



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

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## ACKNOWLEDGEMENTS

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

This project was supported by a dedicated team and contributors: A/Prof Robert Ali (DASSA-WHO Collaborating Centre), Jennifer Harland (DASSA-WHO Collaborating Centre), Prof John Marsden (King's College London), A/Prof Linda Gowing (DASSA-WHO Collaborating Centre), Sue Henry Edwards (DASSA-WHO Collaborating Centre), Janette Curtis, Phil Burge and Amy Fadden.

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

This manual has been designed to support the *ASSIST on Ice* instructional video and is complimented by two resources that are available on the World Health Organization web site: [http://www.who.int/substance\\_abuse/activities/assist/en/index.html](http://www.who.int/substance_abuse/activities/assist/en/index.html)

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

All resources shown in the instructional video and in this manual are available on the ASSIST Portal ([assistportal.com.au](http://assistportal.com.au)). The portal has been developed by the DASSA-WHO Collaborating Centre, University of Adelaide, as a repository for ASSIST tools, training resources, research articles and publications.

The eASSIST shown in the instructional video was developed by the Alcohol, Tobacco and Other Drugs Association, ACT (ATODA). Thanks is given to the ATODA team for their ongoing support and commitment to the ASSIST project.

The project team is grateful for the support and funding for the ASSIST project provided by the Australian Government, Department of Health.

The *ASSIST on Ice* instructional video was directed by Paul Ewing, produced by Adam Preston (University of Wollongong) and presented by John Marsden. Gratitude is given to John, Paul, Adam and the film and production team for their ongoing support, professionalism and commitment to the project. A big thank you is given to the actors, friends and colleagues across Canberra and Wollongong who happily gave of their time to support and appear in the video.

The *ASSIST on Ice* resource has been endorsed by the Drug and Alcohol Nurses of Australasia (DANA).

Suggested citation:

Harland, J. and Ali, R. (2017) *ASSIST on Ice: The Alcohol, Smoking and Substance Involvement Screening Test and Brief Intervention for Methamphetamine Use*, DASSA-WHO Collaborating Centre, University of Adelaide, Australia

Edited by William Mundy

# OVERVIEW

There are continued growing concerns about the use of methamphetamine and the impact it has on the person and their community.<sup>1</sup> The primary health care workforce is ideally placed to identify methamphetamine use and provide brief information and referrals to persons wanting to address their methamphetamine use. However, competing demands make it challenging for primary health care professionals to gain the knowledge and skills to screen for substance use and provide a targeted brief intervention.

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

This manual provides an overview of methamphetamine, how screening and brief intervention fits within a stepped care model and information on how to use the principles of motivational interviewing to provide an effective brief interventions. The manual includes suggestions on how to use this package as a training resource and helpful information on the planning and delivering of an educational session.

## Why use the ASSIST and linked brief intervention?

Most people who use methamphetamine do not seek specialist care.<sup>2</sup> Screening and brief intervention aims to identify current or potential problems resulting from substance use and motivate those at risk to change their substance use behaviour. It does this by increasing their awareness of the relationship between consumption and a range of health and social risks and harms.<sup>3</sup>

Clinicians working in primary health care settings are well placed to play a key role in the identification and prevention of methamphetamine related problems. Due to competing demands in a clinician's busy schedule, priority is given to tasks with the greatest immediate impact. Unfortunately, screening for drug and alcohol use may 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 addiction specialists, as a tool that is easy to use to detect substance use and related problems. The ASSIST is an eight-item questionnaire and takes about five to ten minutes to administer. ASSIST can help identify a range of issues including: regular use, dependent or 'high risk' use and injecting behaviour.<sup>4</sup> The ASSIST-linked Brief Intervention (ASSIST-BI) presented in this package can be delivered in less than ten minutes. The principles and practice suggestions can also be used for longer or recurrent intervention sessions as needed.<sup>5</sup>

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

- a lack of time
- feeling that they are not competent or capable of giving an intervention
- concern that they will experience resistance and defensiveness from their clients.<sup>6</sup>

This resource addresses these barriers using a simple step-by-step approach. Brief interventions have been shown to be acceptable and motivating for many people with hazardous or harmful substance use, while also offering the health professional a plan to match the individuals risk level and need.

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

<sup>1</sup> Roche, A., McEntee, A., Fischer, J., & Kostadinov, V. (2015). Methamphetamine use in Australia. Adelaide: National Centre for Education and Training on Addiction (NCETA).

<sup>2</sup> 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.

