BRIEF INTERVENTION

The ASSIST-linked brief intervention for hazardous and harmful substance use

Manual for use in primary care

World Health Organization

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1 Nature and purpose of this manual

This manual is a companion to *'The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): manual for use in primary care'*[1] *and is based on 'Brief Intervention for Substance Use: Guidelines for Use in Primary Care. Draft Version 1.1 for Field Testing'*[2]. The purpose of this manual is to explain the theoretical basis and evidence for the effectiveness of brief interventions and to assist primary health care workers in conducting a simple brief intervention for clients whose substance use is putting them at risk. Together with the companion manual[1], this manual presents a comprehensive approach to screening and brief intervention which is tailored to the specific circumstances of primary care and is designed to improve the health of populations and client groups as well as of individuals. This manual describes:

- the rationale for brief intervention in primary care;
- a model of behaviour change;
- the components of brief interventions that work;
- principles of motivational interviewing and essential skills;
- how to link the ASSIST screening procedure with a brief intervention;
- how to give feedback to clients;
- how to conduct brief intervention for people at moderate risk;
- examples of ASSIST-linked brief interventions;
- how to help clients who inject drugs;
- how to address multiple substance use;
- how to give longer or recurrent interventions.

Although the manual is particularly aimed at primary health care workers, it may also be useful for others who work with high-risk clients or clients who are more likely to engage in drug use such as hospital physicians and nurses, midwives and obstetricians, social workers, prison workers and community correction workers.

2 What is the ASSIST-linked brief intervention?

As the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed mainly for drug use but can be used for other substances including alcohol and tobacco as well, particularly in high prevalence settings, it is being considered as an instrument of choice when the goal is to address a range of different psychoactive substances. Thus, the focus of this manual is mainly on drug use rather than alcohol or tobacco use, because of the relative lack of tools around screening and brief intervention for illicit drugs within primary health care settings. The brief intervention technique described in this manual is focused predominantly on modifying behaviour of drug users around the substance used most frequently or the one causing the most problems for the client (as identified by the client or highest ASSIST score). However, the techniques described in this manual also can be used to target alcohol and tobacco use, particularly in poly-drug use, although it is likely that this would take longer than 3 minutes.

The ASSIST-linked brief intervention is a short intervention lasting 3 to 15 minutes given to clients who have been administered the ASSIST by a health worker. The ASSIST screens for use of all substance types (tobacco products, alcohol, cannabis, cocaine, amphetamine-type stimulants (ATS), sedatives, hallucinogens, inhalants, opioids and 'other' drugs) and determines a risk score ('lower', 'moderate' or 'high') for each substance[3, 4]. The risk scores are recorded on the ASSIST feedback report card which is used to give personalised feedback to clients by presenting them with the scores that they have obtained, and the associated health problems related to their level of risk. Asking clients if they are interested in viewing their scores allows the health worker to commence a discussion (brief intervention) with the client in a non-confrontational way, and has been found to be a successful way of getting clients at moderate risk, in particular, to change their substance use[5].

As outlined in *'The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): manual for use in primary care'*[1], ASSIST scores are linked to the following risk categories and associated recommended interventions (see Table 1).

TABLE 1 | ASSIST risk score and associated risk level and intervention

Alcohol	All other substances[a]	Risk level	Intervention
0 - 10	0 - 3	Lower risk	▌General health advice
11 - 26	4 - 26	Moderate risk	▌Brief intervention ▌Take home booklet & information
27+	27+	High risk	▌Brief intervention ▌Take home booklet & information ▌Referral to specialist assessment and treatment
Injected drugs in last 3 months		Moderate and High risk[b]	▌Risks of injecting card ▌Brief intervention ▌Take home booklet & information ▌Referral to testing for BBVs[c] ▌Referral to specialist assessment and treatment

[a] Tobacco products, cannabis, cocaine, ATS, sedatives, hallucinogens, inhalants, opioids and 'other drugs'.

[b] 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.

[c] Bloodborne viruses including HIV and hepatitis B and C.

Screening and brief intervention aim to identify current or potential problems with substance use and motivate those at risk to change their substance use behaviour by creating a connection, for the client, between their current pattern of use and the associated risks and harms[6]. In general, brief interventions in primary care can range from 3 minutes of brief feedback and advice, to 15-30 minutes of brief counselling[7]. The ASSIST-linked brief intervention presented in this manual is intended to last for around 3 – 15 minutes, however the principles can be used for longer or recurrent intervention sessions should time allow.

