedback.

In summary, feedback is the provision of personally relevant information which is pertinent to the individual and is delivered by the screener in a non-judgemental and objective way in the *Spirit of Motivational Interviewing* (Chapter 3).

[50] Miller W, Zweben A, Di Clemente C and Rychtarik R (1992). Motivational enhancement therapy manual: A clinical resource guide for therapists treating individuals with alcohol abuse and dependence. (Project MATCH Monograph Series Vol 2). Rockville Maryland: National Institute on Alcohol Abuse and Alcoholism.

[51] Miller W and Rollnick S (2002). Motivational Interviewing (2nd ed) New York and London, Guilford Press

Responsibility

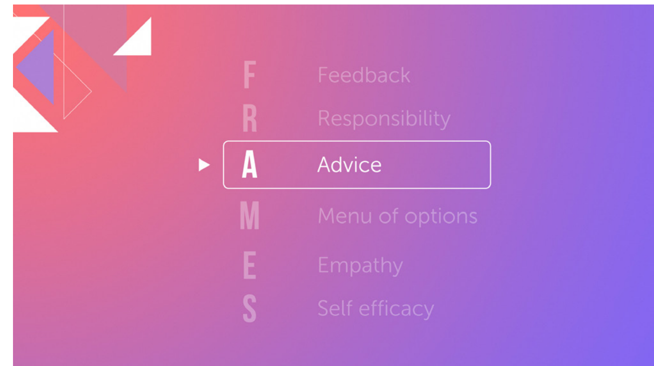


A key principle of working to help people is to acknowledge and accept that they are **responsible** for their own behaviour and will make choices about their substance use. Communicating with individuals in terms such as: *"Are you interested in seeing how you scored on this questionnaire?", "What you do with this information I'm giving you is up to you" and "How concerned are you by your score?"* enables the person to retain personal control over their behaviour and its consequences, and the direction of the intervention.

This sense of control has been found to be an important element in motivation for change and in decreasing resistance. Using language with people such as "I think you should…", or "I'm concerned about your substance use" may create resistance in individuals and motivate them to maintain and adopt a defensive stance when talking about their substance use patterns.

A key principle of working to help people is to acknowledge and accept that they are responsibe for their own behaviour.

Advice

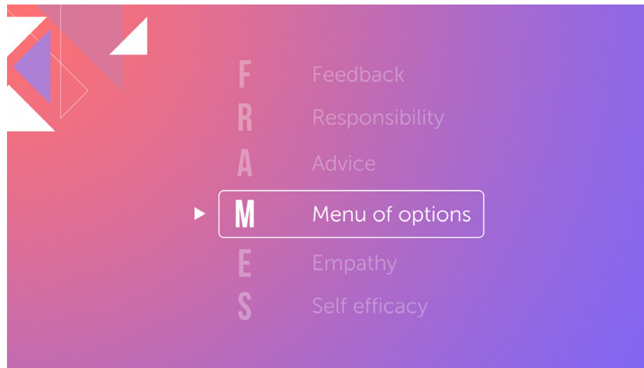


A central component of effective brief interventions is the provision of clear objective **advice** regarding how to reduce the harms associated with continued use. This needs to be delivered in a non-judgmental manner and in the *Spirit of Motivational Interviewing* (Chapter 3). People may be unaware that their current pattern of substance use could lead to problems or make existing problems worse. Ask permission to give advice and then provide clear advice. Explain that cutting down or stopping substance use is the best way to reduce their risk of problems both now and in the future. This will increase their awareness of their personal risk and provide reasons to consider changing their behaviour.

Advice can be summed up by delivering a simple statement such as *"the best way you can reduce your risk of (e.g. depression, anxiety, injuries) is to cut down or stop using"*. Once again, the language used to deliver this message is an important feature and comments such as *"I think you should stop using substances"* does not provide clear, objective advice.

Advice needs to be delivered in a non-judgmental manner and in the Spirit of Motivational Interviewing.

Menu of options



Effective brief interventions provide the individual with a range or **menu of options** to cut down or stop their substance use. This allows the individual to choose the strategies which are most suitable for their situation and which they feel will be most helpful. Providing choices reinforces the sense of personal control and responsibility for making change and can help to strengthen the person's motivation for change. Giving individuals the *"Self-Help Strategies for Cutting Down or Stopping Substance Use: Self-Help Guide"*[52] is a good way to start as it contains strategies for helping clients change their behaviour, and can be used alone or in conjunction with other options.

Menu Options allow the individual to choose the strategies which are most suitable for their situation.

Examples of options for clients to consider include:

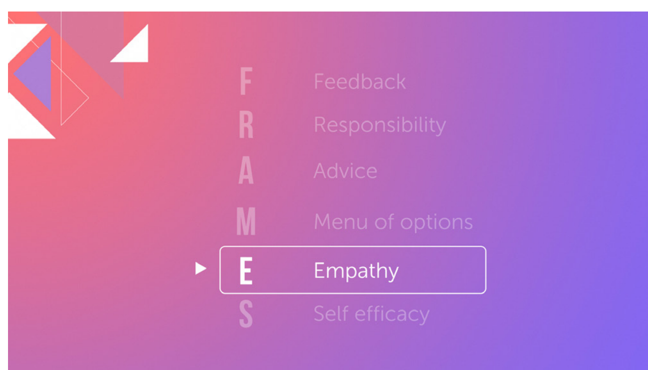
- keeping a diary of substance use (where, when, how much used, how much spent, with whom, why)
- identifying high risk thoughts and beliefs and challenging them
- identifying high risk associates and situations and strategies to avoid them
- identifying other activities instead of drug use (constructive use of leisure)—education, volunteering, hobbies, sports, gym, etc.
- identifying non-drug rewards and pleasurable activities
- identifying people who could provide support and help for the changes they want to make
- attending a self-help or mutual aid group
- putting aside the money they would normally spend on substances for something else
- setting goals and working towards achieving them

You can also assist by:

- providing information about other self-help resources and written information
- providing information about groups or programs that specialise in drug and alcohol issues

[52] Humeniuk RE, Henry-Edwards S and Ali RL (2003). Self-help Strategies for Cutting Down or Stopping Substance Use: A guide. Draft version 1. 1 for Field Testing. Geneva, World Health Organization.