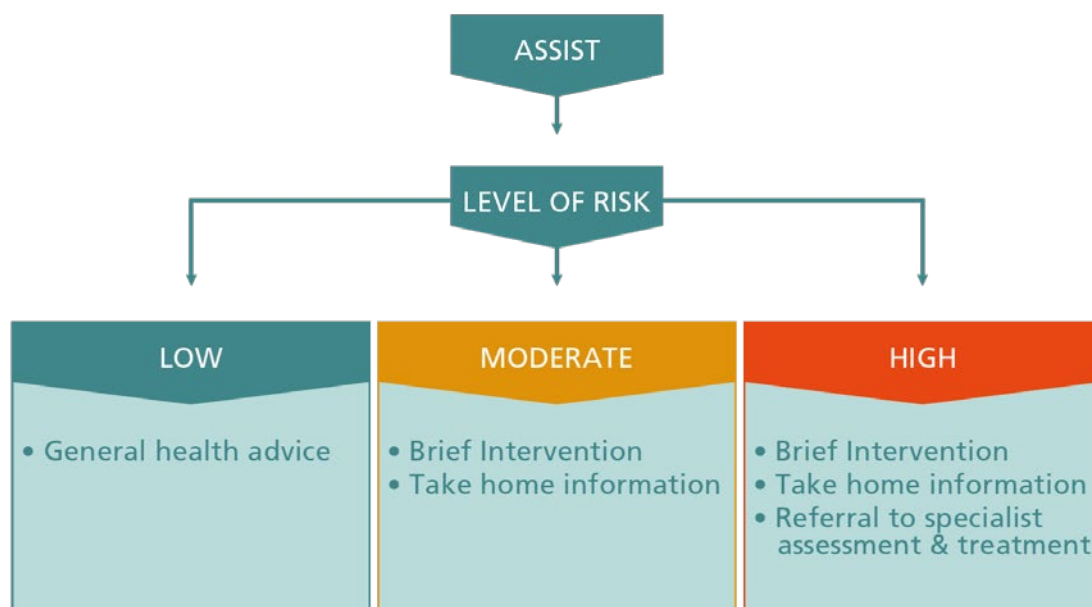
<sup>3</sup> Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V and Monteiro M (2010). The ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care. Geneva, World Health Organization.

<sup>4</sup> World Health Organisation (2010) The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Manual for use in primary care. World Health Organization, Geneva.

<sup>5</sup> McPherson TL and Hersh RK (2000). Brief substance use screening instruments for primary care settings: A review. *J Subst Abuse Treat*, 18:193-202.

<sup>6</sup> 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

FIGURE 1: ASSIST flow chart



## A word from the developers

Following the success of *ASSIST with Substance*<sup>7</sup>, the team was delighted to be approached to develop another training resource, this time with a focus on screening and brief intervention for methamphetamine use. Based on the same formula as *ASSIST with Substance*, we documented common realistic clinical scenarios, based on the teams combined clinical experience. We noted that a lot of methamphetamine users do not present to drug and alcohol services until they are experiencing quite serious problems. To prevent this progression, early identification and brief intervention in primary health care settings was the focus.

The two scenarios in the *ASSIST on Ice* instructional video are based on clinical presentations that are common in primary health care settings. We want to highlight that the adverse effects of methamphetamine use may start

to impact on a person's life, even after occasional use. In the first scenario, we demonstrate how administering the ASSIST during a routine doctor's appointment is an excellent opportunity to start a conversation with Jade about her drug use and link the brief intervention to her presenting issues.

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

<sup>7</sup> Harland, J. Curtis, J. Ali, R. and Marsden J. (2014) *ASSIST with Substance: The Alcohol, Smoking and Substance Involvement Screening Test and Brief Intervention Resource for Nurses*, DASSA-WHO Collaborating Centre for Research in the Treatment of Drug and Alcohol Problems, University of Adelaide, Australia.



## How to use this manual

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

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

The package can be delivered in a short session (one to two hours), as part of a workshop or online. The scenarios in the instructional video highlight different settings where the ASSIST and linked brief intervention takes place. Facilitators can select one or both of the scenarios that they consider relevant to the session, the needs of the participants and the purpose of the workshop or training.

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

We are delighted you are using this resource and would be keen to hear your feedback. If you have any suggestions or comments, please contact:  
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## CHAPTER 1

### Methamphetamine

#### What do I need to know?

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

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

- Feelings of pleasure and confidence
- Increased alertness and energy
- Reduced appetite
- Enlarged pupils
- Teeth grinding and dry mouth
- Increased perspiration
- Increased heart rate, blood pressure and respiration
- Repeating actions (picking and scratching)
- Increased sex drive<sup>8</sup>

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

Long term-effects include:

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

<sup>8</sup> Alcohol and Drug Foundation (2016) Alcohol and drug information factsheet – Ice <http://www.druginfo.adf.org.au/images/ice-19jul16.pdf>



Overdose can occur and unwanted effects may include:

- Heart arrhythmias (racing heart beat)
- Involuntary muscle movements
- Seizures
- Extreme agitation, confusion, anxiety, hallucinations and psychosis
- Sudden, severe headaches
- Stroke
- Heart attack
- Death<sup>9</sup>

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

- Exhaustion
- Irritability and confusion
- Headaches
- Depressed mood
- Paranoia and hallucinations

A number of people use other drugs such as alcohol, benzodiazepines, opiates and cannabis to help with the 'come down'. This can add to the complexity of a person's situation and may result in toxicity or dependence on a number of drugs.

Methamphetamine use has increased in a number of countries in recent years and seizure data suggests that its production and trafficking has spread into new areas of the globe<sup>10</sup>. In Australia, important changes to the form and pattern of methamphetamine use have occurred that have increased related risks and harms. This has included an increase in the frequency of use and a shift to smoking the crystalline, more potent form. The growing harms associated with changing patterns of methamphetamine use has seen an increase in methamphetamine-related hospitalizations and the numbers of people seeking drug treatment for methamphetamine use.<sup>11</sup>

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

<sup>9</sup> Alcohol and Drug Foundation (2016) Alcohol and drug information factsheet – Ice <http://www.druginfo.adf.org.au/images/ice-19jul16.pdf>

<sup>10</sup> Dargan PI, Wood DM. (2012) Recreational drug use in the Asia Pacific region: improvement in our understanding of the problem through the UNODC programmes. *J Med Toxicol* 2012; 8:295–299.