The ASSIST-linked brief intervention was specifically designed to be applied to people who are at 'moderate risk' from their substance use according to their ASSIST scores, and to provide them with an appropriate brief intervention. That is, people who are *not* dependent, but are using substances in a hazardous or harmful way that may be creating health, social, legal, occupational or financial problems for the person, or has the potential to create those problems should the substance use continue. Generally, brief interventions are **not intended as a stand-alone treatment** for people who are dependent or at 'high risk' from their substance use. However, a brief intervention should be used to encourage such clients to accept a referral to specialized drug and alcohol assessment and treatment, either within the primary care setting, or at a specialized 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 personalized and offered in a supportive, non judgmental manner.

The ASSIST-linked brief intervention is based on the FRAMES techniques[8, 9, 10] and Motivational Interviewing[7], which will be discussed later in this manual. In summary the ASSIST-linked brief intervention follows 10 suggested main steps (or the first 5 steps for a shorter three minute intervention) as outlined below:

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 by their scores.
6. Weighing up the **good things** about using the substance against the;
7. **Less good things** about using the substance.
8. **Summarize 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.

Many health care professionals avoid screening for substance use and hence avoid intervening. Research shows that the main reasons health workers reported for not getting involved are: a lack of time, feeling that they are not competent or capable of giving an intervention, and concern that they will experience resistance and defensiveness from their clients[11]. The ASSIST screening and linked brief intervention process outlined in this manual has attempted to address all these concerns. Both the screening and the brief intervention can be effectively delivered relatively quickly – particularly the brief intervention which can be delivered in as little as 3 minutes if focussing on the main substance used by the client. Further, the delivery of the brief intervention – which is outlined in a simple step by step approach in this manual – has been found to motivate clients to reduce their substance use and produces very little resistance or client defensiveness.

3 Rationale for brief intervention in primary care

Tobacco, alcohol and illicit drugs are among the top 20 risk factors for ill-health identified by the World Health Organisation[12]. It is estimated that tobacco is responsible for 8.7% of all deaths and for 3.7% of the global burden of all disease, which is measured as the number of years lost due to premature death or disability (Disability Adjusted Life Years – DALYs), while alcohol is responsible for 3.8% of deaths and 4.5% of DALYs. Illicit drugs are responsible for 0.4% of deaths and 0.9% of DALYs. Hazardous and harmful alcohol use and other substance use also are risk factors for a wide variety of social, financial, legal and relationship problems for individuals and their families. Globally, there is an increasing trend for people to use multiple substances, either together or at different times, which is likely to further increase the risks.

Primary care workers are in a unique position to identify and intervene with clients whose substance use is hazardous or harmful. Health promotion and disease prevention play an important role in the work of primary care workers, who are often already engaged in implementing activities around screening and prevention including immunisation, and detection of high blood pressure, obesity, smoking and other risk factors. Clients view primary care workers as a credible source of advice about health risks including substance use.

In the developed world, eighty five percent of the population visits a primary health care worker at least annually. Clients whose alcohol and other substance use is hazardous or harmful may have more frequent consultations. This means that primary care workers have the opportunity to intervene at an early stage before serious substance related problems and dependence develop. Many common health conditions seen in primary care may be related to tobacco, alcohol or other substance use, and the primary care worker can use this link to introduce screening and brief intervention for substance use. The intervention then comprises part of the management of the presenting complaint.

Primary care workers often have an ongoing relationship with their clients which enables them to develop rapport and gain an understanding their clients' needs. Clients generally expect their primary care clinician to be involved in all aspects of their health and are likely to feel more comfortable about discussing sensitive issues such as substance use with someone they know and trust. The ongoing nature of the relationship also means that interventions can be spread out over time and form part of a number of consultations.

There is substantial evidence of the benefits of screening and brief intervention for alcohol problems in primary health care settings[8, 13-18]. Senft et al. (1997)[17] showed a reduction in frequency of alcohol consumption at 6 and 12 months in hazardous drinkers who had received a 15 minute brief intervention and self-help materials, in a primary care setting. The WHO Brief Intervention Study Group[18] found that five minutes of simple advice were as effective as 20 minutes of counseling. Moreover, brief interventions have been shown to be a cost effective way of reducing alcohol consumption and associated problems[19].