Empathy

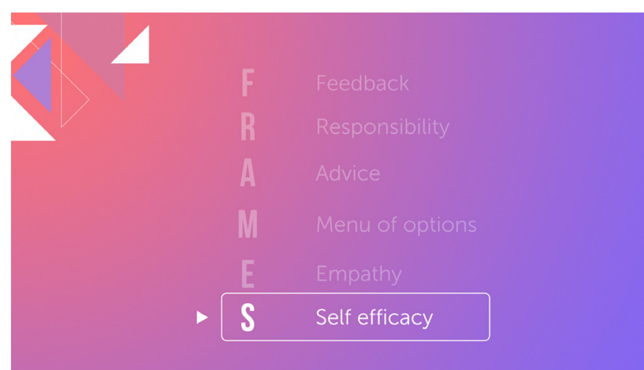


Empathy is taking an active interest and effort to understand another's internal perspective, to see the world through their eyes. It does not mean sympathy, a feeling of pity, camaraderie or identification with the person. Statements such as *'I've been there and know what you are experiencing, let me tell you my story'* are not useful. The opposite of empathy is the imposition of one's own perspective, perhaps with the assumption that the other's views are irrelevant or misguided. Empathy is the ability to understand another's frame of reference and the conviction that it is worthwhile to do so.[53]

In a brief intervention, empathy comprises an accepting, non-judgmental approach that tries to understand the individual's point of view. It is especially important to avoid confrontation and blaming or criticism of the individual. Adopting a position of '*curious intrigue*' is helpful. Skilful reflective listening which clarifies and amplifies the person's experience and meaning is a fundamental part of expressing empathy. The empathy and understanding of the professional are important contributors to how well the individual responds to the intervention.[54]

Empathy comprises an accepting, non-judgmental approach that tries to understand the individual's point of view.

Self-efficacy



The final component of effective brief interventions is to encourage the person's confidence that they are able to make changes in their substance use and offending behaviour. Exploring other areas where the individual has made positive change is helpful. People who believe that they are likely to make changes are much more likely to do so than those who feel powerless or helpless to change their behaviour. It is particularly helpful to elicit **self-efficacy** statements from individuals as they are likely to believe what they hear themselves say and belief in the possibility of change is an important motivator.[55]

Encourage the person's confidence that they are able to make changes in their substance use.

[53] Bien TH, Miller WR and Tonigan S (1993). Brief intervention for alcohol problems: A review. Addiction, 88;315–336.

[54] Miller W and Rollnick S (2002). Motivational Interviewing (2nd ed) New York and London, Guilford Press.

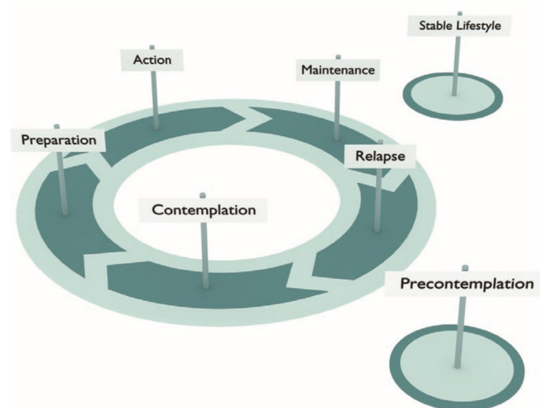
[55] Miller W and Rollnick S (2002). Motivational Interviewing (2nd ed) New York and London, Guilford Press.

CHAPTER 5

Model of behaviour change

The trans-theoretical model of behaviour change developed by Prochaska and DiClemente provides a useful framework for understanding the process by which people change their behaviour, and for considering how ready they are to change their substance use or other lifestyle behaviour. The model proposes that people go through discrete stages of change and that the processes by which people change seem to be the same with or without treatment.[56]

The aim of the ASSIST-Lite Brief Intervention is to support people to move through one or more stages of change commencing with movement from pre-contemplation to contemplation to preparation to action and maintenance. Movement from the stage of pre-contemplation to contemplation may not result in a tangible decrease in substance use; however, it is a positive step that may result in clients moving on to the action stage at some time in the future.



It is worth noting that there is no set amount of time that a person will spend in each stage (may be minutes, months or years), and that people cycle back and forth between stages. Some individuals may move directly from pre-contemplation to action following an ASSIST-Lite Brief Intervention. The following provides a brief description of the underlying behavioural and cognitive processes of each stage (Adapted from Connors, G., DiClemente, C. C., Velasquez, M., & Donovan, D. (2012)).[57]

[56] Prochaska JA, DiClemente CC and Norcross JC (1992). In search of how people change. Applications to addictive behaviour. American Psychologist, 47:1102-1114.

[57] Connors, G., DiClemente, C. C., Velasquez, M., & Donovan, D. (2012). Substance Abuse Treatment and the Stages of Change (Second Edition). Guilford Press

Pre-contemplation

In this stage the person is not necessarily thinking about changing their substance use. Common characteristics of this stage include:

- being focused on the positive aspects of their substance use
- unlikely to have any concerns about their use of psychoactive substances
- may show resistance to talking about their substance use
- unlikely to know or accept that their substance use is risky or problematic
- unlikely to respond to direct advice to change their behaviour but may be receptive to information about the risks associated with their level and pattern of substance use

Contemplation

People in this stage have thought about cutting down or stopping substance use, but are still using. Common characteristics of this stage include:

- ambivalence about their substance use — they may be able to see both the good things and the not so good things about their substance use
- having some awareness of the problems associated with substance use and may be weighing up the advantages and disadvantages of their current substance use pattern
- may respond to information about their substance related risks, advice to cut down or engage in discussion about their substance use

A proportion of people in the contemplation stage may be willing to make a change but they may not know how to make the change and/or may not be confident that they are able to change. An effective brief intervention that provides personalised and appropriate feedback and information can help tip the balance for positive behaviour change.

Preparation

Preparation follows contemplation and involves planning to take action in the near future and making the final preparations before behaviour change begins. People in this stage are committed to action and ready to change but may still have some level of ambivalence. People in the preparation stage are:

- intending to take action
- may vocalise their intentions to others
- making small changes in their substance use behaviour
- re-evaluating their current behaviour and considering what different behaviour could offer them
- becoming more confident and ready to change their behaviour
- considering the options available to them
- setting dates and determining strategies to assist change

Action

People in the action stage:

- have made the decision that their use of substances needs to change
- have commenced cutting down or stopping
- are actively doing something about changing their behaviour
- have cut down or stopped completely
- are likely to continue to feel somewhat ambivalent about their substance use and to need encouragement and support to maintain their decision

Maintenance

Long-term success means remaining in this stage. People in the maintenance stage are:

- attempting to maintain the behaviour changes that have been made
- working to prevent relapse (the risk of relapse decreases with time)
- focusing attention on high risk situations and the strategies for managing these
- best equipped when they develop strategies for avoiding situations where they are at risk of relapse
- more likely to remain abstinent if they receive reward, support and affirmation

Relapse

A relapse (or lapse — a one off or short period) is a return to the old behaviour that was the focus of change. Most people who try to make changes in their substance use behaviour may relapse to substance use, at least for a time. This should be viewed as a learning process rather than failure. Few people change on the first attempt and relapse is an opportunity to help clients review their action plan. A review should examine timeframes; what strategies did actually work and whether the strategies used were realistic. Substance users may make a number of attempts to stop before they are successful. For many people, changing their substance use gets easier each time they try until they are eventually successful.

In summary, the trans-theoretical model of behaviour change can be used to match interventions with a person's readiness to take in information and change their substance use. While a client's stage of change is not formally measured, or assessed during the ASSIST-linked Brief Intervention, it is important that screeners understand these underlying processes.

It is also worth noting that the suggested 10 Step Brief Intervention outlined in Chapter 6 is aimed predominantly at individuals who are currently engaged in the least amount of change; that is in pre-contemplation and some contemplation. The principles can be built on and expanded for people who are preparing for change but lack the confidence and knowledge, and for individuals who are in the action stage.

