ASSIST WITH SUBSTANCE

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and Brief Intervention Resource for Nurses - 2nd Edition

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CONTENTS

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

This manual was developed by Jennifer Harland and Janette Curtis. Reference material included the ASSIST-*linked brief intervention for hazardous and harmful substance use, Manual for use in primary care* (Humenuik et al 2010) and Aware of Amphetamines (2011), reproduced with permission, Australian Drug Foundation 2014.

This manual has been designed to support the ASSIST with Substance instructional video that can be viewed on the ASSIST Portal: **assistportal.com.au/resources/**

Video production team: The ASSIST with Substance instructional video was directed by Paul Ewing and produced by Adam Preston (University of Wollongong) and presented by John Marsden. Gratitude is given to John, Paul, Adam and team for their professionalism, good humour and commitment to the project.

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OVERVIEW

ASSIST WITH SUBSTANCE: The Alcohol, Smoking and Substance Involvement Screening Test and Brief Intervention Resource for Nurses has been developed by nurses for nurses. It aims to show nurses how the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) coupled with a targeted brief intervention, can be easily incorporated into their routine clinical practice and ultimately make a difference in a person's life.

Why use the ASSIST and linked brief intervention?

It is well known that psychoactive substance use is one of the global leading causes of preventable morbidity and mortality[1]. Globally, alcohol use disorders have been identified as the most prevalent of the substance use disorders - over 100 million estimated cases in 2016. Cannabis is the most common drug use disorder (22 million cases) and almost 27 million cases of opioid dependence were identified[2]. The burden of disease attributable substance use does vary across diverse countries. In 2019:, 77% of Australians over the age of 14 had drunk at least one full serve of alcohol and 25% had exceeded the single occasion risk guidelines; 12 % of men and just under 10% of women over the age of 14 smoked tobacco daily; and approximately 1 in 8 Australians had used at least 1 illegal drug in the last 12 months.[3]

Most people with substance use disorders do not seek specialist care[4]. Screening and brief intervention aim to identify current or potential problems with substance use and motivate those at risk to change their substance use behaviour by increasing awareness between consumption and related health and social risks and harms[5].

Nurses working in primary and acute medical settings are well placed to play a key role in the identification and prevention of hazardous alcohol consumption, smoking and substance-related problems. Due to competing demands in a nurse's busy schedule, greatest priority is given to tasks with the greatest immediate impact. Unfortunately, screening for drug and alcohol use may not be able to compete for scarce time in this context.

The ASSIST was developed for the World Health Organization (WHO) by an international group of alcohol and other drug specialists, as a tool that is easy to use to detect substance use and related problems. The ASSIST is an eight-item questionnaire and takes about 10 minutes to administer.

ASSIST can help identify a range of issues, including: regular use; dependent or 'high risk' use; and, injecting behaviour[6].

The ASSIST-linked Brief Intervention (ASSIST-BI) presented in this package can be delivered in less than 15 minutes.

The principles and practice suggestions can also be used for longer or recurrent intervention sessions as needed[7].

For a variety of reasons, many nurses might avoid screening for substance use and hence lose opportunities to identify a key health concern, that may be contributing to a presenting problem and its management, and do not provide a brief intervention that might have benefits. Research shows that the main reasons health workers reported for not getting involved are: a lack of time; feeling that they are not competent or capable of giving an intervention; and, concern that they will experience resistance and defensiveness from their clients[8].

The present resource addresses these barriers using a simple step-by-step approach that is easy to incorporate into routine practice. Brief interventions have been shown to be acceptable and motivating for many people with hazardous or harmful substance use, while also offering the nurse a plan to match the individual to the best response. While the evidence is stronger for tobacco and alcohol, there is some evidence that the approach can be useful with illicit drug use[9] and possibly, where indicated, as part of a strategy to engage people in more intensive support.[10]

In Figure 1 we summarise the steps of administering the ASSIST and provide a linked Brief Intervention.

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[1] World Health Organization (2010) ATLAS on substance use: resources for the preventions and treatment of substance use disorders. World Health Organization, Geneva.

[2] Global Burden of Disease 2016 Alcohol and Drug Use Collaborators (2018) The global burden of disease attributable to alcohol and drug use in 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study Lancet Psychiatry 5: 987–1012 http://dx.doi.org/10.1016/ S2215-0366(18)30337-7

[3] Australian Institute of Health and Welfare 2020. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW

[4] Madras, B.K., Compton, W.M., Avula, D., Stegbauer, T., Stein, J.B., Clark, H.W., (2009) . Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare. *Drug Alcohol Dependence* 1;99(1-3):280-95 doi: 10.1016/j.drugalcdep.2008.08.003.

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

[6] World Health Organization (2010) The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Manual for use in primary care. World Health Organization, Geneva.

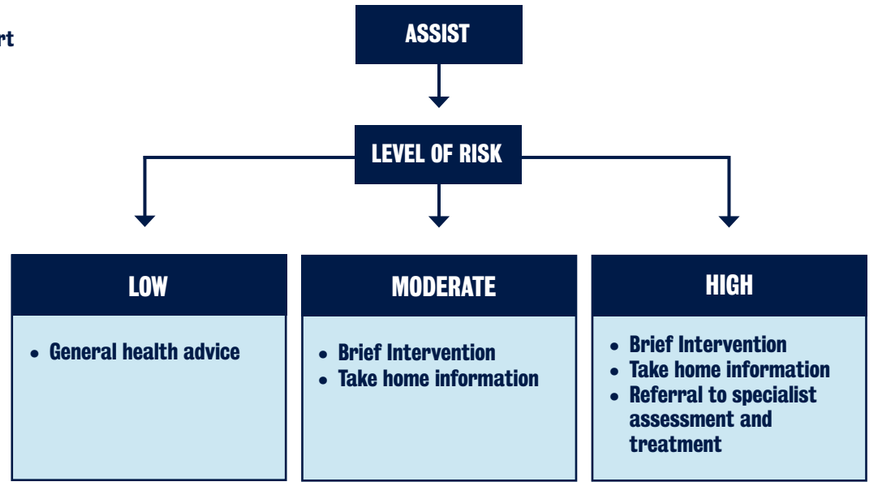
[7] McPherson TL and Hersh RK (2000). Brief substance use screening instruments for primary care settings: A review. J Subst Abuse Treat,18:193-202.

[8] Barry K L, Blow FC, Willenbring M, McCormack R, Brockmann LM and Visnic S (2004). Use of alcohol screening and brief interventions in primary care settings: Implementation and barriers. Substance Abuse, 25(1):27-36.

[9] Kaner,EFS, Beyer, FR, Muirhead, C, Campbell, F, Piennar ED, Bertholet, N, Daeppen, JB, Saunders, JB, Burnard, B (2018) Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database of Systematic Reviews 2018, Issue 2 Art. No CD004148 DOI: 10.1002/14651858.CD004148.pub4.9

[10] Saitz, R, Palfai, T, Cheng, D, Alford, D et al (2014) Screening and brief intervention for drug use in Primary Care. The ASPITRE Randomised Clinical Trial Journal of the American Medical Association 312 (5) 502-513T

FIGURE 1:
ASSIST flow chart



A word from the developers

As nurses, we wanted this resource to be relevant to our practice. The usual approach to counselling style training videos is that a leader in the field lassos one of their colleagues, tells them to be certain type of client, sit in chairs at arm's length, someone presses record on the stand-alone camera and they are off. Granted, much can be learned from watching others do what they do best; however, we wanted our production to be as realistic as possible.