Research suggests that brief interventions may also be effective in primary care settings for substance use other than alcohol, and evidence to date suggests that brief interventions can work for cannabis[20, 21, 22], benzodiazepines[23], amphetamines[24], opiates[25], and cocaine[26].

A randomized controlled trial investigating the effectiveness of a brief intervention linked to ASSIST scores for moderate risk cannabis, cocaine, amphetamine-type stimulant or opioid use was recently conducted[5] in the framework of the WHO ASSIST project.

Participants were recruited from primary health care settings and scored within the moderate risk range for at least one of these substances. The study was conducted between 2003 and 2007 in Australia, Brazil, India and the United States of America. The brief intervention, which focussed on the highest scoring illicit substance, lasted between 3 and 15 minutes and was based on the FRAMES model[8] and Motivational Interviewing[7]. It focused on the delivery of personalised feedback regarding the participant's ASSIST scores and associated risk through the use of a purpose-designed ASSIST feedback report card. The brief intervention was bolstered with take-home self-help information including a client self-help manual[27]. The results showed that participants receiving a brief intervention for illicit substances demonstrated significant reduction in ASSIST scores after 3 months compared with control participants. Moreover, over 80% of participants reported attempting to cut down on their substance use after receiving the brief intervention, and many participants provided positive comments on the impact of the brief intervention on their health behaviour[5].

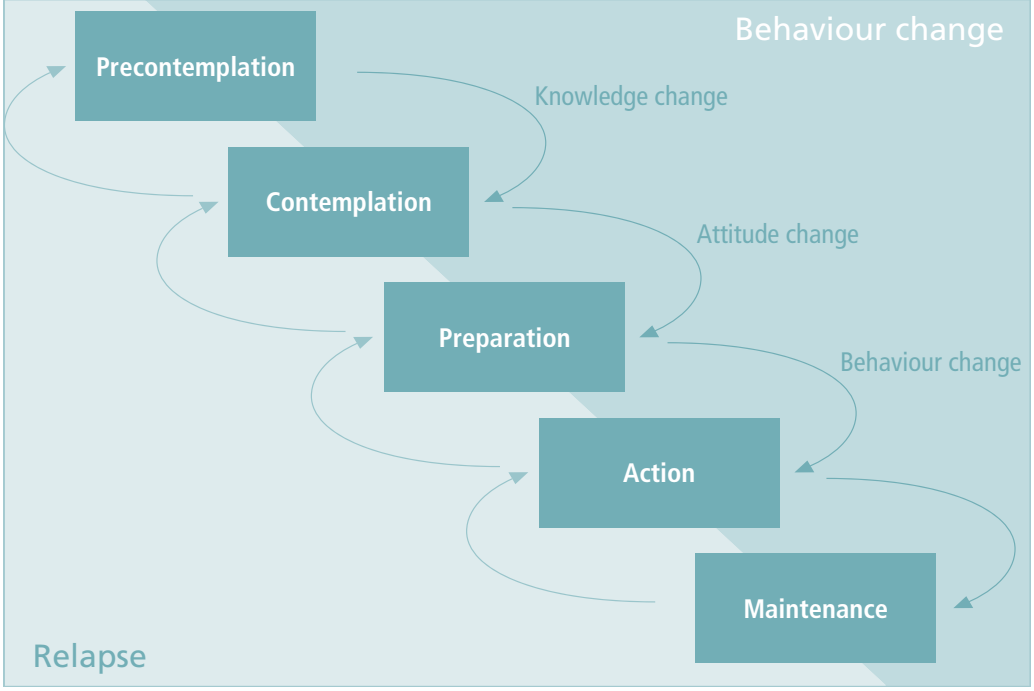
4 Model of behaviour change

A model of behaviour change developed by Prochaska and DiClemente[28] 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. 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[7].

The model includes several stages (Precontemplation, Contemplation, Preparation, Action and Maintenance) and is shown in Figure 1.

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 precontemplation to contemplation to preparation (also called determination) to action and maintenance. Movement from the stage of precontemplation to contemplation may not result in a tangible decrease in substance use, however is a positive step that may result in clients moving on to the action stage at some time in the future.

