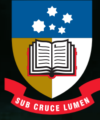

THE UNIVERSITY of ADELAIDE

ASSIST ON ICE

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and Brief Intervention for Methamphetamine Use

2nd Edition

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This manual was developed by Jennifer Harland and Robert Ali. It is based on material included in the ASSIST with Substance — Screening and Brief *Intervention for Nurses manual* (Harland & Curtis, 2014) and the ASSIST-linked Brief Intervention for Hazardous and Harmful Substance use, Manual for Use in Primary Care. Geneva, World Health Organization (Humenuik et al 2010).

This manual has been designed to support the ASSIST on Ice instructional video and is complimented by two resources that are available on the World Health Organization web site: **who.int/publications/i/item/978924159938-2**

- Brief Intervention: The ASSIST-linked brief intervention for hazardous and harmful substance use; Manual for use in primary care (2010), Geneva, World Health Organization.
- Self-Help Strategies: For cutting down or stopping substance use: a guide (2010), Geneva, World Health Organization.

All resources shown in the instructional video and 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.

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OVERVIEW

There are continued concerns about the use of methamphetamine and the impact it can have on the person, their family, their friends and their community[1,2]. The primary health care workforce is ideally placed to identify methamphetamine use, and related problems, and provide brief information and referrals to persons wanting to address their methamphetamine use. However, competing demands make it challenging for primary health care professionals to gain the knowledge, confidence, and skills to screen for substance use and provide a targeted brief intervention and to make this part of their clinical routine.

The ASSIST on Ice instructional video and manual, was developed to support primary health care professionals in a range of settings. The video presents two scenarios where the clinicians administer the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) as part of a routine presentation. Linked with a targeted brief intervention, it shows how the investment of five to ten minutes can help people make better decisions about their methamphetamine use.

This manual provides an overview of methamphetamine, how screening and brief intervention fits within a stepped-care model and information on how to use the principles of motivational interviewing to provide an effective brief intervention. The ASSIST Portal includes suggestions on how to use this package as an education and training resource. **assistportal.com.au**

Why use the ASSIST and linked brief intervention?

Most people who use methamphetamine do not seek specialist care but may seek help from primary health care services for a range of issues[2]. Screening and brief intervention aims to identify current or potential problems resulting from substance use and motivate those at risk to change their substance use behaviour. It does this by increasing their awareness of the relationship between consumption and a range of health and social risks and harms[3].

Clinicians working in primary health care settings are well placed to play a key role in the identification and prevention of methamphetamine related problems. Due to competing demands in a clinician's busy schedule, priority is given to tasks with the greatest immediate impact. Unfortunately, screening for drug and alcohol use may compete for scarce time in this context.

The ASSIST was developed for the World Health Organization (WHO) by an international group of alcohol and other drug clinical and research specialists, as a tool that is easy to use to detect substance use and related problems. The ASSIST is an eight-item questionnaire and takes about five to ten minutes to administer. ASSIST can help identify a range of issues including: regular use, dependent or 'high risk' use and injecting behaviour[4]. The ASSIST-linked Brief Intervention (ASSIST-BI) presented in this package can be delivered in less than ten minutes. The principles and practice suggestions can also be used for longer or recurrent intervention sessions as needed[5].

Many health care professionals avoid screening clients for substance use and hence lose the opportunity to provide a brief intervention. Research shows that the main reasons health professionals reported for not getting involved are:

- a lack of time;
- feeling that they are not competent or capable of giving an intervention; and,
- concern that they will experience resistance and defensiveness from their clients.

This resource addresses these barriers using a simple step-by-step approach. Brief interventions have been shown to be acceptable and motivating for many people with hazardous or harmful substance use, while also offering the health professional a plan to match the individuals risk-level and need. While the evidence is stronger for tobacco and alcohol, there is some evidence that the approach can be useful with illicit drug use and possibly, where indicated, as part of a strategy to engage people in more intensive support.

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FIGURE 1:
ASSIST flow chart

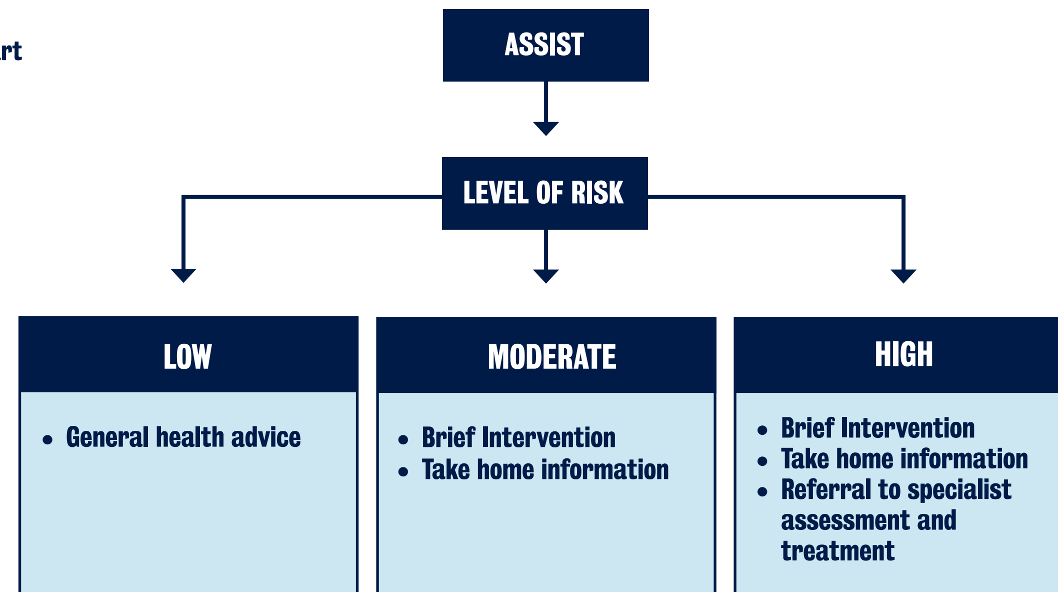

Figure 1 provides a summary of how to administer the ASSIST and provide a linked Brief Intervention.

A word from the developers

Following the success of *ASSIST with Substance*[9], the team was delighted to be approached to develop another training resource, this time with a focus on screening and brief intervention for methamphetamine use and related problems. Based on the same formula as *ASSIST with Substance*, we documented common realistic clinical scenarios, based on the team's combined clinical experience. We noted that a lot of methamphetamine users do not present to drug and alcohol services until they are experiencing quite serious problems. To prevent this progression, early identification and brief intervention in primary health care settings was the focus. Of course, some people might not progress to more severe problems, but nevertheless might benefit from an intervention in a primary health care setting.

The two scenarios in the *ASSIST on Ice* instructional video are based on clinical presentations that are common in primary health care settings. We want to highlight that the adverse effects of methamphetamine use may start to impact on a person's life, even after occasional use. In the first scenario, we demonstrate how administering the ASSIST during a routine doctor's appointment is an excellent opportunity to start a conversation with Jade about her drug use and link the brief intervention to her presenting issues.

The team recognized the association of methamphetamine use with mental illness. This is portrayed in the second scenario as the community health worker effortlessly conducts the ASSIST to see if there have been any such events. Noting a higher score for his methamphetamine use, the community worker frames the brief intervention around Dan's past history and explores possible options for the future. This case is also an example of how the ASSIST can be used effectively within a stepped care framework.

How to use this manual

This package has been designed to complement the ASSIST on Ice instructional video and can be used in a number of ways. These include:

- Personal learning and professional development;
- Face-to-face group setting (recommended for health care professionals);
- On-line (recommended for people who are unable to participate in face to face sessions); and/or,
- Flipped classroom model (recommended for students — see Chapter 9 for more information).

The package can be delivered in a short session (one to two hours) as part of a workshop or online. The scenarios in the instructional video highlight different settings where the ASSIST and linked brief intervention takes place. Facilitators can select one or both of the scenarios that they consider relevant to the session, 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 and of the various ways in which it can be delivered and implemented into practice. Advice on structuring education and training can be found in the ASSIST Portal at **assistportal.com.au**

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

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PART 1

CHAPTER 1

METHAMPHETAMINE

What do I need to know?

Methamphetamine is classed as stimulant drug, as it stimulates and speeds up the central nervous system and brain function. The stimulant class of drugs also includes caffeine, amphetamine, ecstasy and cocaine. There are three main forms of methamphetamine: powder (speed); base; and, crystal. The crystalline form of methamphetamine (Ice, crystal meth, crystal) is the most potent form of methamphetamine and is usually smoked or injected.

The effects of smoking crystal methamphetamine can be felt in seconds and can last for six to eight hours. Common effects include:

- Feelings of pleasure and confidence;
- Increased alertness and energy;
- Reduced appetite;
- Enlarged pupils;
- Teeth grinding and dry mouth;
- Increased perspiration;
- Increased heart rate, blood pressure and respiration;
- Repeating actions (picking and scratching); and,
- Increased sex drive[10]

Regular methamphetamine use can result in an increased tolerance (requiring more of the drug to experience the same effect) and dependence (physical and psychological signs of withdrawal if a person significantly reduces or stops using).

Long term-effects include:

- Extreme weight loss;
- Sleep problems;
- Dry mouth and dental problems;
- Regular colds and flu;
- Difficulty concentrating;
- Muscle stiffness;
- Anxiety, paranoia and aggression;
- Depression;
- Psychosis;
- Heart and kidney problems; and,
- Financial, work or social problems.