One of the most important elements we wanted to capture was to put the client in context. We believe that nurses would be more prepared to administer the ASSIST if they could see that what they were doing had a positive impact in someone's life. That is why we developed the three scenarios in this package (Chapter 9). The focus was to make the instructional video realistic. Importantly, we intend to show that screening is a 'normal' part of life if nurses found just ten minutes in their busy schedule to make a difference.

As alcohol is the most widely used substance in Australia and cannabis is the most used illicit drug, we developed two characters around alcohol use (moderate and high risk) and one character with a cannabis-related problem. To keep with the element of being realistic, the characters were based on real clients who the project team members had worked with in clinical settings. Naturally their names were changed; however, gender, age, pattern of use, history and social situation details were unchanged.

How to use this manual

This package has been designed to be used in a diverse ways and contexts. These include:

1. Individual study and support for the ASSIST Portal;
2. Flipped classroom model (recommended for Nursing students);
3. Face-to-face group setting (recommended for Registered and Enrolled Nurses); and,
4. Online (recommended for nurses who are unable to participate in face-to-face sessions).

The package can be used flexibly and has been designed for use in a short session (1–2 hours), as part of a workshop or on-line. The instructional video contains three scenarios, Ben, Mel and Eddie. Each scenario portrays different settings where the ASSIST and linked Brief Intervention takes place. Facilitators can select any, or all of, the scenarios they consider relevant to the session, the needs of the participants and the purpose of the workshop or training.

It is recommended that facilitators read the whole of the manual to gain a better understanding of the ASSIST and of the various ways in which it can be taught and implemented into practice. While you are reading you find it useful to think of your own working and training context. You will find guidance on staff development and training related to this package in the ASSIST Portal. **assistportal.com.au/resources**

The manual provides relevant background information and an overview of the key principles which underpin brief interventions. Much of the more recent research literature on brief interventions has used adaptations of a style of client-centred and change-focused counselling called Motivational Interviewing. The resource provides practical suggestions for capturing a motivational approach and the spirit of motivational interviewing; however, training in Motivational Interviewing is not the goal of this manual. Facilitators are directed to further information and materials throughout the manual.

Part Two of the manual provides practical advice on how to deliver teaching and training sessions using this resource. You will also find further background information on the characters in the video (Mel, Ben and Eddie) and ASSIST resources.

Feedback

We are delighted you are using this resource and are keen to hear your feedback. If you have any suggestions or comments please contact:

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PART 1

CHAPTER 1

OVERVIEW OF ASSIST-BI

What is the ASSIST?

The Alcohol, Smoking and Substance Involvement Screening Test ASSIST (Appendix A) was developed under the auspices of the World Health Organization (WHO) by an international group of researchers and clinicians in response to the overwhelming public health burden associated with psychoactive substance use worldwide. It is an eight-item questionnaire designed to be administered by a health worker which takes about 10 minutes to administer. The ASSIST screens for risky use of all main substance types (tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (ATS), sedatives, hallucinogens, inhalants, opioids and 'other drugs') and determines a risk score for each substance.

The risk score for each substance helps to initiate and frame a brief discussion with clients about their substance use.

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

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

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

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

What is the ASSIST-linked brief intervention?

The ASSIST-linked Brief Intervention lasts 3 – 15 minutes and is for clients who have been administered the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) by a health worker and are at 'moderate risk' from their substance use. 'Moderate risk' describes people who are not dependent, but are using substances in a risky, hazardous or harmful way that may be creating health, social, legal, occupational or financial problems or has the potential to create those problems should the substance use continue.

Brief interventions are not intended as a stand-alone treatment for people who are dependent or at 'high risk' from their substance use. However, a brief intervention can be used to encourage such clients to accept a referral to specialised drug and alcohol assessment and treatment, either within the primary care setting, with an addiction medicine specialist or at a specialised alcohol and other drug treatment agency.

The aim of the intervention is to help the client understand that their substance use is putting them at risk which, if presented in an empathic, personally relevant, supportive and non-judgmental manner, may serve as, or contribute to, a motivation for them to reduce or cease their substance use.

The ASSIST-linked Brief Intervention is based on the FRAMES guidance about important approaches (Chapter 2) and Motivational Interviewing (Chapter 4). It can be summarised in the 10 steps to an ASSIST- linked Brief Intervention (Chapter 5)

CHAPTER 2

THE FRAMES MODEL

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

These features were summarised using the acronym FRAMES – a framework first described more than 25 years ago, but still referenced today. FRAMES is the acronym for: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy[11] [12] [13].

The features of FRAMES include:

- **Feedback**
- **Responsibility**
- **Advice**
- **Menu of options**
- **Empathy**
- **Self-efficacy**

Feedback

The provision of personally relevant feedback (as opposed to general feedback) is a key component of a brief intervention. This may comprise information about the individual's substance use obtained from an assessment or screening and the level of risk associated with those scores. It is worth noting that many clients are interested in knowing their questionnaire scores and what they indicate.

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

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

Responsibility

A key principle of working to help a client affected by substance use is to acknowledge and accept that they alone are responsible for their own behaviour and will make choices about their substance use and about the course of the brief intervention given by the nurse. This is not the same as blaming or judging the client. Communicating with clients in terms such as: *"Are you interested in seeing how you scored on this questionnaire?"*, *"What you do with this information is up to you"* and *"How concerned are you by your score?"* or "What concerns do you have about your score?" enables the client to retain personal control over their behaviour and its consequences, to focus on the issues that are of most concern to them, and the direction of the intervention. This does not stop you ***sharing*** your expertise in terms of providing advice (see below).

This sense of control has been found to be an important element in motivation for change and in decreasing resistance[13]. Using language with clients such as "I think you should…", or *"I'm concerned about your (substance) use"* may create resistance in clients and motivate them to maintain and adopt a defensive stance when talking about their substance use patterns – as opposed to saying something such as "I'm not sure how you see this, but your score indicates …. What do you think about this?"

Advice

A central component of effective brief interventions is the provision of clear objective advice regarding how to reduce the harms associated with continued use. This needs to be delivered in a non-judgmental manner. Clients may be unaware that their current pattern of substance use could lead to health or other problems or make existing problems worse. Providing clear advice that cutting down or stopping substance use will reduce their risk of future problems, will increase their awareness of their personal risk, and provide reasons to consider changing their behaviour.

Advice can be summed up by delivering a simple statement such as *"the best way you can reduce your risk of (e.g. depression, anxiety) 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 (substance)"* or *"I'm concerned about your use of (substance)"* does not comprise clear, objective advice.

Menu of options

Effective brief interventions provide the client with a range of alternative strategies to cut down or stop their substance use. This aims to facilitate the client's ability to choose the strategies which are most suitable for their situation and which they feel will be most helpful. Providing choices reinforces the sense of personal control and responsibility for making change and can help to strengthen the client's motivation for change. It is also likely to reduce resistance. Giving clients the "Self-Help Strategies for Cutting Down or Stopping Substance Use: *Self-Help Guide*[14] (available at: **assistportal.com.au/download/self-help-manual/?wpdmdl=482&masterkey=5dbc3f6a25ea1**) is a good way to start as it contains strategies to help clients change their behaviour, and can be used alone or in conjunction with several options. Examples of options for clients to choose could include:

- Keep a diary of substance use (where, when, how much used, how much spent, with whom, why);
- Identify high risk situations and develop strategies to avoid or manage them;
- Identify other activities instead of drug use— hobbies, sports, clubs, gymnasium, 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 and written information;
- Invite the client to return for regular sessions to review their substance use;
- Provide information about other groups or health workers that specialise in drug and alcohol problems; and,
- Put aside the money they would normally spend on substances for something else.