FIGURE 1 | Model of stages of change*



* Illustration reproduced with permission: McDonald J, Roche AM, Durbridge M & Skinner N (2003). Peer Education: From Evidence to Practice. *An Alcohol and Other Drugs Primer, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide."*

It is also worth noting that there is no set amount of time that a person will spend in each stage (may be minutes to months to years), and that people cycle back and forth between stages. Some clients may move directly from precontemplation to action following an ASSIST-linked brief intervention. The following provides a *brief* description of the underlying behavioural and cognitive processes of each stage. However, health care workers providing interventions longer than 15 minutes, or ongoing sessions with clients, may require a more comprehensive knowledge of the model of change and associated techniques, and some of this can be found in Chapter 11 on *'Giving longer or recurrent interventions – information, skills and techniques'*.

Precontemplation

Many people seen in primary care who score positive on the ASSIST are likely to be in this stage. The 10 step ASSIST-linked brief intervention suggested in this manual is aimed predominantly at precontemplators. People in this stage are:

- not necessarily thinking about changing their substance use;
- focused on the positive aspects of their substance use;
- unlikely to have any concerns 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 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 (if approached appropriately by health care worker).

Contemplation

Some people seen in primary care who score positive on the ASSIST may be in this stage. The 10 step ASSIST-linked brief intervention suggested in this manual is aimed at the majority of contemplators. People in this stage are:

- thinking about cutting down or stopping substance use;
- ambivalent about their substance use when they may be able to see both the good things and the 'less good things' about their substance use;
- likely to have some awareness of the problems associated with substance use and may be weighing up the advantages and disadvantages of their current substance use pattern;
- likely to respond to information about their substance related risks, advice to cut down or engage in discussion about their substance use (if approached appropriately by health care worker).

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

- may not know how to make a change;
- may not be confident that they are able to change.

Preparation/Determination

Preparation follows contemplation which 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. The 10 step ASSIST-linked brief intervention suggested in this manual can be used and expanded for people 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;
- are more likely to remain abstinent if they receive reward, support and affirmation.

Relapse

Most people who try to make changes in their substance use behaviour will relapse to substance use, at least for a time. This should be expected and viewed as a learning process rather than failure. Few people change on the first attempt and relapse is a good time to help clients review their action plan. A review should examine timeframes, what strategies did actually work and whether the strategies utilised were over-ambitious and perhaps unrealistic. Smokers, for example, make an average of 6 attempts to quit smoking tobacco before they are successful. Having relapsed, they will return to one of the preceding stages: precontemplation, contemplation, preparation or action. For many people, changing their substance use gets easier each time they try until they are eventually successful.

In conclusion, the stages of change model 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 outlined in this manual, it is important that health care workers understand these underlying processes to provide the best care for their clients, and not to be too hard on themselves when client change is not immediately obvious.

It is also worth noting that the suggested 10 step ASSIST-linked brief intervention outlined in this manual is **aimed predominantly** at clients who are currently engaged in the **least** amount of change – that is **precontemplators** and some **contemplators**. However, the principles can be built and expanded on for contemplators and preparers who want to change but lack the confidence and knowledge, and for clients who are in the action stage.

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

5 Components of brief interventions that work – FRAMES

Clinical experience and research into brief interventions for substance use have found that effective brief interventions comprise a number of consistent and recurring features. These features have been summarised using the acronym FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy[8, 9, 10]. A number of the features of FRAMES also are associated with Motivational Interviewing (described below) which is a style of intervention aimed at helping people move through the stages of change[7].

It is not the intention of this manual to provide full or comprehensive training in FRAMES or Motivational Interviewing; however, it is important that health care workers have some understanding of these techniques, particularly related to providing an ASSIST-linked brief intervention lasting between 3 to 15 minutes. Accordingly the features of FRAMES and Motivational Interviewing most relevant to a short intervention are outlined below, but further information on these techniques can be found in Chapter 11 concerning the provision of longer or ongoing interventions.

The features of FRAMES most relevant to a short ASSIST-linked brief intervention include Feedback, Responsibility and Advice. A description of each of these is given below along with examples of using these techniques within the confines of the ASSIST-linked brief intervention. Menu of options, Empathy and Self-efficacy are discussed further in Chapter 11 of this manual on *'Giving longer or recurrent interventions – information, skills and techniques'*.

Feedback

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

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

In short, feedback is the provision of personally relevant information which is pertinent to the client, and is delivered by the health care worker in an objective way. 'Much of the feedback given in an ASSIST-linked brief intervention can be delivered by reading directly from the ASSIST feedback report card'[1].

