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ASSIST with Mental Health

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) in Specialist Mental Health Settings.

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make history.

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Part 1

The Relationship between Mental Health and Substance Use Disorders

There is a complex relationship between mental health and substance use disorders. From a clinical perspective, understanding how one affects the other, will have implications for prevention and treatment.

Estimates suggest that between 30 and 50% of people with mental health disorders will experience a substance use disorder at some point in their lifetime.[1] Community surveys have consistently found an increased prevalence of alcohol and other substance use disorders among individuals with co-occuring mental health conditions - mood and anxiety disorders in particular. Higher rates of substance use disorders are reported in people who have been diagnosed with an antisocial personality disorder, bipolar disorder as well as schizophrenia.[2-4] The 2019 Australian National Drug Strategy Household Survey (NDSHS) found higher proportions of self-reported mental health disorders among people who reported using cannabis, methamphetamine, and cocaine.[5] Research has also estimated that people with a psychotic illness who drink alcohol are five times more likely to be alcohol dependent.[6] People with psychosis who use cannabis are also three times more likely to be dependent on cannabis, particularly among adolescents.[7,8] There is also evidence that people with severe mental health disorders with a comorbid substance use disorder may also experience strained relationship, stigma and victimisation in the community.[9] Individuals with comorbid mental health and substance use disorders also typically have poorer access to health services with adequately trained staff.[10]

As a result, individuals with a dual diagnosis will often experience poorer treatment outcomes compared to individuals with a single diagnosis; leading to increasing recognition of the need for clinicians capable of dealing with both disorders.[11-13]

Complex and reciprocal associations underpin these links. People who experience emotional, psychological, and physical trauma are more likely to engage in harmful patterns of alcohol and other drug use.[14,15] Sustained use of alcohol and other drugs can lead to lower mood and increased anxiety. A vicious cycle can then occur in which alcohol and other drugs are used more often and in greater amounts. Some clients of mental health services also report that they use alcohol and other drugs as a self-medicating coping strategy to manage side effects associated with medications such as anti-depressants.[16] Unfortunately, it is likely that this coping is maladaptive, making symptoms worse.

People with mental health and substance use disorders may present to the specialist mental health treatment system with complex and interacting problems.

Not everyone will experience a serious co-morbidity, and there is a wide continuum of risk and harm. But the evidence is clear. The relationship between mental health and substance use should not be ignored. It is critically important that all clients are offered screening to determine whether they have a coexisting risky pattern of substance use. Overlooking this during case formulation misses a key factor, with opportunities lost to help the person understand, accept, engage and benefit from interventions.

This manual is designed for specialist mental health clinicians, to equip you with the knowledge and skills to identify and respond to comorbid substance use disorders in an evidence-informed manner.

References

1. Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) study. *Jama*, 264(19), 2511-2518.
2. Kessler, R. C., Crum, R. M., Warner, L. A., Nelson, C. B., Schulenberg, J., & Anthony, J. C. (1997). Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. *Archives of general psychiatry, 54*(4), 313-321.
3. Sher, K. J., Trull, T. J., Bartholow, B. D., & Vieth, A. (1999). Personality and alcoholism: Issues, methods, and etiological processes. In K. E. Leonard & H. T. Blane (Eds.), *Psychological theories of drinking and alcoholism* (pp. 54–105). The Guilford Press.
4. Torgersen, S., Kringlen, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. *Archives of general psychiatry, 58*(6), 590-596.
5. Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW.
6. Petrakis, I. L., Gonzalez, G., Rosenheck, R., & Krystal, J. H. (2002). Comorbidity of alcoholism and psychiatric disorders: anoverview. *Alcohol Research & Health, 26*(2), 81.
7. Fergusson, D. M., Horwood, L. J., & Swain-Campbell, N. R. (2003). Cannabis dependence and psychotic symptoms in young people. *Psychological medicine, 33*(1), 15-21.
8. Semple, D. M., McIntosh, A. M., & Lawrie, S. M. (2005). Cannabis as a risk factor for psychosis: systematic review. *Journalof psychopharmacology, 19*(2), 187-194.
9. Hiday, V. A., Swartz, M. S., Swanson, J. W., Borum, R., & Wagner, H. R. (1999). Criminal victimization of persons with severe mental illness. *Psychiatric services, 50*(1), 62-68.
10. Stewart, S. H. (1996). Alcohol abuse in individuals exposed to trauma: a critical review. *Psychological bulletin, 120*(1), 83.
11. Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: an integrative literature review. J*ournal of substance abuse treatment, 61*, 47-59.
12. Tiet, Q. Q., & Mausbach, B. (2007). Treatments for patients with dual diagnosis: a review. *Alcoholism: Clinical and Experimental Research, 31*(4), 513-536.
13. Boden, M. T., & Moos, R. (2009). Dually diagnosed patients' responses to substance use disorder treatment. *Journal of Substance Abuse Treatment, 37*(4), 335-345.
14. Enoch, M. A. (2011). The role of early life stress as a predictor for alcohol and drug dependence. *Psychopharmacology, 214*(1), 17-31.
15. Center for Substance Abuse Treatment. (2000). Substance abuse treatment for persons with child abuse and neglect issues.
16. Bolton, J. M., Robinson, J., & Sareen, J. (2009). Self-medication of mood disorders with alcohol and drugs in the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of affective disorders, 115*(3), 367-375.

Overview of the ASSIST

What is the ASSIST?

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a screening instrument, connected to a Brief Intervention framework, that is designed to help identify and reduce risk of harm of substance use disorders. ASSIST was developed by a group of international clinical and research experts on alcohol and other drugs in collaboration with the World Health Organisation (WHO), and in response to the overwhelming public health burden associated with psychoactive substance use worldwide.[17]

ASSIST is an eight-item questionnaire designed to be administered by a clinician or health worker and takes about five minutes to complete. ASSIST screens for risky use of all main substance types (tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (ATS), sedatives, hallucinogens, inhalants, opioids and 'other drugs') and determines a risk score for each substance. ASSIST has been validated for use in a variety of settings, including community mental health.

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

The risk scores are recorded on the ASSIST Feedback Report Card which is used to give personalised feedback to clients by presenting them with their individual scores and the associated health problems related to their level of risk.

As outlined in figure 1, ASSIST scores are linked to the following risk categories and associated recommended interventions.

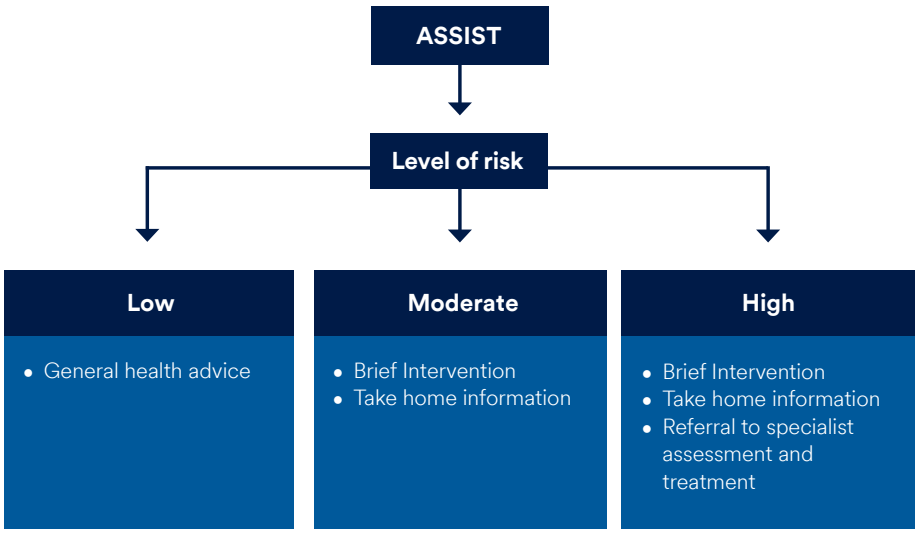


Figure 1: ASSIST flow chart

What is the ASSIST-linked Brief Intervention?

One of the features of the ASSIST, that differentiates it from other screening tools, is that it links directly to a targeted Brief Intervention. The ASSIST-linked Brief Intervention is quick, and can usually be done in under ten minutes. it is the optimal risk reduction strategy for individuals scoring 'moderate' risk on the ASSIST. 'Moderate-risk' substance use reflects a pattern of usage that may currently have started, or may soon be impacting other areas of an individual's life. Individuals who are at 'moderate-risk' are not considered dependent, and are therefore still in a position to benefit from brief psychosocial interventions. Specifically, individuals reporting 'moderate-risk' usage may have experienced health, social, legal, occupational or financial problems as a result of their substance use.

The ASSIST-linked Brief Intervention in this context is designed to help the client understand the existing and longer-term risks associated with their current pattern of substance use. This can often be a strong motivator for reducing risks, including reducing or quitting substance use altogether. Brief Interventions in general should be personalised and offered in a supportive, non-judgmental manner.

Individuals reporting 'high-risk' use on the ASSIST are also not necessarily dependent, though their current pattern of use may be approaching dependence. High-risk individuals are also able to benefit from a Brief Intervention that encourages them to accept a referral to specialised alcohol and other drug assessment and treatment. Referrals to treatment through specialist alcohol and other drug agencies are commonplace in Mental Health settings.

From that perspective, the ASSIST-linked Brief Intervention is designed to help reduce the risk of harm or dependence for moderate and high-risk individuals, and to connect those at the riskier end to appropriate levels of specialist treatment or care. ***Remember though, Brief Interventions are not intended as a standalone treatment for dependence.***

A major benefit of the ASSIST stepped-care framework is that it can help reduce the burden on specialist alcohol and other drug services, by providing you with the capacity to deal with low and moderate risk substance use, rather than referring those cases on.

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

References

17. Humeniuk, R., Ali, R., Babor, T. F., Farrell, M., Formigoni, M. L., Jittiwutikarn, J., ... & Simon, S. (2008). Validation of the alcohol, smoking and substance involvement screening test (ASSIST). *Addiction, 103*(6), 1039-1047.

The ASSIST-linked Brief Intervention in this context is designed to help the client understand the existing and longer-term risks associated with their current pattern of substance use.

Motivational Interviewing and the ASSIST-linked Brief Intervention

Individuals that access Mental Health services may have a number of comorbidities that require care.

In many cases, substance use may either be a primary driver of, or a contributing factor associated with their mental health.[18-20] Given the relationship between mental health and substance use, screening should be completed as part of case formulation for each patient at assessment and review.

One of the challenges that mental health clinicians face in the context of alcohol or other drugs is the limited consultation time with clients when compared to health professionals working in specialist alcohol and other drug services. From that perspective, many mental health clinicians face a potentially long list of priorities – and therefore addressing substance use may not be seen as being as important as other behaviours.

This chapter will demonstrate that the delivery of an effective Brief Intervention can be done quickly and easily. But as you will come to see, delivering a a Brief Intervention to reduce substance use can have a profound effect on an individual's overall mental health.

This chapter will predominantly focus on individuals with moderate-risk substance use, and will cover the practical skills and techniques necessary for the delivery of an effective Brief Intervention. This chapter assumes that you, the clinician will have adequate knowledge and experience in delivering ongoing care to their clients.

Motivational Interviewing

The Brief Intervention approach adopted throughout this manual is based on the motivational interviewing (MI) principles developed by William R. Miller and further elaborated by Miller and Stephen Rollnick.[21-23]

Motivational Interviewing is an approach to therapeutic engagement and behaviour change guided by the principle the principle that change is most likely to occur in individuals when there is sufficient intrinsic motivation to change.[21-23] This means that effective motivation to change comes from within the individual, according to their goals, wants and needs, rather than from being instructed to do so. It is important to be mindful that Motivational Interviewing is collaborative – meaning it is done *with* or *for* the client, not *to* or *on* them.

In this context, Brief Interventions should be delivered within the *Spirit of Motivational Interviewing*.[22] The spirit of MI reflects a collaborative approach between client and clinician, which is built upon an empathic understanding of the client's unique circumstances.

Accepting this position means that you, the clinician should aim to evoke responses from the client that may provide insight into current barriers to change, and reasons for ambivalence towards the need for change. Highlighting potential barriers to change will help your client to identify sources of ambivalence towards changing behaviour, and may help guide them through the journey of developing motivation to change.

Exploring and responding to reasons for ambivalence about change is one of the key features of MI. This is particularly useful when working with clients who might not see their substance use as being problematic, or contributing to their mental health, or who may be uncertain about wanting to cut-down or stop, but have not yet made the decision. Motivational Interviewing considers the fact that change can involve a natural cyclical process. Therefore MI recognizes that effective interventions should assist individuals in these so-called "pre-contemplative" or "contemplative" stages, to progress to a more concrete stage of "readiness to change".

Feedback
1. Elicit
2. Provide
3. Elicit

The following section outlines the key Motivational Interviewing skills required to deliver an effective Brief Intervention:

Feedback

Providing feedback to clients is an important part of the Brief Intervention process. How feedback is presented can have a significant impact on the way it is received by the client. In that sense, feedback should be provided in such a way that compliments what the client is ready to hear, and what they already know. The most effective feedback will be that which demonstrates an appreciation of the client's existing knowledge and interest, and respects their right to choose how to progress with the information given. A simple but effective format for providing feedback is through a three-step approach:[24]

Elicit. The first step is to elicit the client's readiness or interest for information. In other words, for example, you might ask the client what and how much they already know about the relationship between substance use and mental health, and what additional information they might be interested in knowing. Remember, the responsibility for behaviour change falls on the client; it is ultimately their decision what they do with the information you provide. To illustrate:

"Thank you for completing the questionnaire, I have your results here and I'd like to show them to you, would that be OK?"