<sup>11</sup> Australian Institute of Health and Welfare (AIHW) 2013 National Drug Strategy Household Survey (NCETA secondary analysis, 2015)



## CHAPTER 2

### Overview of the ASSIST

#### What is the ASSIST?

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed under the auspices of the World Health Organisation (WHO) by an international group of addiction researchers 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 and takes about ten minutes to administer. The ASSIST screens for risky use of all main substance types (tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (ATS), sedatives, hallucinogens, inhalants, opioids and 'other drugs') and determines a risk score for each substance.

The risk score for each substance helps to initiate and frame a brief discussion with clients about their substance use. The score obtained for each substance falls into a 'low', 'moderate' or 'high' risk category which determines the most appropriate intervention for that level of use. The risk scores are recorded on the ASSIST Feedback Report Card (Appendix C) which is used to give personalised feedback to clients by presenting them with the scores that they have obtained, and the associated health problems related to their level of risk. As outlined in figure 2, ASSIST scores are linked to the following risk categories and associated recommended interventions.<sup>12</sup>

**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, opioids, 'other drugs')	Risk level	Intervention
0 – 10	0 – 3	Low risk	<ul style="list-style-type: none"> <li>General health advice</li> </ul>
11 – 26	4 – 26	Moderate risk	<ul style="list-style-type: none"> <li>Brief Intervention</li> <li>Take home booklet &amp; information</li> </ul>
27 +	27 +	High risk	<ul style="list-style-type: none"> <li>Brief Intervention</li> <li>Take home booklet &amp; information</li> <li>Referral to specialist assessment &amp; treatment</li> </ul>
Injected drugs in last 3 months (Score of 2 on Q8)	Moderate to High risk**		<ul style="list-style-type: none"> <li>Risks of Injecting Card</li> <li>Brief Intervention</li> <li>Take home booklet &amp; information</li> <li>Referral to testing for BBVs*</li> <li>Referral to specialist assessment &amp; treatment**</li> </ul>

\* 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

<sup>12</sup> 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.



### **What is the ASSIST-linked brief intervention?**

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

Brief interventions are not intended as a stand-alone treatment for people who are dependent or at '*high risk*' from their substance use. A brief intervention should be used to encourage such clients to accept a referral to

specialised drug and alcohol assessment and treatment, either within the primary care setting, or at a specialised alcohol and drug treatment agency.

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

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



## CHAPTER 3

### Using Motivational Interviewing in an ASSIST Linked Brief Intervention

In the context of the ASSIST screening and linked brief intervention, it is likely that the health care professional will have a relatively short time to spend with clients, compared with the amount of time that a counsellor, psychologist or drug and alcohol worker has to spend with clients. This chapter focuses predominantly on the practical skills and techniques required to deliver a brief intervention to people at moderate risk, rather than detailing the underlying theory or providing training on delivering lengthy or on-going sessions with clients.

The brief intervention approach adopted in this manual is based on the motivational interviewing (MI) principles developed by William R. Miller in the USA and further elaborated by Miller and Stephen Rollnick.<sup>13</sup> It is based on the assumption that people are most likely to change when motivation comes internally, rather than externally from other sources.

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

Motivational interviewing techniques are designed to promote behaviour change by helping clients to explore and resolve ambivalence. This is especially useful when working with clients in the pre-contemplation (happy to continue using) and contemplation (some uncertainty about use but not enough to change) stages, but the principles and skills are important at all stages. Motivational interviewing is based on the understanding that effective intervention assists a natural process of change.<sup>14</sup> It is important to note that motivational interviewing is done *for or with* someone, not *on or to* them.

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

#### Feedback

Providing feedback to clients is an important part of the brief intervention process. The way that feedback is provided can affect what the client really hears and takes it in. Feedback

should be given in a way that takes account of what the client is ready to hear and what they already know. A simple and effective way of giving feedback which takes account of the client's existing knowledge and interest, and is respectful of their right to choose what to do with the information involves three steps<sup>15</sup>:



#### FEEDBACK

1. Elicit
2. Provide
3. Elicit

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

*"Would you like to see the results of the questionnaire you completed?"*

*"What do you know about the effects of methamphetamine?"*

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

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

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

*"How concerned are you by your score for methamphetamine?"*

*"How do you feel about that?"*

*"What do you see as your options?"*

*"Does your score surprise you?"*

*"What concerns you most?"*

<sup>13</sup> Miller W and Rollnick S (2012) *Motivational Interviewing* (3<sup>rd</sup> Ed) Helping People Change. New York and London, Guilford Press

<sup>14</sup> Miller W and Rollnick S (2002). *Motivational Interviewing* (2<sup>nd</sup> Ed) New York and London, Guilford Press

<sup>15</sup> Miller W and Rollnick S (2012) *Motivational Interviewing* (3<sup>rd</sup> Ed) Helping People Change. New York and London, Guilford Press

## Create discrepancy and reduce ambivalence

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

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

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



**OARS**  
Open questions  
Affirming  
Reflecting  
Summarising

### Open questions

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

Within the context of the ASSIST-linked Brief Intervention examples of the types of questions asked include: "*What are some of the good things about using methamphetamine?*" and "*What are the less good things for you about using?*" This approach is termed a *decisional balance* and encourages the client to explore the pros and cons of their use in a balanced way.<sup>16</sup> Asking open-ended questions of clients also reinforces the notion that the client is responsible for the direction of the intervention and of their substance use choices.