Empathy

An important principle of motivational interviewing is the expression of empathy by the health care worker to the client. In a clinical situation empathy is expressed through an accepting, non-judgmental approach that tries to understand the client's point of view and avoids the use of labels such as 'alcoholic' or 'drug addict'. It is especially important to avoid confrontation and blaming or criticism of the client. Empathy requires reflective listening. [16]Reflective listening has been described as the capacity to listen, to understand and to communicate understanding to the client16. Skillful reflective listening which clarifies and amplifies the person's own experience and meaning is a fundamental part of expressing empathy. The empathy of the nurse is an important contributor to how well the client responds to the intervention[15].

Self-efficacy (confidence)

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

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

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

[13] Bien TH, Miller WR and Tonigan S (1993). Brief intervention for alcohol problems: A review. *Addiction*, 88;315–336., 14 Aldridge, A. Dowd, W. and Bray, J (2017) The relative impact of brief treatment versus brief intervention in primary health-care screening programs for substance use disorders. *Addiction* **doi.org/10.1111/add.13653**

[14] Humeniuk RE, Henry-Edwards S and Ali RL (2003). *Self-help Strategies for Cutting Down or Stopping Substance Use: A guide. Draft version 1.1 for Field Testing*. Geneva, World Health Organization.

[15] Miller W and Rollnick S (2012). *Motivational Interviewing*. 3rd ed. New York and London, Guilford Press.

[16] Egan, G (1990) The skilled helper: a systematic approach to effective helping (4th edition) california, Brooks/Cole Publishing Company

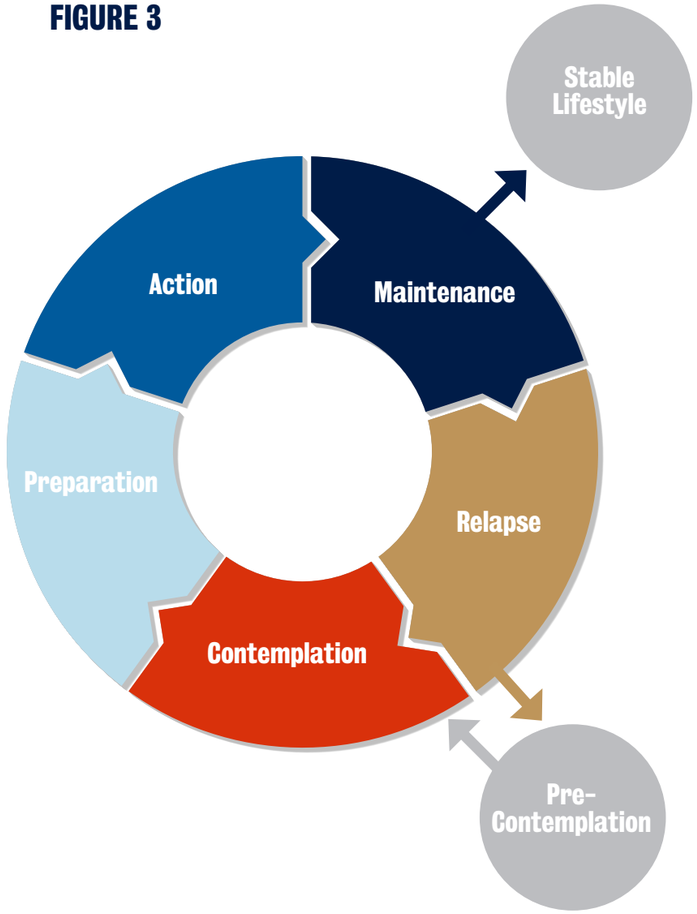
CHAPTER 3

MODEL OF BEHAVIOUR CHANGE

A 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[17]. In the model it is proposed that people go through different stages of change and that the processes by which people change seem to be the same with or without treatment[18].

The model includes several stages (Precontemplation, Contemplation, Preparation, Action and Maintenance) and is shown in Figure 3. While the model is a useful way of thinking about the process of change, be careful of simple categorization of clients. Also be aware that there is some contention in the research about the predictive value of the model and some authors have critiqued the idea of the stages as being stable and discrete.[18]. But a key aspect of the model in ASSIST-BI is to remind us that whilst we might be tempted to leap into action strategies with a client, we might need to spend more time on thinking through "why" there is a need for change and planning to act.

FIGURE 3



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

It is worth noting that there is no set amount of time that a person will spend in each stage (maybe minutes, months or years) and that people move 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 possible underlying behavioural and cognitive processes of each stage

Pre-contemplation

Many people seen by nurses who score positive on the ASSIST are likely to be in this stage. People in this stage are:

- Not necessarily thinking about changing their substance use;
- 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 or accept that their substance use is risky or problematic; and,
- Unlikely to respond to direct advice to change their behaviour, but may be receptive to information about the risks associated with their level and pattern of substance use.

Contemplation

Some people seen in primary care or hospital setting who score positive on the ASSIST may be in this stage. People in this stage are:

- Ambivalent about their substance use. They may be able to see both the good things and the not so good things about their substance use;
- Thinking about changing their substance use;
- Likely to have 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,
- Likely to respond to information about their substance related risks, advice to cut down or engage in discussion about their substance use (if approached appropriately by health care worker).

A proportion of people in the contemplation stage may be willing to make a change but they:

- May not know how to make a change; and/or,
- May not be confident that they are able to change.

Preparation

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

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

Action

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

- Have made the decision that their use of substances needs to change;
- Have commenced cutting down or stopping;
- Are actively doing something about changing their behaviour;
- Have cut down or stopped completely;
- Have some relapse prevention strategies as relapse is most likely in the first three-months after change;
- Might initially engage in avoidance of high risk situations, but later develop other coping strategies, and the confidence to implement these; and,
- Might continue to feel somewhat ambivalent about their substance use and to need encouragement and support to maintain their decision.

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

[18] West, R. (2006) The transtheoretical model of behaviour change and the scientific method. *Addiction*, 101, 768-778.

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

Maintenance

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

- Attempting to maintain the behaviour changes that have been made;
- Continuing to work 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,
- Are more likely to remain maintain change if they receive support and affirmation and if the quality of their life improves – in short, the effort is worth it.

Relapse

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

A review should examine timeframes, what strategies did actually work and whether the strategies used were over- ambitious and perhaps unrealistic. Smokers, for example, make a number of attempts to quit smoking tobacco before they are successful. For many people, changing their substance use gets easier each time they try until they are eventually successful. So, the reframe might include: why was the client successful for so long – what worked well; what challenges occurred and why, on this occasion, did the slip occur; why might they still want to change; and, what can be learned from this experience going forward.

In summary, the stages of change model 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 nurses understand these underlying processes to provide the best care for their clients, and not to be too hard on themselves when client change is not immediately obvious.

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

Nurses should not be overly concerned if they are wondering how to give the brief intervention and determine where the client is in terms of change. Gaining experience by administering the ASSIST and linked Brief Intervention is the best way to get an understanding of how clients change and to develop the 10-step intervention further.

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

[18] West, R. (2006) The transtheoretical model of behaviour change and the scientific method. *Addiction*, 101, 768-778.

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

CHAPTER 4

USING MOTIVATIONAL INTERVIEWING IN AN ASSIST LINKED BRIEF INTERVENTION

In the context of the ASSIST and linked brief intervention, it is likely that the nurse will have a relatively short time to spend with clients (compared with the amount of time that a counsellor, psychologist, addiction medicine specialist, or drug and alcohol worker, has to spend with clients).

Therefore, this manual focuses predominantly on the practical skills and techniques required to deliver a short brief intervention to those at moderate risk, rather than detailing the underlying theory or providing training on delivering lengthy or on-going sessions with clients.

