ASSIST
with Corrections

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and Brief Intervention in the Criminal Justice System

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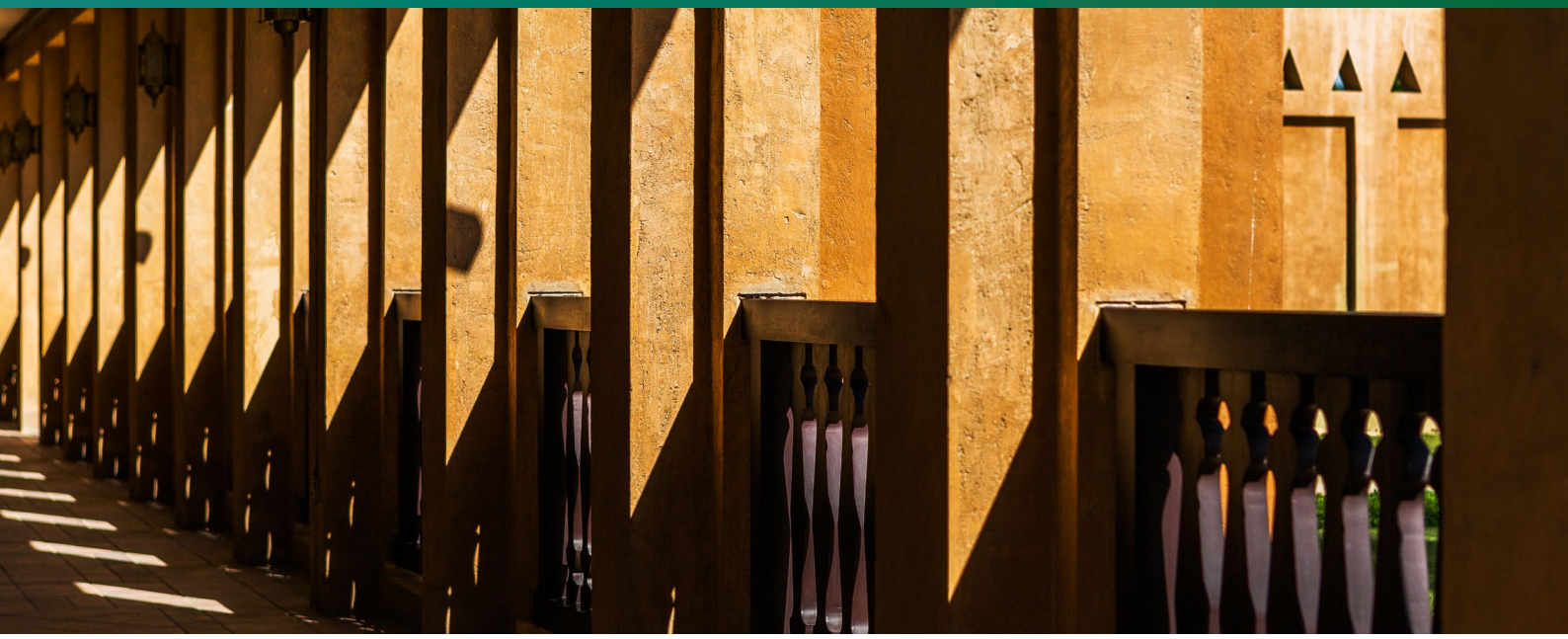

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The Alcohol, Smoking and Substance Involvement Screening Test and Linked Brief Intervention was developed by the World Health Organization, Geneva.

This manual was developed by Susan Henry-Edwards, 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) *ASSIST on Ice – The Alcohol Smoking and Substance Involvement Screening Test (ASSIST) and Brief Intervention for Methamphetamine Use* (Harland and Ali 2017) 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 is complemented by three resources that are available on the World Health Organization web site: www.who.int/substance_abuse/activities/assist/en

- The Alcohol Smoking and Substance Involvement Screening Test (ASSIST): Manual for use in primary care. (2010) Geneva, World Health Organisation
- 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 this manual are available on the ASSIST Portal (assistportal.com.au). The portal has been developed by the DASSA-WHO Collaborating Centre, University of Adelaide, as a repository for ASSIST tools, training resources, research articles and publications. The ASSIST Portal is freely accessible to all.

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OVERVIEW

Substance use among offenders

Alcohol and other drug use is a major concern for the criminal justice system. The prevalence of substance use among offenders is significantly higher than in the general population and a majority of offenders report that at least one of their current offences was related to their substance use[1].

Substance misuse is a risk factor for reoffending and for the escalation of offending behaviour[2]. Therefore, identification of substance use risk is important for corrections as well as for correctional health services concerned about the health risks of substance misuse. Contact with the criminal justice system, including police, courts and corrections, provides an important opportunity to screen for alcohol and other drug misuse in a population group which may have little contact with general primary care and specialist drug and alcohol services[3].

Screening and assessment are the foundation for evidence based approaches to offender rehabilitation including the Risk Needs Responsivity (RNR) model[4] and the Good Lives Model (GLM)[5]. Case planning requires accurate identification of risks and needs which form the targets for intervention[6]. Screening for alcohol and other drug problems in this population provides valuable information for case planning and decision making at all stages of an offender's contact with the system. The use of validated screening and assessment tools increases the accuracy of screening and assessment.

Why use the ASSIST and linked brief intervention?

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

The ASSIST was developed and validated for the World Health Organization (WHO), by an international group of addiction specialists, as a tool that is quick and easy to use in frontline settings including corrections.

- The ASSIST is an eight-item questionnaire and takes about five to ten minutes to administer.
- The ASSIST screens for hazardous and harmful use of tobacco, alcohol and all main types of illicit drugs (cannabis, amphetamine type stimulants including ice, opioids such as heroin and morphine, sedatives, cocaine, inhalants, and hallucinogens).
- The ASSIST determines a Specific Substance Involvement Score for each substance which indicates risk of harm from use of that substance.
- These scores form the basis for decisions about whether further assessment is required and the intensity of intervention that may be needed.
- These scores can be used to initiate and inform a brief discussion with the client about their substance use
- ASSIST scores can inform the substance use sections of offender risk/need assessments by providing a valid measure of alcohol and other drug problems and an indication of severity.

The ASSIST-linked Brief Intervention (ASSIST-BI) presented in this package can be delivered in 5 to 15 minutes. The principles and practice suggestions can also be used for longer or recurrent intervention sessions as needed.[7]

The ASSIST has been trialled in custodial correctional settings in South Australia[8] and the USA[9] and has been found to be feasible, valid and reliable in these settings. The study conducted in the USA[10] compared computer administered and interviewer administered screening and found that the computer assisted screening was as effective as interviewer assisted screening and was an efficient method of screening.

Many criminal justice professionals avoid screening and brief intervention for substance use. Reasons for not implementing screening and brief intervention in correctional settings include:

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

This resource addresses these barriers using a simple step-by-step approach. Screening and brief interventions have been shown to be acceptable and motivating for many people with hazardous or harmful substance use. In correctional settings, screening and brief intervention offers an opportunity to provide assistance to those offenders who are not eligible for more intensive interventions such as arrestees, remandees and those at low risk of reoffending as well as for building

the motivation of those who will be referred for further assessment and intervention. It provides probation and parole officers with a simple, valid method of monitoring progress and providing timely support and brief intervention to those under community based supervision as well as alerting officers to those in need of referral for further assessment and treatment.

Administering the ASSIST and providing a linked Brief Intervention is summarised in Figure 1.

How to use this manual

This package has been designed to complement the *ASSIST with Corrections* 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 correctional professionals)
- On-line (recommended for people who are unable to participate in face to face sessions)
- 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 a longer workshop, or online. The scenarios highlight different settings where the ASSIST and linked brief intervention can take place. Facilitators can select one or more 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 in practice.

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

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

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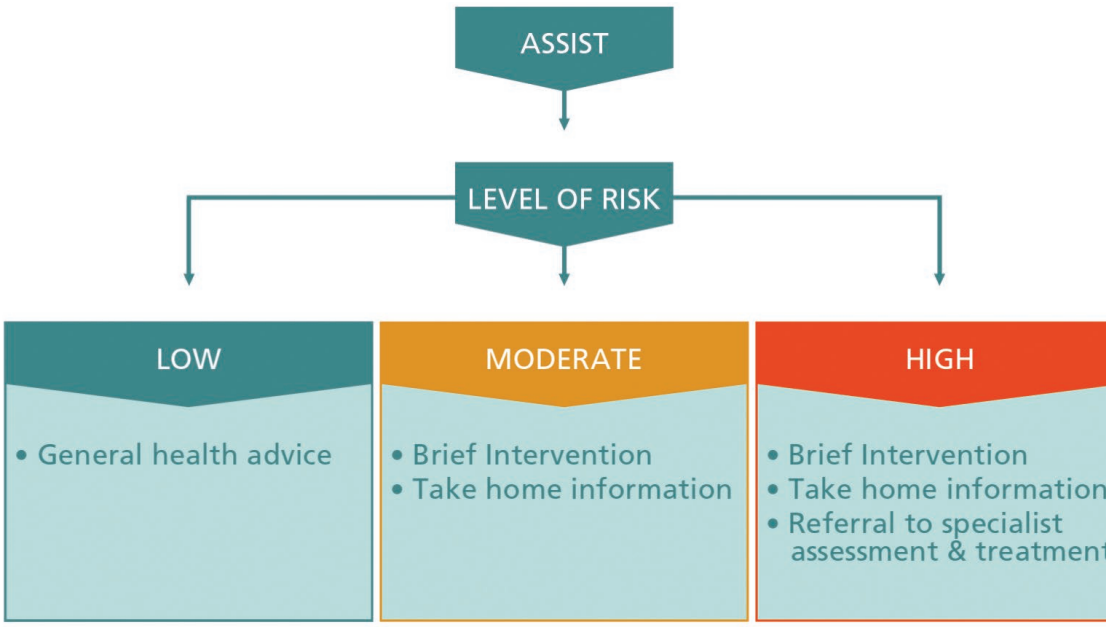