## Affirming

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

## Reflecting

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

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

## Summarising

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

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

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

<sup>16</sup> Miller W and Rollnick S (2012) *Motivational Interviewing (3rd Ed) Helping People Change*. New York and London, Guildford Press



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

## Eliciting change talk

As outlined by Miller and Rollnick (2013) eliciting change talk is a strategy for helping the client to resolve ambivalence and is aimed at enabling the client to present the arguments for change. There are four main categories of change talk:

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

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

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

## Important tips

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

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

## Suggested further reading

Miller, W. and Rollnick, S. (2013) *Motivational Interviewing, Helping People Change*, 3rd ed. Guildford Press, NY. USA.



## CHAPTER 4

### 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 have been summarised using the acronym FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy.<sup>17,18</sup>



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

#### Feedback

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

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

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

In summary, feedback is the provision of personally relevant information which is pertinent to the client, and is delivered by the health professional in a non-judgemental and objective way. Much of the feedback information provided in an ASSIST-linked Brief Intervention can be delivered by reading from the ASSIST Feedback Report Card.

#### Responsibility

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

This sense of control has been found to be an important element in motivation for change and in decreasing resistance.<sup>19</sup> Using language with clients such as *"I think you should..."*, or *"I'm concerned about your methamphetamine use"* may create resistance in clients and motivate them to maintain and adopt a defensive stance when talking about their substance use patterns.

<sup>17</sup> 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.

<sup>18</sup> 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.

<sup>19</sup> Bien TH, Miller WR and Tonigan S (1993). Brief intervention for alcohol problems: A review. *Addiction*, 88;315–336.

## 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 may 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 methamphetamine"* does not comprise clear, objective advice.

## Menu of options

Effective brief interventions provide the client with a range of options to cut down or stop their substance use. This allows the client 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. Giving clients the *"Self-Help Strategies for Cutting Down or Stopping Substance Use: Self-Help Guide"*<sup>20</sup> is a good way to start as it contains strategies for helping clients change their behaviour, and can be used alone or in conjunction with other options.

Examples of options for clients to consider include:

- Keeping a diary of substance use (where, when, how much used, how much spent, with whom, why)
- Identifying high risk situations and strategies to avoid them
- Identifying other activities instead of drug use — hobbies, sports, clubs, gym, etc.
- Encouraging the client to identify people who could provide support and help for the changes they want to make

- Providing information about other self-help resources and written information
- Inviting the client to return for regular sessions to review their substance use
- Providing information about other groups or health workers that specialise in drug and alcohol issues
- Putting aside the money they would normally spend on substances for something else

## Empathy

Empathy is taking an active interest and effort to understand another's internal perspective, to see the world through their eyes. It does not mean sympathy, a feeling of pity, camaraderie or identification with the person. Statements such as *'I've been there and know what you are experiencing, let me tell you my story'* are not useful. The opposite of empathy is the imposition of one's own perspective, perhaps with the assumption that the other's views are irrelevant or misguided. Empathy is the ability to understand another's frame of reference and the conviction that it is worthwhile to do so.<sup>21</sup>

In a brief intervention, empathy comprises of an accepting, non-judgmental approach that tries to understand the client's point of view. It is especially important to avoid confrontation and blaming or criticism of the client. Adopting a position of *'curious intrigue'* is helpful. Skilful reflective listening which clarifies and amplifies the person's experience and meaning is a fundamental part of expressing empathy. The empathy and understanding of the health professional is an important contributor to how well the client responds to the intervention.<sup>22</sup>

## Self efficacy (confidence)

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

<sup>20</sup> 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.

<sup>21</sup> Miller W and Rollnick S (2012) *Motivational Interviewing (3rd Ed) Helping People Change*. New York and London, Guilford Press

<sup>22</sup> Miller W and Rollnick S (2002). *Motivational Interviewing*. 2nd ed. New York and London, Guilford Press.