Few people change on the first attempt and relapse is an opportunity to help clients review their action plan.

Recommended further reading:

Connors, G., DiClemente, C. C., Velasquez, M., & Donovan, D. (2012). Substance Abuse Treatment and the Stages of Change (Second Edition). Guilford Press

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CHAPTER 6

Putting it all together — a step by step approach to the ASSIST-Lite Brief Intervention

A step by step approach can help busy clinicians deliver an effective brief intervention in a time critical area. As a guide, The ASSIST-Lite Brief Intervention can follow the same ten steps outlined in the ASSIST-Linked Brief Intervention.[58]

Attempting to change a number of behaviours at the same time can be difficult and may lead to the client feeling overwhelmed and discouraged. Accordingly, focusing the intervention on one substance and linking other substances can be advantageous. More often than not, the substance of most concern will be the one that is being injected, or has attracted the highest ASSIST-Lite score or it may be the substance that the client believes is most closely related to their admission to the emergency department.

This step by step approach was designed by Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V, and Monteiro M (2010) to assist and build confidence in workers who are not specifically trained in motivational interviewing and substance use interventions. It also serves as a framework for more experienced behaviour change professionals and can be expanded and explored further for longer or recurrent sessions, or to address multiple substance use.

This step by step approach was designed to assist and build confidence in workers who are not specifically trained in motivational interviewing and substance use interventions.

10

The 10 steps to an ASSIST-linked Brief Intervention

1. ***Asking clients if they are interested in seeing their questionnaire scores***
2. ***Providing personalised feedback to clients about their scores***
3. ***Giving advice about how to reduce risk associated with substance use***
4. ***Allowing clients to take ultimate responsibility for their choices***
5. ***Asking clients how concerned they are about their scores***
6. ***Weighing up the good things about using the substance against;***
7. ***Weighing up the less good things about using the substance***
8. ***Summarise and reflect on clients' statements about their substance use with emphasis on the less good things***
9. ***Asking clients how concerned they are by the less good things***
10. ***Giving clients take-home materials to bolster the brief intervention***

[58] Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V and Monteiro M (2010). The ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care. Geneva, World Health Organization.

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STEP 1. Asking clients if they are interested in seeing their questionnaire scores

A good way to start the brief intervention is to ask the person:

> *"Are you interested in seeing how you scored on the questionnaire you just completed?"*

This question is the screener's entrance into delivering a brief intervention. Phrasing it in this way gives the individual a choice about what happens next and immediately helps reduce any resistance. An affirmative response from the individual gives permission to provide personally relevant feedback and information to the person about their scores and associated risk, and how the person can best reduce risk. It is worth noting that most people are interested in seeing and understanding their scores.

STEP 2. Providing personalised Feedback to clients about their scores

The electronic version of the ASSIST-Lite and the ASSIST-Lite Checkup (available at www.assistportal.com.au) provides personalised feedback on the relevant substance and risk category. This information can be discussed during brief intervention and / or emailed for future reference. The results and information can also be printed and serve as something tangible for both the screener and the individual to focus on during the course of the intervention.

Screeners should go through each substance score on the ASSIST-Lite and inform the individual whether they are at low, moderate or high risk from their use of that substance. Following this, explain the definition of moderate risk and/or high risk, An example of feedback is shown below:

> *"These are all the substances I asked you about and these are your scores for each of the substances (point to scores). As you can see you scored low risk for most of the substances but you scored moderate risk for tobacco, cannabis, and methamphetamine. Moderate risk means that you are at risk of legal, health and other problems from your current pattern of substance use, not only now but also in the future if you keep using in the same way."*

The second part of the feedback comprises communicating the risks associated with each particular substance used, focussing on the highest scoring substance (or substances). You should also include any problems that were revealed during the administration of the ASSIST-Lite. An example of personalised feedback around a moderate risk score for methamphetamine is:

> *"Because you're in the moderate risk range for your use of methamphetamine, the kinds of things associated with your current pattern of use are problems with the law, difficulty sleeping, dehydration, headaches, mood swings, and, at the serious end of things, aggressive and violent behaviour, psychosis and permanent damage to brain cells. You said that your family is concerned about your use and that you have been irritable lately, …"*

STEP 3. Giving advice about how to reduce risk associated with substance use.

Giving advice is simply about creating a link between reduction of drug use and reduction of harms. People may be unaware of the relationship between their substance use and existing or potential problems. The advice informs individuals that cutting down or stopping their substance use will reduce the risk of problems both now and in the future. An example of providing advice to individuals is to say:

> *"The best way you can reduce your risk of these things happening to you either now or in the future is to cut down or stop using."*

Expressing this advice briefly and objectively provides the individual with accurate information to help them make their own decision in a neutral yet supportive environment.

STEP 4. Allowing patients to take ultimate responsibility for their choices

As stated previously in this manual, maintaining personal control is an important motivating factor in achieving change. Screeners need to be mindful that the individual is responsible for their own decisions regarding substance use and this should be re-iterated to patients during the brief intervention, particularly after feedback and advice have been given. For example, this could be expressed by saying:

> *"What you do with this information is up to you. I am just letting you know the kinds of harms associated with your current pattern of use."*

The above example not only encourages patients to take responsibility, it also reinforces the relationship between the patient's substance use and the associated harms.

STEP 5. Asking clients how concerned they are about their scores

This is an open-ended question designed to get the individual thinking about their substance use and to start verbalising any concerns they may have about their use. Using open-ended questions in this context is a powerful motivational interviewing technique, and may be the first time the person has ever verbalised concerns about substance use in their life. There is evidence that verbalising concerns in a supportive context leads to change in beliefs and behaviour. Say something like:

> *"How concerned are you by your scores for …… (drug)?"*

The level of concern they express also gives some indication of their stage of change.

STEPS 6 and 7. Exploring the good things and less good things about using the substance

Getting a person to consider and verbalise both the good things and less good things about their substance use is a standard motivational interviewing technique designed to develop discrepancy, or create cognitive conflict within the person. It may be the first-time the individual has thought about, or verbalised, the pros and cons of their use and is a first and important step in changing behaviour. It is important to ask about the positive as well as the negative aspects of substance use as it acknowledges to the individual that the screener is aware that the individual has pertinent or functional reasons for using a substance.

The best way to get individuals to weigh up their substance use is through the use of two open-ended questions. Commencing with the positive aspects of substance use say something like:

> *"What are the good things for you about using … (drug)?"*

After the person has finishing talking about good things, ask about less positive aspects of drug use. Say something like:

> *"What are some of the less good things about using …(drug)?"*

Note that if a person is in the pre-contemplative stage, they may have already expressed the '*good things*' so there is no need to ask again. If an individual has difficulty verbalising the less good things, screeners can prompt with answers given by the individual during the administration of the ASSIST-Lite questionnaire or with open-ended questions around the following areas:

- Health — physical and mental
- Social — relationships with partner, family, friends, associates, colleagues
- Financial — impact on personal and family budget
- Occupational — difficulty with work, study, looking after home and family
- Spiritual — feelings of self-worth, guilt, wholeness
- Legal — accidents, driving while under the influence of a substance or other offending behaviour

STEP 8. Summarise and reflect on individual's statements about their substance use with emphasis on the less good things

Reflecting to individuals by summarising what they have just said about the good, and less good aspects of their substance use is a simple but effective way of acknowledging the individual's experiences and preparing the person to move on. If a person feels that they have been 'listened to' they are more likely to receive and consider the information and advice given by the professional.