Figure 1 ASSIST flow chart

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PART 1

CHAPTER 1

AOD and the Criminal Justice System

Prevalence and patterns of use

Research in New South Wales, Australia indicates that over 75% of offenders reported the use of tobacco and alcohol and 85% reported the use of illicit drugs in the 12 months prior to entering custody. Sixty three percent of males and 40% of females were drinking alcohol at hazardous or harmful levels. Over 42% of offenders reported daily or almost daily use of illicit drugs[11]. The most commonly used drugs apart from tobacco were alcohol, cannabis, and amphetamines. 36% of offenders reported experiencing withdrawal on entry to prison indicating that they were dependent.[12]

A study in South Australia used the ASSIST to identify medium and high risk substance use in the previous 3 months by newly admitted prisoners[13]. The results are shown in Table 1.

Substance	Male	Female
Tobacco	87%	88%
Cannabis	72%	41%
Stimulants	51%	47%
Opioids	25%	27%
Alcohol	20%	11%
Sedatives	12%	27%

Table 1: Medium and High Risk Substance Use Among Newly Admitted Prisoners in SA[14]

Wolff and Shi (2015)[15] administered the ASSIST to screen male high security prisoners in the USA and found that 72% had used alcohol in the 3 months prior to arrest with 41% at moderate to high risk of alcohol related harm while 68% had used any illicit drug and 66% were at moderate to high risk of drug related harm. Cannabis (59%), cocaine, (33%) and opioids (21%) were the most commonly used drugs in the 3 months prior to arrest.

Globally, the United Nations Office on Drugs and Crime (UNODC) estimates that around one third of offenders have used illicit drugs while incarcerated at some time with 20% reporting use while incarcerated in the past year and 16% reporting such use in the past month.[16]

These figures demonstrate the high level of need for identification of and intervention for alcohol and other drug use among offenders.

Relationship between drug use and offending

Seventy three percent of New South Wales offenders reported that at least one of their current offences was related to their substance use. The most common reason given for the link was intoxication at the time of the offence with 58% reporting drug intoxication and 56% reporting alcohol intoxication.[17]

Substance use has been identified consistently in the international literature as a factor associated with criminal behaviour and as a risk factor for reoffending.[18]

Studies suggest that substance users are 2.8 to 3.8 times more likely to re-offend than those who do not use substances.[19]

Multiple drug use adds to the risk of offending. Those who use more than one type of drug are twice as likely to have offended in the past 12 months as those who use only one drug type and multiple drug users who used larger numbers of different substances committed more offences than those using fewer substances.[20]

The type of drugs used also influences the rate of reoffending with multiple drug users who include so called 'hard drugs' such as opioids and cocaine, committing more offences than those who do not.[21]

A recent US study by Gilmore (2017) administered the ASSIST to screen for substance use and identified distinct groups with different patterns of substance use severity, type of drug used, and criminal involvement. Polydrug users had extensive involvement in offending behaviour.[22]

The Australian Institute of Criminology found that the prevalence of drug use varies among different offending types with regular multiple offenders, regular drug sellers, and regular property offenders most likely to report use of multiple drugs. Offending typically starts 1-2 years prior to drug use.[23]

Explanations of the relationship between substance use and offending include that substance misuse causes offending, that offending causes substance misuse or that both are caused by a third factor.[24]

It is likely that the relationship is complex, multifactorial and bi-directional incorporating elements of these three explanations and that different factors are influential at different stages in the criminal or drug use career and in relation to particular situations or offence cycles.[25] This complexity needs to be taken into account in assessment that explores the relationship between substance misuse and offending behaviour.

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"Screening identifies those who need further assessment and intervention enabling the targeting of resources to those at higher need."

Screening and Brief Intervention in the Criminal Justice System

Screening is the first step in assessment. Screening tools such as the ASSIST are quick and easy to administer and can be used with everyone. Screening identifies those who need further assessment and intervention enabling the targeting of resources to those at higher need.

The ASSIST screens for risk of harm from substance use, identifies which substances are of concern, and gives an indication of the severity of drug related problems. It can rapidly identify risk factors for offending such as the use of multiple drugs and drug type(s) used. Consequently it can form a valuable part of a comprehensive assessment system covering risk of reoffending, criminogenic needs, and needs affecting responsivity.

In the Risk Need Responsivity (RNR) model alcohol and other drug use is one of the 'Big Eight' risk factors for reoffending[26] and Offender Risk Need assessment instruments such as the Offender Risk Needs Inventory-Revised (ORNI-R), the Level of Service Inventory-Revised (LSI-R), the Level of Service /Case Management Inventory (LS/CMI), the Level of Service Risk Need Responsivity (LS/RNR) include sections on substance use and problems. The ASSIST risk scores can be used to inform the substance use sections of these assessment instruments by providing a valid measure of alcohol and other drug use problems and an indication of severity. For example the instructions for the alcohol and drug section of the LSI-R recommend that validated instruments be used to inform the alcohol and other drug related problem score.

In the Good Lives Model (GLM), alcohol and other drug use is also considered one of the 'Big Eight' risk factors or problem areas but the GLM also considers what human needs or life goals the offender is trying to meet through their alcohol and drug use. Ward and his colleagues have identified 11 human needs that all individuals strive for to some extent (see www.goodlivesmodel.com/information). Offending occurs when anti-social means are used to obtain particular life goals. For example alcohol and other drugs may be used to have fun, to boost energy and confidence, relieve physical or mental pain, attain peace of mind, to relieve withdrawal or individuals may seek friendships with individuals who also use drugs, or equate drug use with leisure activities. These motivations can be explored in the ASSIST Brief Intervention or more detailed assessments.

Screening for substance use problems can also be used

- while the offender is in police custody;
- by courts to inform bail or remand decisions and pre-sentence reports;

- in correctional services, justice health, or associated agencies to inform the provision of services to individuals on remand.

Repeat screening (at 3 month intervals) with the ASSIST can also be used to monitor progress and changes over time, provided offenders are able to answer honestly without fear of being subject to legal consequences for their honesty. Interventions can be stepped up if the score has increased and the Brief Intervention can be used to intervene early if it appears that problems are developing.

The Brief Intervention (BI) is an important part of the process of using the ASSIST and adds to the benefits of screening. While screening alone has been shown to lead to reductions in substance misuse, the addition of the brief intervention enhances this effect.[27]

The RNR model[28] indicates that those at low risk of reoffending require low intensity interventions. The BI provides a mechanism to do something for those at low risk of reoffending. The ASSIST BI is an effective low intensity intervention which can be implemented with minimal resources. Use of the brief intervention with offenders at low risk of reoffending but who are at moderate to high risk of alcohol and drug related harm will assist in building motivation to address substance misuse and encourage referral into treatment when needed. It can also reduce alcohol and drug related harm and, hence, may prevent escalation in the risk of reoffending.

The BI can assist with Responsivity by providing an opportunity to build rapport and increase motivation to participate in further assessment and interventions.

The Responsivity principle refers to all of the characteristics of the individual and the intervention which can maximize the offender's ability to learn from a rehabilitative intervention. Individual characteristics include strengths, motivation, confidence, and bio-psycho-social characteristics of the individual such as mental and physical health, gender, ethnicity and social circumstances. Treatment providers may need to deal firstly with these factors in order to enable the individual to attend and participate fully in a treatment program[29]. The ASSIST BI provides an opportunity to explore these factors and to enhance motivation and confidence through the use of motivational interviewing and a supportive non-judgemental approach.

Both the RNR model and the Good Lives Model emphasise the importance of staff establishing collaborative and respectful working relationships with individuals[30]. The ASSIST BI uses motivational interviewing techniques and a collaborative empathic approach which can help build rapport and form the foundation of collaborative and respectful relationships.

Screening vs Assessment

Screening is part of a population approach to substance use problems. It aims to reduce the overall burden of substance related harms in the community or in particular target groups such as those involved in the criminal justice system. Generally, screening is undertaken routinely even if the person has not reported having alcohol or other drug problems. Screening provides an indication of whether the person is at risk of alcohol and other drug related harm and, therefore, in need of more detailed assessment.

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

If a person scores moderate risk on a screening tool this should be followed by a brief intervention, exploration of the relationship between substance use and offending, and possibly further support and services if required. If a person scores high risk on a screening tool then they need further detailed assessment and interventions.

Assessment is conducted with individuals whose screening results have indicated risky or harmful substance misuse or who present with drug and alcohol related problems. Assessment is more detailed and individualized than screening. In the criminal justice system it is important that assessment includes exploration of the relationship between substance use and offending, exploration of the legal, social, health, psychological, financial, occupational, family, relationship and spiritual antecedents and consequences of substance use as well as diagnostic assessment of dependence.