## CHAPTER 5

### Model of behaviour change

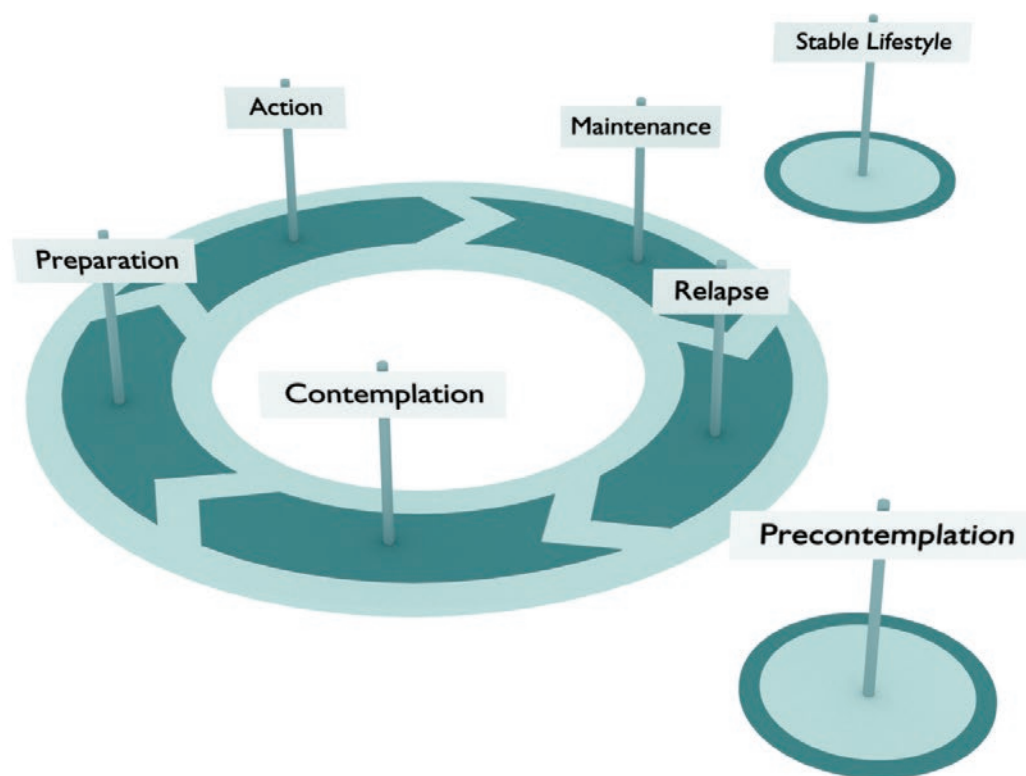
The transtheoretical model of behaviour change developed by Prochaska and DiClemente provides a useful framework for understanding the process by which people change their behaviour, and for considering how ready they are to change their substance use or other lifestyle behaviour.<sup>23</sup> The model proposes that people go through discrete stages of change and that the processes by which people change seem to be the same with or without treatment.<sup>24</sup>

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

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

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

FIGURE 3: Stages of change



<sup>23</sup> Prochaska JA, DiClemente CC and Norcross JC (1992). In search of how people change. Applications to addictive behaviour. *American Psychologist*, 47:1102-1114.

<sup>24</sup> 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.



## Pre-contemplation

Many people seen in primary health care settings, who score positive on the ASSIST, are likely to be in the pre-contemplation stage. In this stage the person is not necessarily thinking about changing their substance use. Common characteristics of this stage include:

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

## Contemplation

Some people seen in primary health care or hospital settings who score positive on the ASSIST may be in this stage. People in this stage have thought about cutting down or stopping substance use, but are still using. Common characteristics of this stage include:

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

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

## Preparation

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

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

## Action

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
- Are likely to continue to feel somewhat ambivalent about their substance use and to need encouragement and support to maintain their decision



## Maintenance

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

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

## Relapse

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

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

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

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



## CHAPTER 6

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

#### Moderate risk clients

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

This step by step approach was designed to assist and build confidence in health care workers who are not specifically trained in motivational interviewing nor deal with substance using clients on a regular basis. It also serves as a framework for more experienced drug and alcohol workers and can be expanded and explored further for longer or recurrent sessions, or to address multiple substance use.

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

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

*“Are you interested in seeing how you scored on the questionnaire you just completed?”*

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

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

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

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

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

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

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

The second part of the feedback comprises communicating the risks associated with each particular substance used, focussing on the highest scoring substance (or substances). The information relating to the second part of the feedback is found inside the ASSIST Feedback Report Card in a series of nine boxes (tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, inhalants, sedatives,

## The 10 steps to an ASSIST-linked Brief Intervention

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

hallucinogens, opioids). Each box lists the harms ranging from less severe (shaded light grey) to more severe (shaded dark grey) for each substance, and feedback comprises verbalising these risks to the client as written, with further explanation if required. Once again, the card should be held so it can be viewed easily by the client, but still be able to be read by the interviewer. An example of personalised feedback around a moderate risk score for methamphetamine is:

*"Because you're in the moderate risk range for your use of methamphetamine, the kinds of things associated with your current pattern of use are problems with difficulty sleeping, dehydration, headaches, mood swings, aggressive behaviour and at the serious end of things, psychosis and permanent damage to brain cells ..."*

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

Giving advice to clients is simply about creating a link between reduction of drug use and reduction of harms. Clients may be unaware of the relationship between their

substance use and existing or potential problems. The advice is about informing clients that cutting down or stopping their substance use will reduce the risk of problems both now and in the future. An example of providing advice to clients is to say:

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

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

### STEP 4. Allowing clients to take ultimate responsibility for their choices

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



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

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

## **STEP 5. Asking clients how concerned they are 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. Clinicians should turn the ASSIST Feedback Report Card back to the front page so that the client can see their scores again, and say something like:

*"How concerned are you by your score for amphetamine?"*

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

## **STEPS 6 and 7. Exploring 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 standard motivational interviewing technique designed to develop discrepancy, or create cognitive conflict within the client. It may be the first-time 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 clinician is aware that the client has pertinent or functional reasons for using a substance.