"Can you tell me about some of the reasons you use cannabis?"

"How do you think using cannabis has affected your mental health?"

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

Provide. The next step is to provide feedback. Feedback should be presented in a neutral and non-judgmental manner. For example:

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

Elicit. The final step in the process is to elicit the client's personal interpretation of what you have said. In other words, ask the client what they think about the information and what they would like to do. Once again, this re-affirms that responsibility for behaviour change ultimately rests with the client. You can do this by asking some simple questions, for example:

"What does it mean to you to have this score for cannabis?"

"How do you feel about that?"

"What concerns you most about this?"

"Does your score surprise you or tell you anything about your substance use?"

"What do you see as your options?"

Develop discrepancy and reduce ambivalence

Motivation to cut-down or stop using substances is more likely when a client can see a tangible difference or *discrepancy* between their current substance use (and their mental health), and the way they would prefer their life to be. In almost all cases, clients will have reasons for and against continuing to use substances; many may even see it as a way to balance their mood or help them cope with depression or anxiety.

Motivational interviewing aims to explore and amplify a discrepancy between current behaviour and broader health and wellbeing goals and values from the client's point of view. Once again, this approach is most effective when the client is able to identify their own goals and values, and to express their own reasons for change.

Ambivalence refers to the contradictory feelings which clients might have about their substance use. Some clients will have positive views of their substance use, such as the way that certain drugs can elevate mood, or help to numb psychological or physical pain.[25] The same clients may also hold negative views of their substance use, such as the health risks involved or problems with everyday functioning, or the strains on relationships it creates.[25]

By only exploring the negative side, and failing to recognise the importance (to the client) of the positive appreciation for the positive side, clients can become defensive. This can have the undesired effect of amplifying the positive things and minimizing the negative. Thorough and effective exploration of discrepancy can therefore help reduce ambivalence to change.

There are four basic counselling techniques central to Motivational Interviewing that every mental health clinician will already be familiar with. Through the use of these techniques, you, the clinician, seeks to build rapport and establish a therapeutic alliance within the context of Motivational Interviewing.

So, MI encourages you to use 'open questions, affirmation, reflective listening, and summary reflections' (OARS) as soon as possible and throughout a discussion with a client. The OARS technique is summarised in Figure 2.

OARS
Open questions
Affirming
Reflecting
Summarising

Open-ended questions. Open-ended questions are those which cannot be answered by a single-word response (e.g., yes/no) and in which an answer cannot typically be anticipated. For example, open-ended questions will usually begin with how, what, who, where, when or why. By asking open-ended questions, you encourage the client to consider their substance use and explore their possible reasons for change. Open-ended questions provide opportunity for the client to lead the discussion – a good measure of whether the intervention is likely to be effective is to ask yourself "who is doing most of the talking?"

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

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

This approach is termed a *decisional balance* and encourages the client to explore the pros and cons of their use in a balanced way. Asking open-ended questions of clients also reinforces the notion that the client is responsible for the direction of the intervention and of their substance use choices. There is a very real phenomenon in which our beliefs can become solidified as we verbalise them aloud: "we believe what we think as we hear ourselves speak".

Affirming. Affirming refers to the process of providing validation of the thoughts and feelings of the client. Typically, affirmation is achieved through complimentary remarks or statements of appreciation, which demonstrate an understanding of the difficulties the choice to change poses for the client. By affirming your client's strengths, and efforts to change, you can help to build confidence that they can. Targeted affirmations of self-motivating statements (or change talk) can also encourage readiness to change. Affirmations are also useful for building rapport, and both validates and supports the client's goals and directions during the process of change. It is important to recognize that affirming is most effective when the client's strengths and efforts for change are noticed and affirmed.

Reflecting. Reflecting is the process of being able to hear and reflect back what the client has said, and what you have understood. Reflecting can involve rephrasing a statement to capture the implicit meaning and feeling of what a client has said. Reflecting encourages continual personal exploration and helps both clinician and client to fully understand the client's motivations. Reflections are therefore useful for amplifying or reinforcing the desire for change.

Part of the reflecting process involves restating both the underlying meanings and feelings that have been expressed, but also the words that the client has used. Reflecting might therefore be conceptualized as holding a mirror to your client, so that they can hear whether what they have said is actually what they intended to communicate.

Reflecting demonstrates that you understand what has been said, and if necessary, allows them to correct any misunderstandings. Reflecting can also be used to clarify what perhaps until that point, has been chaotic and confusing.

Summarising. Summarising refers to the process of briefly distilling the key points of the discussion and providing the client with the opportunity to correct any misunderstanding. Summarising is an important way of gathering together the pieces of discussion and 'checks in' with the client to ensure mutual understanding of the discussion. Summarising complements the reflecting process, particularly in relation to concerns and change talk. First, clients hear themselves verbalize something, then they hear you reflect it back to them, and then they hear it again in the summary. You can then choose what to include in the summary to help emphasize the clients identified reasons for change.

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

The following are some examples of OARS in practice for substance use in a Mental Health setting:

Eliciting change talk

As outlined by Miller and Rollnick,[22,23] eliciting change talk is a strategy for helping your client to resolve ambivalence. Eliciting change talk aims to enable them to develop and present their arguments for change. There are four main categories of change talk:

- Recognising the disadvantages of staying the same;
- Recognising the advantages of change;
- Expressing optimism about change; and,
- Expressing an intention to change.

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

"What concerns you about your cannabis use?"

"What do you think will happen to your mental health if you don't make any changes?"

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

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

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

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

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

"What are your thoughts about your substance use now?"

Important tips

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

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

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

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

Who is doing most of the talking?

Are you jumping to conclusions?

Are you judging the client or what they say?

Are you giving advice too soon?

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

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

References

18. Kingston, R. E., Marel, C., & Mills, K. L. (2017). A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia. *Drug and Alcohol Review, 36*(4), 527-539.
19. Lai, H. M. X., Cleary, M., Sitharthan, T., & Hunt, G. E. (2015). Prevalence of comorbid substance use, anxiety and mood disorders in epidemiological surveys, 1990–2014: A systematic review and meta-analysis. *Drug and alcohol dependence, 154*, 1-13.
20. Cerdá, M., Sagdeo, A., & Galea, S. (2008). Comorbid forms of psychopathology: key patterns and future research directions. *Epidemiologic reviews, 30*(1), 155-177.
21. Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing?. *Behavioural and cognitive Psychotherapy, 23*(4), 325-334.
22. Miller, W. & Rollnick, S. (2002). Motivational Interviewing, Helping People Change. 2nd ed. Guildford Press, NY. USA.
23. Miller, W. & Rollnick, S. (2012). Motivational Interviewing, Helping People Change, 3rd ed. Guildford Press, NY. USA.
24. Rollnick, S. (2008). The 'elicit–provide–elicit' framework. *The Foundation Years, 2*(4), 77-80.
25. Rooke, S. E., Hine, D. W., & Thorsteinsson, E. B. (2008). Implicit cognition and substance use: A meta-analysis. *Addictive behaviors, 33*(10), 1314-1328.

FRAMES

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

These features were summarised using the acronym FRAMES – a framework first described almost three decades ago, but still referenced today.[26] FRAMES is the acronym for Feedback; Responsibility; Advice; Menu of options; Empathy; and, Self-efficacy.

FRAMES
Feedback
Responsibility
Menu of options
Empathy
Self-efficacy

Feedback

Feedback is a critical component of any Intervention. The provision of personally relevant, or tailored feedback, will really help to ensure that the message is received. Feedback in this case therefore will include individualized information about the risks associated with the substances identified through the questionnaire. It is important to mention that, in almost all cases, clients will be open and interested in discussing their ASSIST scores and what they mean. In some cases however, there may be discord between you, the mental health clinician, and your client. In such cases discord can be responded to through specialized techniques (see Chapter 10).

For the feedback to be most effective, you should seek to identify subjectively relevant risks and harms associated with the client's current pattern and level of substance use. The key point is that what you are concerned about might not resonate with the client.

For example: for one person a hangover may be the worst experience they have ever had, for another an indicator of a great night out; for one person being charged with a drug offence could be devastating, for another perceived as a reputation enhancement among their peers; clinicians may be particularly concerned by health, for others wealth might be a prime motivator. Being able to draw attention to the link between substance and subjectively relevant harms will have a more profound effect for the individual than generalized feedback alone. For example, many individuals who use cannabis will report its calmative effects in the short term, but will begin to feel anxious and even paranoid with continued use. In such a case, the feedback provided by mental health clinicians might draw attention to individuals use of cannabis (in this example), and the strain it is having on their work and relationships due to heightened anxiety and paranoia.

The ASSIST Feedback Report Card which is completed for each client after completion of the ASSIST was designed for this purpose. The ASSIST Feedback Report Card is a useful resource that can help match the client's personal level of risk (i.e. low, moderate or high) with the most commonly experienced problems.

In summary, feedback features individualized information provided by the clinician in an objective and non-judgemental style. Much of the feedback information (i.e., risks and harms) provided in an ASSIST-linked Brief Intervention can be delivered by reading from the ASSIST Feedback Report Card. However, it is important not to assume that what may concern you as a clinician is of equal concern to the client.

Responsibility

Responsibility for behaviour change always rests with the client. A key component of working to help people, is to help them acknowledge and accept responsibility for their own behaviour and choice to use in the future. This acknowledgement and acceptance is not assigning blame or judgement. Responsibility can be encouraged through communicating with the client in terms such as:

"Are you interested in seeing how you scored on this questionnaire?", "What you do with this information I'm giving you is up to you" and, "How concerned are you by your score?" or "What concerns you about your score?"

Questions framed in this way enable the client to take ownership of their behaviour and the associated outcomes. They also help to drive the intervention. Importantly however, that responsibility does not prevent you, from sharing your wisdom or experience in the form of advice about how to reduce risk (see below).

Helping to foster a sense of responsibility and control of future behaviour has been shown to promote motivation for change and reducing ambivalence.[27] Providing feedback to your clients in ways that focus on you, and your thoughts and feelings are likely to create resistance and ambivalence towards change, and may motivate them to develop a more defensive approach to their substance use. For example, saying "I think you should...", or *"I'm concerned about your cannabis use" is clearly not as effective as "I'm not sure how you see this, but your score indicates to me that ... What do you think about this?"*

Advice

A key feature of effective Brief Intervention is the provision of clear objective advice about reducing risk of substance use. After you have outlined some of the risks and harms associated with current patterns of use, it is critical that the clinician provides practical solutions to the client to encourage the taking of next steps. Once again, advice should be presented in an objective and non-judgemental manner. In many cases, clients might be unaware that their substance use is contributing to their poor mental health – in fact it is a common belief of many clients that the use of certain drugs has a balancing effect on their mood. While this may be the case in the short term, the medium- and longer-term use of substances has an unequivocally reductive effect on their mental health. As a mental health clinician, your ability to draw attention to the links between the client's substance use and their mental (and physical) health is critical – again recognising that you do not assume that your concerns are the primary concerns of your client. Motivational Interviewing can help you to achieve this.

As mental health clinicians, you play an important part in helping your clients make connections between their substance use and their mental health. Providing clear advice about how to effectively cut down or stop substance and/or to prevent or reduce risks are important components of helping your clients to reduce their risk of future harm. Advice can also help raise your client's awareness of their personal risk, and can help them solidify their reasons for change. Advice can be summed up by delivering a simple statement such as *"the best way you can reduce your risk of (e.g. depression, anxiety) is to cut down or stop using".* Once again, the language used to deliver this message is an important feature and comments such as *"I think you should stop using cannabis"* does not comprise clear, objective advice.

Menu of options

Another important component of effective Brief Interventions is the provision of various options on how to cut down or stop their substance use. Every individual has differing circumstances and personal barriers toward change, meaning that a one-size-fits-all approach is not likely to work for everyone. Providing the client with a menu of options on how to cut down or stop their substance use, and helping them make informed choices, may help them to identify and select a strategy that they feel will be most helpful, and best suited to their personal circumstances. Providing options also encourages informed choice-making, and therefore reinforces the sense of personal control and responsibility which is crucial for effective behaviour change. A menu of options may also help to strengthen motivation for, and reduce resistance towards change, by demonstrating clear and objective solutions to perceptual barriers.

There is some evidence that helping clients choose an approach suited to them results in more commitment and perseverance to a change strategy in the face of challenges.

A useful starting point for options are the downloadable Self Help Sheets available on ASSIST plus. Directing clients to this site so that they can navigate and identify practical solutions to common problems. These sheets contain a number of strategies and tools that might help to encourage motivation to change within your client. The sheets are downloadable as individual forms, so they can be used as stand-alone works, or in conjunction with other options.

Examples of options for clients to consider include:

- Keep a diary of substance use . The ASSIST Check-up smartphone app (available on both Apple and Android devices) has a diary function which can help your client keep track of their use. Remember to encourage your client to be specific – focus on where, when, how much used, how much spent, with whom, and why;
- Identify high risk situations and develop strategies to avoid or manage them;
- Identify other purposeful activities that can replace drug use — hobbies, sports, clubs, gym, etc;
- Encourage the client to identify people who could provide support and help for the changes they want to make;
- Provide information about other self-help resources, including on-line, and written information;
- Invite the client to return for regular sessions to review their substance use;
- Provide information about other groups or health workers that specialise in alcohol and other drug issues; and,
- Put aside the money they would normally spend on substances for something else.