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

"The ASSIST-BI is an effective low intensity intervention which can be implemented with minimal resources."

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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 addiction researchers in response to the overwhelming burden associated with psychoactive substance use worldwide. A copy of the ASSIST can be found at Appendix A. It is an eight-item questionnaire designed to be administered by a worker and takes about five to ten minutes to administer. The ASSIST screens for risky use of all main substance types (tobacco, alcohol, amphetamine-type stimulants (ATS), cannabis, opioids, cocaine, sedatives, hallucinogens, inhalants and 'other drugs') and determines a risk score for each substance.

The ASSIST risk score refers to risk of harm from current patterns of tobacco, alcohol and illicit drug use. Harm is broadly defined and includes legal, social, financial, work and family issues as well as health problems.

The risk of harm score for each substance helps to initiate and frame a brief discussion with individuals about their substance use. The score obtained for each substance falls into a 'low', 'moderate' or 'high' risk category which determines the most appropriate intervention for that level of use. The risk scores are recorded on the ASSIST Feedback Report Card (Appendix C) which is used to give personalised feedback to individuals by presenting them with the scores that they have obtained, and the associated problems related to their level of risk.

As outlined in table 2, ASSIST scores are linked to the following risk categories and associated recommended interventions.[31]

ASSIST Risk Score			
Alcohol	**All other substances** (tobacco, cannabis, cocaine, ATS, sedatives, hallucinogens, inhalants, opioids, '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 & information
27 +	27 +	High risk	• Brief Intervention • Take home booklet & 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 & information • Referral to testing for BBVs* • Referral to specialist assessment and 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

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

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How to Administer the ASSIST

There is considerable concern within the Criminal Justice System that assessors will experience resistance and defensiveness from offenders when screening for alcohol and other drug use, and that offenders may not answer honestly. However, 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 (education, employment, family, etc) to allow time to build rapport before introducing the ASSIST. Screening with the ASSIST should be administered in the context of the assessment of needs to guide intervention, not to catch people out or punish them. There should not be any negative consequences for honesty.

The ASSIST Questionnaire (Appendix A) comes with an introduction which may be modified to suit the circumstances. However, it must include a number of key elements.

- An explanation of the Response Card (Appendix B) and the list of substances and terms used.
- That you are only interested in non- medical use of drugs (using prescription medications that were not prescribed for the person or using them in ways that were not intended).
- The limits of confidentiality as specified by the organization
- Clarification of lifetime use versus use in the last three months.

Some questions in the ASSIST ask about use and problems in the past 3 months. This is valid for people who have been in the community for the past 3 months. For those who have been in prison for the last 3 months or who have just come out of prison, for example on parole or a community based sentence following a period on remand, you should use the 3 months prior to arrest or incarceration to get a more accurate view of use and risk. If the individual discloses using drugs while in prison this should be taken into account when interpreting the ASSIST Score as drug use in prison reflects a higher level of drug involvement and poses a higher risk of harm to the individual than drug use in the community, particularly in relation to blood borne virus infections and other health risks.

Question 1

The first question asks about lifetime use to identify which substances have ever been used. This question is not included in scoring. You may need to remind clients of other names (including street names) of substances.

When you ask about the 'other drugs' category give some examples of other drugs that may be used by the target group. Examples could include steroids, GHB, Fantasy, Kava, and synthetic cannabis. Record the name of the 'other drug' in the space provided.

If a substance has never been used you should not ask about that substance again. All responses for that drug will be zero. It is important to make sure that every response for every drug in every question is circled including all zeros or negative responses otherwise it is easy to make mistakes when adding up the scores.

Question 2

Only move on to Question 2 (use in the past 3 months) if there is a 'Yes' response for at least one drug in Question 1. Only ask Question 2 for those substances which have been ever used.

When scoring Question 2 you should average the person's drug use over the whole 3 months. For example, if someone used daily for 2 weeks and then did not use again in the past 3 months, they would have used on 14 days. Averaged across the three months this would be scored as Weekly use.

If no substances have been used in the past three months, or for the three months prior to arrest or incarceration for those in prison or just released from prison, then skip to Questions 6, 7 and 8 which again ask about lifetime use. Questions 3 – 5 should only be asked for those substances for which there were 'Yes' responses in Question 2.

You may need to rephrase questions if the individual does not understand them and you may need to ask probing questions to ensure that you are getting complete responses. This is particularly the case for questions 4 – 6

When asking **Question 3** emphasise that a strong desire or urge is a craving and not just a mild or transient desire.

For **Question 4** you should particularly probe for legal, social, work, financial and family problems. Prompt with examples of the most common problems for each substance used (see the Feedback Report Card (Appendix C). It may be helpful to ask specifically about the relationship between substance use and offending and breaches. Someone who uses substances when they have abstinence conditions on a bail order or community corrections order automatically has a legal problem.

When asking **Question 5** emphasise that failure to do what was expected of you is broader than just the current expectations of family and friends or keeping appointments, although these are included. It can include not looking after children properly, neglecting relationships, missing work or education, failure to do what you have planned to do and failure to fulfil normal societal expectations around managing daily life. If substance use has contributed to unemployment or failure to complete education then these also constitute failure to do what was expected of you.

Question 6 refers to ANYONE who has expressed concern, this could include a magistrate or judge, police, correctional officer or parole officer, teacher, employer, health professional, family member, friend or anyone else. Ask Question 6 for all substances reported as ever used in Question 1.

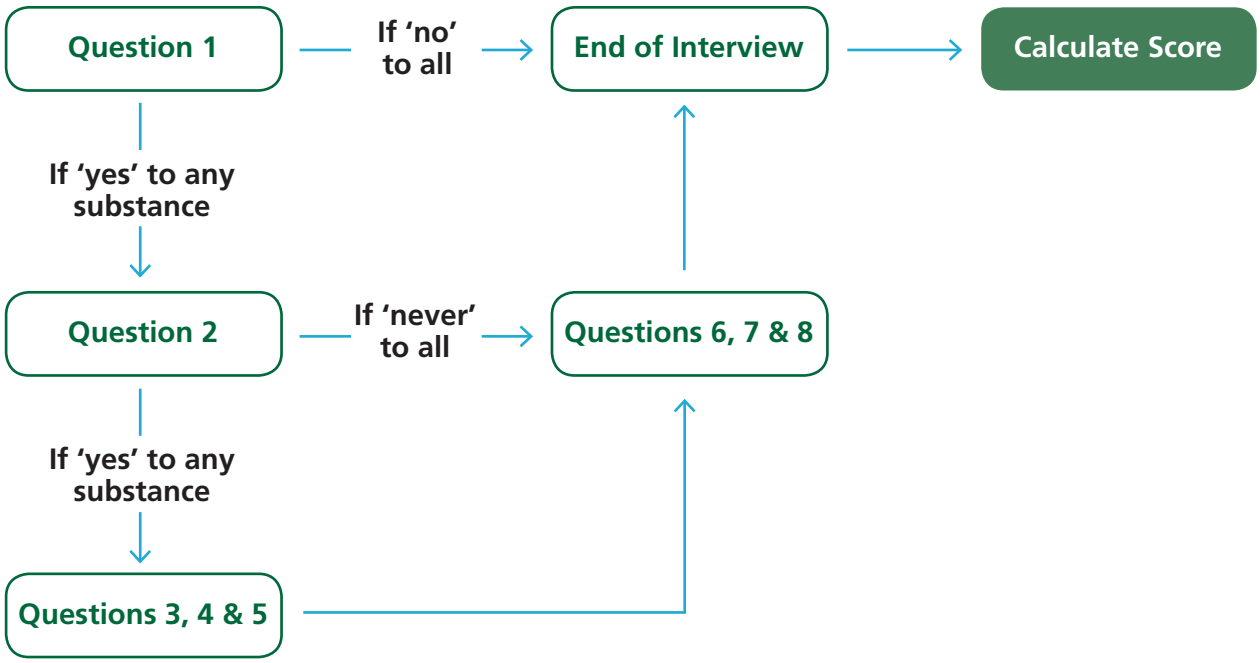
Question 7 asks "Have you ever tried to cut down on using (substance) but failed?" This question reflects dependence or high risk use. It should be asked about all substances reported as ever used in Question 1. You may need to break the question into parts to make it clearer. For example:

- Have you ever tried to cut down on (substance).
- Were you successful?
- When was the last time you tried and were not successful?

Question 8 asks "Have you used any drug by injection?" Injecting is a high risk behaviour and increases the risk of harm and dependence. Question 8 is not included in the final ASSIST scores but helps determine treatment options. The Risks of Injecting Card, (Appendix D) can be used as the basis for a brief intervention for those who have injected in the past 3 months or in the 3 months before arrest or incarceration.

Figure 2 shows the ASSIST Administration Flowchart which is a quick guide to administering the ASSIST.