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

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

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

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

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

- Health — physical and mental
- Social — relationships with partner, family, friends, work colleagues
- Legal — accidents, contact with law, driving while under the influence of a substance
- Financial — impact on personal budget
- Occupational — difficulty with work, study, looking after home and family
- 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 provides the opportunity to actively highlight a client's cognitive conflicts and to emphasize the less good aspects of their substance use. An example of reflecting back the good and less good things of a client's substance use, with final emphasis on the less good things is:

*"So you said you like using crystal meth because it gives you energy and you have fun... but you do not like comedowns and impacts it is having on your work and relationships, including fighting with your boyfriend..."*

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

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

*"Do the less good things concern you?  
How?" or*

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

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

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

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

- Client's ASSIST Feedback Report Card (Appendix C)
- 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<sup>25</sup> available at: [http://www.who.int/substance\\_abuse/activities/assist/en/index.html](http://www.who.int/substance_abuse/activities/assist/en/index.html)
- Risks of Injecting Card (if relevant) (Appendix D)

The ASSIST Feedback Report Card serves as a reminder of the 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. Health professionals can use the booklet as a platform for longer or ongoing interventions if relevant.

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

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

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

<sup>25</sup> 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.





## 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.
- Information they are given may be passed onto friends or family who do have substance use issues.

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

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

It is also 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. It is likely that a brief intervention for these clients will take at least 15 minutes given the seriousness of the problem. If the client has tried unsuccessfully to cut down or stop their substance use in the past (as indicated in question 7 on the ASSIST), discuss these past attempts. Praise their attempts in the past but also recognise how difficult it can be to maintain the commitment. This may help the client understand that they may need treatment to change their substance use.

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

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

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

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

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

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

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

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



## CHAPTER 7

### The Stepped Care Model

#### How do I put stepped care into practice?

A stepped-care model purports that *'a more intensive or different form of care or treatment is offered only when a less intensive form has been insufficient.'*<sup>26</sup> Stepped care involves the provision of a series of interventions, from the least to the most intensive, with each incremental step made available on the basis of the client's response to the previous one. A stepped care approach provides a best practice framework for integrating assessment, case formulation and treatment planning into the treatment process. It is used when deciding what level of intervention may be appropriate for a particular client.

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

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

Jade attended weekly sessions with the counsellor for four weeks. Jade really struggled with cravings in the beginning and lapsed on one occasion. Based on Jade's presenting issues and best practice guidelines<sup>27</sup>, Jade received four sessions that focused on:

- Session 1: Building motivation for change
- Session 2: Strategies to cope with cravings
- Session 3: Links between thoughts and behaviours (triggers)
- Session 4: Relapse prevention

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

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

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

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

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

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

<http://nceta.flinders.edu.au/nceta/resource-kits/methamphetamine-publications-resources/>

<sup>26</sup> NSW Department of Health (2008) NSW Health Drug and Alcohol Psychosocial Interventions, Professional Practice Guidelines, Better Health Centre Publications, Sydney.

<sup>27</sup> Baker, A., Kay-Lambkin, F., Lee, N.K., Claire, M., & Jenner, L. (2003). A brief cognitive behavioural intervention for regular amphetamine users: A treatment guide. Canberra: Australian Government Department of Health and Ageing.





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

## CHAPTER 8

### Providing training and education sessions using the ASSIST on Ice resource

#### PLANNING FOR YOUR TARGET AUDIENCE

##### Planning

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

##### Who?

It is important to consider who is the intended audience and how many will be participating in the training. If you are coordinating the training, you also need to think about facilitation. Do you plan to facilitate the session? How many facilitators will be needed? Do the facilitators have the necessary expertise?

##### What?

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

##### Why?

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

##### How?

What is the best format for the training to take place? Will the participants want to attend a face to face session or would an on-line session be more suitable for the target audience? Would a mixture of face to face and online be the best mix? These decisions need to be made prior to contacting potential participants.

##### When?

Consider when the training is to take place. If you plan to offer a face to face session, then consider the best time for this to take place. Is there a time limit on the session? Do you need to offer a two-hour tutorial or a one day workshop? Does it need to be conducted on a specific day or date?

##### Where?

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

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



## Publicity

If you are offering the training to people across a number of sites, or from different facilities, you need to promote your workshop. Here is a short list of some places you might consider:

- Primary Health Networks
- General Practitioners
- Practice Nurse networks
- Community Health Services
- Local chapters of peak professional bodies
- Non-government organizations

## Register of Participants

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

## Confirmation to participants

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

## Evaluation and reporting

Organisations have different evaluation requirements and reporting needs. You need to consider these during the planning process. You need to consider what it is that you want to evaluate and why. Do you want to evaluate the content? Do you want to evaluate the way the information was delivered? Do you want the evaluation to be written or verbal? Do you plan to set up a database for future comparisons? There is no need to collect information that is not useful. Think about confidentiality. Remember if you ask participants to identify themselves, it may reduce the honesty of responses.

Note that if you are providing certificates of attendance and/or participation, you will need to check with the organisation which has requested the session(s) what information they need on the certificates. Many organisations require the learning objectives to be stated on the certificate. Remember that the Australian Health Practitioner Agency (APHRA) requires Continuing Professional Development to be allocated in hours rather than points. Consult with your professional organisation about conversion rates.

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

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

## Principles of adult learning

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

Malcolm Knowles is one of the foremost theorists on adult learning (andragogy)<sup>28</sup>. These components of adult learning can be useful when planning your session. We have used this approach in the design of the package and suggest you facilitate with these assumptions as your primary focus:

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<sup>28</sup> Knowles, M.S. (1970). The modern practice of adult education: Andragogy versus pedagogy. New York: New York Association Press.