The brief intervention approach adopted in this manual is based on the Motivational Interviewing principles developed by Professor William Miller in the USA and further elaborated by Miller and Rollnick[20]. It is based on the assumption that people are most likely to change when a person's motivation is developed for reasons that are important to them rather than just externally from other sources.

Brief interventions are often delivered within the "Spirit of Motivational Interviewing"[21].

There is a **collaborative** approach based on **compassion** and **acceptance** of the client's circumstances. The nurse aims to **evoke** responses that will provide the client with insight into their current pattern of use and consider options for change.

Motivational Interviewing techniques are designed to promote behaviour change by helping clients explore and resolve ambivalence. This is especially useful when working with clients in the pre-contemplation and contemplation stages, but the principles and skills are important at all stages[22].

Motivational Interviewing is based on the understanding that effective intervention assists a natural process of change. It is important to note that Motivational Interviewing is done **for** or **with** someone, not **on** or **to** them.

Administering the ASSIST and providing a targeted, linked brief intervention aligns with the four processes in Motivational Interviewing. That is: engaging; focusing; evoking; and, planning[23]. The client is first engaged by explaining the purpose of the ASSIST, outlining the confidentiality requirements of the organisation and,answering any concerns. The process of engaging leads to focusing on the purpose of the session: to administer the ASSIST. On completion of the eight questions, the score is tallied and a risk category identified for each of the substances. During the brief intervention, the nurse helps elicit the client's own motivation for change. This is achieved by asking open ended questions, affirming the client's strengths, reflective listening and summarising.

Open-ended questions

One of the ways that clients can be encouraged to express their own reasons for change is for the nurse to ask them open-ended questions. Asking open-ended questions is a technique used often in Motivational Interviewing to encourage clients to start thinking and talking about their substance use. Open-ended questions are more likely to encourage the client to do most of the talking (a good measure of how the intervention is going is "Who's doing most of the talking?").

Within the context of the ASSIST-linked Brief Intervention, examples of the types of questions asked include: *"What are the good things about using (substance)?"* and *"What are the less good things for you about using (substance)?"* Asking open-ended questions of clients also reinforces the notion that the client is responsible for the direction of the intervention and of their substance use choices.

Affirming

Including statements affirming and showing understanding helps to create a more supportive atmosphere. Affirming the client's strengths and efforts to change helps build confidence, while affirming self-motivating statements (or change talk) encourages readiness to change. Examples include:

"I appreciate that you are willing to talk to me about your substance use."

"You are obviously a resourceful person to have coped with those difficulties."

"It must be hard to talk about… I really appreciate your keeping on with this."

Reflective listening and summarising

Reflective listening involves: hearing; understanding; and, communicating what you have heard/understanding. A reflective listening response is a statement clarifying what the client has said and ensuring that what you have heard is what they mean and/or a statement to capture the meaning and feeling of what a client has said. Therefore, it is important to reflect back what you understand as the underlying meanings and feelings that the client has expressed as well as the words they have used. Using reflective listening is like being a mirror for the person so that they can hear the nurse say what they have communicated and correct what has been misunderstood or add to the information. Reflective listening shows the client that the nurse understands what has been said or it can be used to clarify what the client means. Sometimes the process can help the client make more sense of what has been chaotic or confusing.

Summarising is an important way of gathering together what has already been said and preparing the client to move forward. Summarising adds to the power of reflective listening, particularly in relation to concerns and change talk. First, clients hear themselves say it, then they hear the nurse reflect it, and then they hear it again in the summary. The nurse can then choose what to include in the summary and can use it to guide the client to consider further the less good things about their substance use.

Within the context of the ASSIST-linked Brief Intervention reflective listening and summarising can be used to highlight the client's ambivalence about their substance use and to guide the client towards a greater recognition of their problems and concerns. For example, in the Ben scenario (see below) the nurse summarised the following:

"So on the one hand you are saying that you smoke cannabis as it helps you sleep and relax, but on the other hand it is affecting your fitness and you actually failed a couple of subjects at uni. What is most important to you at the moment, Ben?"

Feedback

Providing feedback to clients is an important part of the brief intervention process. The way that feedback is given can affect whether the client really hears the feedback and takes it in. Feedback should be given in a way that takes account of what the client is ready to hear and what they already know. Using the empathic style and specific skills described earlier in the manual can have a significant effect on how well clients feel they have understood the feedback. A simple and effective way of giving feedback which takes into account the client's existing knowledge and interest, and is respectful of their right to choose what to do with the information, involves three steps[24]:

1. Elicit
2. Provide
3. Elicit

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

"What do you know about the effects of cannabis?"

"Is there anything else you'd like to know about the impact of cannabis on …?"

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

"Your score for cannabis was 18, which means that your current level of use puts you at risk of experiencing health and other problems."

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

"How concerned are you by your score for cannabis?"

"What concerns you most about this?"

"What do you see are your options?"

Key components of an effective brief intervention are to raise the client's awareness of the risks related to their current pattern of substance use, elicit reasons for change and present a menu of options for consideration. This can be facilitated by exploring discrepancy and ambivalence within the client.

Exploring discrepancy and ambivalence

Clients are more likely to be motivated to change their substance use behaviour when they see a difference or discrepancy between their current substance use and related problems and the way they would like their life to be, including their health and relationships with others. Motivational Interviewing aims to create and amplify any discrepancy between current behaviour and broader goals and values from the client's point of view. It is important for the client to identify their own goals and values and to express their own reasons for change. Ambivalence refers to the contradictory feelings clients might have about their substance use. Some feelings are positive, such as the associated pleasures. Other feelings are negative, such as the risks involved or problems it creates. If we simply make people feel defensive, they may amplify the former, and minimize the latter.

Eliciting change talk is a strategy for helping the client to resolve ambivalence and is aimed at encouraging the client to present the arguments for change. There are four main categories of change talk[25, 26]:

1. Recognising the disadvantages of staying the same;
2. Recognising the advantages of change;
3. Expressing optimism about change; and,
4. Expressing an intention to change.

There are a number of ways of evoking change talk from the client. Asking relevant questions, such as the following, may help start this process:

"What concerns you about your substance use?"

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

"What would be the good things about cutting down on your substance use?"

"How would you like your life to be in a couple of years time?" "How does your current drug use contribute to this goal?"

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

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

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

Important tips

In brief, the nurse administering the ASSIST-linked Brief Intervention:

- is empathic and non-judgemental;
- provides relevant feedback (using the elicit, provide, elicit, process);
- helps the client raise discrepancy and resolve ambivalence around their substance use;
- uses open-ended questions to evoke answers;
- listens for 'change talk';
- respects the client's choices regarding the decisions they make about their drug use, and the choices they make during the course of the brief intervention; and,
- uses respectful language toward the client.