Overdose can occur and unwanted effects may include:

- Heart arrhythmias (racing heart-beat);
- Involuntary muscle movements;
- Seizures;
- Extreme agitation, confusion, anxiety, hallucinations and psychosis;
- Sudden, severe headaches;
- Stroke;
- Heart attack; and,
- Death[11]

People who have used crystal methamphetamine often report that they were not prepared for the intensity of the experience. Use can lead to a loss of inhibitions and is associated with a range of risk-taking behaviours including driving, sexual and injecting risk. Coming off or the ‘come down’ from crystal methamphetamine is reported as unpleasant and may encourage people to keep using to avoid the ‘come down’. The effects often experienced include:

- Exhaustion;
- Irritability and confusion;
- Headaches;
- Depressed mood; and,
- Paranoia and hallucinations.

A number of people use other drugs such as alcohol, benzodiazepines, opiates and cannabis to help with the ‘come down’. This can add to the complexity of a person’s situation and may result in toxicity and/or dependence on a number of drugs. ASSIST can help understand this as it covers a range of different substances.

As already noted, there are a range of mental health disorders that are related to methamphetamine use. Some clients may have significant relationship problems, anxiety and sometimes agitation, suspiciousness, and persecutory beliefs are manifest. These can impair the ability to build a connection to treatment This emphasises the need to have a client-centred approach that builds a sense of safety (for clients and staff) avoids judgement and builds trust towards client engagement.

Related to frequency of use and severity of dependence, depression is also relatively common, and clinicians need to be aware of the need to consider treatment of this where indicated. This could be included in a stepped care approach (see below).

Sometimes, clients will not identify methamphetamine as a presenting issue – but they might present with conditions related to mood and anxiety, nutrition, relationship problems, sleep disorders and lifestyle concerns (legal issues; housing; finances; etc).

In recent years, methamphetamine use has increased in a number of countries, and seizure data suggest that its production and trafficking has spread into new areas of the globe[12]. In Australia, important changes to the form and pattern of methamphetamine use have occurred that have increased related risks and harms. This has included an increase in the frequency of use and a shift to smoking the crystalline, more potent form. Smoking and injecting have been associated with increased risks of dependence. The growing harms associated with changing patterns of methamphetamine use was, in recent years, associated with increases in methamphetamine-related hospitalizations and the numbers of people seeking drug treatment for methamphetamine use[13].

From occasional use to dependence, methamphetamine use presents a risk to a person’s health and social wellbeing as well as the broader community. Identifying the pattern of use is a key to identification and assessment of risk and providing the appropriate intervention.

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CHAPTER 2

OVERVIEW OF THE ASSIST

What is the ASSIST?

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed under the auspices of the World Health Organisation (WHO) by an international group of alcohol and other drug clinical and research experts in response to the overwhelming public health burden associated with psychoactive substance use worldwide. It is an eight-item questionnaire designed to be administered by a health worker and takes about ten minutes to administer. The ASSIST screens for risky use of all main substance types (tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (ATS), sedatives, hallucinogens, inhalants, opioids and 'other drugs') and determines a risk score for each substance.

The risk score for each substance helps to initiate and frame a brief discussion with clients 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. The risk scores are recorded on the ASSIST Feedback Report Card (Appendix C) which is used to give personalised feedback to clients by presenting them with the scores that they have obtained, and the associated health problems related to their level of risk. As outlined in figure 2, ASSIST scores are linked to the following risk categories and associated recommended interventions.

FIGURE 2: ASSIST Risk Score and Associated Risk Level and Intervention

ASSIST Risk Score			
Alcohol	**All other substances** (tobacco, cannabis, cocaine, ATS, sedatives, hallucinogens, inhalants, opiods, 'other drugs')	**Risk level**	**Intervention**
0-10	0-3	Low risk	• General health advice
11-26	4-26	Moderate risk	• Brief intervention • Take home booklet and information
27+	27+	High risk	• Brief intervention • Take home booklet and information • Referral to specialist assessment & treatment
Injected drugs in last 3 months (Score of 2 on Q8)	Moderate to High risk**		• Risks of Injecting Card • Brief intervention • Take home booklet and information • Referral to testing for BBV's* • Referral to specialist assessment & treatment

* Blood Borne Viruses including HIV and Hepatitis B and C
** Need to determine pattern of injecting - Injecting more than 4 times per month (average) over the last 3 months is an indicator of dependence requiring further assessment and treatment

What is the ASSIST-linked brief intervention?

The ASSIST-linked Brief Intervention lasts three to ten minutes and is for clients who have been administered the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) by a health worker and are at *'moderate risk'* from their substance use. People in the moderate risk range who are not dependent, may be experiencing health, social, legal, occupational or financial problems or have the potential for these problems should the substance use continue.

Brief interventions are 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 clients to accept a referral to specialised drug and alcohol assessment and treatment, either within the primary care setting, or at a specialised alcohol and drug treatment agency.

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

The ASSIST-linked Brief Intervention is based on Motivational Interviewing (Chapter 3) and the FRAMES model (Chapter 4) and can be summarised in the 10 steps to an ASSIST — linked Brief Intervention (Chapter 6).

CHAPTER 3

USING MOTIVATIONAL INTERVIEWING IN AN ASSIST LINKED BRIEF INTERVENTION

In the context of the ASSIST screening and linked brief intervention, it is likely that the health care professional will have a relatively short time to spend with clients, compared with the amount of time that an addiction medicine specialist, counsellor, psychologist or drug and alcohol worker has to spend with clients. 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. It is based on the assumption that people are most likely to change when a person's motivation is developed for reasons that are important to them rather than just externally from other sources.

Brief interventions are often delivered within the *Spirit of Motivational Interviewing*. That is, there is a collaborative approach based on compassion and acceptance of the client's circumstances. The clinician aims to evoke answers that will provide the client with insight to their current situation and option for change.[12,13]

Motivational interviewing techniques are designed to promote behaviour change by helping clients to explore and resolve ambivalence. This is especially useful when working with clients 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. [15] 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.

Feedback

Providing feedback to clients is an important part of the brief intervention process. The way that feedback is provided can affect what the client really hears and takes it 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 which takes account of the client's existing knowledge and interest, and is respectful of their right to choose what to do with the information, involves three steps[16]:

FEEDBACK
1. Elicit
2. Provide
3. 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 methamphetamine?"

"Is there anything else you would like to know?"

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

"Your score for methamphetamine was in the moderate risk range. This means that your current level of use puts you at risk of experiencing health and other problems, either now or in the future."

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

"What concerns you about your score for methamphetamine?"

"How do you feel about that?"

"What do you see as your options?"

"Does your score surprise you?"

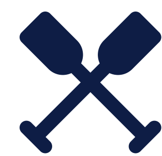
"What concerns you most about this?"

Develop discrepancy and reduce ambivalence

Clients 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 explore and amplify a discrepancy between current behaviour and broader goals and values from the client's point of view. It is important for the client to identify their own goals and values and to express their own reasons for change.

Ambivalence refers to the contradictory feelings clients might 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. If we simply make clients feel defensive, they may amplify the former and minimise the latter. By exploring discrepancy, you can reduce their ambivalence to change.

Using basic counselling techniques, the clinician aims to assist 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 client 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. Open-ended questions are more likely to encourage the client to do most of the talking (a good measure of how the intervention is going is to ask yourself – "Who is doing most of the talking?")

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

"What are some of the good things about using methamphetamine?" and, "What are the less good things for you about using?"

This approach is termed a *decisional balance* and encourages the client to explore the pros and cons of their use in a balanced way. [17] Asking open-ended questions of clients also reinforces the notion that the client is responsible for the direction of the intervention and of their substance use choices.

Affirming

Affirming the client's strengths, and efforts to change, helps build confidence. 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.

Reflecting

Reflective listening involves hearing, understanding and communicating what you have heard/understood. Thus, reflecting can involve rephrasing a statement to capture the implicit meaning and feeling of what a client has said. It encourages continual personal exploration and helps you and the client more fully understand their motivations. Reflections can be used to amplify or reinforce the desire for change.

It is important to reflect back the underlying meanings and feelings the client 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 clinician say what they have intended to communicate.

Reflecting shows the client that the clinician understands what has been said and/or allows the client to correct what has been misunderstood and can be used to clarify what the client means. Sometimes it can help the client make more sense of what has been till now chaotic and confusing.

Summarising

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

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

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

Eliciting change talk

As outlined by Miller and Rollnick (2012) eliciting change talk is a strategy for helping the client to resolve ambivalence and is aimed at enabling the client 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; and,
- 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 concerns you about your methamphetamine 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?"

"What do you think the benefits of change will be for you?"

"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 clinician administering the ASSIST-linked Brief Intervention can be most effective if they adopt the principles of motivational interviewing techniques and are:

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

You can make a quick judgment on how the encounter is progressing by thinking about the following questions/processes:

Are you focussed on hearing and understanding what the client is saying?

Who is doing most of the talking?

Are you jumping to conclusions?

Are you judging the client or what they say?

Are you giving advice too soon?

Are you dominating with your personal views, values or assumptions?[18]

Suggested further reading

Miller, W. and Rollnick, S. (2012) Motivational Interviewing, Helping People Change, 3rd ed. Guildford Press, NY. USA.

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

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

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

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

[18] Helfgott, S and Allsop, S (2009) Helping Change: The Drug and Alcohol Counsellors Training Program. Drug and Alcohol Office and National Drug Research Institute. Government of Western Australia Perth.

Technique	Examples
Open question	What do think are some of the benefits of addressing your methamphetamine use? You mentioned that you would like to stop using again, what has worked for you in the past?
Affirming	It sounds that 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 meth use with me today.
Reflecting	You enjoy using methamphetamine, though it sounds as if it is having an impact on your work & relationships. You have had treatment in the past and now you are not really sure what to do.
Summarising	So just to make sure I understand, you enjoy using, though it is causing some struggles in your life. You have been to detox before, but you left because of the no-smoking policy. You are keen to stop but not sure what other options are available. Am I on the right track?

CHAPTER 4

FRAMES

Clinical experience and research into brief interventions for substance use have found that effective brief interventions comprise a number of consistent and recurring features.