## Principles of adult learning

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

### Timing

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

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

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

### Reference points

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

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

### Language

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

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

### Handouts

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

### Technology

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



## Information

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

Limit the information that you present. Keep key points to a minimum. It is better to remember three key points rather than forgetting ten! Emphasize the major concepts and do not introduce too many at any one time. As a rule of thumb, introduce a major concept every 8 to 10 minutes. Any more than that, people will not be able to take in. Talk about every day experiences. Participants relate better to personal anecdotes. Ask participants to contribute. Many will have their own personal experiences to draw on.

## Self awareness

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

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

Be aware of how you speak. Is your voice monotonous? Do you slur some words? Do you often say 'um', you know' 'OK' when you speak? Do you speak very quickly or slowly?

Do you have a soft voice or a very loud voice? By becoming aware of any problems and pinpointing them, you can then practise and minimise or eliminate their use. Some other hints for public speaking include:

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

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

## Be enthusiastic

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

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

Above all ENJOY.



## CHAPTER 9

### Training and education session options

#### Face to face sessions

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

- One hour session (e.g. in-service or professional development)
  - » For experienced health professionals, the instructional video can be shown as a focal point for discussion. Suggested topics for discussion could include:
  - » How is screening and brief intervention currently being conducted in their practice?
  - » How could the ASSIST be implemented into their practice.
- Two hour session
  - » As above plus role play. In groups of three (as per flipped classroom model outlined later in this chapter)
- As part of a workshop
  - » As screening and brief intervention is part of a range of clinical practices, this package can be adapted to a range of professional development workshops. Depending on the allocated time, any of the above activities could be included. It is recommended that the participants adapt the role-play to their professional area or work practice.

#### On-line learning

The ASSIST on Ice instructional video can be used in the Blackboard application for on-line teaching. It is suggested that the participants be asked to watch the video and answer questions. Depending on the objectives of the subject, the linked activity could be short answer or the basis for a discussion board, assignment or essay.

Depending on the IT platform, a suggested approach is:

- Participants view the DVD on-line
- Discussion points are posted on a '*discussion board*' or '*chat room*'
- Participants are encouraged to conduct a role play using the ASSIST-BI with a fellow student, friend, colleague or in either in '*chat room*', via Skype or over the telephone.
- The experience of conducting the ASSIST- BI would form the basis of postings on the discussion board. Suggested topics for discussion include:
  - » How was the experience of conducting an ASSIST-BI?
  - » What did you learn from the experience?
  - » How is screening and brief intervention currently being conducted in your area?
  - » What has been successful?
  - » What are the barriers to screening and brief intervention?
  - » Discuss possible ways to overcome these barriers.

General discussion questions for consideration:

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

## Flipped classroom method

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

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

- Given access to the ASSIST on Ice instructional video and ASSIST resources (Appendices A–D)
- Encouraged to watch the video and familiarise themselves with the ASSIST tools
- Explore background information on the WHO ASSIST website and PORTAL:
  - » [http://www.who.int/substance\\_abuse/activities/assist/en/index.html](http://www.who.int/substance_abuse/activities/assist/en/index.html)
- Role play at least one ASSIST on a family member or friend
- Prepare themselves to come to class and administer an ASSIST and to role play a character with a fellow student
- The character developed for the role play should be researched and based on evidence that is available related to patterns of drug use. This would include associating the age and gender of the character with the pattern of drug use and associated consequences of use.
- Students are to research what services are available in their area and be prepared to provide an ASSIST-linked, targeted intervention.

NOTE: Students may build on the characters shown in the video. Further background information on Jade and Dan are included in Chapter 10.

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

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

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



## CHAPTER 10

### Scenarios<sup>29</sup>

#### Jade

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

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

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

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

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<sup>29</sup> NOTE: The people depicted in the scenarios are actors and the histories are not based on one any single individual alive or deceased.





## Dan

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

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

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

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

## SUGGESTED RESOURCES

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

ASSIST with Substance: The Alcohol, Smoking and Substance Involvement Screening Test for Nurses. Copies are available on [assistportal.com.au](http://assistportal.com.au) or can be requested from [jennifer.harland@adelaide.edu.au](mailto:jennifer.harland@adelaide.edu.au)

Alcohol and Drug Foundation: Druginfo provides easy access to information about alcohol and other drugs and drug prevention: [www.druginfo.adf.org.au](http://www.druginfo.adf.org.au)

Alcohol, Tobacco and Other Drugs Association, ACT (ATODA) <http://www.atoda.org.au/>

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

For further information and online Motivational Interviewing training opportunities visit: [www.motivationalinterview.org](http://www.motivationalinterview.org)

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

Australian Government, Department of Health <http://www.health.gov.au/internet/alcohol/publishing.nsf/Content/guide-adult>

Australian Institute of Health and Welfare <http://www.aihw.gov.au/publication-detail?id=32212254712>

Drug and Alcohol Nurses Australasia (DANA) <http://www.danaonline.org>

# APPENDIX A: ASSIST V3.1

HO6A

WHO - ASSIST V3.1

CLINICIAN NAME

CLINIC

CLIENT ID OR NAME

DATE

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**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 <u>ever used</u> ? ( <b>NON-MEDICAL USE ONLY</b> )	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Alcoholic beverages (beer, wine, spirits, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
c. Cannabis (marijuana, pot, grass, hash, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
d. Cocaine (coke, crack, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
e. Amphetamine type stimulants (speed, meth, ecstasy, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
g. Sedatives or Sleeping Pills (Diazepam, Alprazolam, Flunitrazepam, Midazolam etc.)	<input type="checkbox"/>	<input type="checkbox"/>
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
i. Opioids (heroin, morphine, methadone, Buprenorphine, codeine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
j. Other - specify:	<input type="checkbox"/>	<input type="checkbox"/>