Reflecting and summarising also provides the opportunity to actively highlight an individual's cognitive conflicts and to emphasize the less good aspects of their substance use. An example of reflecting back the good and less good things of a person's substance use, with final emphasis on the less good things is:

> *"So you said you like using crystal meth because it gives you energy and you have fun… but you do not like comedowns and the impacts it is having on your health and relationships, including fighting with your girlfriend …"*

STEP 9. Asking individuals how concerned they are by less good things

This is another open-ended question not unlike the one asked in Step 5 regarding concern about the ASSIST-Lite score. While it is similar to a previous question, it serves to strengthen change-thought in the client and provides a platform for workers to take the brief intervention further if time is available. The question could be phrased as:

> *"How do the less good things concern you?"*
>
> *Or*
>
> *"What is most important to you at the moment?"*

STEP 10. Giving individuals take-away materials to bolster the brief intervention

The individual should receive a copy of their ASSIST-Lite results and other written information to take away with them when the session is over. The written information can strengthen and consolidate the effects of the brief intervention if they are read by the individual. They also can serve as a secondary outreach if read by friends and family or associates of the individual who also may be using substances.

If a person feels that they have been 'listened to' they are more likely to receive and consider the information and advice given by the professional.

CHAPTER 7

Responding to Resistance and Challenging Behaviour

There is concern within emergency care settings that staff will experience resistance and defensiveness from patients when screening for alcohol and other drug use, and that patients may not answer honestly. The use of motivational interviewing techniques and an empathic non-judgemental approach can help build rapport and reduce resistance.

Evidence has shown that people will be more likely to respond positively and honestly if they are approached in a respectful manner, the reason for administering the ASSIST-Lite is clearly explained, and questions are asked in a non-judgemental manner.[59]

It may be helpful to assess less contentious needs first to allow time to build rapport before introducing the ASSIST-Lite. Screening with the ASSIST-Lite should be administered in the context of the assessment of needs to guide intervention. There should not be any negative consequences for honesty.

Resistance to answering the ASSIST-Lite may occur if the patient is unsure why they are being asked the questions or they feel like they are being targeted or judged. A clear explanation of the purpose and scope of the ASSIST-Lite coupled with a non-judgemental attitude will help reduce resistance.

Remember that completing the ASSIST-Lite is voluntary, if a patient does not want to complete it, they do not have to. Similarly, if they start answering the questions and do not want to finish them, their decision is to be respected. Seek to understand why the patient did not complete the questions, in a non-judgemental manner, to help identify any underlying issues or concerns. Ultimately, the choice is theirs.

Challenging behaviour is any behaviour that causes significant distress or danger to the person of concern or others. It can include an outburst of aggression, or resistant type behaviour by clients. Any situation or feeling can act as a trigger for challenging behaviour. This is frequently unpredictable. However, the approach made towards the person is very important.

Most hospitals and emergency care settings have policies and procedures for managing challenging behaviours. Here are some practical tips from WorkSafe Victoria (2017) to help reduce challenging behaviour:

- Pause — stand back, take a moment before approaching and assess the situation
- Speak slowly and clearly in a calm voice
- Explain your actions
- Try not to rush the person, act calmly
- Show respect and treat people with dignity at all times

[59] Ali, R., Gowing, L. & Harland J. (2017) Report on the feasibility study of ASSIST-Lite with brief advice in the Royal Adelaide Hospital Emergency Department, University of Adelaide (unpublished report)

- Minimise boredom, social isolation and irritating factors in the environment such as noise, uncomfortable clothing
- Enhance comfort, exercise, participation in activities, decision making and dignity
- Communication is the key
- Avoid harsh aggressive or abrupt statements. Don't say things such as "You must…", "Don't…", "Stop…". Use alternatives and "I' language like "I would like you to…" It would help me if…", "I feel scared when…".[60]

As outlined in Chapter 3, conducting the ASSIST-Lite within the *'Spirit of Motivational Interviewing'* will help portray an acceptance of the person's situation and respect their autonomy. This will help reduce resistance as the person feels in control of their situation and they can make informed decisions based on their previous experiences and any new information being offered.

Do not be discouraged if a person seems ambivalent and does not commit to change. Change is fundamentally self-change and people need time to consider their options. Change is not a power struggle whereby if change occurs, we 'win'. People have their own strengths, motivations and resources that are vital to activate in order for change to occur.[61] Just raising a person's awareness of the risks associated with their current pattern of substance use can be the catalyst to explore options for change in the future.

> *"What people really need is a good listening to."*
> \- Mary Lou Casey

Do not be discouraged if a person seems ambivalent and does not commit to change. Change is fundamentally self-change and people need time to consider their options.

[60] WorkSafe Victoria (2017) https://prod.wsvdigital.com.au/sites/default/files/2018-06/ISBN-Prevention-and-management-of-violence-and-aggression-health-services-2017-06.pdf

[61] Miller W and Rollnick S (2012) Motivational Interviewing (3rd Ed) Helping People Change. New York and London, Guildford Press

PART 2

This section provides options for delivery of the *ASSIST-Lite in the Emergency Department* training package. It begins with an overview of points to consider when planning to deliver an education session and provides example training models; face-to-face, on-line and flipped classroom (Chapter 9). Chapter 10 provides more information on the characters portrayed in the *ASSIST-Lite in the Emergency Department* video scenarios.

CHAPTER 8

Providing training and education sessions

Planning for your target audience

Planning

Before you commence any training, there are a number of things to be considered. This section outlines some questions which need to be considered prior to commencing any training whether it is a full day workshop, a tutorial, a brief information session or online teaching. A simple format when planning a session is to think of who, what, why, how, when, and where.

Who?

It is important to consider who is the intended audience, what existing knowledge, skills and attitudes are they likely to have, and how many will be participating in the training.

- Do they have sufficient knowledge about alcohol and other drug problems and addiction?
- Do they have sufficient knowledge about the relationship between substance misuse and offending?
- Do they have appropriate communication and interpersonal skills?

2

If you are coordinating the training, you also need to think about facilitation.

- Do you plan to facilitate the session? If not, who will facilitate the training?
- How many facilitators will be needed?
- Do the intended facilitators have the necessary expertise?
- How will they be trained to facilitate? You may train facilitators yourself or you can contact the DASSA WHO Centre (dassawhocentre@adelaide.edu.au) to arrange for face to face training of trainers.

What?

What is your training objective? It is important to always keep this in mind and return to it when you are planning and conducting your training. It is useful to have it written down.

What specific needs do the participants have?