Clinical 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 were summarised using the acronym FRAMES - a framework first described more than 25 years ago, but still referenced today. FRAMES is the acronym for Feedback; Responsibility; Advice; Menu of options; Empathy; and, Self-efficacy. [19, 20, 21]

FRAMES
Feedback
Responsibility
Menu of options
Empathy
Self-efficacy

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, and the level of risk associated with those scores. It is worth noting that most clients are interested in knowing their questionnaire scores and what they indicate.

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

The ASSIST Feedback Report Card (Appendix C) which is completed for each client after completion of the ASSIST was designed to match personal risk (i.e. low, moderate or high) with the most commonly experienced problems.

In summary, feedback focusses on the provision of personally relevant information, and is delivered by the health professional in an objective and non-judgemental way. Much of the feedback information provided in an ASSIST-linked Brief Intervention can be delivered by reading from the ASSIST Feedback Report Card. Do not assume that what might concern you is of equal concern to the client.

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. This is not the same as blaming or judging the client. Communicating with clients 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?" or *"What concerns you about your score?"*

enables the client to retain personal control over their behaviour and its consequences, and the direction of the intervention. This does not stop you ***sharing*** your expertise in terms of providing advice (see below)

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

"I'm not sure how you see this, but your score indicates to me that …What do you think about this?".

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. Clients may be unaware that their current pattern of substance use could lead to health or other problems or make existing problems worse. You have an important role in helping make this link using the approaches described in motivational interviewing. Providing clear advice that cutting down or stopping substance use may reduce their risk of future problems can increase their awareness of their personal risk and be part of the identification of 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) 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 methamphetamine"* does not comprise clear, objective advice.

Menu of options

Effective brief interventions provide the client with a range of options to cut down or stop their substance use. This aims to facilitate the client's ability 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 client's motivation for change. It is also likely to help avoid or reduce resistance.

Giving clients the "*Self-Help Strategies for Cutting Down or Stopping Substance Use: Self-Help Guide*" [22] (available at: **assistportal.com.au/download/self-help-manual/?wpdmdl=482&masterkey=5dbc3f6a25ea1**) is a good way to start as it contains strategies to help clients change their behaviour, and can be used alone or in conjunction with other options.

Examples of options for clients to consider include:

- Keep a diary of substance use (where, when, how much used, how much spent, with whom, why);
- Identify high risk situations and develop strategies to avoid or manage them;
- Identify other activities instead of drug use — hobbies, sports, clubs, gym, etc.;
- Encourage the client to identify people who could provide support and help for the changes they want to make;
- Provide information about other self-help resources, including on-line, and written information;
- Invite the client to return for regular sessions to review their substance use;
- Provide information about other groups or health workers that specialise in drug and alcohol issues; and,
- Put aside the money they would normally spend on substances for something else

Empathy

Empathy is taking an active interest and expending effort to understand another's internal perceptive, 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.[23]

In a clinical situation, empathy comprises an accepting, non-judgmental approach that tries to understand the client's point of view and avoids labels such as addict or alcoholic. It is especially important to avoid confrontation and blaming or criticism of the client. Adopting a position of *'curious intrigue'* is helpful. Empathy requires reflective listening. Reflective listening has been described as the capacity to listen, to understand and to communicate understanding to the client.[24]

Skilful reflective listening which clarifies and amplifies the person's experience and meaning is a fundamental part of expressing empathy. The empathy of the health professional is an important contributor to building a therapeutic alliance and to how well the client responds to the intervention.[22]

Self-efficacy (confidence)

The final component of effective brief interventions is to encourage clients' confidence that they are able to make changes in their substance use behaviour. Exploring other areas where the client has made positive change is helpful. People who believe that they are able to implement a behaviour or action are more likely to do so and to persist in the face of challenges than those who feel powerless or helpless to change their behaviour. It is particularly helpful to elicit self-efficacy statements from clients as they are likely to believe what they hear themselves say. It is important to recognise that self-efficacy is most likely to develop with: success experiences that are attributed to their own efforts; previous successful attempts at behaviour change; cognitive rehearsal of implementation; and/or identifying success in individual who they can identify with.

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[19] Miller W and Sanchez V (1993). Motivating young adults for treatment and lifestyle change. In Howard G, ed. Issues in alcohol use and misuse by young adults. Notre Dame IN. University of Notre Dame Press.

[20] 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

[21] Aldridge, A. Dowd, W. and Bray, J (2017) The relative impact of brief treatment versus brief intervention in primary health-care screening programs for substance use disorders. Addiction **https://doi.org/10.1111/add.13653**

[22] 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.

[23] Miller W and Rollnick S (2012) Motivational Interviewing (3rd Ed) Helping People Change. New York and London, Guildford Press 22 Miller W and Rollnick S (2002). Motivational Interviewing. 2nd ed. New York and London, Guilford Press.

[24] Egan, G. (1990) The skilled helper: a systematic approach to effecting helping (4th ed) California, Brooks/Cole Publishing Company

CHAPTER 5

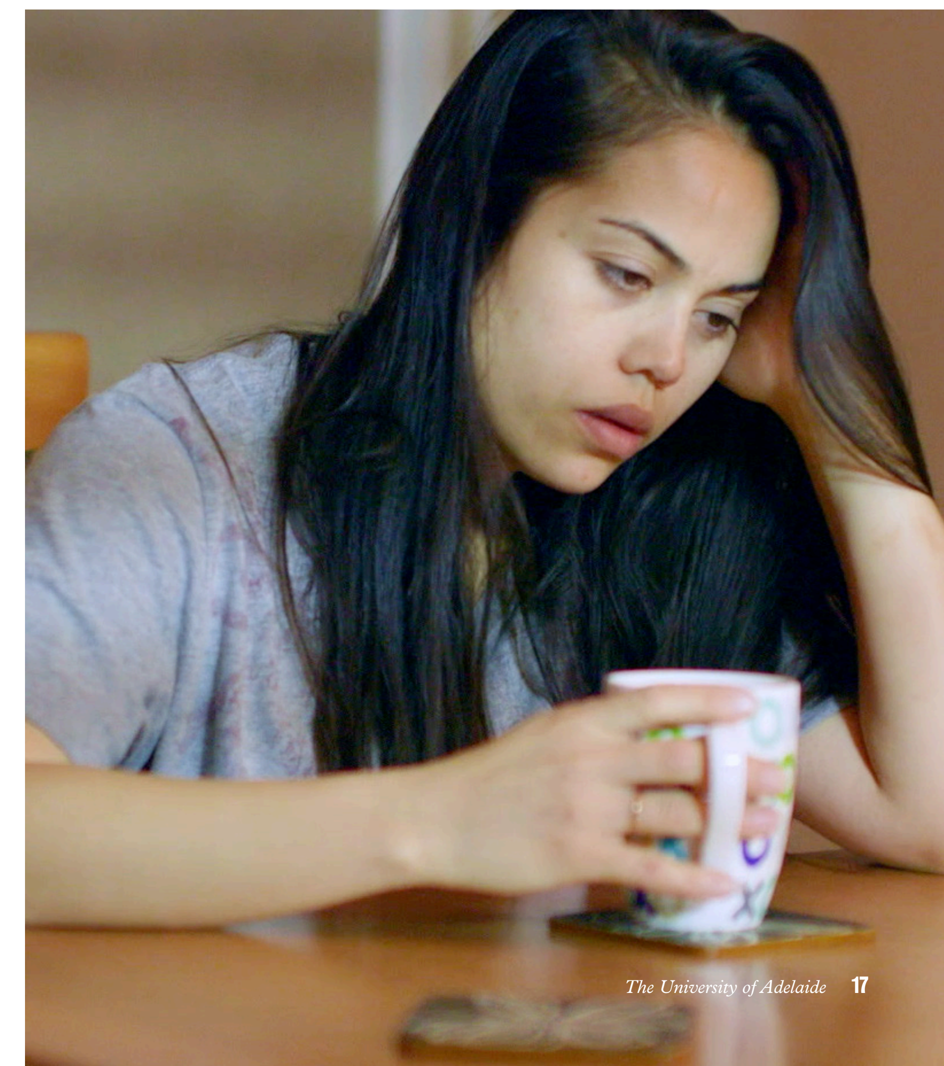
MODEL OF BEHAVIOUR CHANGE

The transtheoretical 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.[25]

In the model it is proposed that people go through different stages of change and that the processes by which people change seem to be the same with or without treatment.[26]

While the model is a useful way of thinking about the process of change, be careful of simple categorisation of clients. Also, be aware that there is some contention in the research about the predictive value of the model and some authors have critiqued the idea of the stages being stable and discrete.[27] But a key aspect of the model in ASSIST-BI is to remind us that, whilst we might be tempted to leap into action strategies, we might need to spend more time on thinking through "why" there is a need for change, and planning to act.

The aim of the ASSIST-linked Brief Intervention is to support people to move through one or more stages of change commencing with movement, for example, 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 an important step that may result in clients thinking about change and possibly 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 (it may be minutes, months or years) and that people cycle back and forth between stages. Some clients may move directly from pre-contemplation to action following an ASSIST-linked Brief Intervention. The following provides a brief description of the underlying behavioural and cognitive processes of each stage.

Pre-contemplation

Many people seen in primary health care settings, who score positive on the ASSIST, are likely to be in the precontemplation stage. 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, or important concerns, about their use of psychoactive substances;
- May show resistance to talking about their substance use;
- Unlikely to know, have noticed or accept that their substance use is risky or problematic; and/or,
- 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.