Responsibility

A key principle of intervention with substance users is to acknowledge and accept that they alone are responsible for their own behaviour and will make choices about their substance use and about the course of the brief intervention given by the health worker. 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[8]. Using language with clients such as, *"I think you should… ",* or *"I'm concerned about your (substance) use"* is likely to create resistance in clients and causes them to maintain and defend their current substance use patterns.

Advice

A central component of effective brief interventions is the provision of clear objective advice regarding how to reduce the harms associated with continued use. This needs to be delivered in a non-judgmental manner. Clients may be unaware that their current pattern of substance use could lead to health or other problems or make existing problems worse. Providing clear advice that cutting down or stopping substance use will reduce their risk of future problems will increase their awareness of their personal risk and provide reasons to consider changing their behaviour. Advice can be summed up by delivering a simple statement such as, *"The best way you can reduce your risk of (e.g. depression, anxiety, etc.) is to cut down or stop using"*. Once again the language used to deliver this message is an important feature and comments such as, *"I think you should stop using (substance)"* or *"I'm concerned about your use of (substance)"* does not comprise clear, objective advice.

6 Components of brief interventions that work – Motivational Interviewing

In the context of the ASSIST screening and linked brief intervention it is likely that health care workers in primary care settings will have a relatively short time to spend with clients (compared with the amount of time that a counselor, psychologist or drug and alcohol worker has to spend with clients, for example). Therefore, this manual focuses predominantly on the practical skills and techniques required to deliver a *short* brief intervention to those at *moderate risk,* rather than detailing the underlying theory or providing training on delivering lengthy or on-going sessions with clients. In brief, the take-home message for motivational interviewing is meant to be empathetic, non-judgmental and objective in the delivery of information pertinent to the client.

The brief intervention approach adopted in this manual is based on the motivational interviewing principles developed by Miller[29] and further elaborated by Miller and Rollnick[7].

Motivational Interviewing is a client centered style of interaction which directs people to explore and resolve their ambivalence about their substance use (the 'good things' versus the 'less good things') and move through the stages of change. It is especially useful when working with clients in the precontemplation and contemplation stages, but the principles and skills are important at all stages[7]. Motivational interviewing is based on the understanding that **effective treatment assists a natural process of change**, and that motivation for change occurs in the context of a relationship between the client and the health care worker, even though the time spent together may be brief.

Empathy

An important principle of motivational interviewing is the expression of *empathy* by the health care worker to the client. In a clinical situation empathy comprises an accepting, non-judgmental approach that tries to understand the client's point of view and avoids the use of labels such as 'alcoholic' or 'drug addict'. It is especially important to avoid confrontation and blaming or criticism of the client. Skilful reflective listening which clarifies and amplifies the person's own experience and meaning is a fundamental part of expressing empathy. The empathy of the health worker is an important contributor to how well the client responds to the intervention[7].

Create discrepancy and ambivalence using open-ended questions

Further, clients are more likely to be motivated to change their substance use behaviour when they see a difference or **discrepancy** between their current substance use and related problems and the way they would like their life to be, including their health and relationships with others. Motivational interviewing aims to create and amplify 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.

One of the ways that clients can be directed to express their own reasons for change is for the health care worker to ask clients **open-ended** *questions*. Asking open-ended questions is a technique used often in motivational interviewing to get clients to start thinking and talking about their substance use. Within the context of the ASSIST-linked brief intervention examples of the types of questions asked include: *"Does your score for (substance) concern you at all? How?"* or *"What are the good things about using (substance)?"* and *"What are the 'less good things' for you about using (substance)?"*. Asking open-ended questions of clients also reinforces the notion that the client is responsible for the direction of the intervention and of their substance use choices.

Roll with resistance

A key principle of motivational interviewing is to accept that ambivalence and resistance to change is normal and to invite the client to consider new information and perspectives on their substance use. When the client expresses resistance, the health worker should reframe it or reflect it rather than oppose it. It is particularly important to avoid arguing in favour of change as this puts the client in the position of arguing against it. It worth noting though, that within the context of an ASSIST-linked brief intervention the opportunities for the expression of resistance by clients are few.

Reflective listening and summarising

A reflective listening response is a statement guessing at what the client means. It is important to reflect back the underlying meanings and feelings the client has expressed as well as the words they have used. Using reflective listening is like being a mirror for the person so that they can hear the health worker say what they have communicated. Reflective listening shows the client that the health worker understands what has been said or it can be used to clarify what the client means.