Figure 2: ASSIST Administration Flowchart



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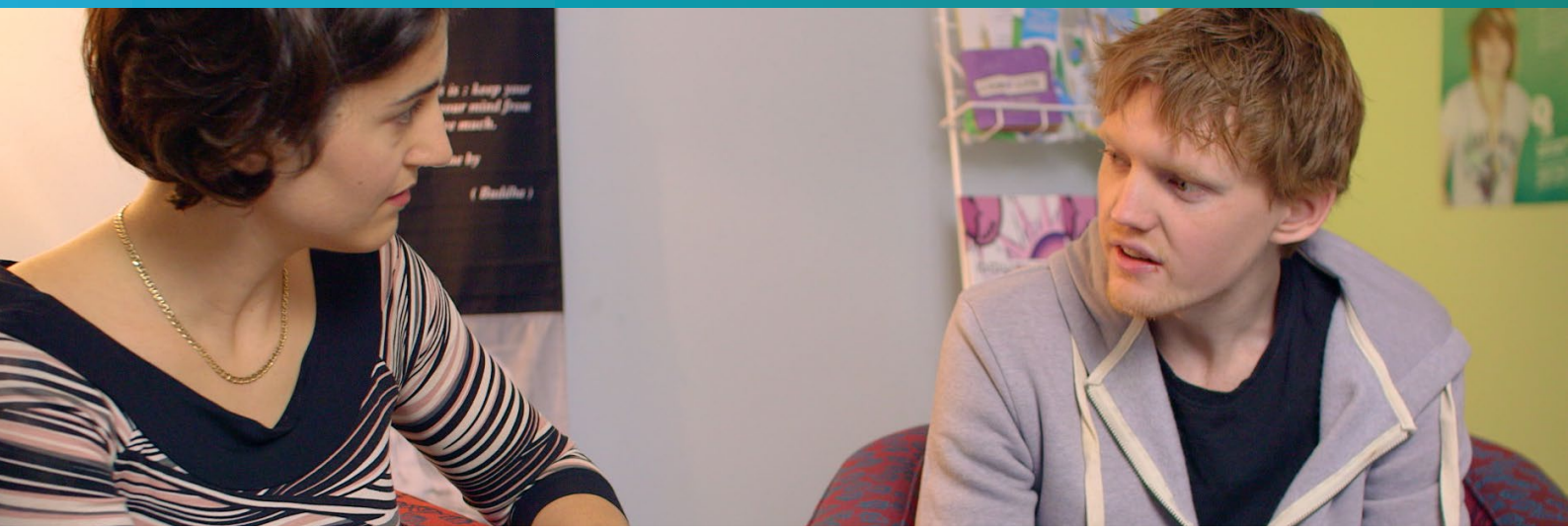

Scoring

When administering the ASSIST you will need to be very familiar with the Response Card (Appendix B), especially the definitions of Never, Once or Twice, Monthly, Weekly and Daily or almost daily.

Make sure you circle every response to every substance and question, even if the response is zero. This makes it much easier to calculate the scores.

To calculate ASSIST scores for each substance add up the responses to Questions 2, 3, 4, 5, 6, and 7 for each substance. Record the scores on the back of the ASSIST Questionnaire (Appendix A) and on the front of the ASSIST Feedback Report Card (Appendix C).

The Feedback Report Card forms the basis of the Brief Intervention and should be given to the client to take with them as a reminder.

Interpreting/Responding to Scores

Risk of Harm vs Risk of Reoffending

The ASSIST does not measure risk of reoffending, although it can identify a risk factor or criminogenic need and can inform the substance use section of an offender risk and need assessment. ASSIST scores measure risk of harm from current use of tobacco, alcohol and illicit drugs. Harm is broadly defined and includes harm to self and others, including offending behaviour, legal, financial, social, educational, work, family, relationship and health problems.

While offending behaviour is one of the harms which may be identified when administering the ASSIST, the ASSIST does not explore the nature of the relationship between substance use and offending. This relationship can be explored in the brief intervention or further assessment.

Using ASSIST Scores to determine intervention in conjunction with Risk of Reoffending

- If someone scores low risk for all substances on the ASSIST they do not need an alcohol and drug intervention, however, those at medium to high risk of reoffending will need interventions addressing other criminogenic needs and should be encouraged and supported to keep their substance use at low risk levels.
- If someone scores moderate risk for any substance on the ASSIST they should receive the BI while those at medium to high risk of reoffending also need further assessment of the relationship between their substance use and their offending behaviour. If there is a relationship they will need interventions targeting offending behaviour and substance use as well as other criminogenic needs.
- If someone scores high risk for any substance on the ASSIST they should receive a BI aimed at motivating them to engage in further assessment and intervention.
    - » If they are at low risk of reoffending they should be referred for further alcohol and drug assessment and treatment.
    - » If they are at medium to high risk of reoffending they need further alcohol and other drug assessment including assessment of the relationship between their substance use and their offending behaviour and should be referred to interventions targeting offending behaviour and substance use as well as other criminogenic needs. They may also need referral for medical treatment for substance use and related problems.

	Low Risk ASSIST	Moderate Risk ASSIST	High Risk ASSIST
Low Risk of Reoffending	• No drug and alcohol intervention • Encouragement to remain low risk	• Brief Intervention	• Brief Intervention • Referral to drug and alcohol services for assessment and intervention
Medium Risk of Reoffending	• No drug and alcohol intervention • Encouragement to remain low risk • Assessment and intervention for other criminogenic needs	• Brief Intervention • Assessment of relationship between substance use and offending. • If relationship:- interventions for substance use and offending behaviour • Assessment and intervention for other criminogenic needs	• Brief Intervention • Referral to drug and alcohol services for assessment and intervention. • Assessment of relationship between substance use and offending. • If relationship:- interventions for substance use and offending behaviour • Assessment and intervention for other criminogenic needs
High Risk of Reoffending	• No drug and alcohol intervention • Encouragement to remain low risk • Assessment and intervention for other criminogenic needs	• Brief Intervention • Assessment of relationship between substance use and offending • If relationship:- interventions for substance use and offending behaviour • Assessment and intervention for other criminogenic needs	• Brief Intervention • Referral to drug and alcohol services for assessment and intervention • Assessment of relationship between substance use and offending • If relationship:- interventions for substance use and offending behaviour • Assessment and intervention for other criminogenic needs

Table 3: Matrix - ASSIST and Risk of Reoffending

1

When you have a lot of previous information

In the case of repeat offenders and offenders recently released or about to be released on parole you may already have a great deal of information about the offender on file before you undertake screening with the ASSIST. In this case screening with the ASSIST may be likened to using it for reviewing progress.

The results of the ASSIST screening will need to be interpreted in conjunction with the previous history of alcohol and other drug use and problems. If the ASSIST score is low or moderate risk but the individual has a past history of dependence, their risk of harm and relapse will be greater than if they have no past history of dependence. This will be reflected in their responses to Questions 6 and 7. However, the low or moderate risk ASSIST score demonstrates that the person has successfully cut down their use and reduced their risk of problems. This is a positive finding which can be fed back in the BI which should focus on risk of relapse and enhancing motivation to remain low risk.

What is the ASSIST-linked Brief Intervention?

The ASSIST-linked Brief Intervention lasts five to ten minutes and is for clients who have been administered the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and are at *'moderate risk'* of harm from their substance use. People in the moderate risk range, who are not dependent, may be experiencing legal, health, social, relationship, 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 individuals to accept a referral to specialised drug and alcohol assessment and treatment.

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

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

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

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

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

Motivational interviewing techniques are designed to promote behaviour change by helping people to explore and resolve ambivalence. This is especially useful when working with people in the pre-contemplation (happy to continue using) and contemplation (some uncertainty about use but not enough to change) stages, but the principles and skills are important at all stages. Motivational interviewing is based on the understanding that effective intervention assists a natural process of change. 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 individuals is an important part of the brief intervention process. The way that feedback is provided can affect what the client really hears and takes in. Feedback should be given in a way that takes account of what the client is ready to hear and what they already know. A simple and effective way of giving feedback 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[34]:

Feedback
Elicit
Provide
Elicit

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

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

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

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

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

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

Create discrepancy and reduce ambivalence

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

Ambivalence refers to the contradictory feelings people have about their substance use. Some feelings are positive, such as the pleasure associated with using. Other feelings are

negative, such as the risks involved or problems it creates. By creating discrepancy you can reduce their ambivalence to change.

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

OARS
Open questions
Affirming
Reflecting
Summarising

Open questions

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

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

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

This approach is termed a *decisional balance* and encourages the individual to explore the pros and cons of their use in a balanced way.[35]

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

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

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

Affirming

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

Reflecting

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

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

Summarising

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

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

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

Technique	Examples
Open-ended questions	What do think are some of the benefits of addressing your drug use? You mentioned that you would like to stop using again, what has worked for you in the past?
Affirming	It sounds as though you are very resourceful to have coped with the challenges over the past few years. I appreciate that it has taken a lot of courage to discuss your drug use with me today.
Reflecting	You enjoy using (substance), though it sounds as if it gets you into trouble and you have had a few injuries. You enjoy using (substance), though it sounds as if it gets you into trouble and you don't want to be arrested again. You are worried about your children and you don't want them growing up with you in prison.
Summarising	So just to make sure I understand, you enjoy using, though it is causing some problems in your life. You have been to detox before, but you left because of the no-smoking policy. You are keen to stop, but are not sure what other options are available. Am I on the right track?

Eliciting change talk

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

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

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

"What worries you about your substance use?"

"What do you think will happen if you don't make any changes?"

"How would you like your life to be in 12 months' time?"

"What do you think would work for you if you decided to change?"

"How confident are you that you can make this change?"

"How important is it to you to cut down your substance use?"

"What are you thinking about your substance use and offending behaviour now?""