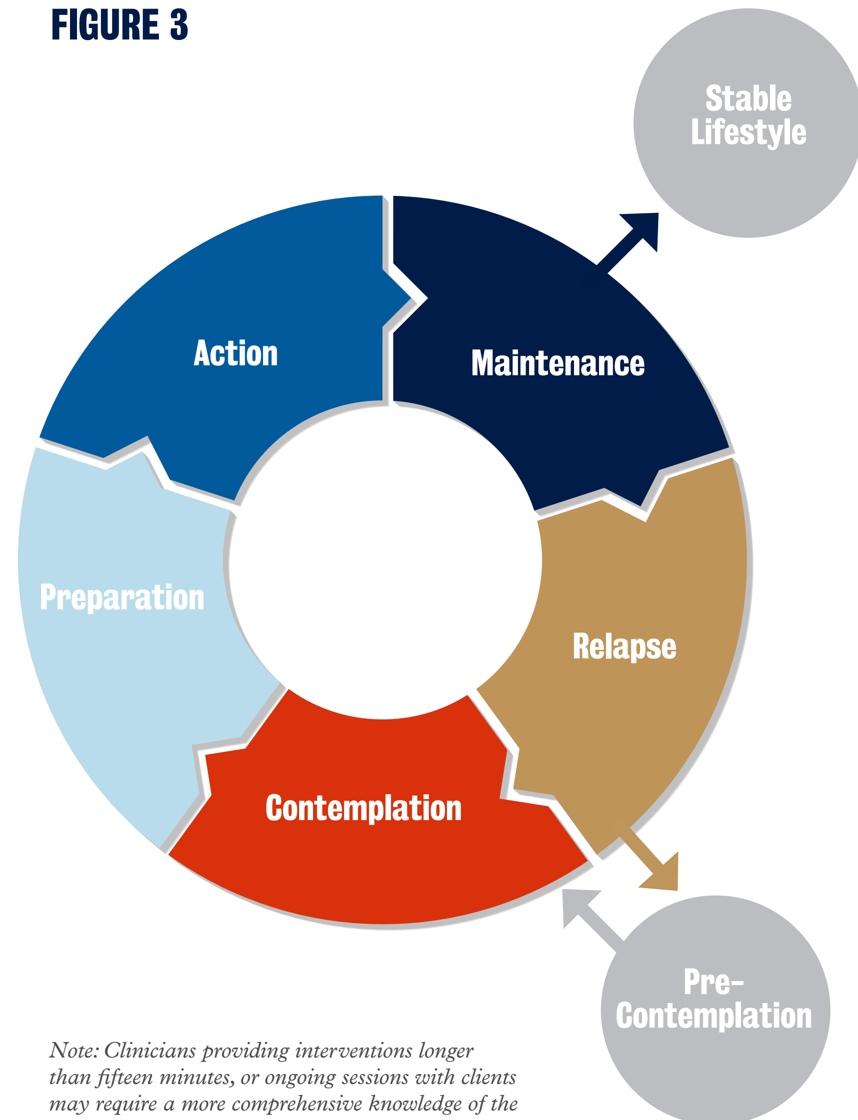
Contemplation

Some people seen in primary health care or hospital settings who score positive on the ASSIST may be in this stage. 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 – maybe it's time to cut down or stop;and/or,
- 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 thinking about change but they may not know how to make a 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.

FIGURE 3



Note: Clinicians providing interventions longer than fifteen minutes, or ongoing sessions with clients may require a more comprehensive knowledge of the model of change and associated techniques.

Preparation

Preparation follows contemplation and involves planning to take action in the near future and making the final preparations before behaviour change begins. Clients 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;
- Possibly vocalising their intentions to others;
- Making small changes in their substance use behaviour;
- Re-evaluating their current behaviour and considering what advantages might come from a change;
- Becoming more confident and ready to change their behaviour;
- Considering the options available to them; and/or
- Setting dates and determining strategies to assist change.

Action

A lesser proportion of primary health care clients are likely to be in the action stage. People in the action stage:

- Have made the decision that their use of substances needs to change;
- Have commenced cutting down or stopping or have already done so;
- Are actively doing something about changing their behaviour;
- Might initially engage in avoidance of high-risk situations, but later develop other coping strategies and the confidence to implement these; and/or,
- Might continue to feel somewhat ambivalent about their substance use and 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 and with success experiences in previously challenging circumstances);
- Focusing attention on high risk situations and the strategies for managing these; and/or
- More likely to maintain change if they received support and affirmation and if the quality of their life improves – in short if the effort is worth it.

Relapse

Change is challenging for all of us. Most people who try to make changes in their substance use behaviour will face challenges and might have a lapse or relapse back to harmful patterns of substance use, at least for a time. . It is useful to prepare for this before it happens (perhaps by developing a "relapse drill" specifically tailored for the individual client– what to do in the event of a lapse or relapse). Such experiences can be re-framed as a learning process rather than failure. Few people change on the first attempt and relapse is an important time to help clients review their action plan.

A review should examine timeframes, what strategies did actually work and whether the strategies used were realistic. Methamphetamine 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. A re-frame might include: why did the lapse occur; why was the client successful for so long – what worked well; what challenges occurred and why, on this occasion, did the lapse occur; why might they still want to change: and, what can be learned from this experience going forward.

In summary, the transtheoretical model of behaviour change can be used to map interventions to 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 health professionals understand these underlying processes to provide the most appropriate care for their clients.

It is also worth noting that the suggested 10 Step ASSIST linked Brief Intervention outlined in Chapter 6 is aimed predominantly at clients who are currently engaged in the least amount of change; that is in pre-contemplation and some contemplation. However, the principles can be built and expanded on for people preparing for change but who might have limited confidence and knowledge about how they can start and support change, and for clients who are in the action stage.

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

[26] Cordoba R, Delgado MT, Pico V, Altisent R, Fores D, Monreal A, Frisas O and Lopez del Val A (1998). Effectiveness of brief intervention on non-dependent alcohol drinkers (EBIAL): a Spanish multicentre study. Family Practice,15(6):562-588.

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CHAPTER 6

PUTTING IT ALL TOGETHER

A step by step approach to the ASSIST-linked Brief Intervention

Moderate risk clients

The ASSIST-linked Brief Intervention follows ten suggested main steps. 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 r has attracted the highest ASSIST score and/or is being injected.

This step-by-step approach was designed to assist and build confidence in health care workers who are not specifically trained in motivational interviewing and perhaps who do not respond to substance using clients on a regular basis. It also serves as a useful framework for more experienced drug and alcohol workers and can be expanded and explored further for longer or recurrent sessions, or to address multiple substance use.

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

The ASSIST Feedback Report Card is completed at the end of the ASSIST interview and is used to provide personalised feedback to the client about their level of substance related risk. A good way to start the brief intervention is to ask the client:

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

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

The ASSIST scores for each substance should be recorded in the boxes provided on the front of the ASSIST Feedback Report Card. On the following pages the level of risk indicated by the ASSIST Risk score should be indicated by ticking the relevant boxes for all substances ('low', 'moderate' or 'high'). A formatted copy of the ASSIST Feedback Report Card appears in Appendix C, and can be copied and used for the brief intervention. Some people find that using the on-line version – eASSIST- is a useful way of conducting the screening. Go to **eassist.assistportal.com.au/#/e-assist**

STEP 2. Provide personalised Feedback to clients about their scores using the ASSIST Feedback Report Card

The ASSIST Feedback Report Card is used during the brief intervention to provide feedback to clients and is given to the client at the end of the session to take home as a reminder of what has been discussed. The ASSIST Feedback Report Card also serves as something tangible for both the clinician and client to focus on during the course of the intervention.

Health professionals can provide personally relevant feedback in an objective way to clients by reading from the ASSIST Feedback Report Card. The card should be held so it can be viewed easily by the client, but still be able to be read by the interviewer (even if it is upside down). There are two parts to giving the feedback. First, the scores and level of risk associated with each substance as presented on the front page of the ASSIST Feedback Report Card.

Clinicians should go through each substance score on the front page of the ASSIST Feedback Report Card and inform the client whether they are at low, moderate or high risk from their use of that substance. Following this, explain to the client the definition of moderate risk and/or high risk, which can be done by reading the definitions from the box at the bottom of the front page. 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. Your score for methamphetamine was 16 which places you in the moderate risk range. Moderate risk means that you are at risk of 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). The information relating to the second part of the feedback is found inside the ASSIST Feedback Report Card in a series of nine boxes (tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, inhalants, sedatives, hallucinogens, opioids). Each box lists the harms ranging from less severe (shaded light grey) to more severe (shaded dark grey) for each substance, and feedback comprises verbalising these risks to the client as written, with further explanation if required. Once again, the card should be held so it can be viewed easily by the client, but still be able to be read by the interviewer. 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 possibly problems with difficulty sleeping, dehydration, headaches, mood swings, aggressive behaviour and at the serious end of things, psychosis and permanent damage to brain cells … I wonder what you think of these possible risks and if you have noticed anything along these lines?"

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

Giving advice to clients is simply about creating a link between reduction of drug use and reduction of harms. Clients may be unaware of the relationship between their substance use and existing or potential problems. The advice is about informing clients 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 clients 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 methamphetamine."

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

STEP 4. Allow clients to take ultimate responsibility for their choices

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

"What you do with this information about your drug use 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 clients to take responsibility, it also reinforces the relationship between the client's substance use and the associated harms.

STEP 5. Ask clients what concerns them about their scores

This is an open-ended question designed to get the client thinking about their substance use and to start verbalising any concerns that 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 client has ever verbalised concerns about substance use. There is evidence that verbalising concerns in a supportive context leads to change in beliefs and behaviour. Clinicians should turn the ASSIST Feedback Report Card back to the front page so that the client can see their scores again, and say something like:

"What concerns you about your score for amphetamine?"

The level of concern they express also assists the clinician to place them within the stages of change.

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

Getting a client to consider and verbalise both the good things and less good things about their substance use is included in motivational interviewing as a way to acknowledge the balance between the positives and negatives of substance use, and can help to explore and develop discrepancy, or create cognitive conflict within the client. It may be the first-time that the client has thought about, or verbalised, the pros and cons of their use and it can be 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 client that the clinician is aware that the client has pertinent or functional reasons for using a substance.