Empathy

Empathy is a critical part of any Brief Intervention or counselling approach. Empathy involves the ability to take an active interest, and expending genuine cognitive effort in attempting to understand another person's internal perceptive; to see the world through their eyes. It has been suggested that empathy is the ability to listen to a client, to understand what is being said and communicating that understanding, allowing the client to correct or amplify what they have been communicating.[28] Empathy is distinct from sympathy – which is a feeling of pity, camaraderie or identification with another person; feeling sorry for them. The focus of an empathic approach is being able to sit with the client, and understand and appreciate their perspectives. Statements such as *'I've been there and know what you are experiencing, let me tell you my story'* are not useful because they focus on you.

In fact, the opposite of an empathic approach is to insert your own perspective, perhaps under the false assumption that the client's views are irrelevant or misguided. Doing so demonstrates that you are not listening or understanding or appreciating their perspective. This is likely to create a barrier between you and the client – something which may discourage their motivation to change. 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 involves the ability to understand another's frame of reference and the conviction that it is worthwhile to do so.

Empathy comprises of an accepting, non-judgemental approach that seeks to understand and appreciate the client's viewpoint. Clearly, empathic approaches avoid labelling clients as "drug-user" or "addict". If a client uses such terms, don't simply accept what that means – ask the client what that means for them (e.g. "Can you help me understand what does it mean for you when you refer to yourself as an 'addict'?" This will help you avoid making assumptions). Empathy in practice should also avoid blaming the client for their situation. The adoption of a position of *'curious intrigue'* might be helpful.

Empathy also involves reflective listening – which is the capacity to hear, make sense of, and then reflect back to the client. Doing so demonstrates an ability and willingness to understand and appreciate the client's point of view and situation. Skilful reflective listening which clarifies and amplifies the person's experience and meaning is a fundamental part of expressing empathy. The empathy of the health professional is an important contributor to building a therapeutic alliance and to how well the client responds to the intervention.

Self-efficacy

The final component of effective Brief Interventions is to promote self-efficacy. Self-efficacy can be described as the individual's confidence and belief in their own ability to make effective behaviour change. Self-efficacy differs from the more general concept of confidence in that it relates less to a broad characteristic ("I'm a confident person"); self-efficacy relates to the confidence to implement a more specific strategy in specific circumstances (e.g. "I am confident I can say 'no' to my friends in the pub tonight"; I am confident I can speak to my friend about how they can help me stop"). There is evidence that self-efficacy can result in a person being more likely to try a strategy and more likely to persevere in the face of challenges.

According to Bandura, the most effective way to promote self-efficacy is through performance mastery, in other words, the experience of successfully overcoming challenging situations where success is attributed to personal capability.[29] Such experiences can provide tangible evidence to the client that they have the capacity to successfully overcome difficult situations. But self-efficacy can also be built in other ways, including through the imagination of success (cognitive or role play rehearsal); the experience of success under similar circumstances; or witnessing the success of others.[29] Clients who believe and are confident that they can successfully modify their substance use behaviour, to cut down or stop using, are more likely to do so. They are also more likely to persist during periods of turbulence, or challenges.

Those individuals that have low self-efficacy are more likely to feel a sense of powerlessness to in such circumstances, and reversion back to more problematic substance use may occur, especially in the face of challenges to any decision.

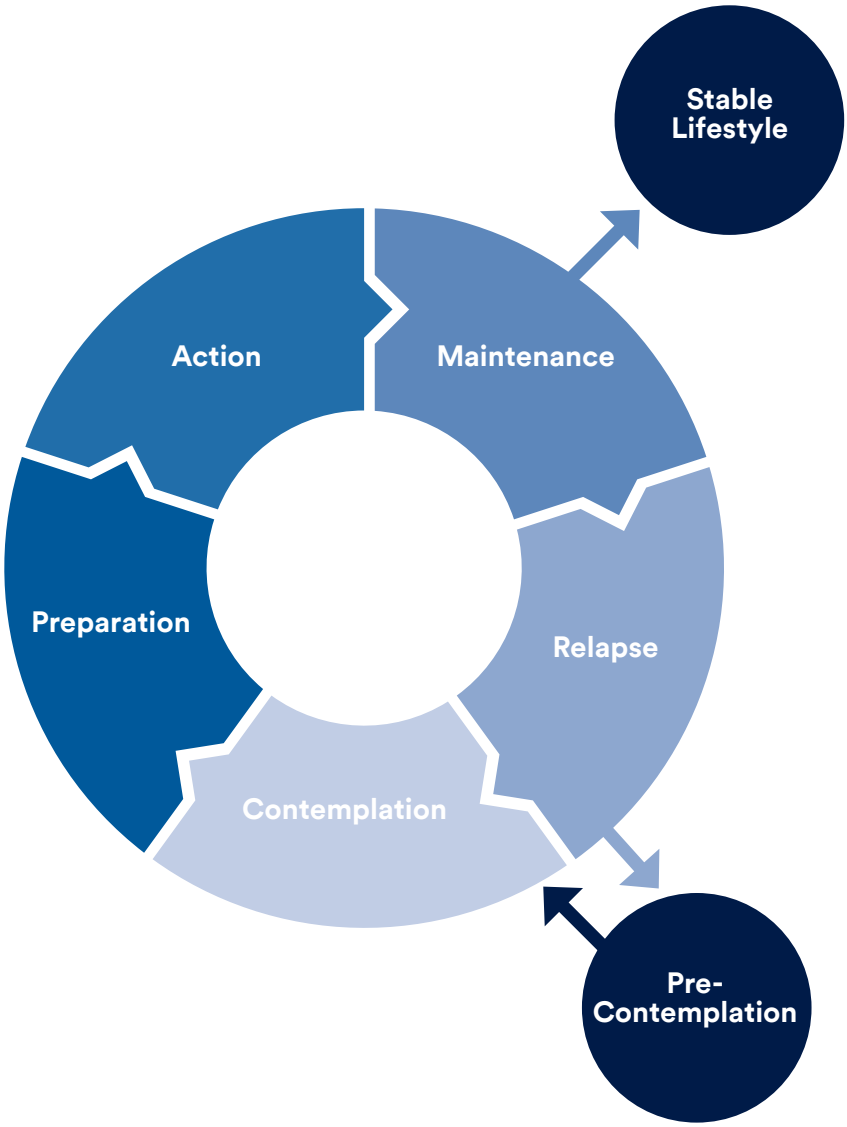
According to Bandura, there are also other ways to promote self-efficacy, through verbal and social persuasion (e.g., being told success is possible).[29] Clinically therefore, one way to encourage self-efficacy might be through the elicitation of self-efficacious (or can-do) statements from the client. In other words, as mentioned previously, getting your client to verbalise a situation in which they were successful in changing their behaviour, may increase their belief in their ability to do so again in the future.

References

26. Miller, W. R., & Sanchez, V. C. (1994). Motivating young adults for treatment and lifestyle change.
27. Miller, W. & Rollnick, S. (2002). Motivational Interviewing, Helping People Change. 2nd ed. Guildford Press, NY. USA.
28. Egan, G. (1990). The skilled helper: *A systematic approach to effective helping.* Thomson Brooks/Cole Publishing Co.
29. Bandura, A., Freeman, W. H., & Lightsey, R. (1999). Self-efficacy: The exercise of control.

Theoretical models 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.[30]



The Trans-theoretical model of change suggests that change is an ongoing, dynamic process; people cycle through different states, or stages of change depending on their readiness and motivation. This is true for all individuals, regardless of what behaviour they are in the process of changing. While the model is useful in conceptualizing the process of change, one should take care to avoid simple categorisation of clients. Also, one should be mindful that there is some contention in the research about the predictive value of the model and some authors have critiqued the idea of the stages being stable and discrete. Regardless, a key aspect of the model in the ASSIST-linked Brief Intervention is to remind us that, whilst we might be tempted to leap into action strategies, we might need to spend more time on thinking through "why" there is a need for change, and planning to act. The aim of the ASSIST-linked Brief Intervention is to support people to move through one or more stages of change, for example, 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 an important step that sets the foundation for progress through future stages.

It is worth noting that there is no set amount of time that a person will spend in each stage (it may be minutes, months or years) and that people may cycle back and forth between stages. Some clients may move directly from pre-contemplation to action following an ASSIST-linked Brief Intervention. The following provides a brief description of the underlying behavioural and cognitive processes of each stage.

Pre-contemplation

- Many individuals encountered in mental health settings, who score in the moderate-risk range on the ASSIST, are likely to be in the **pre-contemplation** stage. When an individual is in a stage of pre-contemplation, they are not necessarily thinking about cutting down or stopping their substance use. Common characteristics of this stage include:
- Being focused on the positive aspects of their substance use;
- Unlikely to have any concerns, or important concerns, about their use of psychoactive substances;
- May show resistance to talking about their substance use;
- Unlikely to know, have noticed or accept that their substance use is risky or problematic;
- Unlikely to recognize the link between their substance use and their mental health, and/or;
- Unlikely to respond to direct advice to change their behaviour but may be receptive to information about the risks associated with their level and pattern of substance use.

Motivational Interviewing can help a person in the pre-contemplation stage to recognize that substance use might be impacting their mental (and physical) health, and begin to lay the foundations for thinking about the need to change (contemplation).

Contemplation

Some people seen in mental health settings who score positive on the ASSIST may be in this stage. Individuals in a stage of **contemplation** are likely to have thought about cutting down or stopping substance use, but are still using. Common characteristics of this stage include:

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

Motivational Interviewing can help a person in the contemplation stage to begin to prepare themselves mentally, physically and emotionally for cutting-down or stopping.

A proportion of people in the contemplation stage may be thinking about change but they may not know how to make a change and/or may not be confident that they are able to change.

A proportion of people may be thinking about change, but may not know how, or may not think they are able to. An effective Brief Intervention during this stage, with personalised feedback and information, can help tip the balance for positive change.

Preparation

Generally, once and individual has decided they are ready to make a change, they enter a stage of **preparation**. Preparation involves planning to take action in the near future and making the final preparations before behaviour change begins. Clients in a stage of preparation are committed to action and ready to change but may still have some level of ambivalence. People in the preparation stage are:

- Intending to take action;
- Possibly vocalising their intentions to others;
- Making small changes in their substance use behaviour;
- Re-evaluating their current behaviour and considering what advantages might come from a change;
-
- Becoming more confident and more ready to change their behaviour;
- Considering the options available to them; and/or
- Setting dates and determining strategies to assist change.

Motivational Interviewing can help a person in the preparation stage begin to recognise that they are ready, and to finally commit to cutting-down or stopping.

Action

Once individuals have made appropriate and necessary preparations for change, they may enter a stage of **action**. Some individuals encountered in mental health settings will be in the action stage. People in the action stage:

- Have made the decision that their use of substances needs to change;
- Have commenced cutting down or stopping or reducing risks or have already done so;
- Are actively doing something about changing their behaviour;
- Might initially engage in avoidance of high-risk situations, but later develop other coping strategies and the confidence to implement these; and/or,
- Might continue to feel somewhat ambivalent about their substance use and need encouragement and support to maintain their decision.

Motivational Interviewing for a person in the action phase might focus on drawing attention to their strengths, and re-affirming the reasons they decided to change in the first place.

Maintenance

In order to achieve a goal of longer-term abstinence or controlled use, individuals necessarily will enter a stage of **maintenance**. Provided the individual does not relapse, the maintenance stage is the final step in the process of successful behaviour change. People in the maintenance stage are:

- Attempting to maintain the behaviour changes that have been made;
- Working to prevent relapse (the risk of relapse decreases with time and with success experiences in previously challenging circumstances);
- Focusing attention on high-risk situations and the strategies for managing these; and/or
- More likely to maintain change if they received support and affirmation and if the quality of their life improves – in short if the effort is worth it.

Relapse

The process of behaviour change is challenging for everyone. Like anyone who tries to change any behaviour, most people who try to make changes in their substance use will face challenges and might have a lapse, or relapse back to harmful patterns of use, at least for a time.[31] Understanding that this is normal, and expected, will make things easier for the client in the event that it does happen. Therefore, it is often useful to prepare for a lapse ahead of time, so that it does not become a relapse back to a previous pattern of use.This might be achieved by developing a "relapse drill" specifically tailored for the individual client– what to do in the event of a lapse or relapse. Such experiences should be re-framed as a learning process rather than failure. **Very few people are successful in changing behaviour on their first attempt;** it commonly takes around six attempts to quit smoking.[32] The relapse stage is an important time to help clients review their action plan.

A review should examine timeframes, what strategies did actually work and whether the strategies used were realistic. Cannabis users may make a number of attempts to stop before they are successful. For many people, changing their substance use gets easier each time they try until they are eventually successful. A re-frame might include: why did the lapse occur; why was the client successful for so long – what worked well; what challenges occurred and why did the lapse occur; why might they still want to change: and, what can be learned from this experience going forward.

In summary, the Trans-theoretical model of behaviour change can be used to map interventions to a person's readiness to take in information and change their substance use. While a client's stage of change is not formally measured, or assessed during the ASSIST-linked Brief Intervention, it is important that health professionals understand these underlying processes to provide the most appropriate care for their clients.