Important tips

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

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

Suggested further reading

Stinson Jill D. and Clark Michael D. (2017) Motivational Interviewing with Offenders. Guildford Press. New York

www.guilford.com/books/Motivational-Interviewing-with-Offenders/Stinson-Clark/9781462529872

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CHAPTER 4

The FRAMES Model

Experience and research into brief interventions for substance use have found that effective brief interventions comprise a number of consistent and recurring features. These features have been summarised using the acronym FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy.[36, 37]

FRAMES
Feedback
Responsibility
Advice
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 people are interested in knowing their questionnaire scores and what they mean.

Information about personal risks associated with a person's current drug use patterns that have been reported during the screening (e.g. low mood, anxiety, relationship problems, offending, legal problems) combined with general information about substance related risks and harms also comprises powerful feedback. The ASSIST Feedback Report Card (Appendix C) which is completed for each person after completion of the ASSIST was designed to match personal risk of harm (i.e. low, moderate or high) with the most commonly experienced problems.

In summary, feedback is the provision of personally relevant information which is pertinent to the individual and is delivered by the screener in a non-judgemental and objective way in the *Spirit of Motivational Interviewing* (Chapter 3). Much of the feedback information provided in an ASSIST-linked Brief Intervention can be delivered by reading from the ASSIST Feedback Report Card.

Responsibility

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

This sense of control has been found to be an important element in motivation for change and in decreasing resistance.[38] Using language with people such as "*I think you should…*", or "*I'm concerned about your substance use*" may create resistance in individuals and motivate them to maintain and adopt a defensive stance when talking about their substance use patterns.

Advice

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

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

Menu of options

Effective brief interventions provide the individual with a range of options to cut down or stop their substance use. This allows the individual to choose the strategies which are most suitable for their situation and which they feel will be most helpful. Providing choices reinforces the sense of personal control and responsibility for making change and can help to strengthen the person's motivation for change. Giving individuals the

"*Self-Help Strategies for Cutting Down or Stopping Substance Use: Self-Help Guide*"[39] is a good way to start as it contains strategies for helping clients change their behaviour, and can be used alone or in conjunction with other options.

Examples of options for clients to consider include:

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

You can also assist by

- Providing information about other self-help resources and written information
- Inviting the individual to return for regular sessions to review their substance use
- Providing information about groups or programs that specialise in drug and alcohol issues

Empathy

Empathy is taking an active interest and effort to understand another's internal perspective, to see the world through their eyes. It does not mean sympathy, a feeling of pity, camaraderie or identification with the person. Statements such as *'I've been there and know what you are experiencing, let me tell you my story'* are not useful. The opposite of empathy is the imposition of one's own perspective, perhaps with the assumption that the other's views are irrelevant or misguided. Empathy is the ability to understand another's frame of reference and the conviction that it is worthwhile to do so.[40]

In a brief intervention, empathy comprises an accepting, non-judgmental approach that tries to understand the individual's point of view. It is especially important to avoid confrontation and blaming or criticism of the individual. Adopting a position of *'curious intrigue'* is helpful. Skilful reflective listening which clarifies and amplifies the person's experience and meaning is a fundamental part of expressing empathy. The empathy and understanding of the professional is an important contributor to how well the individual responds to the intervention.[41]

Self efficacy (confidence)

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

"Empathy is the ability to understand another's frame of reference and the conviction that it is worthwhile to do so."

CHAPTER 5

Model of behaviour change

The trans-theoretical model of behaviour change developed by Prochaska and DiClemente provides a useful framework for understanding the process by which people change their behaviour, and for considering how ready they are to change their substance use or other lifestyle behaviour.[42] The model proposes that people go through discrete stages of change and that the processes by which people change seem to be the same with or without treatment.[43]

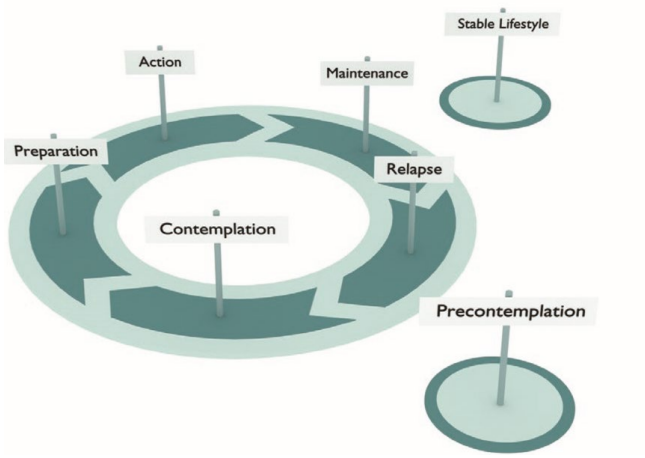

Figure 3: Stages of change

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

It is worth noting that there is no set amount of time that a person will spend in each stage (may be minutes, months or years), and that people cycle back and forth between stages. Some individuals may move directly from pre-contemplation to action following an ASSIST-linked Brief Intervention. The following provides a brief description of the underlying behavioural and cognitive processes of each stage. Professionals providing interventions longer than fifteen minutes, or ongoing sessions with individuals may require a more comprehensive knowledge of the model of change and associated techniques.

Pre-contemplation

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

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

Contemplation

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

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

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

Preparation

Preparation follows contemplation and involves planning to take action in the near future and making the final preparations before behaviour change begins. 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
- May vocalise their intentions to others

- Making small changes in their substance use behaviour
- Re-evaluating their current behaviour and considering what different behaviour could offer them
- Becoming more confident and ready to change their behaviour
- Considering the options available to them
- Setting dates and determining strategies to assist change

Action

People in the action stage:

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

Maintenance

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

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

Relapse

A relapse (or lapse – a one off or short period) is a return to the old behaviour that was the focus of change. Most people who try to make changes in their substance use behaviour may relapse to substance use, at least for a time. This should be viewed as a learning process rather than failure.

Few people change on the first attempt and relapse is an opportunity to help clients review their action plan. A review should examine timeframes, what strategies did actually work and whether the strategies used were realistic. Substance users may make a number of attempts to stop before they are successful. For many people, changing their substance use gets easier each time they try until they are eventually successful.

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

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

For further reading:

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

"Most people who try to make changes to their substance use behaviour may relapse to substance use, at least for a time."

CHAPTER 6

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

Moderate Risk on the ASSIST

All offenders who score in the moderate risk range on the ASSIST should receive the brief intervention outlined below. Those who are at medium to high risk of reoffending need further exploration of the relationship between their substance use and their offending behaviour. This can occur as part of the brief intervention. If there is a relationship they may need to attend an alcohol and drug program that addresses substance use and offending as well as receiving interventions for other criminogenic needs.

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 is being injected or has attracted the highest ASSIST score or it may be the substance that the client believes is most closely related to their offending behaviour.

This step by step approach was designed to assist and build confidence in workers who are not specifically trained in motivational interviewing and substance use interventions. It also serves as a framework for more experienced behaviour change professionals and can be expanded and explored further for longer or recurrent sessions, or to address multiple substance use.

STEP 1. Asking 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 screener's entrance into delivering a brief intervention. Phrasing it in this way gives the individual a choice about what happens next and immediately helps reduce any resistance. An affirmative response from the individual gives permission to provide personally relevant

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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***
7. ***Weighing up the less good things about using the substance***
8. ***Summarise and reflect on clients' statements about their substance use with emphasis on the less good things***
9. ***Asking clients how concerned they are by the less good things***
10. ***Giving clients take-home materials to bolster the brief intervention***

feedback and information to the person about their scores and associated risk, and how the person can best reduce risk. It is worth noting that most people are interested in seeing and understanding their scores.

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 or it can be downloaded from the ASSIST Portal (www.assistportal.com.au).

STEP 2. Providing 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 individuals and is given to the person 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 screener and the individual to focus on during the course of the intervention.

Screeners can provide personally relevant feedback in an objective way by reading from the ASSIST Feedback Report Card. The card should be held so it can be viewed easily by the participant, 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.

Screeners should go through each substance score on the front page of the ASSIST Feedback Report Card and inform the individual whether they are at low, moderate or high risk from their use of that substance. Following this, explain the definition of moderate risk and/or high risk, 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 but you scored moderate risk for tobacco, cannabis, and methamphetamine. Your highest score, for methamphetamine, was 16, which places you well into the moderate risk range. Moderate risk means that you are at risk of legal, health and other problems from your current pattern of substance use, not only now but also in the future if you keep using in the same way."*

The second part of the feedback comprises communicating the risks associated with each particular substance used, focussing on the highest scoring substance (or substances). 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 individual, with further explanation if required. You should also include any problems that were revealed during the administration of the ASSIST. Once again, the card should be held so it can be viewed easily by the participant, 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 problems with the law, difficulty sleeping, dehydration, headaches, mood swings, and, at the serious end of things, aggressive and violent behaviour, psychosis and permanent damage to brain cells. You said that your family is concerned about your use and that you have been irritable lately, …"*

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

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

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

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

STEP 4. Allowing 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. Screeners need to be mindful that the individual 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:

> *"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. Asking clients how concerned they are about their scores

This is an open-ended question designed to get the individual thinking about their substance use and to start verbalising any concerns they may have about their use. Using open-ended questions in this context is a powerful motivational interviewing technique, and may be the first time the person has ever verbalised concerns about substance use in their life. There is evidence that verbalising concerns in a supportive context leads to change in beliefs and behaviour. Screeners should turn the ASSIST Feedback Report Card back to the front page so that the individual can see their scores again, and say something like:

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

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

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

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

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

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

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

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

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

- Legal —current and previous offences, accidents, driving while under the influence of a substance or other offending behaviour
- Health — physical and mental
- Social — relationships with partner, family, friends, associates, colleagues

- Financial — impact on personal and family budget
- Occupational — difficulty with work, study, looking after home and family
- Spiritual — feelings of self-worth, guilt, wholeness

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

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

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

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

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

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

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

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

The individual should receive a copy of their ASSIST 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 individual. They also can serve as a secondary outreach if read by friends and family or associates of the individual who also may be using substances.