The best way to get clients to weigh up their substance use is through the use of two open-ended questions, explaining why you are doing this, such as saying:

"I'm just going to ask some questions to help me understand what influences your substance use"

What are the good things for you about using methamphetamine?"

After client has finishing talking about good things, summarise this and then ask about less positive aspects of drug use. Say something like:

"So, the main things your get from your methamphetamine use are x, y and z - What are some of the less good things about using methamphetamine for you?"

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

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

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

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

Reflecting and summarising also provides the opportunity to actively highlight a client'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 client'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 impacts it is having on your work and

relationships, including fighting with your boyfriend…"

STEP 9. Ask clients how concerned they are by less good things

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

"What concerns you about the less good things?

How?" or

"What is most important to you at the moment?"

STEP 10. Give clients take-home materials to bolster the brief intervention

The client should receive a copy of their ASSIST Feedback Report Card 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 client. They also can serve as a secondary outreach if read by friends and family of the client, who also may be using substances.

In brief, there are three to four items that should be given to clients upon the completion of the brief intervention session.

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 using the ASSIST Feedback Report Card
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 the;
7. 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

These are:

- Client's ASSIST Feedback Report Card (AppendixC);
- General information pamphlets on the substance(s) being used by the client (obtained from the relevant agency in your country);
- Self-Help Strategies for Cutting Down or Stopping Substance Use: Self-Help Guide booklet available at: **who.int/publications/i/item/978924159938-2** – the booklet can also be found on the ASSIST Portal**assistportal.com.au/download/self-help-manual/?wpdmdl=482&masterkey=5dbc3f6a25ea1**
- Risks of Injecting Card (if relevant) (Appendix D) or from the ASSIST Portal **assistportal.com.au/download/ho9-who-assist-v3-0-risks-of-injecting-card/?wpdmdl=478&masterkey=5dbc3e3b48495**
- The ASSIST Feedback Report Card serves as a reminder of the client's scores and the risks associated with their primary substance use that has been the focus of the brief intervention. The card also contains information on the risks associated with the use of other substances that may not have been directly addressed during the course of the brief intervention but which may be being used by the client.

The Self-Help Strategies for Cutting Down or Stopping Substance Use: Self-Help Guide booklet is a generic guide which helps clients decide if they want to change their substance use and contains a number of simple but effective strategies to help clients cut down or stop using. It has been written to be appropriate for people with at least five years of education and is pictorial in nature. Health professionals can use the booklet as a platform for longer or ongoing interventions if relevant.

The Risks of Injecting Card should be given to clients who have injected substances in the last three months. It contains information on the harms associated with injecting practices and also some harm minimisation strategies for clients who choose to continue to inject substances.

The booklet and other materials should be given to the client with a brief explanation of their contents using neutral language that still respects the client's right to choose what they do about their substance use. Say something like:

"People find this booklet useful if they're thinking about whether or not they want to cut down or stop their substance use, if they do want to cut down, then it provides them with some useful strategies for helping them to cut down or stop."

Low Risk clients

Clients whose scores are all in the low risk range do not need any intervention to change their substance use, and treatment can continue as usual. 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 clients with a past history of risky substance use about the risks of returning to hazardous substance use; and,
- Information they are given may be passed onto friends or family who do have substance use issues.

What to do with 'high risk' and injecting clients

Clients whose ASSIST scores are in the 'high risk' range (27 or higher) for any substance and/or have been injecting drugs regularly over the last three months, require more than just the brief intervention. It is helpful to provide these clients with encouragement and reassurance about the effectiveness of treatment, and information about what treatment involves and how to access it. The brief intervention including the take-home materials should also be given to these clients as a means of motivating them to seek further treatment.

It is likely that, given the seriousness of the problem, a brief intervention for these clients will take at least 15 minutes. If the client has tried unsuccessfully to cut down or stop their substance use in the past (as indicated in question 7 on the ASSIST), discuss these past attempts. Praise their attempts in the past, identify where things went well, and also discuss the challenges they experienced. This may help the client understand that they may need treatment to change their substance use.

At a minimum, high risk clients need further assessment, including taking their substance use history, and preferably referral for further treatment. Depending on the needs of the client, treatment can include:

- recurrent sessions with the primary health care worker;
- inpatient or ambulatory withdrawal;
- specialist drug and alcohol counselling;
- medication to treat the dependence and prevent relapse;
- residential rehabilitation;
- group counselling; and/or
- a 12-step, SMART Recovery, peer support or similar program.

There are other treatment options available depending on availability in the client's country or culture. In addition, there may be underlying reasons associated with a client's substance use that may need to be addressed such as chronic pain, mental health issues, relationship difficulties, occupational demands or homelessness. All clients should be reviewed and monitored whenever they return to the health care facility, whether they agree to more intensive treatment or not. They should be invited to make an appointment to come back and talk about their substance use at any time in the future.

It is also very important that high risk and injecting clients undergo appropriate physical health checks including blood and other biological screening. For example, heavy drinking clients should have their liver enzymes checked.

Injecting clients should be screened for Hepatitis and HIV/ AIDS and be given information about harm minimisation associated with injecting as shown in the Risks of Injecting Card.

Clients 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, abscesses and ulcers, collapsed veins and communicable diseases such as Hepatitis B/C and HIV. Clients who choose to continue to inject should be informed of appropriate harm reduction strategies. These may include:

- not sharing injecting equipment and drug paraphernalia;
- hygiene around injecting;
- avoiding the use of other substances at the same time, especially alcohol and sedatives;
- in case of overdose, letting a friend know when they are going to use;
- ensuring friends and/or family have attended first-aid and resuscitation training (offered in most jurisdictions);
- having a small amount to start with to check the potency of the substance being used; and
- being informed of where they can access clean injecting equipment (or how to clean existing equipment if unavailable) and how to safely dispose of their used injecting equipment.

Note: Question 8 on the ASSIST asks about the recency of injecting substances. While the score from question 8 is not included in the calculation of the ASSIST Specific Substance Involvement score, clients who are injecting more than 4 times per month on average are likely to require more intensive treatment. These are guidelines based on patterns of injecting use that would reflect moving towards dependent use for heroin users (more than weekly) and amphetamine/cocaine users (more than three consecutive days in a row). Health professionals will have to make a clinical judgment about the best course of action based on the information they have available to them at the time.

[28] 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.

CHAPTER 7

THE STEPPED–CARE MODEL

How do I put stepped-care into practice?

A stepped-care approach means that *'a more intensive or different form of care or treatment is offered only when a less intensive form has been insufficient.'*[29] Stepped-care involves the provision of a series of interventions, from the least to the most intensive, with each incremental step made available on the basis of the client's response to the previous one. A stepped-care approach provides a best practice framework for integrating assessment, case formulation and treatment planning into the treatment process. It is used when deciding what level of intervention may be appropriate for a particular client. As noted by Baker and colleagues, who provide a clinical illustration of the approach, stepped care "… allows a flexible approach with methamphetamine users, many of whom will benefit sufficiently from only a few sessions of counselling …. The key to stepped care is to plan a stepped approach together, with ongoing monitoring and flexibility in goal setting and revision".[31 p341]

Jade's and Dan's scenarios can be used to demonstrate stepped-care for methamphetamine use.

The initial step for Jade was completing the ASSIST and identifying that she was in the moderate risk range for her current pattern of methamphetamine use. The doctor appropriately matched the intervention to Jade's risk range; that was, a brief intervention and arranging follow-up with the practice counsellor.

Jade attended weekly sessions with the counsellor for four weeks. In the beginning, Jade struggled with cravings and lapsed on one occasion. Based on Jade's presenting issues and best practice guidelines[30], Jade received four sessions that focused on:

Session 1: Building motivation for change;

Session 2: Strategies to cope with cravings;

Session 3: Links between thoughts and behaviours (triggers);

Session 4: Relapse prevention.

The counsellor used a combination of Cognitive Behavioural Therapy (CBT) and Motivational Interviewing in the sessions. Jade was given homework activities that included a self-monitoring record and an activity plan. Although Jade didn't always complete the tasks, she found them a helpful reminder of her goal, and a discussion point for her sessions.

Jade was able to reduce and then stop her use during this time. Should jade wish to come back, the counsellor has *'left the door open'* for her. Jade is receiving peer support from a friend who has also quit methamphetamine in the last year, and from work colleagues who have never used.

If Jade was unable to reduce or quit, or increased her use following the sessions with the counsellor, the next option in the stepped-care model would have been referral for a further assessment by a specialist drug and alcohol service. At that time, an option of more intensive outpatient care may have been considered.

In Dan's case, as he scored in the high-risk range for his methamphetamine use, the focus of the brief intervention was on him agreeing to a further assessment with the drug and alcohol service. Based on his history and current presentation, within the stepped-care model, this matched his current level of need. Following assessment, detox and rehabilitation, Dan *'stepped down'* into less intensive treatment: follow-up and support by the local community drug and alcohol team.

It is worth noting that stepped-care is an inclusive, not exclusive approach. For example, Dan received support from the community drug and alcohol service while waiting to enter detox and rehabilitation. His case worker kept in contact during the rehabilitation phase and continued his care when he was discharged. This continuity of care assisted Dan in a smooth transition from the community into treatment and ultimately back home.

For more information on methamphetamine, interventions and treatment resources go to NCETA for a list of peer reviewed publications and guidelines:

nceta.flinders.edu.au/nceta/resource-kits/ methamphetamine-publications-resources/

A variety of clinical approaches with methamphetamine users are described in Allsop, S and Lee, N (eds) (2012) Perspectives on Amphetamine-Type Stimulants, IP Communications, Melbourne.

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[29] NSW Department of Health (2008) NSW Health Drug and Alcohol Psychosocial Interventions, Professional Practice Guidelines, Better Health Centre Publications, Sydney.