- If your intended participants have limited knowledge and experience with substance misuse and addiction you may need to include some additional material such as information about various drugs and the nature of addiction. These can be found in the online training section of the ASSIST Portal www.assistportal.com.au. Additional information about individual drugs can be found at www.druginfo.adf.org.au.
- If they need to develop skills in motivational interviewing and brief intervention then it will be important to offer a face to face session with plenty of time for skills practice.

Why?

Why is this training required? If you have been invited to facilitate training, you need to think about why you have been invited and whether your experience and knowledge fits with the expectations of the group or organisation.

How?

What is the best format for the training to take place?

- Do the intended participants need to attend a face to face session or would an on-line session be more suitable for the target audience?
- Would a mixture of face to face and online be the best mix?

These decisions need to be made prior to contacting potential participants.

When?

Consider when the training is to take place. If you plan to offer a face to face session, then consider the best time for this to take place.

- Is there a time limit on the session?
- Do you need to offer a two-hour tutorial or a one-day workshop?
- Does it need to be conducted on a specific day or date?

Where?

If you are offering the training face to face, then you need to consider the following when deciding on a suitable venue:

- Tables and spaces for activities
- Sufficient seating
- Size of the room
- Access to teaching aids such as computer, data projector and whiteboard
- Breakout space for group activities
- Toilet facilities
- Tea/coffee facilities
- Access to public transport
- Access for people with disabilities
- Noise
- Cost of hiring training room if applicable

Publicity

If you are offering the training to people across a number of sites, or from different facilities, you need to promote your workshop across all of those sites and facilities.

Register of Participants

You will need to keep a list of who is registering for the workshop. You will need to determine whether you want to keep a list of participants for further workshops. If you want to do this, you will need to ensure confidentiality and ask participants if they are willing to be contacted about future training. You also need to request their permission prior to providing a class list to participants or sharing any personal or contact information. You must also seek permission from participants prior to taking any photos that you may want to use for future training or publicity.

Confirmation to participants

Remember to send confirmation to participants registering for the workshop. This can be done either via email or in hard copy. This is a good time to ask about any dietary requirements or disability constraints.

Evaluation and reporting

Organisations have different evaluation requirements and reporting needs. You need to consider these during the planning process. You need to consider what it is that you want to evaluate and why.

- Do you want to evaluate the content?
- Do you want to evaluate the way the information was delivered?
- Do you want the evaluation to be written or verbal?
- Do you plan to set up a data base for future comparisons?

There is no need to collect information that is not useful. Think about confidentiality. Remember if you ask participants to identify themselves, it may reduce the honesty of responses.

Note that if you are providing certificates of attendance and/or participation, you will need to check with the organisation which has requested the session(s) what information they need on the certificates. Many organisations require the learning objectives to be stated on the certificate.

It does not matter whether the training is on-line or face-to-face, as a workshop or tutorial; the amount of time you spend on planning and practice prior to the commencement of the course is equally as important as the session itself.

Preparation is the key. If you prepare the groundwork and ensure that the foundation is sound, then your training is likely to be a success. This section outlines some important hints and considerations.

Principles of adult learning

Learning is acquiring new skills, knowledge, behaviours and values and may involve synthesising different types of information. The process of learning is primarily controlled by the learner themselves. Each person has a wealth of experience that they bring with them which they then draw on to reflect, problem solve and learn.

Malcolm Knowles is one of the foremost theorists on adult learning (andragogy).[62] These components of adult learning can be useful when planning your session. We have used this approach in the design of the package and suggest you facilitate with these assumptions as your primary focus:

Principles of adult learning	
Need to Know	Adults need to know the reason for learning something
Foundation	Experience (including error/mistakes) provides the basis for learning activities
Self-concept	Adults need to be responsible for decisions about their education; including involvement in the planning and evaluation of their learning
Readiness	Adults are most interested in learning subjects that have immediate relevance to their work and/or personal lives
Orientation	Adult learning is often problem-centred rather than content-oriented
Motivation	Adults respond better to internal versus external motivators

Timing

Once you have the information ready and your session planned, it is a good idea to run through everything. Note how long each section takes. There is nothing worse than getting to the end of the session and realising that you have not covered everything. Allow time to introduce yourself and the objectives of the training. Leave extra time for questions or those unscheduled interruptions that often occur.

Use prompts such as notes or a session outline and work out how long you plan to spend on each section. Write it down and work within the time allocation. Make sure you have a watch or clock but remember to only glance at it and not to be constantly looking at it as this can be distracting for participants. A clock on a mobile device is useful as a last resort, but it can be very distracting for participants when the device goes into sleep mode and you have to fiddle with it to get it to wake up.

Remember, it is better to have too much time allocated rather than too little.

[62] Knowles, M. S. (1970). The modern practice of adult education: Androgogy versus pedagogy. New York: New York Association Press.

Reference Points

Keep your objective in mind as you work through the training. If your participants are in the room, make sure the objective is visible. Write it on the whiteboard or even have it as footer on any slides that you use.

This is a technique used by experienced presenters; tell the participants what you want to tell them and then tell them the same thing in a different way. You can tell them again using an example to emphasise your point. This ensures that the most important points are reinforced.

Language

The language you use is very important. Avoid using jargon and use plain language. People for whom English is not their first language may miss nuances and not understand some colloquialisms. When presenting, take time to check that participants understand what you are talking about.

Assess your participants and use non-technical terms. Remember that although you may be speaking to other health professionals, they may not be familiar with terms related to alcohol and other drugs.

Handouts

It is preferable to provide participants with handouts of your presentation. Participants can write additional notes on these handouts. Manilla folders are inexpensive and if your budget allows it, we suggest that you place each participant's handouts in a folder which is labelled with the title of your session. The extra time spent to make the handouts look professional is well worth the effort.

Technology

Always test any technology you are using. If possible, check the projector, computer or any other equipment the previous day. This allows time for any adjustments to be made. If this is not possible, allow extra time prior to the session to check the technology and to be comfortable using it.

Information

Begin the session by outlining what the session will be about and explaining your objectives. Adapt each session to suit your particular requirements. Remember to have some alternate examples in case you find you need to spend some extra time on any specific section. It is always good to have some additional exercises in case participants are having difficulty understanding the examples you are using.

Limit the information that you present. Keep key points to a minimum. It is better to remember three key points rather than forgetting ten! Emphasize the major concepts and do not introduce too many at any one time. As a rule of thumb, introduce a major concept every 8 to 10 minutes. Any more than that, people will not be able to take in.

Talk about every day experiences. Participants relate better to personal anecdotes. Ask participants to contribute. Many will have their own personal experiences to draw on.

Self-awareness

The effectiveness of your presentation is influenced by how you look and speak. This section is not about telling you how to dress, rather it is about being aware of your facial expression, gestures, posture and voice volume.

Prepare by practising your presentation to a friend, or if this is not possible, record it and practise in front of a mirror. Take particular notice of any distracting habits or mannerisms you might not be aware of such as scratching your head, drumming your fingers or clicking your pen.