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

- Are you focused 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?[27]

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[23] Miller W and Rollnick S (2012). *Motivational Interviewing: Helping People Change. 3rd ed.* New York and London, Guilford Press

[24] ibid. Miller W and Rollnick S (2012). *Motivational Interviewing: Helping People Change. 3rd ed.* New York and London, Guilford

[25] Day, P. Gould, J. and Hazelby, G. (2017). The use of motivational interviewing in community nursing. Journal of Community Nursing, 31 (3), 59-63

[26] Miller W and Rollnick S (2012). *Motivational Interviewing: Helping People Change.* 3rd ed. New York and London, Guilford Press

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

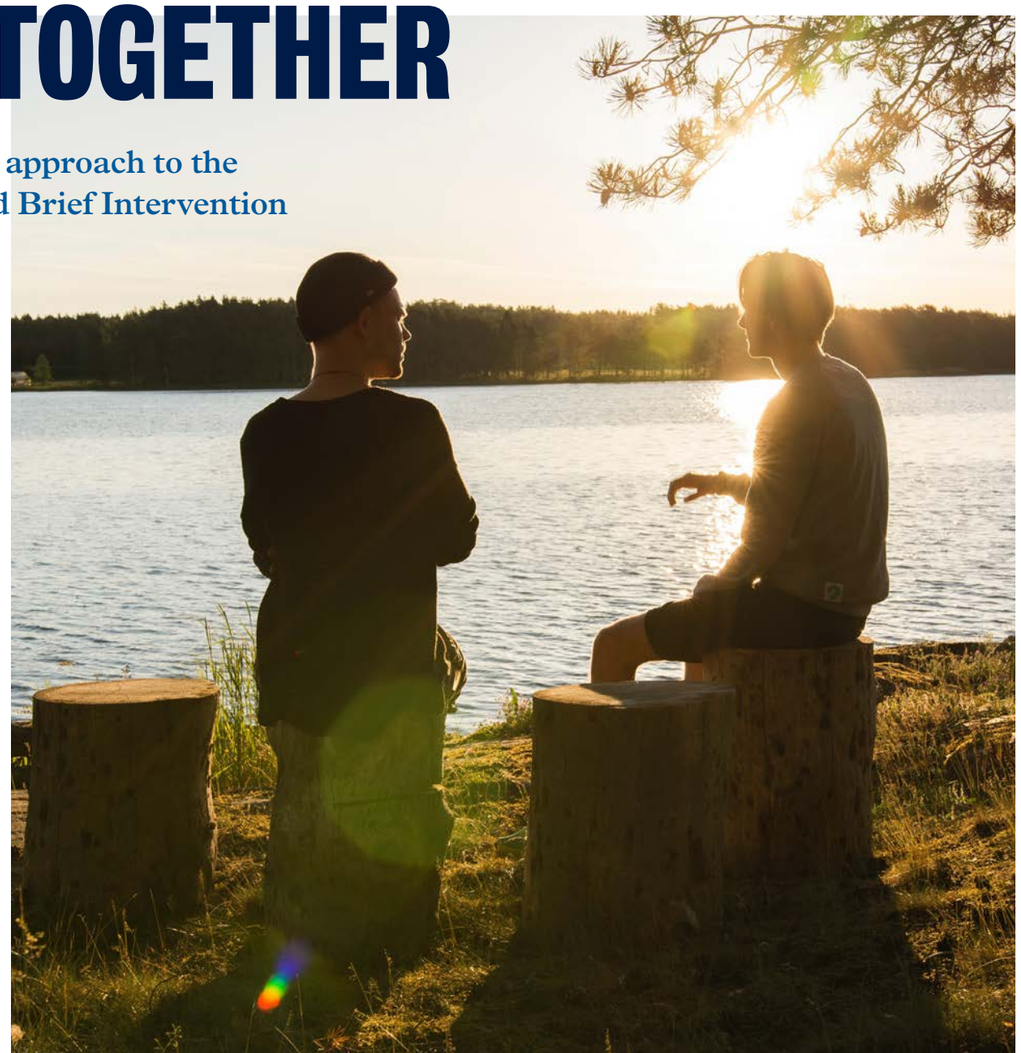
Suggested further reading:

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

CHAPTER 5

PUTTING IT ALL TOGETHER

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



The ASSIST-linked Brief Intervention follows ten suggested main steps. Attempting to change a number of behaviours at the same time can be difficult and may lead to the client feeling overwhelmed and discouraged. Accordingly, focusing the intervention on one substance and linking other substances can be advantageous. More often than not, the substance of most concern will be the one that has attracted the highest ASSIST score and/or is being injected.

Moderate risk clients

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

1. **Ask** clients if they are interested in seeing their questionnaire scores;
2. Provide personalised **Feedback** to clients about their scores using the ASSIST Feedback Report Card;
3. **Give Advice** about how to reduce risk associated with substance use;
4. Allow and encourage clients to take ultimate **Responsibility** for their choices;
5. Ask clients how **Concerne**d they are about their scores;
6. Weigh up the: **Good things** about using the substance against the

   Less good things about using the substance (you might need to change the language depending on your client– for example, you could say "the things you get out of your substance use" instead of "Good things" and you could say "the consequences you would rather not have" instead of the "less good things";
7. Summarise and Reflect on clients' statements about their substance use with emphasis on the less good things;
8. Ask clients how Concerned they are by the less good things; and,

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

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

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

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

The ASSIST scores for each substance should be recorded in the boxes provided on the front of the ASSIST Feedback Report Card. On the following pages the level of risk indicated by the ASSIST Risk score should be indicatedby ticking the relevant boxes for all substances ('low', 'moderate' or 'high'). A formatted copy of the ASSIST Feedback Report Card appears in Appendix C, and can be copied and used for the brief intervention.

Some people find that using the on-line version – eASSIST – is a useful way of conducting the screening – go to **eassist.assistportal.com.au/#/e-assist**

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

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

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

Nurses should go through each substance score on the front page of the ASSIST Feedback Report Card and inform the client whether they are at low, moderate or high risk from their use of that substance. Following this, explain to the client the definition of moderate risk and/or high risk, which can be done by reading the definitions from the box at the bottom of the front page. An example of feedback is shown below:

"These are all the substances I asked you about and these are your scores for each of the substances (point to scores). As you can see you scored low risk for most of the substances. Your score for tobacco was 16 which places you in the moderate risk range, your score for alcohol was 15 which is in the moderate risk range. Your score for cannabis was 18 which also is in the moderate risk range. Moderate risk means that you are at risk of health and other problems from your current pattern of substance use, not only now but also in the future if you keep using in the same way."

The second part of the feedback comprises communicating the risks associated with each particular substance used—focusing on the highest scoring substance (or substances). The information relating to the second part of the feedback is found inside the ASSIST Feedback Report Card in a series of nine boxes (tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, inhalants, sedatives, hallucinogens, opioids). Each box lists the harms ranging from less severe (shaded light grey) to more severe (shaded dark grey) for each substance, and feedback comprises verbalising these risks to the client as written, with further explanation if required.

Once again, the card should be held so it can be viewed easily by the client, but still be able to be read by the interviewer. An example of personalised feedback around a moderate risk score for 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, feeling anxious, panicky or depressed, difficulty solving problems or remembering things, high blood pressure, asthma, bronchitis and at the serious end of things, psychosis, heart and airways disease and cancers… I wonder what you think of these possible risks; have you noticed anything along these lines?"

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

Giving advice to clients is simply about creating a link between reduction of drug use and reduction of harms. Clients may be unaware of the relationship between their substance use and existing or potential problems, and advice is about telling clients that cutting down or stopping their substance use will reduce the risk of problems both now and in the future. An effective way of providing advice to clients is to say:

"The best way you can reduce your risk of these things (harms) happening to you is to either cut down or stop using (drug)."

It is worth noting that advice should not be given in a judgmental or subjective way that conveys the opinion of the nurse. For example, expressing advice in terms of: *"You really need to do something about your drug use"* or *"I am concerned about your cannabis use."* may not be helpful because clients may feel judged, embarrassed, angry, criticised, and ultimately resistant to change. Expressing advice objectively provides the client with accurate information to help them make their own decision in a neutral yet supportive environment.

STEP 4 – Allow clients to take ultimate Responsibility for their choices

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

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

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

STEP 5 – Ask clients what Concerns them about their scores

This is an open-ended question designed to get the client thinking about their substance use and to start verbalising any concerns they may have about their use. Using open-ended questions in this context is a powerful motivational interviewing technique and may be the first time the client has ever verbalised concerns about substance use in their life. There is evidence that verbalising concerns in a supportive context leads to change in beliefs and behaviour. Nurses 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 (drug)?"