[30] Baker, A., Kay-Lambkin, F., Lee, N.K., Claire, M., & Jenner, L. (2003). A brief cognitive behavioural intervention for regular amphetamine users: A treatment guide. Canberra: Australian Government Department of Health and Ageing.

PART 2

THIS SECTION PROVIDES OPTIONS FOR DELIVERY OF THE ASSIST ON ICE 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 ON ICE VIDEO SCENARIOS.

CHAPTER 8

RESPONDING TO RESISTANCE AND CHALLENGING BEHAVIOUR

Often there is concern that people will become resistant and defensive when asked about their alcohol and other drug use, and that people may not answer entirely 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 is clearly explained, and questions are asked in a non-judgemental manner.

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

Resistance to answering the ASSIST 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 coupled with a non-judgemental attitude will help reduce resistance.

Remember that completing the ASSIST is voluntary, if a person 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 should be respected.

In a non-judgemental manner seek to understand why the person did not complete the questions will help to 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. This is frequently unpredictable. However, the approach made towards the person is very important.

Most health 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
- Minimise irritating factors in the environment such as noise, uncomfortable clothing
- Enhance comfort, 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…".[32]

As outlined in this manual, conducting the ASSIST within the 'Spirit of Motivational Interviewing' will help portray an acceptance of the persons 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[33]. 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.

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[32] WorkSafe Victoria (2017) **content.api.worksafe.vic.gov.au/sites/default/files/2018-06/ISBN-Prevention-and-management-of-violence-and-aggression-health-services-2017-06.pdf**

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

CHAPTER 9

DEVELOPING YOUR SKILLS AND HELPING OTHERS DEVELOP THEIRS

Developing and maintaining our skills is important. You might find it useful to look at the case studies below and practice your skills with a colleague.

Spend a little time reviewing the case studies, and then one of you practice as the client and the other as the clinician. Before you commence, agree how you will give and want to receive feedback – feedback needs to be constructive (that means the person can do something about the critique – it's no use suggesting someone is too tall for example – there is nothing they can do about that) and give feedback the way you would want to receive it. There are also other resources and demonstration videos at **assistportal.com.au/resources**

You might be interested in delivering training on ASSIST-BI to others. If you go to the ASSIST Portal you will find a variety of resources that can help you in this, including some planning and implementation strategies, located at **assistportal.com.au/resources/**.

You might be interested in delivering training to others on ASSIST-BI. If you go to the ASSIST Portal you will find a variety of resources that can help you in this, including some planning and implementation strategies.

Reflective Practice

Reflective practice is an important skill to develop. We might reflect on our own performance and activity at work, in our social lives and in sport. Formalising this as a skill, through reflective practice, is a process that allows us to recognize our own strengths and areas for development. We can use this to guide our on-going learning and ensuring quality practice. Reflective practice is critical to develop our skills through self-directed learning, contributing to quality supervision and practice, improving motivation, and improving the quality of care we can provide.

Often, we reflect on things that didn't go as well as we would have liked. It is important to recognise that we should also reflect on things that went well, as they can be rewarding and just as useful – knowing what went well, and why, and what can be improved are both important to improving practice. It can also build confidence and help us to repeat it again on future occasions. Indeed, being able to reflect on what went well, alongside how you might improve it, are important components of continuing development and learning, and quality practice.

There are numerous approaches that can be adopted for reflection, but the critical thing is to understand why you are asking questions such as the ones suggested below, and how that will help you to reflect. Broadly the process is: what happened; why does this matter; and, what are the next steps?

- What went well – as well as what you could do differently (avoid broad conclusions such as "It was awful")?
- Think about the situation in detail: What happened exactly and in what order? What was the final outcome?
- What were your main thoughts and how did you feel about them (Be honest with yourself. If you can understand how you were feeling at the time it will help you put together why things happened as they did. It may also help you to recognize similar situations in the future)?
- Have you now recognized things that would have otherwise gone unnoticed? Spend a moment to think about why things happened the way they did. If the situation went well – why- how did that develop? If there was room for improvement – specifically what would you change?
- With the benefit of hindsight how would you have managed the situation differently (Think about the factors that you could have influenced)?
- Have you identified anything that might be an immediate or critical issue that needs to be addressed and do you understand the process(es) for contacting your supervisor or other key person in this situation? and/or,
- What will you do differently in the future— how will you change your practice? How will you lock in what went well? This is a critical stage in reflective practice.

It can be very useful review your reflections with peers or a senior colleague/supervisor for review, as they may be able to draw light onto things that you have not thought through. Debriefing is also a vital strategy for managing the stress generated when working as a clinician.

Supervision

Supervision is an important factor in quality clinical practice and in looking after your wellbeing. It is worthwhile working out with your supervisor what the aims of supervision are – how do they want supervision to progress and how do you want it to progress. It is worthwhile agreeing on the aims of supervision, its structure and process and timing/frequency. Key aims for supervision include, but are not restricted to:

- Ensuring administrative requirements are met (processes adhered to; clinical notes completed; data bases completed etc);
- Reflective practice is encouraged, and this identifies educational and developmental need;
- Support and debriefing are provided;
- Stress and concerns are identified and managed; and,
- Constructive feedback is given and received.

In short, supervision should ensure clinicians are accountable to the service and its policy and procedures, that evidence-based guidelines are adhered to, that staff developmental needs are identified and addressed, skills are maintained and, where indicated, enhanced, professional standards are maintained, and any stress or other needs are identified and managed. Useful tools for supervision can be found at **nceta.flinders.edu.au/workforce/publications_and_resources/nceta-workforce-development-resources/csk/**

CHAPTER 10

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 health 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 practice?

  How could the ASSIST be implemented into their practice;

- Two-hour session

  As above plus role play. In groups of three (as per flipped classroom model outlined later in this chapter);

- As part of a workshop

  As screening and brief intervention is part of a range of clinical practices, this package can be adapted to a range of professional development workshops. Depending on the allocated time, any of the above activities could be included.

  It is recommended that the participants adapt the role-play to their professional area or work practice.

On-line learning

The ASSIST on Ice instructional video can be used in the Blackboard application 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 subject, the linked activity could be short answer or the basis for a discussion board, assignment or essay.

Depending on the IT platform, a suggested approach is:

- Participants view the DVD on-line;
- Discussion points are posted on a ‘discussion board’ or ‘chat room;’
- Participants are encouraged to conduct a role play using the ASSIST-BI with a fellow student, friend, colleague or in either in ‘chat room’, via Skype or over the telephone;
- The experience of conducting the ASSIST-BI would form the basis of postings on the discussion board. Suggested topics for discussion include:

  How was the experience of conducting an ASSIST-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-BI?
- What stage of change was Jade in the scenario? Explain your reasoning.
- Describe where in 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 leverage the learning in the classroom, so that you can spend more time interacting with students 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 students are:

- Given access to the ASSIST on Ice instructional video and ASSIST resources (Appendices A–D);
- Encouraged to watch the video and familiarise themselves with the ASSIST tools;
- Explore background information on the WHO ASSIST website and PORTAL: **assistportal.com.au/resources/**
- Role play at least one ASSIST on a family member or friend;
- Prepare themselves to come to class and administer an ASSIST and to role play a character with a fellow student;
- 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;
- Students are to research what services are available in their area and be prepared to provide an ASSIST-linked, targeted intervention.

NOTE: Students may build on the characters shown in the video. Further background information on Jade and Dan are included in Chapter 10. Alternatively, they might create clients from their own experience as a clinician (de-identified of course).

During class time, students are divided into groups of three. In turns they spend some time preparing for the role play then 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. Feedback should be constructive – that is the person should be able to use the information to alter their approach (it’s not constructive to say “you are too tall for example). Feedback should also be given as you would want to receive it. The observer asks and assesses what stage of change the client 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?
- 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 and Brief Intervention?
- Discuss possible ways to gain more information and experience in administering an ASSIST-Linked Brief Intervention.

CHAPTER 11

SCENARIOS

Jade

Jade is 22 and works as a retail assistant. Jade is currently living with her mother after breaking up with her boyfriend (Josh) three weeks earlier. Jade has a lot of friends and spends most of the weekend out partying. Jade enjoys singing and dreams of being a famous singer/song writer.

Jade completed year 12 and worked in hospitality and on a cruise ship. She found it difficult to be away from her boyfriend and friends so returned home after 3 months. On returning home she moved in with her boyfriend and started work as a retail assistant.

Jade started drinking at 17, has tried cannabis and smoked cigarettes off and on. Jade started using crystal methamphetamine a year ago and enjoyed the feeling and energy it gave her to have fun. Jade smokes crystal meth most weekends and tried to hide it from her boyfriend who disapproves of its use.

Jade's partying with her friends caused friction between her and Josh and a recent disclosure of her infidelity resulted in Jade being 'kicked out'. Jade is keen to reconnect with Josh, but he is refusing all contact. Jade's mum is concerned about her lack of motivation and moodiness when she is at home.

Dan

Dan is 19 and is living rough. Originally from the country, Dan moved to city to be with his paternal father. After a couple of failed business ventures, Dan and his father fought and his father moved interstate leaving Dan with substantial debts. Dan did not want to return home a failure so hooked up with a few 'mates' to make some quick cash. This resulted in criminal activity and Dan is facing a number of charges.

Dan was described as an active child, disruptive at school and a born risk taker. He started drinking at 13, smoking cannabis at 14 and tried LSD and ecstasy. He started using crystal meth 1 year ago and progressed to daily use over a period of six months.

Dan was diagnosed with schizoaffective disorder at 19 and has multiple admissions to hospital. He was recently admitted to a mental health facility for one month following a psychotic episode. Dan was discharged into supported accommodation where he engaged well with the community mental health team and was compliant with his medications.