Be aware of how you speak. Is your voice monotonous? Do you slur some words? Do you often say 'um', you know' 'OK' when you speak? Do you speak very quickly or slowly? Do you have a soft voice or a very loud voice? By becoming aware of any problems and pinpointing them, you can then practise and minimise or eliminate their use. Some other hints for public speaking include:

- Looking at individual participants to make them feel acknowledged
- Using hand movements for emphasise (but use them consciously and sparingly to make a point, rather than them being distracting)
- Moving around the room
- Inserting pauses for emphasis

Remember, the more presentations you do, the more confident you will become and the more relaxed you will feel.

Be enthusiastic

Remember, you are selling a message. You need to believe in your message. If you have a genuine interest in your topic, your enthusiasm will come across. Enthusiasm is catching. If you are enthusiastic about your topic, participants are more likely to engage with the session and to actively participate by being involved in discussions and seeking clarification when required.

Welcome participants, thank them for coming along and let them know that you are really pleased that they are here. Keep up the pace of your presentation, use an expressive voice, humour when appropriate and use gestures to emphasise specific points.

Above all ENJOY.

CHAPTER 9

Training and education session options

Face to face sessions

This resource can be easily adapted to a face-to-face setting. This can be in any of the following situations:

- One-hour session (e.g. in-service or professional development)
- For experienced professionals, the instructional video can be shown as a focal point for discussion. Suggested topics for discussion could include:
    - » How is screening and brief intervention currently being conducted in their organisation?
    - » How could the ASSIST-Lite be implemented in their organisation?
- Two-hour session
    - » As above plus role play in groups of three (as described in the flipped classroom model outlined later in this chapter)
- As part of a longer workshop
    - » If participants are new to screening and brief intervention enough time should be allocated for presentation of the knowledge in this package and any additional knowledge required. Interactive activities to assist participants to integrate the new knowledge, and role plays to develop and practice the skills needed to administer the ASSIST-Lite questionnaire and BI.
    - » Further training materials are available on the ASSIST Portal (www.assistportal.com.au) which may be used with participants who are new to addiction, screening and brief intervention
    - » The instructional video can be shown as a focal point for discussion and to demonstrate the skills required
    - » It is recommended that the participants adapt the role-plays to their professional area or work practice

On-line learning

The ASSIST-Lite in the Emergency Department instructional video can be used for on-line teaching. It is suggested that the participants be asked to watch the video and answer questions. Depending on the objectives of the training, the linked activities could include short answer questions, or a discussion board, assignment or essay.

Depending on the IT platform, a suggested approach is:

- Participants view the instructional video on-line
- Discussion points are posted on a 'discussion board' or 'chat room'
- Participants are encouraged to conduct a role play using the ASSIST-Lite BI with a fellow student, friend, colleague or in either the 'chat room', via Skype or over the telephone.

- The experience of conducting the ASSIST-Lite BI would form the basis of postings on the discussion board or of an assignment or essay. Suggested topics for discussion include:
  - » How was the experience of conducting an ASSIST-Lite BI?
  - » What did you learn from the experience?
  - » How is screening and brief intervention currently being conducted in your area?
  - » What has been successful?
  - » What are the barriers to screening and brief intervention?
  - » Discuss possible ways to overcome these barriers.

General discussion questions for consideration:

- Explain how you used the FRAMES model in your role play?
- How do you measure if you are expressing empathy throughout the ASSIST-Lite BI?
- What stage of change was the client in the scenario? Explain your reasoning.
- Describe the stage of change your client was in the role play. What techniques did you use to help move your client to the next stage?

Flipped classroom method

This model is particularly useful for undergraduate and post graduate students. The flipped classroom model encompasses the use of technology to enhance the learning in the classroom, so you can spend more time interacting with participants instead of lecturing. It is called the flipped class because the whole classroom/homework paradigm is "flipped". What used to be class work (the "lecture") is done at home via teacher-created videos and what used to be homework (assigned problems) is now done in class. Another way of describing this is 'pre-loading' the information before the session.

To use this package in a 'flipped model' the following is suggested. Prior to class the participants are:

- Given access to the ASSIST-Lite in the Emergency Department instructional video.
- Encouraged to watch the video and familiarise themselves with the ASSIST-Lite.
- Explore background information on the ASSIST Portal: www.assistportal.com.au.
- Role play at least one ASSIST-Lite on a family member or friend.
- Prepare themselves to come to class and administer an ASSIST-Lite and to role play a character with a fellow participant.
- The character developed for the role play should be researched and based on evidence that is available related to patterns of drug use. This would include associating the age and gender of the character with the pattern of drug use and associated consequences of use.
- Participants are to research what services are available for patients with drug and alcohol problems in their area or jurisdiction and be prepared to provide an ASSIST-linked, targeted intervention.

NOTE: Participants may build on the characters shown in the video. Further background information on these and additional characters is included in Chapter 10.

During class time, participants are divided into groups of three. In turns they role play the scenario and provide an appropriate, targeted brief intervention. The third person in the group acts as an observer and provides feedback at the conclusion of each role play. The observer asks and assesses what stage of change the character was at?

The session is concluded with a large group discussion. Suggested key discussion points include:

- What are some of the benefits of screening and brief intervention for drug and alcohol use in emergency care settings?
- What are some of the potential barriers to screening and brief intervention?
- Explain some of the ways to overcome the barriers.
- How confident are you to administer an ASSIST-Lite and Brief Intervention?
- Discuss possible ways to gain more information and experience in administering an ASSIST-Lite Brief Intervention.

CHAPTER 10

Scenarios

NOTE: The patients in the intervention scenes are actors and the scenarios are based on a number of interactions with patients during the trial phase of the ASSIST-Lite in the Emergency Department.

Scenario 1: Maggie

Maggie is 62-years-old and works as a Media Consultant. With an expansive and impressive career as a journalist, Maggie is highly sought after and jokes 'I will never be able to retire'. Recently divorced after 34 years of marriage, Maggie is adjusting to her new life. Considered quite a 'socialite' Maggie enjoys social events and spending time with her friends. Maggie lives alone and has one son and two grandchildren.

Prior to her admission to the Emergency Department, Maggie was attending a charity fundraising luncheon. Whilst waiting for a taxi Maggie became unwell and reported her heart was racing very fast. Maggie had experienced this before but it usually stopped when she took a deep breath and held it in. This time it wasn't stopping and she began feeling light headed. Her friend called an ambulance.

On admission to the ED, Maggie was in SVT and quite distressed. Maggie was given Adenosine and was warned that it may give her 'an unpleasant feeling'. Maggie reported that she 'felt like I was going to die', though felt much better since being back in sinus rhythm.

Prior to discharge, Maggie completed the ASSIST-Lite on the computer tablet. In the past 3 months Maggie reported alcohol use only. With regards to the first supplementary question, Maggie answered 'Yes' that she had drank more than four standard drinks on any one occasion. Maggie answered 'no' to the other supplementary questions as she had never tried to cut down or stop drinking and no one had ever expressed concern about her drinking. This placed Maggie in the moderate risk range for alcohol. Maggie said that she did not mind completing the ASSIST-Lite and emailed the results home.