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

References

30. Prochaska, J., & DiClemente, C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. Journal of Consulting and Clinical Psychology, 51(3), 390-395.

31. Moos, R. H., & Moos, B. S. (2006). Rates and predictors of relapse after natural and treated remission from alcohol use disorders. *Addiction, 101*(2), 212-222.

32. Chaiton, M., Diemert, L., Cohen, J. E., Bondy, S. J., Selby, P., Philipneri, A., & Schwartz, R. (2016). Estimating the number of quit attempts it takes to quit smoking successfully in a longitudinal cohort of smokers. *BMJ open, 6*(6), e011045.

It is often useful to prepare for a lapse before it happens, so that lapse does not become relapse. This might be achieved by developing a "relapse drill" specifically tailored for the individual client– what to do in the event of a lapse or relapse.

Putting it all together

The following outlines a step-by-step approach to the ASSIST-linked Brief Intervention.

Moderate-risk clients

Cutting down, or stopping substance use is likely to be challenging for anyone. Attempting to change multiple behaviours concurrently can be especially difficult, and may lead to the client feeling overwhelmed and discouraged. In addition, individuals with co-morbid mental health issues will present a greater challenge, given their mental health is likely both exacerbating, and being exacerbated by their substance use. Accordingly, a targeted Brief Intervention which focuses on managing one substance – the most immediate and problematic – at a time, can be advantageous. For example, this could mean dealing with the substance with the highest-risk score on the ASSIST, and/or a drug that the client administers through injection.

The approach to delivering the ASSIST-linked Brief Intervention can be summarized in 10-steps. This 10-step approach was designed to provide a structured framework that will help build confidence of mental health clinicians who may not be trained in motivational interviewing or in regularly dealing with substance use. The approach that follows also provides a useful framework for more experienced mental health and specialist alcohol and other drug workers and can be expanded and explored further for longer or recurrent sessions, or to address multiple substance use.

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

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

"I'd like to show you how you scored on the questionnaire you just completed, would that be OK?"

This question is your entrance into delivering a Brief Intervention. Phrased in this way, the question offers the client a choice to engage, thereby promoting a sense of responsibility and autonomy, which will help to reduce early resistance. An affirmative response from the client gives you permission to provide personally relevant feedback and information to the client about their scores and associated risk, and how the client can best reduce risk. **It is worth noting, in general, the majority of clients are interested in seeing and understanding their scores.** There may be some that are resistant, and therefore tips to managing early resistance is covered in subsequent chapters.

With respect to the ASSIST, the individual's scores should be recorded in the box provided on the front of the ASSIST Feedback Report Card. For clinicians administering the questionnaire online –the scores and ASSIST Feedback Report Card will be automatically calculated. On the pages following the summary scores, 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 can be copied and used for the Brief Intervention. Some people find that using the on-line version – eASSIST - is a useful way of conducting the screening. Go to https://eassist.assistportal.com.au/#/e-assist

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

The ASSIST Feedback Report Card is used during the Brief Intervention to help you to provide targeted feedback to clients. The card should also be given to the client at the end of the session as a take-home reminder of the information discussed. The ASSIST Feedback Report Card also serves as a tangible reference point for both you and your client to focus on during the course of the intervention.

Mental Health clinicians can provide personally relevant feedback in an objective way to clients by reading from the ASSIST Feedback Report Card. The card should be held in such a way that both you and the client are able to read the information. This will encourage a collaborative approach between you, which will help to reinforce the message, and lower the likelihood of any potential resistance.

The provision of tailored feedback should occur in two parts: discussing the client's scores and level of risk; and then outlining what those risks and harms mean for them and their mental and physical health. In order to provide score and risk summaries, you should use the ASSIST Feedback Report Card. The summary scores for each substance and corresponding level of risk are displayed on the front page of the ASSIST Feedback Report Card. The clinician should then step the client through the score, and their level of risk for each of the substances indicated. It is important to engage the client in a discussion about what their levels of risk represent. For reference, you might choose to read the definitions in the box at the bottom of the ASSIST Feedback Report Card to the client. An example of feedback might be:

"These are all the substances I asked you about and these are your scores for each of the substances (point to scores). As you can see you scored low-risk for most of the substances. Your score for cannabis was 16 which places you in the moderate-risk range. Moderate-risk means that you are at risk of health and other problems from your current pattern of substance use, not only now but also in the future if you keep using in the same way."

Once the client has indicated their interest in hearing more about their specific risks and harms of their current patterns of use, the clinician can commence the second part of feedback provision. The second part focuses on communicating the risks associated with each substance indicated, starting with the highest scoring substance (or substances). Information pertaining to the specific risks and harms associated with each substance or class of substances can be found in the ASSIST Feedback Report Card on the pages following the summary score page. The ASSIST Feedback Report Card contains a series of nine columns (tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, inhalants, sedatives, hallucinogens, opioids). Each box lists the harms for each substance ranging from less severe at the top (shaded light orange) down to more severe at the bottom (shaded darker red). Feedback should comprise of the verbalisation of these risks to the client as written, with further explanation if required. Once again, the card should be held so it can be viewed easily by the client, but still be able to be read by the interviewer. An example of personalised feedback around a moderate risk score for cannabis is:

"Because you're in the moderate-risk range for your use of cannabis, the kinds of things associated with your current pattern of use are possibly problems with attention and motivation, increased anxiety, paranoia, panic, or depression; decreased memory and problem-solving ability; Asthma, bronchitis ... I wonder what you think of these possible risks and if you have noticed anything along these lines?"

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

Advice about how to reduce risk is simply a process of helping the client to connect the dots between reducing their drug use and reducing their risks and harms. Clients may be unaware of the relationship between their substance use and their existing or potential problems, and in many cases, some individuals may be conditioned to believe that their drug use helps them cope with aversive states, or balances their mood.

The advice is therefore designed to highlight to clients that cutting down or stopping their substance use will reduce the risk of problems, both now and in the future. An example of providing advice to clients is to say:

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

Expressing advice objectively provides the client with accurate information to help them make their own decision in a neutral yet supportive environment. Remember, advice is not about telling your client what to do, rather it is about being clear with them that reducing or stopping substance use is the best way to reduce risk of harm.

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

Responsibility is a key feature of motivational interviewing in general, and in the approach to delivering the ASSIST-linked Brief Intervention. As outlined previously, maintaining a sense of personal responsibility and control over ones' actions is an important motivating factor to achieving lasting behaviour change. The mental health clinician should constantly try to re-iterate to the client that they are responsible for their decisions and behaviours around substance use, both now and in the future. This is especially important after feedback has been provided. For example, you might say to the client:

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

Framed in this way, the client is encouraged to take responsibility for their future substance use, but it also reinforces the connection between substance use and risk established in Step 3.

STEP 5. Ask clients what concerns them about their scores

The next step involves the clinician establishing the degree to which the clients' scores and associated level of risk concern them. This involves asking an open-ended question about their substance use, which is designed to encourage the client to express or verbalise any concerns that they may have about their substance use, but which they may or may not have thought about, or expressed verbally up until that point. Open-ended questions can be powerful if used correctly during a Brief Intervention, such as getting the client to verbalise for the first time their concerns about their substance use. There is evidence to suggest that changes in beliefs and behaviour are stronger in individuals who have expressed those concerns in a supporting and non-judgemental environment.

Clinicians should turn the ASSIST Feedback Report Card back to the front page so that the client can see their scores again, and say something like:

"What concerns you about your score for cannabis?"

Asking the question in this way also allows you, the clinician to gauge the degree of concern that the individual has, and can help establish their position along the stage of change continuum.

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

The next step in the ASSIST-linked Brief Intervention is to encourage the client to discuss the factors of their substance use which they like and dislike. Clients who can express both the good and *less good* things about their substance use are then able to acknowledge that there is a balance between the positives and negatives of substance use. In some situations, it is advisable to use the term *less good* instead of *bad* because it can be seen as less of a value-laden label, but of course you may need to adapt this to the particular client in front of you. This approach is another powerful tool of motivational interviewing, called *developing discrepancy* in which the client may begin to see how their current pattern of substance use is preventing them from taking part in, or achieving some of the things that they would like to do or achieve. Once again, this may be the first time that the client has actively thought about, or expressed verbally, the pros and cons about their behaviour – a crucial first step in any behaviour change. One of the other reasons why the clinician will ask the client about the good things about their substance use is that it takes into account the reality of the client's situation. Many individuals take various substances for a variety of reasons – and purposeful substance use is common. The client may be taking certain substances for functional reasons, and by only focusing on the negatives, you risk creating a barrier between themselves and the client. One of the best ways to encourage clients to evaluate their substance use is through the use of two open-ended questions, explaining why you are doing this, such as saying:

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

And then ask:

"So what are the good things for you about using cannabis?"

Once the client has finished discussing the things they enjoy, you should then summarize what was said to demonstrate empathy and understanding. You should then ask about the less good things. You might say something such as:

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

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

- Health — physical and mental;
- Social — relationships with partner, family, friends, work colleagues;

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

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

Once the client has begun to articulate some of the positive and negative features of their substance use, the next step is to summarise and reflect back to the client while emphasising the less good things. Summarising and reflecting involves digesting and interpreting what the client has said about the good and less good things, and then re-emphasizing the reasons that may encourage their motivation to change. Doing so in this way demonstrates to the client that they have been listened to, and understood. Clients who feel as though they have been listened to and understood are more likely to be receptive to advice about ways to reduce their risk of harm.

Reflections and summaries also provide an opportunity to actively highlight a client's cognitive conflicts (discrepancy) and to emphasize the less good aspects of their substance use, leaving the client with the knowledge and awareness that their substance use is material to their current conflict. An example of reflecting back the good and less good things of a client's substance use, with final emphasis on the less good things is:

"So, you said you like using cannabis because it helps you relax... but you do not like feeling unmotivated and the impacts it is having on your work and relationships, including fighting with your partner. And sometimes it makes you feel really agitated"

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

The penultimate step in the ASSIST-linked Brief Intervention is to encourage the clients to discuss their level of concern by the negative aspects of their substance use. The aim of this step is to encourage those individuals who may be in a stage of pre-contemplation or contemplation to begin to take the next steps. This is achieved by asking another open-ended question, similar to the question asked in Step 5 regarding concern about the ASSIST score. While it is similar to a previous question however, this question is designed to strengthen motivation to change, and to provide a platform for health workers to take the Brief Intervention further if time is available. The question in this stage might be phrased as:

"What concerns you about the less good things? How do these feel about these concerns?"

Or,

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

STEP 10. Give clients take-home materials to bolster the Brief Intervention

The final stage of the 10-step Brief Intervention is to provide the client with information to take home. Take home information is a vital part of sustained behaviour change, because it will prevent the client from forgetting about what was discussed during the session once they leave. At this stage, the client should be given a copy of their ASSIST Feedback Report Card and any other written information. Written information can strengthen and consolidate the effects of the Brief Intervention if they are read by the client. They also can serve as a secondary outreach if read by friends and family of the client, who also may be using substances.

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

- Client's ASSIST Feedback Report Card;
- General information pamphlets on the substance(s) being used by the client (obtained from the relevant agency in you state or territory);
- Self-help strategies for cutting down or stopping substance use. A full suite of downloadable PDF sheets can be found on the ASSIST Plus site
- Risks of Injecting Card (if relevant) from the ASSIST Portal

The ASSIST Feedback Report Card helps to remind the client of their scores and the risks associated with their primary substance use that has been the focus of the Brief Intervention. The card also contains information on the risks associated with the use of other substances that may not have been directly addressed during the course of the Brief Intervention but which may be being used by the client.

The Self-Help Strategies are downloadable single or double-page resources that can be used to quickly convey practical information about cutting down or stopping substance use. The cards cover a number of topics, including how to identify and manage high-risk situations, how to be assertive, and how to cope with stress. The sheets can be printed off and given to the client.

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

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

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

Low-risk clients

Clients scoring in the low-risk range do not need any structured intervention to change their substance use, and treatment can continue as usual. It is good practice to reinforce to them that their current pattern of use (or abstinence) is responsible and encourage them to continue their current low-risk substance use patterns. If time permits provision of general information about alcohol and other drugs to low-risk users may be appropriate for several reasons:

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

What to do with 'high-risk' and injecting clients

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

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

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

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

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

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

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

Clients should be made aware that injecting drugs is associated with an increased likelihood of dependence, overdose (particularly if injecting opioids), psychosis (particularly if injecting stimulants), local and systemic infections, abscesses and ulcers, collapsed veins and communicable diseases such as Hepatitis B/C and HIV. Clients who choose to continue to inject should be informed of appropriate harm reduction strategies. These may include:

- not sharing injecting equipment and drug paraphernalia;
- hygiene around injecting;
- avoiding mixing drugs, especially alcohol and sedatives;
- avoid using alone;
- ensuring friends and/or family have attended first-aid and resuscitation training (offered in most jurisdictions);
- having a small amount to start with to check the potency of the substance being used; and,
- being informed of where they can access clean injecting equipment (or how to clean existing equipment if unavailable) and how to safely dispose of their used injecting equipment;
- make client aware of the first aid for opioid overdose: DRSABC + Naloxone.