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

- Individual's ASSIST Feedback Report Card (Appendix C)
- General information pamphlets on the substance(s) being used by the individual (obtained from the relevant agency in your state or country)
- Self-Help Strategies for Cutting Down or Stopping Substance Use: Self-Help Guide booklet available at:
  - » https://assistportal.com.au
  - » www.who.int/substance_abuse/activities/assist/en/index.html
- Risks of Injecting Card (if relevant) (Appendix D)

The ASSIST Feedback Report Card serves as a reminder of the individual'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 may be being used by the individual.

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 individuals 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. Professionals can use the booklet as a platform for longer or ongoing interventions if relevant.

The Risks of Injecting Card should be given to individuals 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 those who choose to continue to inject substances.

The booklet and other materials should be given to the individual with a brief explanation of their contents using neutral language that still respects the individual'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, and 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 Individuals

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

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

What to do with 'high risk' and injecting individuals.

(See also using ASSIST Scores to determine intervention in conjunction with risk of reoffending p 18)

People who have been injecting drugs regularly over the last three months (or the three months prior to arrest or incarceration) and/or whose ASSIST scores are in the 'high risk' range (27 or higher) for any substance, require more than just the brief intervention. The brief intervention including the take-home materials still should be given to these individuals as a means of motivating them to engage in further treatment and programs.

It is likely that a brief intervention for these individuals will take at least 15 minutes given the seriousness of the problem. If the individual 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 but also recognise how difficult it can be to maintain the commitment. This may help the client understand that they may need treatment to change their substance use.

It is also helpful to provide these individuals with encouragement and reassurance about the effectiveness of treatment and the types of treatment available.

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

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

Those who are at medium to high risk of reoffending will also need further assessment of the relationship between substance use and offending and referral to correctional programs addressing substance use and offending as well as any other criminogenic needs.

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

"If a person feels that they have been listened to they are more likely to receive and consider information and advice."

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

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

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

- not sharing injecting equipment and drug paraphernalia
- hygiene around injecting
- avoiding the use of other substances at the same time, especially alcohol and sedatives
- letting a friend know when they are going to use in case of overdose
- learning first aid and resuscitation techniques
- having a small amount to start with to check the potency of the substance being used
- 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: While the score from question 8 is not included in the calculation of the ASSIST Specific Substance Involvement score, people who have injected more than 4 times per month on average over the past three months (or the three months prior to arrest or incarceration) are likely to require more intensive treatment than those who do not inject or who inject less frequently as they are likely to be progressing towards dependent use.

CHAPTER 7

Using the ASSIST in the Criminal Justice System

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

The ASSIST can be used at a number of points in an individual's contact with the Criminal Justice System.

Arrest/Police cells

The ASSIST can be used after arrest while an individual is held in police cells or other custodial environment to quickly identify those who may be at risk of problems as a result of their substance use and may be in need of closer monitoring, behavioural management, and/or medical intervention. For those who score High risk of harm the ASSIST can be followed by a specific question about what substance(s) have been used in the past few days and the quantities used so that a judgement can be made about the risk of withdrawal or other problems and the detaining authority can meet its duty of care obligations.

Court

Bail/Remand decisions

Courts frequently request further information about individuals to inform decisions about whether to grant bail or to remand the person in custody. In some cases a duty officer of the court is asked to undertake a rapid assessment and provide a brief report to the magistrate. In other cases the individual's legal representative may request a report, either from correctional staff or from a private assessor. The ASSIST can be used to inform the drug and alcohol section of such a report.

Pre – Sentence Reports

Pre-sentence reports are provided to the court to assist the magistrate to decide the most appropriate sentence for a convicted offender including whether the offender is suitable for a community based sentence or should receive a custodial sentence. Substance use forms a significant section of a pre-sentence report. The ASSIST can be used as the basis for the substance use section of a pre-sentence report although those who score moderate or high risk of harm on the ASSIST will need further exploration of the relationship between their substance use and the offence for which they are being sentenced.

Prison

Intake Screening

Intake screening is usually undertaken within hours of a person being admitted to prison as part of the institution's duty of care. The ASSIST can be used to identify potential risk of harm from substance use so that those at moderate to high risk can receive closer monitoring particularly for problems related to intoxication and withdrawal.

To inform offender risk need assessments and case planning

As previously indicated, the ASSIST can inform the alcohol and other drug section of offender risk need assessments and can be used as part of a comprehensive assessment system to inform case planning for offenders both in custody and on community based orders. In a comprehensive system, the ASSIST is the first part of an alcohol and other drug assessment with those scoring moderate to high risk on the ASSIST receiving further more detailed and individualised assessment.

Pre-release assessment and planning

The ASSIST can also be used as part of the pre-release assessment process where it can inform planning for post release referrals and services. When administering the ASSIST as part of a pre-release assessment use the 3 months prior to incarceration. Those who score High Risk on the ASSIST will need to be referred to drug and alcohol services for support and intervention post release.

Community Corrections

To inform offender risk need assessments and case planning

As described above, community corrections officers can use the ASSIST to inform the drug and alcohol section of offender risk need assessments and to inform case planning.

Monitoring of progress during a community corrections order

The ASSIST can be readministered every 3 months and so makes an ideal tool for monitoring progress during a community corrections order provided offenders are able to answer honestly without fear of being subject to legal consequences for their honesty. Interventions can be stepped up if the score has increased and the Brief Intervention can be used to intervene early if it appears that problems are developing.

2

PART 2

This section provides options for delivery of the *ASSIST with Corrections* 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 with Corrections* video scenarios.

CHAPTER 8

Providing training and education sessions using the ASSIST with Corrections resource

Planning for your target audience

Planning

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

Who?

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

- Do they have sufficient knowledge about alcohol and other drug problems and addiction?
- Do they have sufficient knowledge about the relationship between substance misuse and offending?
- Do they have appropriate communication and interpersonal skills?
- If you are coordinating the training, you also need to think about facilitation.
- Do you plan to facilitate the session? If not, who will facilitate the training?
- How many facilitators will be needed?
- Do the intended facilitators have the necessary expertise?
- How will they be trained to facilitate? You may train facilitators yourself or you can contact the DASSA WHO Centre (dassawhocentre@adelaide.edu.au) to arrange for face to face training of trainers.

What?

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

What specific needs do the participants have?

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

Why?

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

How?

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

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

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

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When?

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

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

Where?

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

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

Publicity

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

Register of Participants

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

Confirmation to participants

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

Evaluation and reporting

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

- Do you want to evaluate the content?
- Do you want to evaluate the way the information was delivered?

- Do you want the evaluation to be written or verbal?
- Do you plan to set up a data base for future comparisons?

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

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

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

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

Principles of adult learning

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

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

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

Timing

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

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

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

Reference Points

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

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

Language

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

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

Handouts

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

Technology

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

Information

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

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

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

Self awareness

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

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

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

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

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

Be enthusiastic

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

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

Above all ENJOY.

2

CHAPTER 9

Training and education session options

Face to face sessions

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

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

On-line learning

The ASSIST with Corrections manual can be used for on-line teaching. It is suggested that the participants be asked to read the manual and answer questions. Depending on the objectives of the training, the linked activities could include short answer questions, or a discussion board, assignment or essay.

Depending on the IT platform, a suggested approach is:

- Participants read the manual 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 the '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 or of an assignment or essay. 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 the client in the scenario? Explain your reasoning.
- Describe the stage of change your client was in the role play. What techniques did you use to help move your client to the next stage?

2

Flipped classroom method

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

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

- Given access to the ASSIST with Corrections Manual and ASSIST resources (Appendices A – D)
- Encouraged to read the Manual and familiarise themselves with the ASSIST tools
- Explore background information on the WHO ASSIST website and the ASSIST Portal:
  - » www.who.int/substance_abuse/activities/assist/en/index.html
  - » assistportal.com.au
- 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 participant
- The character developed for the role play should be researched and based on evidence that is available related to patterns of drug use and offending. This would include associating the age and gender of the character with the pattern of drug use and associated consequences of use.
- Participants are to research what services are available for offenders with drug and alcohol problems in their area or jurisdiction and be prepared to provide an ASSIST-linked, targeted intervention.

NOTE: Participants may build on the characters shown in Chapter 10 of the Manual.

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

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

- What are some of the benefits of screening and brief intervention for drug and alcohol use in the criminal justice system?
- 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 10

Scenarios[1]

Scenario 1
Simon

Simon is a 20 year old male who was born in Sudan and is one of 6 siblings. His immediate biological family still reside in Sudan. His father died when he was 12 and he was taken from his home and became a child soldier. He became a refugee and was resettled in Australia. He lives with a friend in a rental property in a small country town and has a girlfriend who is expecting their first child. He is currently unemployed and receives unemployment benefits.