STEPS 6 and 7 – Explore the Good things and Less good things about using the substance

Getting a client to consider and verbalise both the good things and less good things about their substance use is a way to acknowledge the balance between the positives and negative of substance use, and can help to explore and develop discrepancy, or create cognitive conflict within the client. It may be the first time that the client has thought about, or verbalised, the pros and cons of their use and is a first and important step in changing behaviour. It is important to ask about the positive as well as the negative aspects of substance use as it acknowledges to the client that the nurse is aware that the client has pertinent or functional reasons for using a substance.

The best way to get clients to weigh up their substance use is through the use of two open-ended questions, explaining why you are doing this "I'm just going to ask some questions to help me understand what influences your substance use."

Then commence with the positive aspects of substance use say something like:

"What are the things you get out of your (substance) use …?"

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

"So the main things you get from your (substance) use are x, y, and z. Flipping the coin over, "What are the consequences you would rather not have…?"

If a client has difficulty verbalising the less good things, nurses can prompt with answers given by the client during the administration of the ASSIST questionnaire (particularly Q4) or with open-ended questions around the following areas:

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

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

Reflecting to clients by summarising what they have just said about the good, and less good things, of their substance use is a simple but effective way of acknowledging the client's experiences and preparing the client to move on. If a client feels that they have been 'listened to', they are more likely to receive and consider the information and advice given by the health worker. Reflecting and summarising also allows nurses to actively highlight a client's cognitive conflicts and to emphasize the less good aspects of their substance use. An example of reflecting back the good and less good things of a client's substance use, with final emphasis on the less good things is:

"So you like drinking because it relaxes you and the first couple of drinks make you feel happy and talkative and confident when you're out, but you don't like that you find it difficult to stop drinking once you've started and that you often get into arguments when you're drinking that can result in you saying or doing things that you regret the next day, including ending up in hospital last week because you were injured in a fight…"

STEP 9 – Ask clients what Concerns them about the less good things

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

"What concerns you most about the arguments with your partner?"

STEP 10 – Give clients Take-home materials to bolster the brief intervention

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

In brief, there are 3 to 4 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 your country);
- Self-Help Strategies for Cutting Down or Stopping Substance Use: Self-Help Guide booklet; and,
- Risks of Injecting Card (if relevant).

The ASSIST Feedback Report Card serves as a reminder of the client's scores and the risks associated with their primary substance use that has been the focus of the brief intervention. The card also contains information on the risks associated with the use of other substances that may not have been directly addressed during the course of the brief intervention, but may be being used by the client.

The *Self-Help Strategies for Cutting Down or Stopping Substance Use: Self-Help Guide* booklet is a generic guide which helps clients decide if they want to change their substance use and contains a number of simple but effective strategies to help clients cut down or stop using. It has been written to be appropriate for people with at least five years of education and is pictorial in nature. Nurses could also use the booklet as a platform for longer or ongoing interventions if relevant. The booklet can be found on the ASSIST Portal **assistportal.com.au/download/self-help-manual/?wpdmdl=482&masterkey=5dbc3f6a25ea1**

The Risks of Injecting Card which is available in Appendix D (or from the ASSIST Portal) **assistportal.com.au/download/ho9-who-assist-v3-0-risks-of-injecting-card/?wpdmdl=478&masterkey=5dbc3e3b48495** 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 on their substance use. If they do want to cut down, then it provides them with some useful strategies for helping them to cut down or stop."

Low risk clients

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

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

High risk client

Clients whose ASSIST scores are in the 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 best 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. 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 care worker;
- inpatient or ambulatory withdrawal;
- specialist drug and alcohol counselling;
- medication to treat the dependence and prevent relapse;
- residential rehabilitation;
- group counselling; and/or
- a 12-step, SMART Recovery, 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, and 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 which is available in Appendix D.

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

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

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

Clients should also be 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.

*Question 8 on the ASSIST asks about the recency of injection of 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). Nurses 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.

CHAPTER 6

RESPONDING TO RESISTANCE AND CHALLENGING BEHAVIOUR

Often there is concern that people will become resistant and defensive when asked about their alcohol and other drug use, and that people may not answer entirely honestly.

Often there is concern that people will become resistant and defensive when asked about their alcohol and other drug use, and that people may not answer entirely honestly. The use of motivational interviewing techniques and an empathic non-judgemental approach can help build rapport and reduce resistance.

Evidence has shown that people will be more likely to respond positively and honestly if they are approached in a respectful manner, the reason for administering the ASSIST is clearly explained, and questions are asked in a non-judgemental manner.[28]

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

WHAT PEOPLE REALLY NEED IS A GOOD LISTENING TO.

Mary Lou Casey

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

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

Challenging behaviour is any behaviour that causes significant distress or danger to the person of concern or others. It can include an outburst of aggression, or resistant type behaviour. This is frequently unpredictable. However, the approach made towards the person is very important.

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

- Pause — stand back, take a moment before approaching and assess the situation
- Speak slowly and clearly in a calm voice
- Explain your actions
- Try not to rush the person, act calmly
- how respect and treat people with dignity at all times
- Minimise irritating factors in the environment such as noise, uncomfortable clothing
- Enhance comfort, decision making and dignity
- Communication is the key
- Avoid harsh aggressive or abrupt statements. Don't say things such as "You must…", "Don't…", "Stop…". Use alternatives and "I' language like "I would like you to…" It would help me if…", "I feel scared when…".

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

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

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

CHAPTER 7

DEVELOPING YOUR SKILLS AND HELPING OTHERS DEVELOP THEIRS

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

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

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

Reflective Practice

Reflective practice is an important skill to develop. We might reflect on our own performance and activity at work, in our social lives and in sport. Formalising this as a skill, through reflective practice, is a process that allows us to recognize our own strengths, and areas for development. We can use this to guide our on-going learning and ensuring quality practice.

Reflective practice is critical to develop our skills through self-directed learning, contributing to quality supervision and practice, improving motivation, and improving the quality of care we can provide.

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

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

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

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

Supervision

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

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

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

PART 2

OVERVIEW

THIS SECTION PROVIDES OPTIONS FOR DELIVERY OF THE ASSIST WITH SUBSTANCE PACKAGE IT OUTLINES THREE TRAINING MODELS: FLIPPED CLASSROOM; FACE-TO-FACE; AND, ONLINE.

THE FLIPPED CLASSROOM MODEL

This model is particularly useful for undergraduate and post graduate students.

The flipped classroom model encompasses the use of technology to leverage the learning in the classroom, so that you can spend more time interacting with students instead of lecturing. It is called the flipped class because the whole classroom/homework paradigm is "flipped". What used to be class work (the "lecture") is done at home via teacher-created videos and what used to be

homework (assigned problems) is now done in class[29]. Another way of describing this is 'pre-loading' on information before the session.

To use this package in a 'flipped model' the following is suggested. Prior to the face-to-face sessions students should be instructed to:

1. Watch ASSIST with Substance video **assistportal.com.au/resources**
2. Familiarlise themselves with the ASSIST tools (Appendix A-D);Explore background information on the ASSIST Portal: **assistportal.com.au**
3. Rehearse at least one ASSIST on a family member or friend (role play);
4. Prepare themselves to come to class and administer an ASSIST and to role play a character with a fellow student;
5. The character developed for the role play should be researched and based on evidence that is available related to patterns of drug use. This would include associating the age and gender of the character with the pattern of drug use and associated consequences of use. Useful sites in Australia include:

   assistplus.com.au

   adf.org.au/resources

6. Students are to research what services are available in their area and be prepared to provide an ASSIST-linked, targeted intervention. Helpful sites in Australia are:

   quitnow.gov.au

   druginfo.adf.org.au/information- for/free-resources

   National Alcohol and other Drug Hotline – 1800 250 015

   Counselling ONLINE
   counsellingonline.org.au

   Hello Sunday Morning
   hellosundaymorning.org

   QUIT
   quitnow.gov.au

NOTE: Students may build on the characters shown in the video. Further background information on Ben, Mel and Eddie are included in Chapter 9. Alternatively, they might create clients from their own experience as a clinician (de-identified).