Dan was doing well in the program and was exploring vocational study options. Following a few altercations with a room mate, Dan started using crystal meth again and left the home. He was living rough on the streets without money and hope for the future.

PART 3

GUIDE TO APPENDICES

The attached appendices contain materials for both the clinicians and clients. These can be photocopied and used freely where necessary, in accordance with the instructions outlined in this manual.

They can also be accessed and downloaded from the ASSIST Portal: **assistportal.com.au/resources**

Appendix A

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST v3.1)

The ASSIST questionnaire can be photocopied for repeated use in learning activities and treatment settings.

Appendix B

ASSIST response card for clients

This is a one-page document which is given to clients when administering the ASSIST in order to aid their responses.

Appendix C

ASSIST feedback report card for clients

The ASSIST report card should be completed by the nurse with the results of the ASSIST and used to give feedback and advice to the client around their substance use. The client should be encouraged to take the card home with them. In the front you can find the ASSIST scores for each substance and risk levels followed by specific health and other problems associated with substance use. Nurses should use the ASSIST feedback report card as part of the brief intervention.

Appendix D

Risk of injecting card for clients

This resource provides advice concerning risks associated with injecting drugs to accompany a brief intervention. This information sheet can be photocopied for general use in the treatment setting and to give to clients who have injected in the last 3 months.

Clients who are high risk injectors (injecting 4 times per month or more in the last 3 months) may also find this card helpful, but will require more intensive treatment.

APPENDIX A – WHO – ASSIST V3.1

CLINICIAN NAME		CLINIC	
CLIENT ID OR NAME		DATE	/ /

INTRODUCTION – (Please read to client. Can be adapted for local circumstances)

The following questions ask about your experience of using alcohol, tobacco products and other drugs across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled or injected (show response card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently, at higher doses than prescribed or in ways in which it wasn't intended, please let me know.

While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

NOTE: BEFORE ASKING QUESTIONS, GIVE ASSIST RESPONSE CARD TO CLIENT

Question 1 (please mark the response for each category of substance)

In your life, which of the following substances have you ever used? (NON-MEDICAL USE ONLY)	NO	YES
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)		
b. Alcoholic beverages (beer, wine, spirits, etc.)		
c. Cannabis (marijuana, pot, grass, hash, etc.)		
d. Cocaine (coke, crack, etc.)		
e. Amphetamine type stimulants (speed, meth, ecstasy, etc.)		
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)		
g. Sedatives or Sleeping Pills (Diazepam, Alprazolam, Flunitrazepam, Midazolam etc.)		
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)		
i. Opioids (heroin, morphine, methadone, Buprenorphine, codeine, etc.)		
j. Other - specify:		

Probe if all answers are negative:
"Not even when you were in school?"

If "No" to all items, stop interview.
If "Yes" to any of these items, ask Question 2 for each substance ever used

ASSIST V3.1

Question 2

In the past three months, how often have you used the substances you mentioned (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Monthly	Weekly	Daily or almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, meth, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Diazepam, Alprazolam, Flunitrazepam, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, Buprenorphine, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.
If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the past three months, how often have you had a strong desire or urge to use (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Monthly	Weekly	Daily or almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, meth, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Diazepam, Alprazolam, Flunitrazepam, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, Buprenorphine, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the past three months, how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, meth, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Diazepam, Alprazolam, Flunitrazepam, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, Buprenorphine, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

If "Never" to all items in Question 2, skip to Question 6.
If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 5

In the past three months, how often have you failed to do what was normally expected of you because of your use of (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Monthly	Weekly	Daily or almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, meth, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Diazepam, Alprazolam, Flunitrazepam, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, Buprenorphine, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC)?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, meth, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Diazepam, Alprazolam, Flunitrazepam, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, Buprenorphine, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

If "Never" to all items in Question 2, skip to Question 6.
If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 7

Have you ever tried to cut down on using (FIRST DRUG, SECOND DRUG, ETC) but failed?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, meth, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Diazepam, Alprazolam, Flunitrazepam, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, Buprenorphine, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

ASSIST V3.1

Question 8 (please mark the response)

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you ever used any drug by injection? (NON-MEDICAL USE ONLY)	☐	☐	

IMPORTANT NOTE: Clients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

PATTERN OF INJECTING	INTERVENTION GUIDELINES
4 days per month, on average, over the last 3 months or less	Brief Intervention including the "Risks of Injecting" card
More than 4 days per month, on average, over the last 3 months	Further assessment and more intensive treatment*

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either **Q1** or **Q8** in this score. For example, a score for cannabis would be calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c**

Note that Q5 for tobacco is not coded, and is calculated as: **Q2a + Q3a + Q4a + Q6a + Q7a**

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record specific substance score	No Intervention	Receive brief Intervention	More intensive treatment*
a. Tobacco		0 - 3	4 - 26	27+
b. Alcohol		0 - 10	11 - 26	27+
c. Cannabis		0 - 3	4 - 26	27+
d. Cocaine		0 - 3	4 - 26	27+
e. Amphetamine		0 - 3	4 - 26	27+
f. Inhalants		0 - 3	4 - 26	27+
g. Sedatives		0 - 3	4 - 26	27+
h. Hallucinogens		0 - 3	4 - 26	27+
i. Opioids		0 - 3	4 - 26	27+
j. Other		0 - 3	4 - 26	27+

Now use ASSIST FEEDBACK REPORT CARD to give client brief intervention.

NOTE *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

APPENDIX B – ASSIST RESPONSE CARD

Response Card – Substances

a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)

b. Alcoholic beverages (beer, wine, spirits, etc.)

c. Cannabis (marijuana, pot, grass, hash, etc.)

d. Cocaine (coke, crack, etc.)

e. Amphetamine type stimulants (speed, meth, ecstasy, etc.)

f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)

g. Sedatives or Sleeping Pills (Diazepam, Alprazolam, Flunitrazepam, etc.)

h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)

i. Opioids (heroin, morphine, methadone, Buprenorphine, codeine, etc.)

j. Other - specify:

Response Card (ASSIST Questions 2 to 5)

Never: not used in the last 3 months.

Once or twice: 1 to 2 times in the last 3 months.

Monthly: average of 1 to 3 times **per month** over the last 3 months.

Weekly: 1 to 4 times per week.

Daily or almost daily: 5 to 7 days per week.

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

APPENDIX C – FEEDBACK REPORT CARD

NAME ______________________ **TEST DATE** ______________________

Specific Substance Involvement Scores

	Score	Risk Level
a. Tobacco products		0-3 Low 4-26 Moderate 27+ High
b. Alcoholic beverages		0-10 Low 11-26 Moderate 27+ High
c. Cannabis		0-3 Low 4-26 Moderate 27+ High
d. Cocaine		0-3 Low 4-26 Moderate 27+ High
e. Amphetamine type stimulants		0-3 Low 4-26 Moderate 27+ High
f. Inhalants		0-3 Low 4-26 Moderate 27+ High
g. Sedatives or Sleeping Pills		0-3 Low 4-26 Moderate 27+ High
h. Hallucinogens		0-3 Low 4-26 Moderate 27+ High
i. Opioids		0-3 Low 4-26 Moderate 27+ High
j. Other - specify		0-3 Low 4-26 Moderate 27+ High

What do your scores mean?

Low: You are at low risk of health and other problems from your current pattern of use.

Moderate: You are at risk of health and other problems from your current pattern of substance use.

High: You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent

Are you concerned about your substance use?

A. Tobacco	Your risk of experiencing these harms is: (tick one)		
Regular tobacco smoking is associated with:	**Low**	**Moderate**	**High**
Premature ageing, wrinkling of the skin			
Respiratory infections and asthma			
High blood pressure, diabetes			
Respiratory infections, allergies and asthma in children of smokers			
Miscarriage, premature labour and low birth weight babies for pregnant women			
Kidney disease			
Chronic obstructive airways disease			
Heart disease, stroke, vascular disease			
Cancers			

B. Alcohol	Your risk of experiencing these harms is: (tick one)		
Regular excessive alcohol use is associated with:	**Low**	**Moderate**	**High**
Hangovers, aggressive and violent behaviour, accidents and injury			
Reduced sexual performance, premature ageing			
Digestive problems, ulcers, inflammation of the pancreas, high blood pressure			
Anxiety and depression, relationship difficulties, financial and work problems			
Difficulty remembering things and solving problems			
Deformities and brain damage in babies of pregnant women			
Stroke, permanent brain injury, muscle and nerve damage			
Liver disease, pancreas disease			
Cancers, suicide			

C. Cannabis	Your risk of experiencing these harms is: (tick one)		
Regular use of cannabis is associated with:	**Low**	**Moderate**	**High**
Problems with attention and motivation			
Anxiety, paranoia, panic, depression			
Decreased memory and problem solving ability			
High blood pressure			
Asthma, bronchitis			
Psychosis in those with a personal or family history of schizophrenia			
Heart disease and chronic obstructive airways disease			
Cancers			

D. Cocaine	Your risk of experiencing these harms is: (tick one)		
Regular use of cocaine is associated with:	**Low**	**Moderate**	**High**
Difficulty sleeping, heart racing, headaches, weight loss			
Numbness, tingling, clammy skin, skin scratching or picking			
Accidents and injury, financial problems			
Irrational thoughts			
Mood swings - anxiety, depression, mania			
Aggression and paranoia			
Intense craving, stress from the lifestyle			
Psychosis after repeated use of high doses			
Sudden death from heart problems			

E. Amphetamine type stimulants	Your risk of experiencing these harms is: (tick one)		
Regular use of amphetamine type stimulants is associated with:	**Low**	**Moderate**	**High**
Difficulty sleeping, loss of appetite and weight loss, dehydration			
Jaw clenching, headaches, muscle pain			
Mood swings – anxiety, depression, agitation, mania, panic, paranoia			
Tremors, irregular heartbeat, shortness of breath			
Aggressive and violent behaviour			
Psychosis after repeated use of high doses			
Permanent damage to brain cells			
Liver damage, brain haemorrhage, sudden death (from ecstasy) in rare situations			