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

How to provide an effective referral

When referring a high-risk client to a specialist Alcohol and Other Drug service for assessment and treatment, there are also some things to consider. Coordinated care approaches involve the delivery of services across multiple sectors which is perceived as a seamless by the clients. Some things you can do as a clinician to make the referral process more seamless include:

- Having information about specialist services ready and on-hand for the client;

- Make sure you are familiar with the referral process. This can include having referral template letters ready to go;
- Consider making an active referral – that is, by contacting the service while the client is with you and facilitating the referral process, with the client's permission. This is the recommended approach when making a referral for comorbid substance use and mental health disorders;[33-35] and,
- Recognizing and addressing the practical barriers that stand in the way of effective coordinated care between services. These might include structural barriers (e.g., lack of available services nearby) or barriers to communication (e.g., staff turnover making inter-service collaboration difficult).

For more information about providing effective coordinated care, visit the Comorbidity Guidelines website, developed by the Matilda Centre in collaboration with the University of Sydney.

References

33. Clemens, S., Cvetkovski, S., & Tyssen, E. (2006). DirectLine Telephone Counselling and Referral Service: what role does it play in the treatment pathway and referral uptake of substance users. Victoria: Turning Point Alcohol and Drug Centre.
34. Saitz, R. (2013). Addressing unhealthy alcohol use in primary care. Springer New York.
35. Rastegar, D. A. (2013). Making effective referrals to specialty care. Addressing unhealthy alcohol use in primary care, 63-71.

There are other treatment options available depending on availability in the client's country or culture. In addition, there may be underlying reasons associated with a client's substance use that may need to be addressed.

Managing 'resistance'

Client resistance is sometimes perceived when the wants and needs of the client do not align with what the mental health clinician would prefer to happen.

This is at odds with current principles of recovery-oriented mental health practice, which has an emphasis on self-defined recovery goals and respecting and empowering people to make their own choices about how they want to lead their lives and what and how to make any changes.

The concept of 'resistance' lends itself to unhelpful, inaccurate tropes such as that people with substance use issues lack insight and will tell lies about their substance use. In fact, the opposite is true – most people have a well-developed awareness of any costs and harms associated with their substance use -although they may choose not to want to discuss this, may avoid thinking or talking about the risks, or may simply have a perception of risk that does not align with a clinician's perception of risk.

Many people will relish the opportunity to have a reflective discussion about their substance use choices if they perceive a non-judgemental environment in which they will not be coerced into making any changes that they are not yet ready to make, or where they perceive being frank will not result in adverse outcomes. Miller and Rollnick, on reflecting on this issue, suggest leaving aside the concept of resistance and focusing instead on *change and sustain talk and discord*.[36]

Change talk is any self-expressed language that argues for change while sustain talk is the opposite – any language that argue for the status quo. Change and sustain talk are natural expressions of an individual's ambivalence about a potential change – the balance of change and sustain talk is predictive of change and is influenced by the interviewer. Expressing sustain talk is an expected part of any change process and should not be taken as an indication that the person is at a stage of pre-contemplation- rather as a prompt to explore further and attempt to evoke the individual's change talk.

Strategies to evoke more and stronger change talk include:

- Asking evocative questions such as;
  - How would you like the future to look?
  - If you did decide to change how would you go about it?
  - What are your reasons for wanting to change?
- Using a scaling question;
  - *How important is this change to you, on a scale of 1 to 10, where 1 is not at all important and 10 is the most important thing right now?*
  - N.B. A follow up question of: *Can you tell me why you are* (number they nominated) *and not a* (lower number)? will usually evoke more change talk

Discord refers to any disharmony or dissonance in your relationship. While sustain talk is about the target behaviour discord is about the clinician-client relationship.

Signs of discord include:

- a person feeling they have to defend themselves - perhaps blaming others or minimising or justifying behaviours;
- displaying an oppositional stance around your relationship or qualities;
- interrupting; and,
- disengaging.

Responding constructively to both sustain talk and discord are critical skills for mental health workers in assisting people with change processes. Strategies to respond to sustain talk and discord include:

- Reflecting the client's concerns will tend to prompt the client to balance the sustain talk with their change talk;
- Emphasising and honouring the client's autonomy- *'what you choose to do is up to yourself'. 'You will work out your own best way to deal with this'*; and,
- Reframing – offering an alternative way to see the issue.

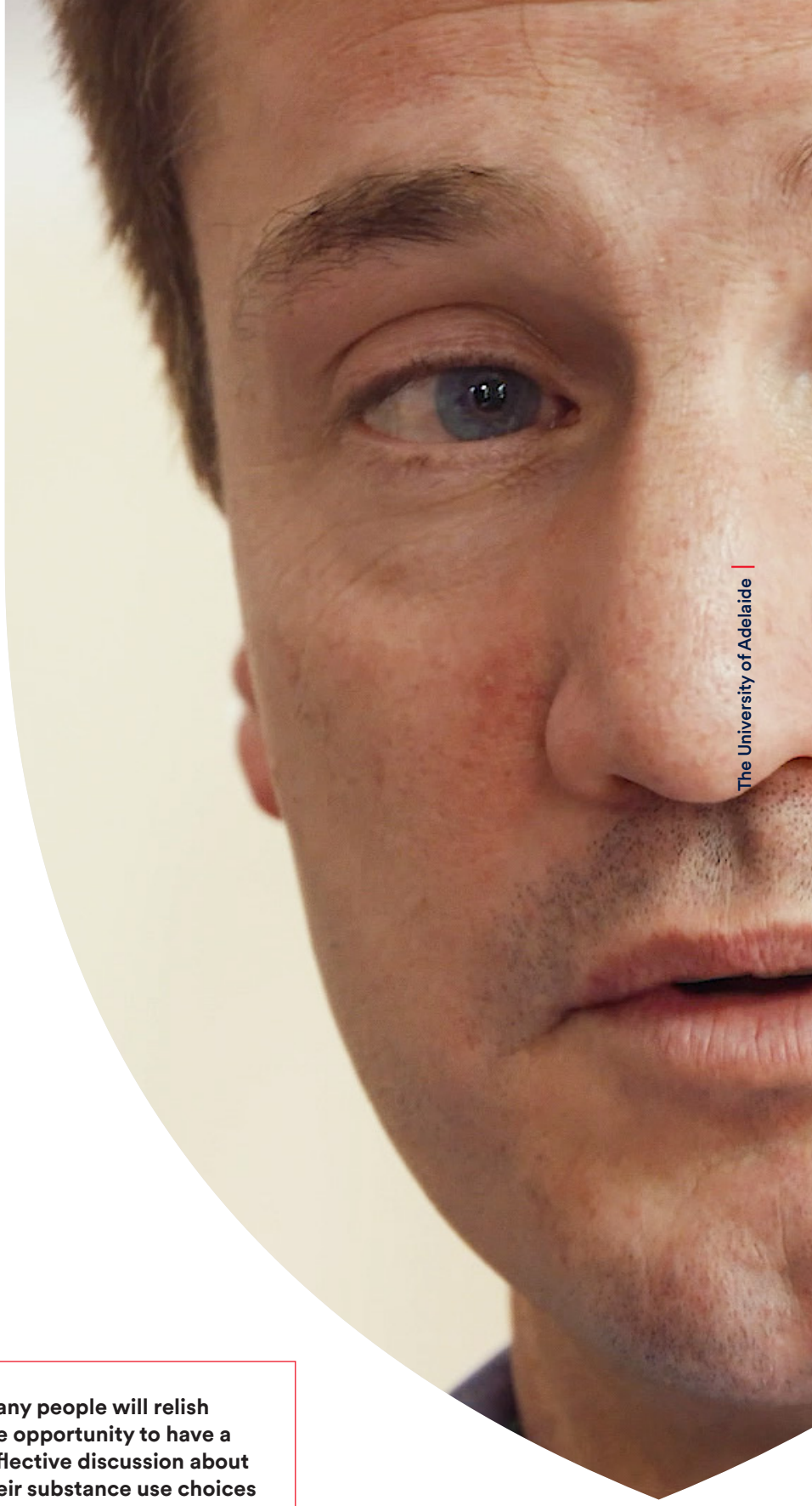
Discord may also be effectively responded to with an apology or a genuine affirmation or by shifting the focus to a less contentious area.

Summary - Practice suggestions

- When a client makes "pre-contemplative statements" about their substance use the most useful response is to remain confident that the person does in fact have concerns - even if they would prefer not to be overt about them initially – and to gently explore to see if you can evoke those concerns.
- Change and sustain talk reflect a person's ambivalence about a potential change. The more and stronger change talk that can be evoked the more likely a person is to attempt and to succeed in making a change.
- Sustain talk is about a person's behaviour while discord is about the client-provider relationship. Both need to be skilfully responded to for change to occur. Useful strategies include reflecting the person's concerns, emphasising client autonomy and reframing the issues.

References

36. Miller, W. & Rollnick, S. (2002). Motivational Interviewing, Helping People Change. 2nd ed. Guildford Press, NY. USA.



Many people will relish the opportunity to have a reflective discussion about their substance use choices if they perceive a non-judgemental environment in which they will not be coerced into making any changes that they are not yet ready to make.

Implementation of ASSIST in mental health settings

Now that you are familiar with the screening and Brief Intervention process, the next step is to learn how ASSIST can be used in Mental Health settings.

This chapter will guide you in the adaptation and adoption of ASSIST for screening and Brief Intervention in mental health settings.

However, there are several important factors to consider.

- Why are screening and Brief Intervention particularly important in Mental Health Settings?
- What is the current practice of assessing alcohol and other drug use in Mental Health Settings?
- How might the ASSIST be included in routine clinical assessment?
- Who is best placed to administer the ASSIST in your service?
- When should the ASSIST be administered?
- How does one go about learning to use ASSIST and provide the linked Brief Intervention?
- In cases of high-risk substance use, what are your referral options?

Let's consider each of these points in turn.

'Why is screening and Brief Intervention particularly important in Mental Health settings?'

There is significant overlap between substance use and serious mental health disorders. People regularly use substances to help them cope in response to physical or psychological trauma (e.g., self-medication or escape). Or in other cases, substance use might also lead to mental health issues (e.g., drug-induced psychosis). Sometimes they are unrelated but simply coincide.

Critically, risky substance use can also interfere with the effectiveness of treatment for their mental health condition. Therefore, it is vital to identify, and respond to problematic substance use in people with mental health issues, in any setting. Identifying risk of substance-related harm, followed by a targeted Brief Intervention can be an important catalyst in raising awareness and informing subsequent treatment.

One of the main sources of apprehension from clinicians is the time needed to administer the ASSIST and Brief Intervention. However, it should be emphasized that the ASSIST can be conducted at any stage during the process of inpatient admission, or contact with the mental health community team. Ideally, the ASSIST should be completed as close to first contact as possible; evidence consistently shows that earlier problem identification and intervention is likely to have better long-term outcomes for the individual. However, this may not always feasible, for example if the individual is unable to undergo screening due to the severity of their acute illness. In such cases, waiting until the individual is stable and able to adequately recall substance use behaviours from memory is necessary.

'What is considered current practice in Mental Health Settings?'

Currently, a typical comprehensive mental health assessment may already include some basic questions about alcohol and other drug use. But while this may help to identify general problems, this approach is not designed to assess severity of an individual's risk, nor does it necessarily provide direction for an appropriate intervention. You might consider adding the ASSIST to the comprehensive assessment.

'How might the ASSIST be included in routine clinical assessment?'

The ASSIST has been successfully adapted for a number of purposes and for use in several clinical settings. For example, the ASSIST can be self-completed in electronic form (e.g., on a PC, smartphone or tablet). This means the ASSIST can be completed reliably by anyone, anywhere, anytime, such as in the waiting room.

There are also other opportunities for the ASSIST and Brief Intervention to be conducted in Mental Health settings. Examples include:

1. Community case reviews.

A large Australian Mental Health Service has installed the ASSIST Checkup App on the clinical phones of the community mental health teams. This provides opportunities for case managers to undertake an ASSIST and Brief Intervention with a client, at a suitable time. The results can then be emailed to the case manager (and consumer if requested) and subsequently uploaded to the client's electronic medical record. Feedback from this particular service has suggested that flexibility to complete the ASSIST at any time helps initiate the conversation about a client's substance use and explore options for change.

2. Mental Health Rehabilitation Settings

Rehabilitation is a time when individuals are likely to be the most reflective about their substance use and eager to change. The ASSIST is designed to help a person identify the risks associated with their substance use, raise awareness and explore options that align with their Recovery goals. The rehabilitation process is typically anywhere be between 3- and 12-months long. Therefore repeating the ASSIST at 3-month intervals can give the case manager and the client valuable insight into the individual's rehabilitation progress, but also provides opportunity to celebrate successes, reassess goals, and identify any areas that may require further intervention.

'Who is able to administer ASSIST in your service?

ASSIST was developed by clinicians and researchers at the World Health Organization and was designed for use in clinical settings. This means anyone engaged in a clinical role and ideally has completed the ASSIST training. As mental health services consist of multidisciplinary teams, this includes, but is not limited to:

- Medical Officers
- Registered Nurses
- Enrolled Nurses
- Allied Health Professionals
- Allied Health Assistants

The range of people able to conduct the ASSIST greatly extends the possibilities of successful implementation.

'How does one go about learning to use ASSIST?'

Several possible training options are available, and can be arranged via the ASSIST Team at the University of Adelaide. These include:

- ASSIST face-to-face workshops (full- or half-days)
- ASSIST virtual workshop (4 x 1-hour sessions)
- ASSIST online training (You can register here)

As an aside, it is preferred that all staff within the mental health service should be trained to administer ASSIST and Brief Intervention. That way, confidence, consistency, and competence in identifying risks and discussing a person's substance use across all clinicians in the health service can be achieved. After all, consistency in approach is necessary for maintaining client engagement. Ideally, all staff within the service should be capable and confident enough with ASSIST to be able to manage each other's cases if need be.