During class time, students are divided into groups of three. In turns they spend a little time preparing for the role play, then role play the scenario and provide an appropriate, targeted brief intervention. The third person in the group acts as an observer and provides feedback to the pair at the conclusion of the role play. Feedback should be constructive – that is the person should be able to use the information to alter their approach (it's not constructive to say "*that was wasn't very good*" for example).

Feedback should also be given as you would want to receive it. The observer asks and assesses what stage of change the client was at?

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

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

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[29] Tucker, B. (2012). The flipped classroom. Education Next, 12(1), 82-83.

CHAPTER 9

FACE-TO-FACE SESSIONS

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

1. One-hour session (e.g in-service or professional development):

For more experienced nurses, the video can be shown as a focal point for discussion. Suggested topics for discussion could include:

- How is screening and brief intervention currently being conducted in their area?
- What has been successful?
- What are the barriers to screening and brief intervention?
- Discuss possible ways to overcome these barriers.
- How could screening and brief intervention be implemented in their area?

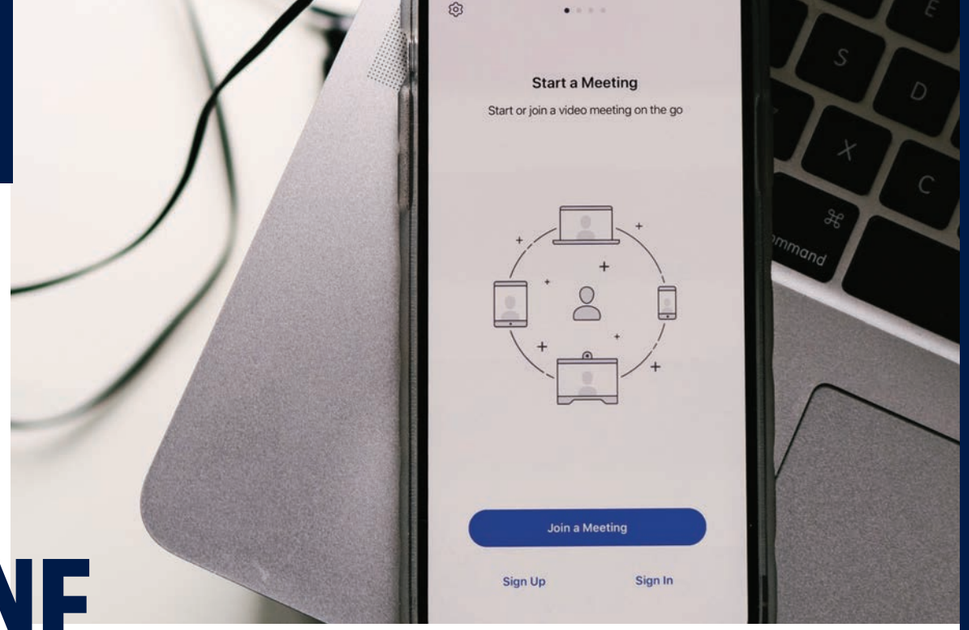
2. Two-hour session

As above plus role play. In groups of three (as per flipped classroom model outlined in chapter 6)

3. As part of a workshop.

As screening and brief intervention are part of a range of clinical practice, 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 are or work practice (i.e.: Emergency Department, Mental Health, Midwifery). An example of a midwifery case study is included in Chapter 9.

CHAPTER 10



ONLINE LEARNING

The ASSIST with Substance video can be used in a variety of platforms for online teaching.

It is suggested that the students be asked to watch the video and answer questions. Depending on the objectives of the subject, the linked activity could be a quiz or the basis for a discussion board topic, assignment or essay.

Online learning

The resources included in this package can be easily adapted to an online audience.

Depending on the learning platform, a suggested approach is:

- Participants view the ASSIST with Substance video online;
- Discussion points are posted on a 'discussion board' or 'chat room';
- Participants are encouraged to conduct a role play using the ASSIST-BI with a fellow student, friend, colleague or in either in 'chat room', via Skype, Zoom or over the telephone;
- The experience of conducting the ASSIST-BI would form the basis of postings on the discussion board.

Suggested topics for discussion include:

- How was the experience of conducting an ASSIST-BI?
- What did you learn from the experience?
- How is screening and brief intervention currently being conducted in their area?
- What has been successful?
- What are the barriers to screening and brief intervention?
- Discuss possible ways to overcome these barriers.

General discussion board questions for consideration:

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

Note: Further information on preparation for role plays is included in Chapter 6.

PART 3

CHAPTER 11

SCENARIOS

Background information is provided about the three scenarios depicted in the ASSIST with Substance video which is included in this resource.

It recommended you read the information to put each character into context. A sample case study with an ante-natal focus is included (Kate).

Mel

Mel is a 30 year-old communication manager for a large finance company. She enjoys her work, though can become quite stressed by the competing demands and tight deadlines on her projects.

Mel grew up in the outer suburbs of Sydney, Australia and five years ago moved to Wollongong after purchasing an apartment on the beach. Mel was engaged to be married but one year ago split from her fiancée. Mel is friendly and outgoing and has developed a solid group of friends through the local theatre group. Although she considers herself 'single' she has just started seeing a guy from work, 'Scott'.

From the age of 15, Mel smoked cigarettes on and off. She had multiple attempts at quitting over the years and is currently six months smoke free after using a combination of nicotine replacement therapy, counselling support and the QUIT Buddy phone app. Mel started drinking alcohol during her final year of school and continued during her three years at University. Mel has her own 'rule' of not drinking through the week, though over the last couple of years her days of consuming and the amount consumed has increased.

A typical week for Mel includes catching up with theatre group friends on Thursday after work. What started as just a couple of drinks has escalated to consuming roughly a bottle of wine and it is sometimes a struggle to get to work on Fridays. Mel generally has a few drinks with her work colleagues on Friday night, plays tennis on Saturday, drinks with tennis pals on Saturday evening and finishes of the weekend with a social event on Sunday lunch.

Mel's colleagues have started to express concern about her work performance. Although normally dedicated and committed to her task, Mel has let a couple of important deadlines lapse and her work has been of poorer quality.

Although her colleagues make a joke about it, they do not schedule any early morning meetings on Mondays or Fridays. Mel is ambitious and has a 'work-hard, play-hard' philosophy to life, though is realising that this is starting to catch up with her and is impacting on her work and relationships.

Ben

Ben grew up in country New South Wales, Australia. Being an only child, he made friends easily and was popular at school. Ben represented his school and district in soccer and liked to ride horses on the family property. Although Ben's father wanted him to follow in his footsteps and become a farmer, Ben had different ideas and was keen to leave his home-town and experience a 'real life'.

Ben moved and, four years ago, started university. In the beginning he was eager to learn, was getting good grades and kept in contact with his family and friends back home. At least once a month, Ben would take the four-hour drive to go home and visit his friends and family.

At university, Ben sought shared accommodation in a near- by suburb to save on accommodation expenses. Ben's three housemates are older and work at the nearby steel works. There is a constant flow of people in and out of the house as the housemates are shift-workers and a lot of friends would 'crash' there.