The following week, prior to seeing her cardiologist, Maggie reviewed the ASSIST-Lite results. She was surprised that her drinking was putting her at risk as she was *'drinking less than some of my friends',* though did recognize that she had been drinking more regularly over the past few months. Maggie read the information on standard drinks and made note of the fact that she should not be drinking more than two standard drinks per day and no more than four standard drinks on anyone occasion.

Maggie has discussed some of the benefits of having cut back on her drinking, such as weight loss and having more energy, with her friends. Maggie has encouraged alcohol-free events; however, her friends are not quite as enthusiastic about her behaviour change, though they are thrilled they now have a designated driver.

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Scenario 2: Steve

Steve grew up on the North Coast of New South Wales and moved to Sydney when he was 11 after his parents separated. Steve made friends easily and was considered the '*class clown*'. After leaving school in year 10, Steve drifted between jobs, valuing his time with mates and having fun over work commitments.

Steve was adventurous and appeared to have no fear. He was always up for a dare and did not consider the consequences. Steve had tried most drugs, that were offered by his older brother and friends, often for their amusement.

Steve met Jess at the local pub and he was surprised when she announced that she was pregnant and wanted to keep the baby. Steve was not ready for commitment, though promised to provide for his son Josh, who he adored. Steve moved in with Jess and her Mum to help raise Josh.

Steve and Jess's relationship was strained. Jess was frustrated by Steve's immaturity and not '*being there*' for her and Josh. Jess suspected Steve was using crystal methamphetamine, though he denied it. When Jess found an Ice pipe in Steve's work bag, she threw him out and stopped him seeing Josh. Steve moved into his workmate's garage.

Prior to being admitted to hospital, Steve was having Friday afternoon drinks on a mate's balcony. Someone yelled "*it's your shout Stevo*". Steve jumped up, couldn't get past his mates and said "*I'll take a short cut*" and jumped over the balcony rail. A thud was heard followed by profanities and a cry for help. Steve's mates went to his aid, carried him to the car and took him to hospital.

On arrival to the Emergency Department, Steve reported right sided chest pain and restricted movement and pain in his right arm. X-ray revealed a fractured humerus. Although relieved that he had not fractured his ribs, Steve was concerned he would be out of work for a while.

Prior to discharge the nurse administered the ASSIT-Lite. Steve reported smoking 'a pack a day', drinking alcohol and occasional cannabis and methamphetamine use. Steve scored in the high-risk range for tobacco and the moderate risk range for alcohol, cannabis and methamphetamine. Given the high-risk score for tobacco in the context of polydrug use, the nurse provided general advice and encouraged him to follow-up with the Alcohol and Drug Information Service.

Two weeks following his accident, Steve was at home feeling bored and in a low mood. He was really missing Josh and decided to do something about it. With a '*nothing to lose*' attitude, he phoned the Alcohol and Drug Information Service. Steve was surprised with how helpful the service was and decided to try some of their suggestions. He tentatively discussed his decision to stop using cannabis and crystal methamphetamine with his best mate, noting that a serious motivator for change was the risk of testing positive for drugs at work and he did not want to risk losing his job. His mate was supportive and although still smoking tobacco, Steve has stopped his cannabis and crystal methamphetamine use.

Scenario 3: Brett

Brett is 28 years old and lives with his girlfriend Tammy. Brett grew up in Sydney and was provided a good education. Brett reported sexual abuse by an older relative at age 13. Shortly after this time he started using cannabis and alcohol. Brett completed year 12, though not with the high scores expected and did not meet the entrance criteria for University. A naturally gifted artist, Brett pursued his love of fine arts, to the disapproval of his family.

Brett moved to the South Coast where his cannabis use escalated and he tried heroin. His heroin use increased over time and by age 24 he was using daily. Following a near fatal over-dose, Brett attended a 5-day detox and started on the Opioid Treatment Program. Brett was doing well on the program though lapsed when his best friend died from an accidental overdose. Brett attended detox again and then attended an inpatient rehabilitation program where he met Tammy.

Brett and Tammy have been together for 3 years and consider each other 'soul mates'. Brett came off Methadone 6 months ago saying he was '*sick of all the BS*'. Tammy was not supportive of his choice, but said she would stand by him no matter what.

Brett and Tammy are regular attenders at Narcotics Anonymous (NA) and are active peer supporters. Tammy had completed the self-administer of Naloxone training and was a strong advocate for the program.

Prior to Brett's admission to the ED, he had a fight with Tammy and she threatened to leave. The fight escalated, and Tammy stormed out. Brett contacted a mate and 'got on'. Concerned for his safety, as he was not answering his phone, Tammy returned home to find Brett unconscious on the lounge. She rang the ambulance and administered Naloxone as per her training. When the paramedics arrived, they administer further Naloxone, though Brett was failing to wake up fully so they transferred him to the ED for further assessment.

Toxicology reports showed traces of fentanyl and heroin. Brett stated that he thought he was only using heroin. The presence of fentanyl helped explain why Brett failed to wake adequately after multiple doses of Naloxone.

Brett was seen by the Drug and Alcohol Consultation Liaison Team prior to discharge from the Emergency Department and agreed to a follow-up with the Opioid Treatment Program. Brett commenced on Buprenorphine and is doing well with the support of Tammy, SMART Recovery and the Opioid Treatment Program staff.

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PART 3

SUGGESTED RESOURCES

ASSIST Portal: The portal has been developed by the DASSA-WHO Collaborating Centre, University of Adelaide, as a repository for ASSIST tools, training resources, research articles and publications. www.assistportal.com.au.

Alcohol and Drug Foundation: Druginfo provides easy access to information about alcohol and other drugs and drug prevention: www.druginfo.adf.org.au.

Australian Drug Information Network (ADIN) is Australia's leading alcohol and other drug search directory. Use ADIN to search for alcohol and other drug information and treatment services across Australia: www.adin.com.au.

Motivational Interviewing. For further information and online Motivational Interviewing training opportunities visit: www.motivationalinterviewing.org.

Naloxone Program For information on a Naloxone Program in Australian Capital Territory www.cahma.org.au/Naloxone.html.

Self Management and Recovery Training (SMART) www.smartrecoveryaustralia.com.au.

Your Room For useful information and facts about drugs and alcohol. www.yourroom.health.nsw.gov.au/Pages/home.aspx.

APPENDIX A:

The ASSIST-Lite Questionnaire

Alcohol, Smoking and Substance Involvement Screening Test
ASSIST-Lite

Instructions

The questions ask about psychoactive substance use in the PAST 3 MONTHS ONLY.

Ask about each substance in order and only proceed to the supplementary questions if the person has used that substance.

On completion of all the questions, count the number of "yes" responses to obtain a score for each substance, and mark the risk category.

Provide a brief intervention relevant to the risk category.