'In cases of high-risk use, what are your referral options?'

When individuals report substance use that places them at high-risk of harm, referral to specialist AOD service for assessment should be made. Therefore, it can be very useful to explore referral options and make contact with your local Alcohol and Other Drug Service in anticipation of future referral. This could include having a meeting with team members to learn more about what the Alcohol and Other Drug Service in your area offers. This will help streamline the referral process, and provide an opportunity to determine next steps as well as manage expectations.

Part 2

Training and Education

This chapter provides a variety of training options to help inform the education of Screening and Brief Intervention for substance use, using the ASSIST.

The options range from brief, in-service sessions in clinical settings, to formal lessons for tertiary education. They have been developed using the principles of adult learning and can be adapted to any learning environment for people caring for clients with mental health conditions.

Face to face sessions

This resource can be used effectively in face-to-face training sessions. Some suggestions include:

- One-hour session (for example an in-service in a mental health community team or inpatient unit)

For experienced health providers, the instructional video can be shown as a focal point for discussion. Suggested topics for discussion include:

- Why is screening for substance use important for people with mental health conditions?
- How is screening for substance use currently being conducted in their practice?
- What is working well and are there any gaps that need to be addressed?
- What are the advantages of introducing the ASSIST and Brief Intervention?
- What are the potential barriers to implementation and how could they be overcome?
- At what stage could the ASSIST be implemented into their practice?

- Two-hour session

  As above for the one-hour session plus role play (as per flipped classroom model outlined later in this chapter)

- As part of a workshop

  As Screening and Brief Intervention is part of a range of clinical practices, this package can be adapted to a range of professional development workshops. Depending on the allocated time, any of the above activities could be included. It is recommended that the participants adapt the role-play to their professional area or work practice.

On-line learning

The instructional video can be used in the used in a variety of applications for on-line learning. This includes online learning platforms for health providers and in tertiary education. It is suggested that the participants watch the video and answer a range of questions. Depending on the objectives of the session, the linked activity could be short answers or the basis for a discussion board or assignment.

Depending on the IT platform, a suggested approach is:

- Participants view the instructional video on-line;
- Discussion points are posted on a 'discussion board' or 'chat room'. (Example questions are included above in the one-hour session);
- Participants are encouraged to conduct a role play using the ASSIST-BI with a fellow student, friend, colleague in person or via a video application such as Zoom or Skype;

- As a means of reflection, the experience of conducting the ASSIST- BI could form the basis of postings on the discussion board. Suggested topics for discussion include:
  - Describe the experience of conducting an ASSIST-BI?
  - What did you do well?
  - How could you improve your approach?
  - What did you learn from the experience?

Suggestions for more advanced learning or as part of a part of an assessment task, consider one or more of the following questions:

- Why is early identification of substance use important for a person with a mental health condition?
- How do you measure if you are expressing accurate empathy throughout the ASSIST-BI?
- Describe the stage of change your client was in the role play (or video). What techniques did / could you use to help move your client to the next stage?
- If a person is resistant to change, what strategies can you use to support a person with their decision making?
- How can the ASSIST be effectively used throughout a person's Recovery?

Flipped classroom method (face-to-face and online)

Face-to-face

This model is particularly useful for undergraduate and post graduate students. The flipped classroom model encompasses the use of technology to leverage the learning in the classroom, so there is more time interacting with students instead of lecturing. It is called the flipped class because the whole classroom/homework paradigm is 'flipped'.[37] What used to be class work (the lecture) is undertaken at home via teacher-created videos and what used to be homework (assigned problems) is now undertaken in class. Another way of describing this is 'pre-loading' the information before the session.

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

- Given access to the instructional video and ASSIST resources (ASSIST questionnaire, Client Response Card, Feedback Report Card, Risks of Injecting Information);
- Instructed to watch the video and familiarise themselves with the ASSIST tools;
- Explore background information on the ASSIST Portal;
- Role play at least one ASSIST on a fellow student, family member or friend;
- Prepare themselves to come to class and administer an ASSIST and to role play a character with a fellow student;
- The character developed for the role play should be researched and based on the evidence related to the mental health disorders and related substance use. This would include associating the age and gender of the character with the pattern of drug use and associated consequences of use; and,
- Students are to research what services are available in their area and be prepared to provide an ASSIST-linked, targeted intervention.

NOTE: Students may build on the characters shown in the video. Further background information on the characters is included in Chapter 10.

During class time, students are divided into groups of three. In turns they role play a scenario, asking the ASSIST questions and providing 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 provides general feedback on approach and tone (with reference to the Spirit of Motivational Interviewing) and asks the clinician to explain what stage of change the client was at?

The session concludes with a large group discussion. Suggested group discussion topics include:

- Describe your experience of conducting an ASSIST-BI?
  - What did you do well?
  - How could you improve your approach?
  - What did you learn from the experience?
- What insights did you gain from role playing a person with a mental health disorders and substance use?
- What are some of the benefits of screening and Brief Intervention for alcohol and other drug use among people with mental health conditions?
- 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.

Online flipped classroom

Based on the information and optioned outlined above, this session can be adapted to be fully online. Prior to the online class, the students would watch the instructional video, practice conducting an ASSIST and develop a character to role-play in the online class. On joining the online session, the teacher would explain the requirements of the session and place the students into breakout rooms in groups of three (as per the role-play explanation above). The teacher has the ability to drop into the breakout rooms to check on progress and provide support where needed. After each student has had a turn in each of the three roles (interviewer, client, observer) they re-join the whole class for a discussion and reflection on the experience (as above).

References

37. Herreid, C. F., & Schiller, N. A. (2013). Case studies and the flipped classroom. Journal of College Science Teaching, 42(5), 62-66.

Case examples

The following case studies have been developed by clinical psychologists and mental health nurses working in specialist alcohol and other drug services. These examples are intended to serve as an opportunity for you to put what you have learned throughout the earlier chapters of this manual into practice.

Case Example 1. Dan

Situation

Dan arrives at the Adult Community Mental Health Service demanding to see Amy, his case worker. He appears agitated and repeatedly tells the receptionist *"just get my stuff"*.

Background

Originally from the country, Dan left school in Year 9 due to ongoing bullying. Dan moved to city a year ago to be with his father. Dan and his father fought often and his father *'kicked him out'* of home. Dan did not want to return to the country, so met up with a few *'mates'* to make some quick cash. This resulted in criminal activity and Dan is currently facing a number of charges.

Dan is 22 years old and was diagnosed with bi-polar disorder at 18. He recently experienced a major depressive episode and was admitted to a mental health facility for 2 weeks. Dan was discharged into supported accommodation where he engaged with some of the other residents and was compliant with his medications. Dan was doing well in the program and was exploring work options. Following a few altercations with a fellow resident, Dan left the home and has been uncontactable for 2 weeks.

Assessment

Dan appears pale and dishevelled, informing Amy he is living on the streets. He appears agitated and distressed. He is hard to engage as he is focused on getting his belongings back. Dan is concerned about his upcoming court appearance and the fact that he has missed multiple appointments with Legal Aid. He admits to using crystal methamphetamine again, although he is not interested in addressing this or exploring options with the Alcohol and other drug Service.

Dan reluctantly agrees to complete the eASSIST as it has been six months since he last completed it.

Activity 1: Role Play

Based on this presentation, ***complete an ASSIST screening assessment*** and ***Brief Intervention for Dan***.

Additional Information

Dan started drinking at 13, smoked cannabis at 14 and tried LSD and ecstasy in his teens. He recently started using crystal methamphetamine again and is currently using daily. He smokes cigarettes almost daily but has not used cannabis since prior to his last admission (6 months ago). He admits to drinking alcohol once or twice during the last few months. The only substance causing him concern at present is crystal meth as he has been charged with possession, failed to appear at court and his family have expressed great concern. He has never tried to cut down or stop using any substance. Dan has not injected any substances.

Activity 2: Discussion

Discuss how Dan's recent behaviour may reflect a maladaptive coping mechanism. What strategies can be used to assist Dan in the future?

Model Answers

From the case study Dan demonstrated the following maladaptive coping mechanisms:

- **Attacking** - Dan has been involved in several altercations with fellow residents at the supported accommodation where he was living.
- **Acting out** - Dan was demanding when he arrived at the Community Centre, focused only on having his belongings returned and he was hard to engage.
- **Avoidance** - Dan had not attended any of his Legal Aid appointments.
- **Escaping** - Resuming crystal methamphetamine use in an attempt to change his mental state.

In the future, counselling would help Dan address his maladaptive coping mechanism. The counsellor could use one (or a combination) of the following approaches:

Cognitive Behavioural Therapy (CBT): The model of CBT is collaborative and would involve Dan learning about CBT to identify his own cognitions. The counsellor would then help him develop methods to alter the faulty ones. Therapist challenging is antithetical to this model and would in fact promote his resistance to change.

Dialectical Behavioural Therapy (DBT): This approach would help Dan gain control over his behaviour. Through DBT, the counsellor would help Dan manage his emotions by letting him recognise, experience and accept them.

Acceptance and Commitment Therapy (ACT): Through ACT, the counsellor would encourage Dan to embrace his thoughts and feelings rather than fighting or feeling guilty about them. It would help Dan accept what is out of his control, and commit instead to actions that enrich his life.

Case Example 2. Maggie

Situation

Maggie is 67 years old and has been admitted to the Older Persons Mental Health Unit with a diagnosis of major depression with suicidal ideation. It is her first admission to the ward and she appears apprehensive and fearful. Maggie is accompanied by her daughter who appears overwhelmed by the situation.

Background

Maggie is a retired journalist, who had an extensive career in local and national media. Due to her involvement in local charity events and the highly publicised death of her husband 12 months prior, she is known by many of the staff. Maggie is struggling to comes to terms with her husband's death, who died by suicide. Previously considered quite a *'socialite'* Maggie now spends most of her time on her own at her country property.

Her daughter started to raised concern when she found her mum was not attending to activities of daily living, withdrawing from all social events, refusing to see her grandchildren and stating *"I just want to fall asleep and never wake up"*. Her daughters' concerns were heightened when she noticed her mother was stockpiling her medications and was hard rouse on her last visit.

Assessment

On admission, Maggie appears withdrawn and hard to engage. Her answers are monosyllabic, preferring her daughter to speak on her behalf. Her mobility is limited due to osteoarthritis in her knees, hips and back.

Maggie is orientated to time, place and person and does not report any perceptual disturbances. She is dressed in a leisure suit, oversized coat, beanie and slippers. Her daughter states her mother is not eating and has lost a lot of weight over the past few weeks. Maggie denies any current thoughts of self-harm or suicide. Her daughter mentions that she is concerned that her mother may have started drinking again. After Maggie has settled into the ward, you complete the ASSIST.

Activity 1: Role Play

Based on this presentation, ***complete an ASSIST screening assessment*** and ***Brief Intervention for Maggie***.

Additional Information

Maggie states she has never smoked tobacco, drinks alcohol and tried cannabis and LSD in the 70's. Maggie states she drinks almost daily *"just to help me sleep"*. She says that she takes Codeine for pain and adds that she takes more that prescribed; *"though it's hard to get now"*. She states that in the last 3 months she has had no strong desire or urge to drink or use codeine and neither drug has led to any health, social, legal or financial problems. Maggie denies having failed to do what was expected of her due to alcohol or codeine use. Maggie said that her daughter has raised concern about her drinking but no-one else has ever raised concern about any other substance. Maggie disclosed that previously she did *'drink a lot'* when she was working and tried to cut down a couple of times but did not succeed. She eventually gave up alcohol 5 years ago when she experienced cardiac arrhythmias but started drinking again shortly after her husband's death.

Activity 2: Discussion

How can alcohol use exacerbate depression and feelings of hopelessness? What strategies can be used to support Maggie in the future?

Model Answers

In many cases, the use of alcohol can exacerbate depression and feelings of hopelessness. Though the exact mechanism is unclear, here are several possible reasons why:

- Alcohol can have a deleterious effect on depression and depressive symptoms and may dampen the impact of treatment for depression;
- People with depression and alcohol dependence have worse depression treatment outcomes;
- Alcohol use can impact a person's adherence to antidepressant medications;
- Hazardous alcohol use has been found to be associated with greater depressive symptoms among individuals who are not undergoing treatment for depression;
- Levels of depressive symptoms have been found to be related to frequency of intoxication, drinking to get drunk, and binge drinking;
- Levels of alcohol intake and dysphoria have been found to be significantly related to one another;
- Heavy drinking has been found to be associated with two to three times the risk of mood disorders, compared with lifetime abstinence from alcohol.

The following strategies may be useful in supporting Maggie in the future:

- **Relapse prevention** – to identify Maggies triggers for drinking alcohol and explore other alternatives to drinking;
- **Support** – Supporting Maggie through the early stages of stopping or cutting down, and re-evaluating the severity of her depressive symptoms over the next 10-days is encouraged. Any lack of change may need more aggressive forms of treatment.
- **Grief counselling** – there was a notable change in Maggie's behaviour since the sudden death of her husband 12 months ago;
- **Older persons community mental health support** – case management from a mental health worker would help Maggie reach her recovery goals and assist with medication adherence; and,
- **Community peer-based support groups** – for example, SMART recovery.