Ben had stayed away from the drinking and drug culture in his home-town. His close friends shared his love for soccer and horse riding which did not fit with the alcohol and drug scene. Ben had tried alcohol during his school years, but did not enjoy the experience, having vomited and passing out on his friend's floor. He had not drunk since or tried any other drug.

Keen to fit into the house culture, Ben started smoking cannabis. This started as just a weekend activity. Ben would not smoke cannabis during the week or when he visited his family and friends back home. Over a two-year period, Ben's cannabis use increased to daily. He now found that he was craving it, couldn't sleep without it and was starting to feel anxious. Although no-one had expressed concern about his use, he was sure if his family and friends knew they would be alarmed and want him to stop.

Ben is in an unfortunate situation. He wants to complete his studies and return home; however, his cannabis use is impacting on his study as he has failed a number of subjects. He has not been home for six months and has lost interest in soccer, friends and family. Ben has not really thought about giving up his cannabis use as it would be difficult given his current living situation. He also finds it difficult to sleep without using cannabis use and is started experience episodes of anxiety and panic.

Eddie

Eddie did not celebrate his 40th Birthday as planned.

His wife had organized a party and when he didn't even turn up; she told him to 'get out' and changed the locks. This was not a one-off event. Eddie was becoming very unreliable, missing family events and not turning up for work. His job as a cook at the local RSL club was under threat.

Six months into the separation from his wife and sons was taking its toll. Eddie had moved back in with parents, and although they were very loving and caring, he was struggling to settle into his once familiar environment. Eddie was not appreciative of his parent's advice to 'just sort it out with Vicki and go home and be a good father'. Eddie's father had also expressed concern about his drinking.

Not academically minded, Eddie was good at sports and popular at school. He loved to have fun and was a risk-taker. Eddie first tried alcohol when he was 14 years old. He experimented with a range of drugs (amphetamine and cannabis) during his youth, and smoked tobacco for 10 years. Eddie had multiple attempts at quitting cigarettes and was successful five years ago using a combination of nicotine replacement therapy and telephone counselling support. Eddie's drug of choice is alcohol and he has never seen a reason to cut down or quit drinking.

For many years, Eddie consumed alcohol in a 'binge' style. His wife, being a non-drinker, would accuse Eddie of being a 'drunk', a 'slob' and being a poor role model for the boys. Eddie believed that because he was not drinking on 'school nights' it was ok and that his boys would understand once they were old enough.

Eddie is now drinking daily. His shifts as a cook have been cut back due to a recent DUI charge that is restricting his availability. Eddie is finding refuge with his new 'mates' at the local pub. When he is not working, Eddie's typical day: stays in bed in until 11am; lunch with his Mum and Dad; walk to the local pub, 10 — 12 schooners; stagger back to his mates place for 'a few cleansing ales'; and, home in the early hours.

Following one of his 'typical days' Eddie fell up the front stairs of his home and badly hurt his leg. Eddie's father feared that he had 'broken his ankle' and took him to the local Emergency Department.

This case study has been included as an addition to the video and is targeted at audiences exploring issues related to pregnancy and substance use.

Kate

Kate is a 33-year-old lawyer, working and living in inner- city Melbourne, Australia. Kate is often considered to be a 'wonder woman' by others, as she recently became partner in a successful law firm, plays A-grade tennis and has a five year-old daughter. When asked by her friends, "How do you do it?", Kate jokingly responds, *"With no sleep and plenty of good wine."*

Following a routine pap-smear, Kate mentions to the nurse that she and her partner are considering having another child. As part of the routine work-up, the nurse administers the ASSIST. Kate scores in the moderate risk range for tobacco and alcohol. When shown the results, Kate said that she would stop smoking the minute she knows she is pregnant, as she had no problem stopping last time. Kate also adds that she doesn't know what all the fuss is about alcohol and pregnancy and adds *"I drank throughout my last pregnancy and Chloe is just fine."*

Questions for consideration:

1. What would be the focus of the Brief Intervention with Kate?
2. What information would you provide back to Kate in the Brief Intervention?
3. What stage of change is Kate in for her tobacco use?
4. What stage of change is Kate in for her alcohol use?
5. What are the common features of Fetal Alcohol Spectrum disorder?
6. What do the current Australian National Health and Medical Research Council guidelines suggest regarding alcohol use and pregnancy?

NHMRC Guideline 4: Pregnancy and breastfeeding

Maternal alcohol consumption can harm the developing fetus or breastfeeding baby.

A. For women who are pregnant or planning a pregnancy, not drinking is the safest option.

B. For women who are breastfeeding, not drinking is the safest option.

Suggested resources:

Australian Guidelines to Reduce Health Risks from drinking alcohol.

nhmrc.gov.au/health-advice/alcohol

National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028
health.gov.au/sites/default/files/national-fasd-strategic-action-plan-2018-2028.pdf

QUIT smoking resources:
quitnow.gov.au

GUIDE TO APPENDICES

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

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

Appendix A

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

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

Appendix B

ASSIST response card for clients

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

Appendix C

ASSIST feedback report card for clients

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

Appendix D

Risk of injecting card for clients

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

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

APPENDIX A – WHO – ASSIST V3.1

CLINICIAN NAME		**CLINIC**	
CLIENT ID OR NAME		**DATE**	/ /

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

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

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

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

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

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

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

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

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

Question 2

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

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

Question 3

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

Question 4

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

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

Question 5

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

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

Question 6

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

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

Question 7

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

Question 8 (please mark the response)

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

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

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

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either **Q1** or **Q8** in this score. For example, a score for cannabis would be calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c**
Note that Q5 for tobacco is not coded, and is calculated as: **Q2a + Q3a + Q4a + Q6a + Q7a**

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

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

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

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

APPENDIX B – ASSIST RESPONSE CARD

Response Card – Substances

a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b. Alcoholic beverages (beer, wine, spirits, etc.)
c. Cannabis (marijuana, pot, grass, hash, etc.)
d. Cocaine (coke, crack, etc.)
e. Amphetamine type stimulants (speed, meth, ecstasy, etc.)
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)
g. Sedatives or Sleeping Pills (Diazepam, Alprazolam, Flunitrazepam, etc.)
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)
i. Opioids (heroin, morphine, methadone, Buprenorphine, codeine, etc.)
j. Other - specify:

Response Card (ASSIST Questions 2 to 5)

Never: not used in the last 3 months.

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

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

Weekly: 1 to 4 times per week.

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

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

APPENDIX C – FEEDBACK REPORT CARD

NAME _____ **TEST DATE** _____

Specific Substance Involvement Scores

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

What do your scores mean?

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

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

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

Are you concerned about your substance use?

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

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

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

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

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

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

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

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

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

APPENDIX D – RISKS OF INJECTING CARD

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

The substance

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

The injecting behaviour

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

Sharing of injecting equipment

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

It is safer not to inject

If you do inject:

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

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

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

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

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

FURTHER INFORMATION

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

ASSIST Portal:

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

ASSIST Plus:

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

assistplus.com.au

Australian Drug Foundation:

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

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

Australian Government, Department of Health

health.gov.au/health-topics/alcohol

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

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

Drug and Alcohol Nurses Australasia (DANA)

danaonline.org

Further Support for People Affected by Alcohol and other Drug Problems

National Alcohol and other Drug Hotline

1800 250 015

Counselling ONLINE

counsellingonline.org.au

Hello Sunday Morning

hellosundaymorning.org

My QuitBuddy

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

QUIT

quitnow.gov.au

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.

FOR FURTHER ENQUIRIES

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