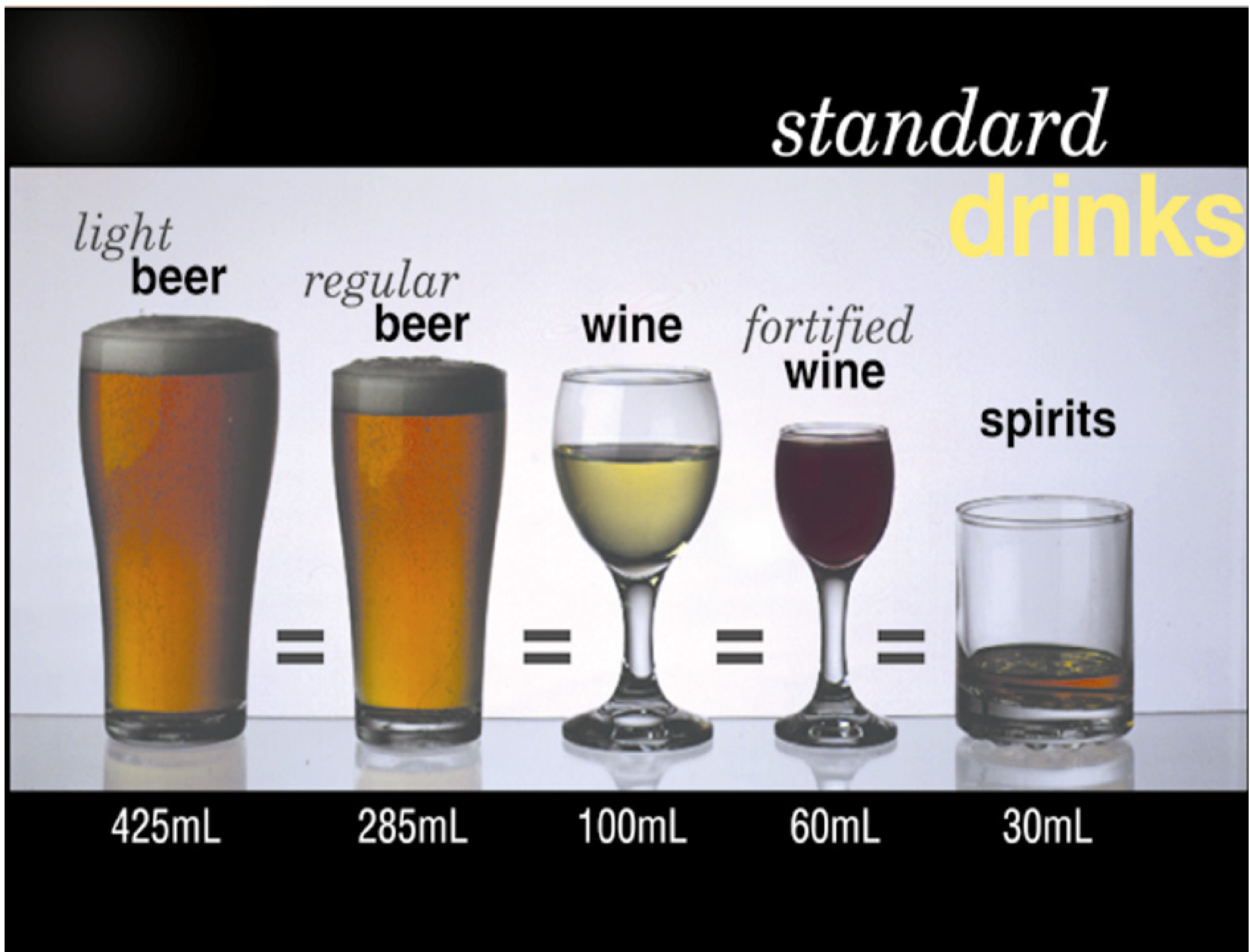
In the past 3 months	YES	NO
1. Did you smoke a cigarette containing tobacco?	☐	☐
1a. Did you usually smoke more than 10 cigarettes each day?	☐	☐
1b. Did you usually smoke within 30 minutes after waking?	☐	☐
Score for tobacco (count "yes" answers)	☐	
Risk category: ☐ Low (0) ☐ Moderate (1 or 2) ☐ High (3)		
2. Did you have a drink containing alcohol?	☐	☐
2a. On any occasion, did you drink more than 4 standard drinks of alcohol?	☐	☐
2b. Have you tried and failed to control, cut down or stop drinking?	☐	☐
2c. Has anyone expressed concern about your drinking?	☐	☐
Score for alcohol (count "yes" answers)	☐	
Risk category: ☐ Low (0 or 1) ☐ Moderate (2) ☐ High (3 or 4)		
3. Did you use cannabis?	☐	☐
3a. Have you had a strong desire or urge to use cannabis at least once a week or more often?	☐	☐
3b. Has anyone expressed concern about your use of cannabis?	☐	☐
Score for cannabis (count "yes" answers)	☐	
Risk category: ☐ Low (0) ☐ Moderate (1 or 2) ☐ High (3)		
4. Did you use an amphetamine-type stimulant, or cocaine, or a stimulant medication not as prescribed?	☐	☐
4a. Did you use a stimulant at least once each week or more often?	☐	☐
4b. Has anyone expressed concern about your use of a stimulant?	☐	☐
Score for stimulants (count "yes" answers)	☐	
Risk category: ☐ Low (0) ☐ Moderate (1 or 2) ☐ High (3)		
5. Did you use a sedative or sleeping medication not as prescribed?	☐	☐
5a. Have you had a strong desire or urge to use a sedative or sleeping medication at least once a week or more often?	☐	☐
5b. Has anyone expressed concern about your use of a sedative or sleeping medication?	☐	☐
Score for sedatives (count "yes" answers)	☐	
Risk category: ☐ Low (0) ☐ Moderate (1 or 2) ☐ High (3)		
6. Did you use a street opioid (e.g. heroin) or an opioid-containing medication not as prescribed?	☐	☐
6a. Have you tried and failed to control, cut down or stop using an opioid?	☐	☐
6b. Has anyone expressed concern about your use of an opioid?	☐	☐
Score for opioids (count "yes" answers)	☐	
Risk category: ☐ Low (0) ☐ Moderate (1 or 2) ☐ High (3)		
7. Did you use any other psychoactive substances?	☐	☐

If yes, what did you take? ....

(Not scored, but prompts further assessment)

APPENDIX B

Standard Drink Chart (Australia)



GLOSSARY

AOD	Alcohol and other Drugs
ATS	Amphetamine Type Stimulants – includes Amphetamine, Methamphetamine, MDMA or Ecstasy and other related substances
ASSIST	Alcohol Smoking and Substance Involvement Screening Test
BI	Brief Intervention
CBT	Cognitive Behavioural Therapy
DASSA	Drug and Alcohol Services South Australia
EPE	Elicit Provide Elicit
FRAMES	Feedback, Responsibility, Affirming, Menu of options, Empathy, Summarising
MDMA	3,4 Methylenedioxymethamphetamine – also known as Ecstasy
MI	Motivational Interviewing
OARS	Open questions; Affirming; Reflecting; Summarizing
SBIRT	Screening, Brief Intervention, Referral into Treatment
SMART	Self Management and Recovery Training
TTM	Trans Theoretical Model of Behaviour Change (Stages of Change)
WHO	World Health Organisation