(From the 2008 suite of training videos developed by Greg Logan with the Victorian Dual Diagnosis Initiative).

Case Example 3. Gavin

Situation

Gavin is a 20-year-old TAFE student returning to the Youth Community Mental Health Service after several months. His mother has raised concern that Gavin has behaving *"oddly"* (distracted and talking to himself) not sleeping, missing family events and becoming agitated when challenged by family members.

Background

Gavin lives with his parents in central Melbourne. Gavin experienced his first psychotic episode at age 18 and was admitted to the Adult Mental Health Unit for two weeks with an initial diagnosis of cannabis induced psychosis. Although he stopped using cannabis, he experienced two further psychotic episodes and was diagnosed with schizophrenia. He was followed up by the Youth Community Mental Health Team and his case was closed after 6 months as he was compliant with his medication, asymptomatic and attending TAFE.

Assessment

Gavin arrived on time for the appointment. He was unshaven and dressed appropriately for the situation. Gavin stated that he had been working on a computer software program for the last two months that will *"change the world"*. Gavin became agitated when questioned about the project, thinking the clinician was trying to steal his ideas. Gavin appears distracted and confirms that he is experiencing auditory hallucinations. Gavin does not share nor understand his mother's concerns. It is unclear if he is currently taking his psychotropic medications.

You discuss Gavin's early warning signs with him and discover he is not sleeping as he is consumed with the project day and night. He also discloses there is no time for self-care such as shaving. Resuming cannabis use is one of Gavin's early warning signs, so you decide to administer the ASSIST. Gavin agrees to this.

Activity 1: Role Play

Based on this presentation, ***complete an ASSIST screening assessment*** and ***Brief Intervention for Gavin.***

Additional Information

Gavin discloses that he smokes cigarettes daily and has failed to quit due to strong daily urges, despite two attempts eight months ago. He states that drinks alcohol 2-3 days a week and has resumed cannabis use (2-3 cones, 5 days a week). He also tried Ecstasy on one occasion in the past three months *'though didn't like it'.* He states that the cannabis is *"helping him think and focus"*. He states that he is spending $100 a week on cannabis and this is a financial strain. He states that he is not attending TAFE, though claims that this is related to poor teaching, not substance use. He missed a family gathering due to his cannabis use and his mother expressed concern about this. Gavin has never used any drugs by injection.

Activity 2. Discussion

Discuss the possible reasons why Gavin may not be adhering to his antipsychotic medications. Why is screening for substance use important for all people presenting with mental health issues?

Model Answers

The following are some of the potential reasons why Gavin may not be adhering to his antipsychotic medication:

- **Unwanted side-effects**. The unwanted side-effects of Anti-Psychotic Medications are a common source of poor medication adherence in individuals. Common side-effects can include: dry mouth, dizziness, weight gain that can lead to diabetes, blurred vision, stiffness, tremors, low mood, menstrual loss, fluid retention, loss of sexual function and headaches;
- **Change in mood**. Gavin may indicate that he is feeling better, therefore decides medications are not required anymore;
- **Forgetting.** Substance use, or an unstable lifestyle may have caused Gavin to forget to take his medication;
- **Paranoia.** Gavin may be experiencing paranoid thoughts, leading him to conclude that the medication is making him worse;
- **Cost.** Gavin may have decided that the costs associated with taking the medication are too high; and,
- **Stigma.** Gavin may also be experiencing stigma or shame about his mental health and decide to stop taking medication in the hope that he will get better.
- **Lack of Insight.** It is clear from Gavin's responses that he may be lacking insight into the consequences of his behaviour. Conducting an ASSIST assessment may help Gavin to develop some insight into his substance use behaviour.

The following are some reasons why screening for substance use is important for all people presenting with mental health issues:

- Substance use may be contributing to their mental health symptoms. Screening for substance use at assessment and review stages will help to identify any changes in behaviour that may be contributing to their symptoms;
- Substance use may contribute to a person not adhering to their antipsychotic medication;
- To identify possible drug interactions;
- To assist with treatment planning; and,
- Screening at initial assessment can help monitor treatment effectiveness.

Case Example 4. Ross

Situation

Ross was brought in to the Emergency Department by the police after being found sitting crossed legged in the middle of a busy intersection. He claimed that he was sick of the bureaucracy and he needed to be heard. He stated he had a *"special message for the Prime Minister"*. He was triaged and admitted to the short stay unit for assessment by Mental Health Consult Liaison Team.

Background

Ross grew up on the North Coast of New South Wales. After leaving school in Year 10, he drifted between jobs before joining the Army at 18. Ross was adventurous and appeared to have no fear. He was always up for a dare and did not consider the consequences.

Ross spent seven years in the Australian Army and had two deployments to the Middle East. After his last deployment, Ross experienced flashbacks of the death of his mate, struggled to sleep, was hypersensitive to noise, became easily agitated and aggressive towards his partner. Ross found alcohol helped calm him down.

Ross enjoyed the *'mateship'* in the Army and felt isolated when he was given an administrative discharge at age 25. Now 28, he is still struggling to assimilate back into civilian life. Following the separation from his partner, Ross has been living at his sister's home, though that relationship has become strained.

Assessment

Ross is agitated and is intimidating. At 185cm he towers over the staff and refuses to sit when asked. After continually demanding to see the Prime Minister, Ross starts to sob as he recalls the last 24 hours. He states that his sister has kicked him out and he has no money, nowhere to live and advises that he hasn't slept or eaten for 24 hours. He says it is the Governments fault for not looking after him. Ross appears to have some regrets for his behaviour, as he starts to apologise for the disruption to the morning traffic. Ross appears dishevelled, anxious and tired. Ross states that he wasn't trying to kill himself this morning, though wouldn't have cared if a truck ran over him. Ross reports persistent suicidal ideation over the past 3 months. After a lengthy conversation and further assessment, Ross agrees to be admitted as a voluntary patient.

Activity 1: Role Play

Based on this presentation, ***complete an ASSIST screening assessment*** and ***Brief Intervention for Ross.***

Additional Information

Ross states that he has tried a variety of drugs during his life. This includes; tobacco (currently daily) alcohol (daily), cannabis (weekly) and crystal methamphetamine (weekly). He admits to trying nitrous and magic mushrooms at school. Although he started drinking at 16, Ross didn't start using cannabis until after leaving the Army to help him sleep when alcohol didn't work. He said he recently started using crystal methamphetamine as it gave him increased energy and motivation. Ross states that he craves tobacco daily and is concerned about not smoking while admitted in the ward. Ross states that his alcohol use has caused problems with his sister who won't let him stay at her home anymore or see his nephews. In the last week, Ross has missed appointments with the Department of Veteran Affairs due to his drinking. Ross's family has recently expressed concern about his alcohol and cannabis use and begged him to stop. Ross has never tried to cut down or stop using any substance stating *"what's the use?"*

Activity 2: Discussion

Ross scores in the high-risk range for alcohol and tobacco. Outline three key priorities for Ross as he is admitted to the Mental Health Unit.

Model Answers

Below are the three key priorities that should be addressed for Ross:

- Explain to Ross that he is in the high-risk range for alcohol and tobacco, and you would like to refer him for a further alcohol and other drug assessment;
- Refer to the Alcohol and Drug Consultation Liaison team for specialist assessment and to explore alcohol withdrawal management options; and,
- Offer and explain Nicotine Replacement Therapy as the inpatient unit is non-smoking.
- There are also other options that might be explored. For example:
- In the event that there is not an Alcohol and Drug Consultation Liaison team:
  - Conduct a full alcohol and other drug assessment, including past alcohol withdrawal experiences (i.e. history of seizures)
  - explore alcohol withdrawal management options with the treating team
- Conduct a suicide risk assessment.

Case Example 5. Stuart

Situation

Stuart presents to a Medical Centre, 21 days after testing positive for COVID-19, complaining of a persistent dry cough. He says he is unable to sleep because of it and is feeling *"tired and over it"*.

Background

Stuart does not have a regular General Practitioner and only presents for medical care when very unwell. Previously a police officer, Stuart says he *"has had enough of docs"*, after being medically discharged from the police force five years ago. At that time, he was diagnosed with Post Traumatic Stress Disorder and Bipolar Disorder.

Assessment

On examination, Stuart looks older than his stated age of 57. He is 182cm and weighs 112kg. Stuart reports no regular medication and states he stopped taking his *"head meds"* 2 years ago as they were not helping. Stuart says he smokes 16-20 cigarettes a day and becomes defensive when asked if he has *'considered stopping'*. Stuart abruptly says, *"only because they are so bloody expensive'*. Stuart is currently living in private rental accommodation, having had to sell his home due to significant gambling debts. It was at this time, 3 months ago, that his third wife left him. Stuart denies any other significant drug use. He tried cannabis in his teens, though did not use it again as *"it did nothing for me"*. Stuart consumed alcohol heavily in the past and reduced to *"social drinking – just a bottle of red every few days"* 4 months ago.

He admits to stopping drinking since having COVID-19, as *"it just makes me feel sick"*. After Stuart chatting with Stuart, you both agree to complete the ASSIST.

Activity 1: Role Play

Based on this presentation, ***complete an ASSIST screening assessment*** and ***Brief Intervention*** for Stuart.

Additional Information

Stuart has smoked since he was 12 years old, and states that he *"has quit more times than he can count"*. He usually goes *"cold turkey"* and the longest period was three months after his first child was born. He has tried patches, though stopped using them as he says he is *"allergic to them; they make me sick"*. Stuart reports that that his father smoked all his life and only died last year at age 84. Stuart says he is not interested in quitting again, as he has too much going on now and his new girlfriend smokes too. Stuart's daughter is pressuring him to stop smoking as she does not want her children around him smoking. He says he only smokes outside, though his daughter has complained about the smell. Stuart is starting to avoid seeing her as it is causing a strain in their relationship.

Activity 2: Discussion

Stuart scores in the high-risk range for tobacco use. Using the FRAMES model, outline what you would focus on in a brief intervention for Stuart?

Model Answers

Feedback – Provide personalised feedback on the risks associated with the score. Start by asking Stuart his thoughts on the score and the potential harms he is aware of. After listening to Stuart's response, fill in any gaps in knowledge (using the feedback form). It is a good idea to end with an open question; *"what are you most concerned about?"*

Responsibility – There is potential that Stuart may become defensive during the brief intervention as he mentioned that he is not keen to stop smoking. This is a good opportunity to remind Stuart that ultimately the choice is his. This helps remind Stuart that he has control over his actions and will help reinforce the behaviour if he decides to make a change.

Menu of options – It would be good to start this part of the discussion by asking Stuart to elaborate on his past quit attempts. Find out what worked well and what was challenging. Based on his response, it would be good to outline the range of Nicotine Replacement Therapy (e.g. patches, gum, and lozenges) options currently available and highlight that the best approach is a combination of therapies. Pharmacotherapies may be considered and discussed with Stuart (considering any risk factors). You may like to offer information on Quit resources, for examples pamphlets, links to online resources, counselling, and apps.

Empathy – Using accurate empathy throughout the discussion will help build rapport and engage Stuart in the discussion. Reflective listening will help create a feeling of acceptance. A non-judgemental attitude will help Stuart open-up about his fears and concerns. Throughout the discussion it is important to reinforce that stopping smoking is hard and that there are people and services available to help him. It would be good to remind Stuart that he has family that care about him (his daughter) and ask what stopping smoking would mean to her?

Self-efficacy – It is important that Stuart is reminded of his previous successes to help build his confidence to change. Focusing on the time that Stuart did stop smoking for three months is a good start and ask him to tell you how he felt during this time. It is a good idea to highlight some of the other benefits he raised, such as saving money.

Note on self-efficacy – If this is challenging, it would be a good idea to focus on other areas where Stuart has made a successful behaviour change.

Part 3

ASSIST Portal

THE UNIVERSITY of ADELAIDE

Alcohol, Smoking, Substance Involvement Screening Test (ASSIST)

Client name:

Date of Birth:

Sex:

INTRODUCTION (please read to client)

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.