F. Inhalants	Your risk of experiencing these harms is: (tick one)		
Regular use of inhalants is associated with:	**Low**	**Moderate**	**High**
Dizziness and hallucinations, drowsiness, disorientation, blurred vision			
Flu like symptoms, sinusitis, nosebleeds			
Indigestion, stomach ulcers			
Accidents and injury			
Memory loss, confusion, depression, aggression			
Coordination difficulties, slowed reactions, hypoxia			
Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys)			
Death from heart failure			

G. Sedatives	Your risk of experiencing these harms is: (tick one)		
Regular use of sedatives is associated with:	**Low**	**Moderate**	**High**
Drowsiness, dizziness and confusion			
Difficulty concentrating and remembering things			
Nausea, headaches, unsteady gait			
Sleeping problems			
Anxiety and depression			
Tolerance and dependence after a short period of use			
Severe withdrawal symptoms			
Overdose and death if used with alcohol, opioids or other depressant drugs			

H. Hallucinogens	Your risk of experiencing these harms is: (tick one)		
Regular use of hallucinogens is associated with:	**Low**	**Moderate**	**High**
Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory			
Difficulty sleeping			
Nausea and vomiting			
Increased heart rate and blood pressure			
Mood swings			
Anxiety, panic, paranoia			
Flash-backs			
Increase the effects of mental illnesses such as schizophrenia			

I. Opioids	Your risk of experiencing these harms is: (tick one)		
Regular use of opioids is associated with:	**Low**	**Moderate**	**High**
Itching, nausea and vomiting			
Drowsiness, constipation, tooth decays			
Difficulty concentrating and remembering things			
Emotional problems and social problems			
Reduced sexual desire and sexual performance			
Relationship difficulties			
Financial and work problems, violations of law			
Tolerance and dependence, withdrawal symptoms			
Overdose and death from respiratory failure			

APPENDIX D – RISKS OF INJECTING CARD

Using substances by injection increases the risk of harm from substance use. This harm can come from:

The substance

- If you inject any drug you are more likely to become dependent.
- If you inject amphetamines or cocaine you are more likely to experience psychosis.
- If you inject heroin or other sedatives you are more likely to overdose.

The injecting behaviour

- If you inject you may damage your skin and veins and get infections.
- You may cause scars, bruises, swelling, abscesses and ulcers.
- Your veins might collapse.
- If you inject into the neck you can cause a stroke.

Sharing of injecting equipment

- If you share injecting equipment (needles & syringes, spoons, filters, etc.) you are more likely to spread blood borne virus infections like Hepatitis B, Hepatitis C and HIV.

It is safer not to inject

If you do inject:

- always use clean equipment (e.g., needles & syringes, spoons, filters, etc.)
- always use a new needle and syringe
- don’t share equipment with other people
- clean the preparation area
- clean your hands
- clean the injecting site
- use a different injecting site each time
- inject slowly
- put your used needle and syringe in a hard container and dispose of it safely

If you use stimulant drugs like amphetamines or cocaine the following tips will help you reduce your risk of psychosis.

- avoid injecting and smoking
- avoid using on a daily basis

If you use depressant drugs like heroin the following tips will help you reduce your risk of overdose.

- avoid using other drugs, especially sedatives or alcohol, on the same day
- use a small amount and always have a trial “taste” of a new batch
- have someone with you when you are using
- avoid injecting in places where no-one can get to you if you do overdose
- know the telephone numbers of the ambulance service

GLOSSARY

ATS Amphetamine-Type Stimulants

CBT Cognitive Behavioural Therapy

DASSA Drug and Alcohol Services South Australia

FRAMES Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy

OARS Open question; Affirming; Reflecting; Summarizing

WHO World Health Organization

FURTHER INFORMATION

More information about the resources used in this manual are available at:

ASSIST Portal:

For all information and resources on the ASSIST and how to conduct an effective brief intervention: **assistportal.com.au/resources/**

ASSIST Plus:

Developed for the general public, this site provides information on a range of substance, self-administration of the ASSIST and how to raise concern about someone else's substance use.

assistplus.com.au

Australian Drug Foundation:

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

ADF search is an electronic library with thousands of online full-text resources on alcohol and other drugs. It is free to join and can be found at: **adf.org.au/drug-facts**

Australian Government, Department of Health

health.gov.au/health-topics/alcohol

Australian Institute of Health and Welfare National Drug Strategy Household Survey Report 2019

aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019-in-brief/related-material

Drug and Alcohol Nurses Australasia (DANA)

danaonline.org

Further Support for People Affected by Alcohol and other Drug Problems

National Alcohol and other Drug Hotline

1800 250 015

Counselling ONLINE

counsellingonline.org.au

Hello Sunday Morning

hellosundaymorning.org

My QuitBuddy

The My QuitBuddy app records quitting progress (e.g. dollars saved, number of days not smoked, mgs of tar avoided) and provides a range of distractions such as a game and motivational messages to assist with cravings. From this link you can download the app onto a smartphone/tablet **quitnow.gov.au/quitbuddy**

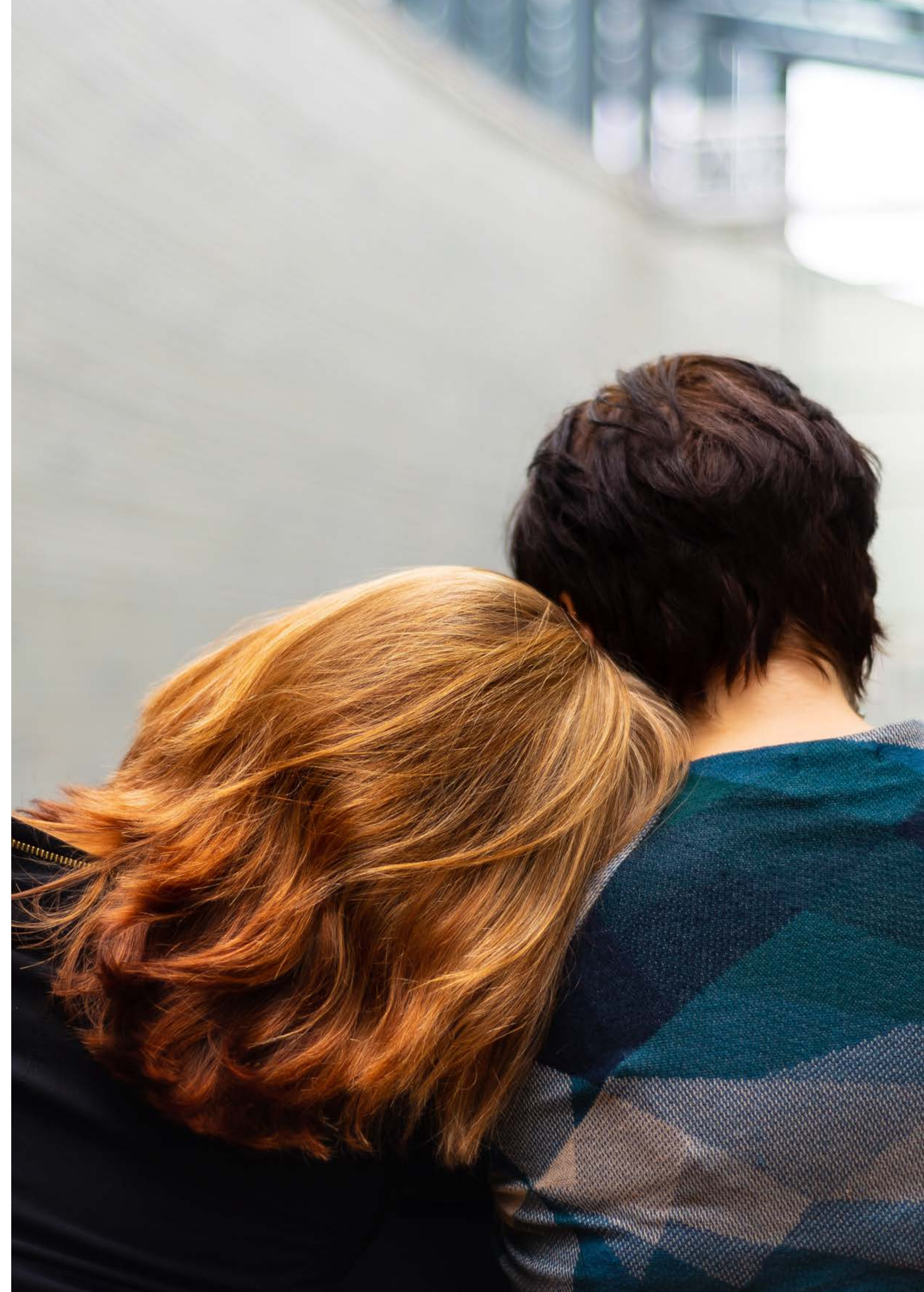
QUIT

quitnow.gov.au

Other resources

For further information and online Motivational Interviewing training opportunities visit: **motivationalinterview.org**

For a comprehensive list of Methamphetamine publications and resources: **nceta.flinders.edu.au/nceta/resource-kits/methamphetamine-publications-resources/**



KAURNA ACKNOWLEDGEMENT

We acknowledge and pay our respects to the Kaurna people, the original custodians of the Adelaide Plains and the land on which the University of Adelaide's campuses at North Terrace, Waite, and Roseworthy are built. We acknowledge the deep feelings of attachment and relationship of the Kaurna people to country and we respect and value their past, present and ongoing connection to the land and cultural beliefs. The University continues to develop respectful and reciprocal relationships with all Indigenous peoples in Australia, and with other Indigenous peoples throughout the world.

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