Simon has been arrested and charged with Theft and Assault after stealing 3 pairs of shoes from a shop. When he was apprehended he assaulted two police officers. Past offending behaviour includes Drink Driving, which resulted in his losing his license for a period of 3 years and 7 other Theft and Assault charges over the past 5 years.

He is at court to apply for bail. The magistrate has requested a brief report about his substance use and other needs before making a decision about whether to grant bail.

Alcohol and Drug Use

Simon commenced smoking at age 14 and currently smokes around 5-6 cigarettes every day.

He drinks alcohol in a binge pattern – at least once per week. When he drinks he keeps drinking until he runs out of money. He says that if he has the money and alcohol is available he drinks as much as he can to make himself feel better and to forget the past. He reports that he has no recollection of committing his current offences as he was intoxicated at the time. Some of his previous offences were committed while he was intoxicated, others were not.

Simon has never used illicit drugs.

Scenario 2
Tammy

Tammy is a 27 year old aboriginal woman with a significant history of physical and sexual abuse and mental health issues. She was diagnosed with depression at the age of fourteen and has a history of suicide attempts. She reports constant low level anxiety and is restless, fidgety and always eager to finish conversations.

Tammy is currently serving a 12 month Community Corrections Order for Breaking and Entering and Resisting Police. At the time of the offences she was "off my face on ice. I had been up for 5 days and I thought the house was mine. I truly believed it was mine, I was in psychosis, I don't even live in that suburb." Tammy has an extensive criminal history that includes several periods of incarceration in both youth and adult detention and several previous non-custodial sentences. Past offences include Theft, Criminal Damage, Shop Steal and Handle Stolen Goods. She says she doesn't usually offend when she is intoxicated, rather her offences have usually been at the behest of her partners and are committed to obtain funds to purchase drugs or settle drug debts.

She is meeting with her parole officer early in her current sentence for screening and assessment to contribute to the development of her case plan.

Alcohol and Drug Use

Tammy currently smokes 15- 20 cigarettes per day which she rolls herself. She used alcohol as a teenager but has not used it for 7 years.

Tammy has used amphetamines sporadically since the age of 13. She had a lapse to ice use several weeks ago which lasted 4 days and resulted in a psychotic episode and a subsequent 3 week involuntary inpatient stay in hospital.

Tammy has a past history of heroin use and injecting. She had a long period of heroin dependence until her incarceration 5 years ago when she chose to stop using. Whilst in prison she commenced on a Methadone program and continued on methadone post release. It has been 5 years since she last injected heroin.

She has attended numerous group alcohol and drug programs, both residential and non residential, and has also accessed individual counselling, however, these don't last as she doesn't like talking about the past.

[1]NOTE: The people depicted in the scenarios are actors and the histories are not based on any single individual alive or deceased.

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Scenario 3
Terry

Terry is a single 32 year old aboriginal man who has been in prison for 11 months. He is serving a total sentence of 2 years with a 1 year period of parole for the following offences: Burglary x 15; Theft x 13; deal stolen goods; retention of stolen goods; theft of a motor vehicle x 3; go equipped to steal; and traffic methamphetamine. This was his first conviction and sentence. He has good insight into his pathway to crime and prison.

Terry has always had good physical and mental health and had a stable life, living at home with his mother, until the age of 30 when he was retrenched from his long term job. He has few recreational or social interests and commenced using ice. He quickly began offending to support his ice use, having been introduced to the drug by peers who also encouraged his offending behaviour.

He is being assessed by a parole officer prior to commencing parole.

Drug Use

Having first tried ice at age 30, Terry quickly developed a pattern of weekly binge/crash use, smoking ice for 2-3 days and then stopping for the next couple of days before repeating the cycle. He was using around 1 gram per week. He has been abstinent since his incarceration and is confident that he will be able to maintain his abstinence post release as he does not want to use ice ever again. He can articulate the negative impact that ice has had on his life and on that of his family. Terry completed a medium intensity drug and alcohol program in prison four months ago and found the intervention beneficial. He is receptive to engaging in further drug and alcohol treatment after he leaves prison to reinforce his relapse prevention strategies and support his abstinence.

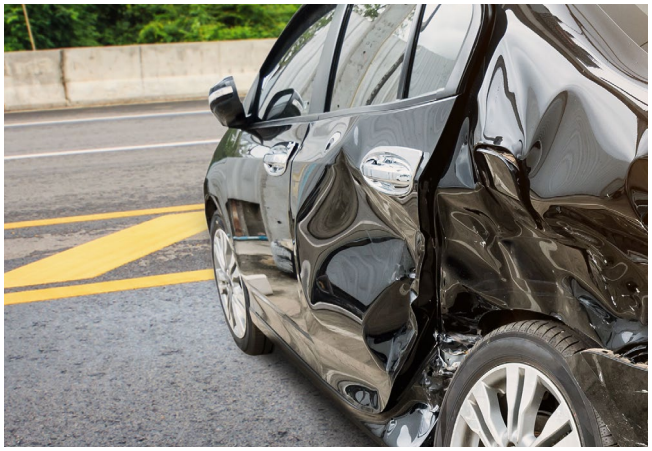
Scenario 4
Tim

Tim is a 30 year old former forestry worker who has been in prison for 10 weeks as a result of breaching a 2 year community based order which was imposed 6 months ago for the following offences: cultivate drugs, possess drugs, contravene family violence intervention order, use carriageway service to harass, commit offence whilst on bail, possess prohibited weapon, possess dangerous article, and drive under the influence of alcohol. He has been unemployed since leaving forestry 2 years ago. He became involved with a group of peers who encouraged him to grow cannabis, deal ice and commit burglaries.

Drug Use

Tim is a daily smoker averaging 20 cigarettes per day. He commenced drinking alcohol at age 12 and since then has had periods of heavy episodic use. Prior to coming into custody he was averaging 6 beers at the weekend at parties and the pub. He last consumed alcohol 10 weeks ago. He began using methamphetamine with his partner in his early 20s, smoking a couple of points at weekends. When they separated his use escalated as he wanted to party. When he was 27 he started using Ecstasy with the methamphetamine 3 to 4 times a week, mixing the drugs to get a better effect. He also used cocaine and ketamine occasionally.

Tim had a drug induced psychotic episode when he was 28 and since then has been prescribed antipsychotics. Now he has seizures whenever he misses his medications. He also experiences anxiety and depression. Following his psychotic episode he attended drug and alcohol counselling and found benefit from talking. He stopped using methamphetamine for 6 months and then resumed and his use escalated until he was again using 3-4 times per week.



Scenario 5
Josh

Josh is a 22 year old male who is currently on bail after being charged with drug possession offences and driving under the influence. He is living with his father in an attempt to remove himself from his drug using lifestyle. He has previous convictions for drug use and possession which resulted in a 2 year community corrections order prior to which he served 21 days in custody in relation to trafficking of methamphetamine. He has been unemployed for the last 3 years and has been in an intermittent relationship with his current girlfriend during that time.

Drug Use

Josh does not use Tobacco. By the age of 16 he had established a pattern of irregular alcohol use and regular use of cannabis. He began using ecstasy weekly at age 17 using 1 tablet on a weekend night. He had no problems ceasing ecstasy use by the age of 20. At 18 years of age Josh stopped using cannabis and began experimenting with ice, smoking 2 points at the weekend but quickly changed to injecting and began using 2- 5 points daily. He experienced multiple problems as a result of his methamphetamine use including a nonfatal head on collision with another car at age 18 which was the result of extreme tiredness after having been on ice for 3 days. He also experienced extreme anger and on one occasion smashed his car with an axe. He continued this level of use until he was 19 when he received his previous convictions and sentence. He is currently trying to abstain from methamphetamine but has weekly lapses.

Scenario 6
Toula

Toula is a 36 year old woman who was born in Greece and migrated to Australia with her parents at age 15. She has just arrived at the remand centre having been charged with assault, theft and trafficking drugs. Past offences include traffic drug, possess drug, resist emergency worker, commit an indictable offence while on bail, deal proceeds of crime, damage property, theft, and unlawful assault, for which she served a 2 month prison sentence followed by a community corrections order.

She is being screened with the ASSIST as part of the remand centre's intake screening procedure.

Drug Use History

Toula says that she has never known a life without drugs. Toula first began smoking cannabis and heroin and chroming paint at the age of 13. She ceased chroming after 3 months and stopped using cannabis at age 18. She commenced smoking tobacco at the age of 15 and has been a regular smoker since then. She currently smokes 25 cigarettes per day. She also started drinking alcohol at age 15 but only drinks occasionally and has never had a problem with alcohol. Toula used steroids from age 25 to age 32 when working out in a gym. Toula has used heroin regularly since the age of 14 and is currently injecting 5 grams per day, using approximately every 2 hours. She contracted a blood borne virus as a result of sharing needles with her brother. From age 17 Toula has used methamphetamine on occasion when not using heroin but heroin is her drug of choice. She has used methamphetamine couple of times recently. She uses cocaine at weekends and uses non prescribed sedatives (Serapax, Valium, or Xanax) daily to manage her anxiety. There have been periods of abstinence in the past, however, she continued to use steroids over those periods. Toula has participated in eight drug detoxification programs but has had no other drug treatment.

2

Scenario 7
Matt

Matt is a 27 year old male who is currently unemployed although he has had intermittent jobs in the automotive and construction industries. He is socially isolated and has little contact with his family. He has experienced homelessness but is now in stable housing. Matt's mother is a heavy drinker and his father is 'cooked on ice'. Matt was neglected as a child and remembers that child protection services were involved throughout his childhood. Matt is at court following a charge of drive while license suspended and theft. The magistrate has requested a brief assessment of Matt's substance use to inform the court proceedings.