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

**If "Never" to all items in Question 2, skip to Question 6.**

**If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.**

## Question 3

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

## Question 4

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

## Question 5

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

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

### Question 6

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

### Question 7

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



**Question 8 (please mark the response)**

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you <u>ever</u> used any drug by injection? (NON-MEDICAL USE ONLY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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**

4 days per month, on average, over the last 3 months or less

**INTERVENTION GUIDELINES**

Brief Intervention including the "Risks of Injecting" card

More than 4 days per month, on average, over the last 3 months

Further assessment and more intensive treatment\*

**HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.**

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

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

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

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco		0 - 3	4 - 26	27+
b. alcohol		0 - 10	11 - 26	27+
c. cannabis		0 - 3	4 - 26	27+
d. cocaine		0 - 3	4 - 26	27+
e. amphetamine		0 - 3	4 - 26	27+
f. inhalants		0 - 3	4 - 26	27+
g. sedatives		0 - 3	4 - 26	27+
h. hallucinogens		0 - 3	4 - 26	27+
i. opioids		0 - 3	4 - 26	27+
j. other drugs		0 - 3	4 - 26	27+

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

## APPENDIX B: RESPONSE CARD

HO7

### WHO ASSIST V 3.0 RESPONSE CARD

#### *Response Card - substances*

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

---

#### **Response Card (ASSIST Questions 2 – 5)**

**Never:** not used in the last 3 months.

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

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

**Weekly:** 1 to 4 times per week.

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

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#### **Response Card (ASSIST Questions 6 to 8)**

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

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# APPENDIX C: FEEDBACK FORM

HO8

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

Name \_\_\_\_\_ Test Date \_\_\_\_\_

### Specific Substance Involvement Scores

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

### What do your scores mean?

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

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

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

### Are you concerned about your substance use?



## HO8

<b>a. tobacco</b>	Your risk of experiencing these harms is:.....		Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
	(tick one)				
<b>Regular tobacco smoking is associated with:</b>					
	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>b. alcohol</b>	Your risk of experiencing these harms is:.....		Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
	(tick one)				
<b>Regular excessive alcohol use is associated with:</b>					
	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				

<b>c. cannabis</b>	Your risk of experiencing these harms is:.....		Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
	(tick one)				
<b>Regular use of cannabis is associated with:</b>					
	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				

## HO8

<b>d. cocaine</b>	Your risk of experiencing these harms is:....	Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
	(tick one)			
	<b>Regular use of cocaine is associated with:</b>			
	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			

<b>e. amphetamine type stimulants</b>	Your risk of experiencing these harms is:.....	Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
	(tick one)			
	<b>Regular use of amphetamine type stimulants is associated with:</b>			
	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			

<b>f. inhalants</b>	Your risk of experiencing these harms is:.....	Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
	(tick one)			
	<b>Regular use of inhalants is associated with:</b>			
	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			

## HO8

<b>g. sedatives</b>	Your risk of experiencing these harms is: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/>		
	(tick one)		
<b>Regular use of sedatives is associated with:</b>			
	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.		

<b>h. hallucinogens</b>	Your risk of experiencing these harms is:..... Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/>		
	(tick one)		
<b>Regular use of hallucinogens is associated with:</b>			
	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		

<b>i. opioids</b>	Your risk of experiencing these harms is: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/>		
	(tick one)		
<b>Regular use of opioids is associated with:</b>			
	Itching, nausea and vomiting		
	Drowsiness, constipation, tooth decay		
	Difficulty concentrating and remembering things		
	Emotional problems and social problems		
	Reduced sexual desire and sexual performance		
	Relationship difficulties		
	Financial and work problems, violations of law		
	Tolerance and dependence, withdrawal symptoms		
	Overdose and death from respiratory failure		



# APPENDIX D: RISK OF INJECTING

HO9

## WHO-ASSIST V 3.0 Risks of Injecting Card – Information

Using substances by injection increases the risk of harm from substance use.

This harm can come from:

- **The substance**
  - If you inject any drug you are more likely to become dependent.
  - If you inject amphetamines or cocaine you are more likely to experience psychosis.
  - If you inject heroin or other sedatives you are more likely to overdose.
- **The injecting behaviour**
  - If you inject you may damage your skin and veins and get infections.
  - You may cause scars, bruises, swelling, abscesses and ulcers.
  - Your veins might collapse.
  - If you inject into the neck you can cause a stroke.
- **Sharing of injecting equipment**
  - If you share injecting equipment (needles & syringes, spoons, filters, etc.) you are more likely to spread blood borne virus infections like Hepatitis B, Hepatitis C and HIV.

### ❖ It is safer not to inject

#### ❖ If you do inject:

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

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

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

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

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

# GLOSSARY

<b>ATS</b>	Amphetamine-Type Stimulants
<b>CBT</b>	Cognitive Behavioural Therapy
<b>DASSA</b>	Drug and Alcohol Services South Australia
<b>FRAMES</b>	Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy
<b>OARS</b>	Open question; Affirming; Reflecting; Summarizing
<b>WHO</b>	World Health Organization

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