	Score Legend	Tobacco (Cigarettes, chewing tobacco, cigars)	Alcohol (Beer, wine, spirits)	Cannabis (Marijuana, pot, grass, hash)	Cocaine (Coke, crack)	Amphetamine type stimulants (Speed, meth, ice, ecstasy)	Inhalants (Nitrous, glue, petrol, amyl nitrite)	Sedatives or sleeping pills (Valium, Serepax, Xanax)	Hallucinogens (LSD, acid, mushrooms, trips, ketamine)	Opioids (Heroin, Morphine, Buprenorphine, Oxycodone)	Other (Kava, GHB, excess caffeine)
Q1. In your life which of the following substances have you ever used?	Tick YES or NO for each substance. **For substances answered YES complete Q2-Q8. If no to all stop interview**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
		(Probe if all answers are negative e.g., 'not even when you were in school?')									
Q2. In the past 3 months, how often have you used _____? **Ask individually for ALL substances answered YES in Q1**	0 – never 2 – once/twice 3 – monthly 4 – weekly 6 – daily/almost daily										
		(If "never" for a substance in the last 3 months skip to question 6 for that substance)									
Q3. During the past 3 months, how often have you had a strong desire or urge to use _____?	0 – never 3 – once/twice 4 – monthly 5 – weekly 6 – daily/almost daily										
Q4. During the past 3 months how often has your use of _____ led to health, social, legal or financial problems?	0 – never 4 – once/twice 5 – monthly 6 – weekly 7 – daily/almost daily										

CONTINUED OVERLEAF

CONTINUED FROM PREVIOUS PAGE

	Score Legend	Tobacco (Cigarettes, chewing tobacco, cigars)	Alcohol (Beer, wine, spirits)	Cannabis (Marijuana, pot, grass, hash)	Cocaine (Coke, crack)	Amphetamine type stimulants (Speed, meth, ice, ecstasy)	Inhalants (Nitrous, glue, petrol, amyl nitrite)	Sedatives or sleeping pills (Valium, Serepax, Xanax)	Hallucinogens (LSD, acid, mushrooms, trips, ketamine)	Opioids (Heroin, Morphine, Buprenorphine, Oxycodone)	Other (Kava, GHB, excess caffeine)
Q5. During the past 3 months how often have you failed to do what was normally expected of you because of your use of _____?	0 – never 5 – once/twice 6 – monthly 7 – weekly 8 – daily/almost daily	Do not ask Q5 for tobacco									
Ask Questions 6 & 7 for all substances used in lifetime											
Q6. Has a friend or relative or anyone else ever expressed concern about your use of _____?	0 – No, never 6 – Yes, in the last 3-months 3 – yes, but not in the last 3-months										
Q7. Have you ever tried and failed to control, cut down or stop using _____?	0 – No, never 6 – Yes, in the last 3-months 3 – yes, but not in the last 3-months										
Q8. Have you ever used any drug by injection (non-medical use)?	☐ YES ☐ NO	If YES - provide information about risks of injecting in brief intervention and take-home information If NO - no action									
Total		0									

Interpret the score			
Risk	**Low** (Drugs 0-3, Alcohol 0-10)	**Moderate** (Drugs 4-26, Alcohol 11-26)	**High** (27 or above)
Treatment	Brief advice about continuing current use pattern	Brief intervention and take-home information	Brief intervention and take-home information
Referral	No referral	No referral	Referral to specialist for further assessment

Information collected by:	**Name:**	**Position/Agency:**	
	Sign:	**Date:**	**Contact number:**

ASSIST Portal

THE UNIVERSITY of ADELAIDE

WHO ASSIST V3.0
Client Response Card

Substance
Tobacco (Cigarettes, chewing tobacco, cigars, etc)
Alcohol (Beer, wine, spirits, etc)
Cannabis (Marijuana, pot, grass, hash, etc)
Cocaine (Coke, crack, etc)
Amphetamine type stimulants (Speed, ecstasy, meth, ice, paste, crystal, base, diet pills, etc)
Inhalants (Nitrous, glue, petrol, sprays, paint thinner, amyl nitrite etc)
Sedatives or sleeping pills (Valium, Serepax, Xanax, Rohypnol, Normison, Diazepam, Temazepam etc)
Hallucinogens (LSD, acid, mushrooms, trips, ketamine etc)
Opioids (Heroin, opium, morphine, methadone, codeine, buprenorphine, oxycodone)
Other (Please specify:)

Response Card (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 (Questions 6 – 8)
No, Never
Yes, but not in the past 3 months
Yes, in the past 3 months

ASSIST Portal

THE UNIVERSITY of ADELAIDE

WHO ASSIST V3.0
Feedback Report Card for Clients

Substance	Score	Risk Level		
Tobacco		☐ 0-3 Low	☐ 4-26 Moderate	☐ 27+ High
Alcohol		☐ 0-10 Low	☐ 11-26 Moderate	☐ 27+ High
Cannabis		☐ 0-3 Low	☐ 4-26 Moderate	☐ 27+ High
Cocaine		☐ 0-3 Low	☐ 4-26 Moderate	☐ 27+ High
Amphetamine type stimulants		☐ 0-3 Low	☐ 4-26 Moderate	☐ 27+ High
Inhalants		☐ 0-3 Low	☐ 4-26 Moderate	☐ 27+ High
Sedatives or sleeping pills		☐ 0-3 Low	☐ 4-26 Moderate	☐ 27+ High
Hallucinogens		☐ 0-3 Low	☐ 4-26 Moderate	☐ 27+ High
Opioids		☐ 0-3 Low	☐ 4-26 Moderate	☐ 27+ High
Other		☐ 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, both now and also in the future if you continue the same pattern of 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 could be dependent.

Are you concerned about your substance use?

CONTINUED OVERLEAF

Tobacco	Alcohol	Cannabis	Cocaine	Amphetamine type stimulants	Inhalants	Sedatives or sleeping pills	Hallucinogens	Opioids
Your risk of experiencing these harms is: *(tick one)* ☐ **Low** ☐ **Moderate** ☐ **High** **Regular tobacco smoking is associated with:**	**Your risk of experiencing these harms is:** *(tick one)* ☐ **Low** ☐ **Moderate** ☐ **High** **Regular excessive alcohol use is associated with:**	**Your risk of experiencing these harms is:** *(tick one)* ☐ **Low** ☐ **Moderate** ☐ **High** **Regular use of cannabis is associated with:**	**Your risk of experiencing these harms is:** *(tick one)* ☐ **Low** ☐ **Moderate** ☐ **High** **Regular use of cocaine is associated with:**	**Your risk of experiencing these harms is:** *(tick one)* ☐ **Low** ☐ **Moderate** ☐ **High** **Regular use of stimulants is associated with:**	**Your risk of experiencing these harms is:** *(tick one)* ☐ **Low** ☐ **Moderate** ☐ **High** **Regular use of inhalants is associated with:**	**Your risk of experiencing these harms is:** *(tick one)* ☐ **Low** ☐ **Moderate** ☐ **High** **Regular use of sedatives is associated with:**	**Your risk of experiencing these harms is:** *(tick one)* ☐ **Low** ☐ **Moderate** ☐ **High** **Regular use of hallucinogens is associated with:**	**Your risk of experiencing these harms is:** *(tick one)* ☐ **Low** ☐ **Moderate** ☐ **High** **Regular use of opioids is associated with:**
Premature ageing, wrinkling of the skin	Hangovers, aggressive and violent behaviour, accidents and injury	Problems with attention and motivation	Difficulty sleeping, heart racing, headaches, weight loss	Difficulty sleeping, loss of appetite and weight loss, dehydration	Dizziness and hallucinations, drowsiness, disorientation, blurred vision	Drowsiness, dizziness and confusion	Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory	Itching, nausea and vomiting
Respiratory infections and asthma	Reduced sexual performance, premature ageing	Anxiety, paranoia, panic, depression	Numbness, tingling, clammy skin, skin scratching or picking	jaw clenching, headaches, muscle pain	Flu like symptoms, sinusitis, nosebleeds	Difficulty concentrating and remembering things	Difficulty sleeping	Drowsiness, constipation, tooth decay
High blood pressure, diabetes	Digestive problems, ulcers, inflammation of the pancreas, high blood pressure	Decreased memory and problem solving ability	Accidents and injury, financial problems	Mood swings – anxiety, depression, agitation, mania, panic, paranoia	Indigestion, stomach ulcers	Nausea, headaches, unsteady gait	Nausea and vomiting	Difficulty concentrating and remembering things
Respiratory infections, allergies and asthma in children of smokers	Anxiety and depression, relationship problems, financial and work problems	High blood pressure	Irrational thoughts	Tremors, irregular heartbeat, shortness of breath	Accidents and injury	Sleeping problems	Increased heart rate and blood pressure	Emotional problems and social problems
Miscarriage, premature labour and low birth weight babies for pregnant women	Difficulty remembering things and solving problems	Asthma, bronchitis	Mood swings - anxiety, depression, mania	Aggressive and violent behaviour	Memory loss, confusion, depression, aggression	Anxiety and depression	Mood swings	Reduced sexual desire and sexual performance
Kidney disease	Deformities and brain damage in babies of pregnant women	Psychosis in those with a personal or family history of schizophrenia	Aggression and paranoia	Psychosis after repeated use of high doses	Coordination difficulties, slowed reactions, hypoxia	Tolerance and dependence after a short period of use.	Anxiety, panic, paranoia	Relationship difficulties
Chronic obstructive airways disease	Stroke, permanent brain injury, muscle and nerve damage	Heart disease and chronic obstructive airways disease	Intense craving, stress from the lifestyle	Permanent damage to brain cells	Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys)	Severe withdrawal symptoms	Flash-backs	Financial and work problems, violations of law
Heart disease, stroke, vascular disease	Liver disease, pancreas disease	Cancers	Psychosis after repeated use of high doses	Liver damage, brain haemorrhage, sudden death	Death from heart failure	Overdose and death if used with alcohol, opioids or other depressant drugs.	Increase the effects of mental illnesses such as schizophrenia	Tolerance and dependence, withdrawal symptoms
Cancers	Cancers, suicide		Sudden death from heart problems					Overdose and death from respiratory failure

PRINT FORM EMAIL FORM

Alcohol Guidelines

Australian guidelines to reduce health risks from drinking alcohol

1: HEALTHY ADULTS

Drink no more than
10 standard drinks a week

AND
no more than 4 standard drinks
on any one day

to reduce the risk of harm from alcohol.

The less you drink, the lower your risk of harm.

2: CHILDREN AND PEOPLE UNDER 18 YEARS OF AGE

Should not drink alcohol

to reduce the risk of harm from alcohol.

3: WOMEN WHO ARE PREGNANT OR BREASTFEEDING

Should not drink alcohol

to prevent harm from alcohol to their unborn child or baby.

What is a standard drink?

Australian Government
National Health and Medical Research Council

LIGHT BEER
425 ml | 2.7% alc/vol

MID STRENGTH BEER
375 ml | 3.5% alc/vol

FULL STRENGTH BEER
285 ml | 4.9% alc/vol

REGULAR CIDER
285 ml | 4.9% alc/vol

SPARKLING WINE
100 ml | 13% alc/vol

WINE
100 ml | 13% alc/vol

FORTIFIED WINE
(e.g. sherry, port)
60 ml | 20% alc/vol

SPIRITS
(e.g. vodka, gin, rum, whiskey)
30 ml | 40% alc/vol

The standard drink is defined in the Australia and New Zealand Food Standards Code.

The low-risk alcohol guidelines and ‘what is a standard drink’ chart are resources developed by the NHMRC. The resources have been reproduced here with permission.

DRSABC + Naloxone

D — **D**ANGERS?
Are there any sharp objects or hazards nearby?

↓

R — **R**ESPONSE?
Is the person responding to you?

↓

S — **S**END FOR HELP
Call 000 for an ambulance

↓

A — **A**IRWAY
Make sure nothing is in mouth

↓

B — **B**REATHING
Is the person breathing? If yes, give naloxone (if available) and place in recovery position

↓

C — **C**PR - IF NOT BREATHING
30 compressions: 2 breaths

+

N — If naloxone is available

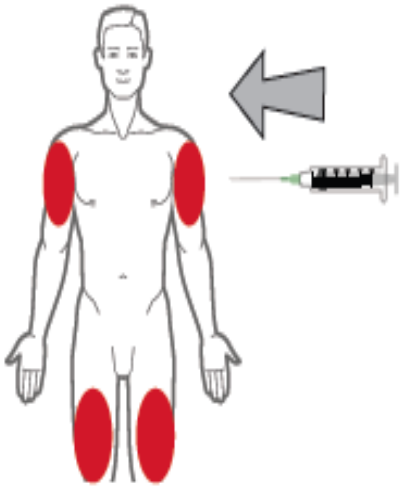
1. **Administer one dose of naloxone**
   - One whole ampoule
   - To the nearest black line of Prenoxad
   - Insert nasal spray nozzle into one nostril and depress plunger fully.
2. Still not breathing? **Continue CPR**
3. If no response after 2-3 minutes of giving naloxone **administer another dose of naloxone** (insert second unit of nasal spray in other nostril and depress plunger fully)
4. Still not breathing? **Continue CPR until the person becomes responsive or the ambulance arrives**

IF YOU THINK SOMEONE HAS DROPPED

- Call 000 for an ambulance
- Stay with them until help arrives
- Police will only attend if:
    - The overdose is suspicious
    - there has been, or is likely to be a death
    - ambos call for help

INJECTING NALOXONE

- If using ampoule: Attach 23 gauge 1-1 ½ inch (blue) needle to syringe. Swirl the ampoule to ensure all the naloxone is in the base. Break the ampoule by placing thumb on blue dot, and break with a quick motion. Draw up one ampoule of naloxone
- If using 2ml Prenoxad: Attach 23 gauge (blue) needle to syringe
- No need to remove clothing
- Inject the needle into the thigh or upper arm
- Using ampoule: Slowly and steadily push plunger all the way down
- Using Prenoxad: Administer one dose – stop at the nearest black line
- Note the time the naloxone was given



- Safely dispose of syringe and needle tips in sharps disposal unit

USING NALOXONE NASAL SPRAY

- Insert nasal spray nozzle into one nostril, then firmly depress plunger to give one complete spray of naloxone
- Remove nozzle from the nostril
- If required give the second dose of nasal spray in the other nostril
- Note which nostril was used and the time the naloxone was given
- Dispose of used nasal sprays safely as per manufacturer's instructions

Reference source:
https://www.sahealth.sa.gov.au/wps/wcm/connect/4bbef0804cb4fdf196689eb8c791be56/Naloxone+-+Client+Handout+Aug+22.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-4bbef0804cb4fdf196689eb8c791be56-oaKU1kq

Notes

Notes

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CRICOS 00123M

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