Drug Use

Matt smokes regularly but not daily. He believes he could stop if he chose to. He drank alcohol regularly during his teenage years and became reliant on it to the point that he would become aggressive if he could not access it and truanted from school in order to drink. He smokes cannabis 5-6 nights per week which he believes improves his mood, reduces his agitation and improves his appetite. After several attempts he reduced his alcohol use significantly at age 20 and commenced smoking ice each weekend. His use escalated at age 22 when his relationship broke down and he began to smoke ice most days. This led to loss of his employment and to his becoming angry, agitated, confused and aggressive towards others. He began to reduce his ice use a year ago but still uses a couple of times per week. He was intoxicated on alcohol and ice at the time of his current offences. He has no memory of any periods of complete abstinence or engaging in any treatment.

Scenario 8
Tracy

Tracy is a 23 year old female who is serving a Community Corrections Order for theft, shoplifting, possess drugs, and resist police. She has been progressing well and complying with her conditions, having secured some casual employment at a warehouse and residing with her parents. Two weeks ago she lost her job as her company were cutting costs and reduced their casual workforce. In the past week she has reconnected with her previous partner, who was also her past dealer and co-offender. This led to a disagreement with her parents and she is considering moving in with her ex-partner.

Tracy is attending a regular appointment with her parole officer. The parole officer is using the ASSIST every 3 months to review Tracy's alcohol and other drug use.

Drug Use

Tracy currently smokes tobacco daily. Tracy commenced using alcohol at age 16 and drank heavily at weekends until she was 22, when she was arrested for her current offences. She also used cannabis 4-5 times a week throughout her teenage years but cut down to occasional use at age 20 after a number of attempts. Tracy used ecstasy and speed occasionally in her late teens but at age 19 her partner introduced her to heroin which she preferred. She commenced injecting and by the time she was 20 she was using heroin daily and was dependent. She also used sedatives on a regular basis to cope with anxiety and agitation and to manage withdrawal symptoms when she could not get heroin. Tracy entered a drug treatment program and ceased using all drugs except tobacco following being charged with her current offences.

PART 3

Suggested resources

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

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

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

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

Risk Need Responsivity Model
For more information about the Risk Need Responsivity Model of offender assessment and rehabilitation visit:
www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx

Good Lives Model
For further information about the Good Lives Model of offender rehabilitation visit:
www.goodlivesmodel.com

APPENDIX A: 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.

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, 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, 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, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During 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					
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, 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, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

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, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 8 (please mark the response)

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you <u>ever</u> 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 drugs		0 - 3	4 - 26	27+

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

APPENDIX B: RESPONSE CARD V3.0

Response Card - substances

a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b. Alcoholic beverages (beer, wine, spirits, etc.)
c. Cannabis (marijuana, dope, pot, grass, hash, etc.)
d. Cocaine (coke, crack, etc.)
e. Amphetamine type stimulants (speed, ecstasy, meth, ice, paste, crystal, diet pills, etc.)
f. Inhalants (nitrous, NOS, glue, petrol, sprays, paint thinner, amyl, etc.)
g. Sedatives or Sleeping Pills (diazepam, alprazolam, flunitrazepam, temazepam, etc.)
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)
i. Opioids (heroin, opium, morphine, methadone, codeine, etc.)
j. Other - specify:

Response Card (ASSIST Questions 2 – 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 FORM

Alcohol, Smoking and Substance Involvement Screening Test (WHO ASSIST V3.0) Feedback REPORT CARD

Name_____ **Test Date** _____

Specific Substance Involvement Scores

Substance	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:…… **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular tobacco smoking is associated with:**
	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:…… **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular excessive alcohol use is associated with:**
	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:…… **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of cannabis is associated with:**
	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:…. **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of cocaine is associated with:**
	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:……. **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of amphetamine type stimulants is associated with:**
	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:……. **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of inhalants is associated with:**
	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: Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of sedatives is associated with:**
	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:…….. Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of hallucinogens is associated with:**
	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: Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of opioids is associated with:**
	Itching, nausea and vomiting
	Drowsiness, constipation, tooth decay
	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: RISK OF INJECTING CARD V3.0

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.

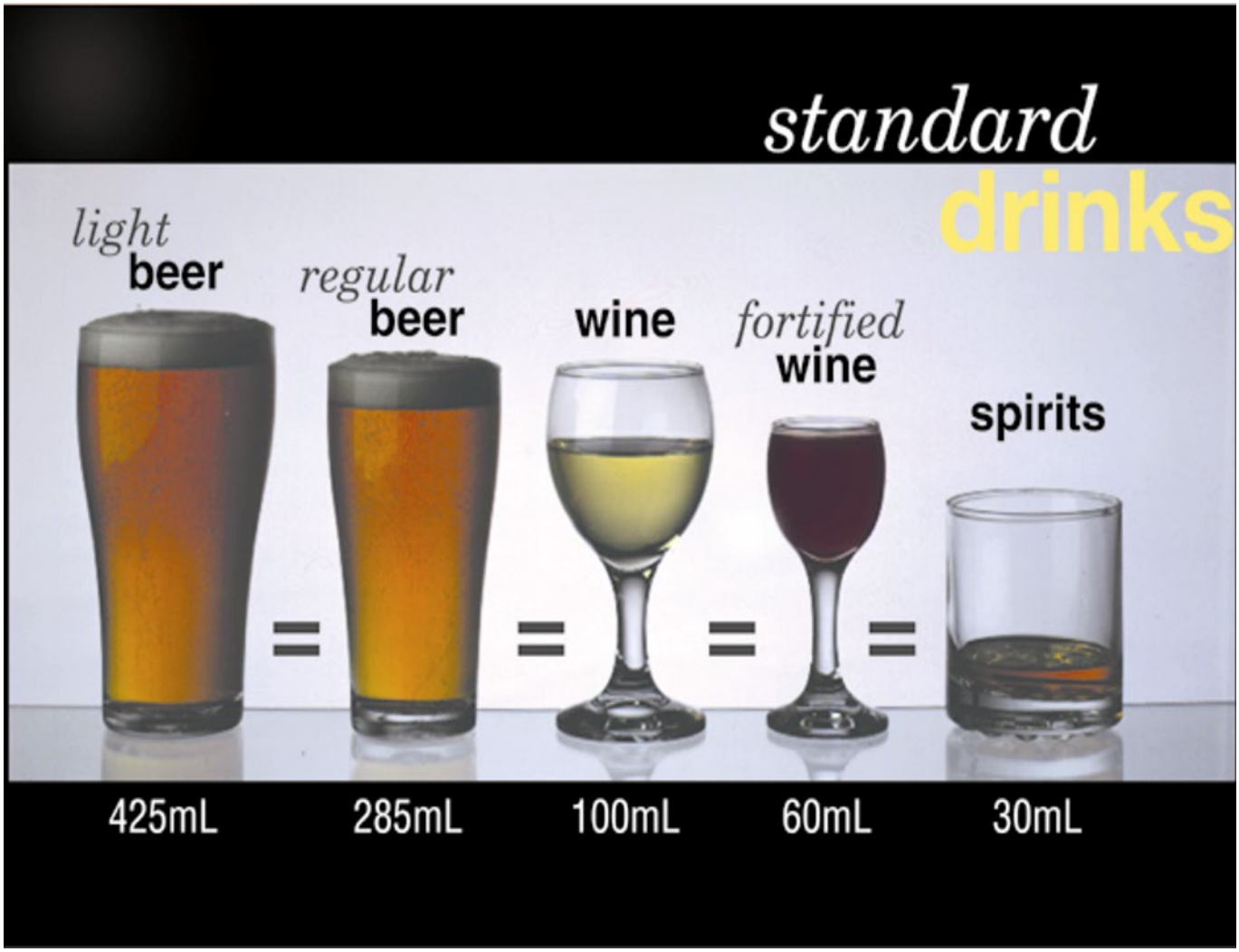
❖ It is safer not to inject

❖ **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

APPENDIX E: STANDARD DRINK CHART (AUSTRALIA)



3

GLOSSARY

Term	Definition
AOD	Alcohol and other Drugs
ATS	Amphetamine Type Stimulants – includes Amphetamine, Methamphetamine, MDMA or Ecstasy and other related substances
ASSIST	Alcohol Smoking and Substance Involvement Screening Test
BI	Brief Intervention
CBT	Cognitive Behavioural Therapy
DASSA	Drug and Alcohol Services South Australia
EPE	Elicit Provide Elicit
FRAMES	Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy
GLM	Good Lives Model
LS/CMI	Level of Service/Case Management Inventory
LSI-R	Level of Service Inventory Revised
LS/RNR	Level of Service Risk Need Responsivity
MDMA	3,4 Methylenedioxymethamphetamine – also known as Ecstasy
MI	Motivational Interviewing
OARS	Open questions; Affirming; Reflecting; Summarizing
ORNI-R	Offender Risk Needs Inventory Revised
RNR	Risk Need Responsivity
SBIRT	Screening, Brief Intervention, Referral to Treatment
TTM	Trans Theoretical Model of Behaviour Change (Stages of Change)
WHO	World Health Organisation
UNODC	United Nations Office on Drugs and Crime

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