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

Within the context of the ASSIST-linked brief intervention reflective listening and summarizing 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. For example: *"So you really enjoy using cocaine at parties and you don't think you use any more than your friends do. On the other hand you have spent a lot more money than you can afford on coke, and that really concerns you. You are finding it difficult to pay your bills on time. As well, you have noticed that you are having trouble sleeping and you're feeling anxious about life."*

Important tips

In brief, the health care worker administering the ASSIST-linked brief intervention:

- is objective;
- is a conduit for the delivery of information pertinent to that client;
- is empathetic and non-judgemental;
- respects the client's choices regarding the decisions they make about their drug use;
- and the choices they make during the course of the brief intervention;
- shows the client that they are listening and not dismissive of the client's responses;
- doesn't argue with the client;
- uses respectful language toward the client and treats the client as an equal;
- uses open-ended questions to direct conversation in the direction of self-discovery for the client and ultimately towards change.

7 Putting it altogether–a step by step approach to the ASSIST-linked brief intervention

Moderate risk clients

In summary the ASSIST-linked brief intervention follows 10 suggested main steps outlined below (or the first 5 steps for a shorter intervention). The process and examples described in this manual describe a brief intervention focusing on one drug only – generally the one causing the most problems for the client (as identified by the client or highest ASSIST score), or the substance that is being used intravenously (if relevant). 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 only, may 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 (generally after tobacco).

The ASSIST-linked brief intervention outlined here lasts between 3 and 15 minutes and targets clients who are in the pre-contemplation or contemplation stages of change, which are likely to comprise the majority of primary care clients screened. Chapter 10 of this manual provides an outline of an intervention for addressing multiple substance use, for longer or ongoing interventions and for those clients who have decided they want to change their substance use and are in the action stage of change.

This step by step approach outlined below 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.

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. **Summarize 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.

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. The ASSIST feedback report card can be found in Appendix C of Humeniuk RE, smoking and substance Involvement Screening Test (ASSIST): manual for use in primary care. Geneva, World Health Organization [1].

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 health worker's entrance into delivering a brief intervention. Phrasing it in this way gives the client a **choice** about what happens next and immediately reduces any resistance. An affirmative response from the client gives the health worker 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. The ASSIST risk score should be indicated by ticking the relevant boxes for all substances ('lower', 'moderate' or 'high').

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

STEP 2 *Providing personalised feedback to clients about their scores using the ASSIST feedback report card*

Health workers 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.

Health workers should go through each substance score on the front page of the ASSIST feedback report card and tell the client whether they are at lower, 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 your score for tobacco was 16 which places you in the moderate risk range, your score for alcohol was 15 which is in the moderate risk range and your score for marijuana was 18 which also is in the moderate risk range. All other substances were in the lower 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 9 boxes (alcohol, tobacco, cannabis, cocaine, ATS, inhalants, sedatives, hallucinogens, opioids). Each box lists the harms ranging from less severe (shaded

light blue) to more severe (shaded dark blue) 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 (even if it is upside down). An example of personalised feedback around a moderate risk score for cannabis is shown below:

"Because you're in the moderate risk range for your use of marijuana the kinds of things associated with your current pattern of marijuana use are problems with attention and motivation, feeling anxious, panicky or depressed, difficulty solving problems or remembering things, high blood pressure, asthma, bronchitis and at the serious end of things, psychosis, heart and airways disease and cancers… "

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, and advice is about telling clients that cutting down or stopping their substance use will reduce the risk of problems both now and in the future. An effective way of providing advice to clients is to say:

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

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

STEP 4 *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. Health workers need to be mindful that the client is responsible for their own decisions regarding substance use and this should be reiterated to clients during the brief intervention, particularly after feedback and advice have been given. For example, this could be expressed by saying to clients:

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

The above written example not only encourages clients to take responsibility, it also reinforces the relationship between the clients' 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[7,29]. Health workers 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 (drug)?"

STEPS 6 and 7 *Weighing up good things about using the substance against the 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 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 health worker 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 (substance)… ?"

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 (substance) for you… ?"

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

- **health** – physical and mental;
- **social** – relationships with partner, family, friends, work colleagues;
- **legal** – accidents, contact with law enforcement, 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 *Summarize and reflect on clients' statements about their substance use with emphasis on the 'less good things'*

Reflecting back to clients by summarizing 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 summarizing also allows health workers 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 shown below:

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

STEP 9 *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?"

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 3 to 4 items that should be given to clients upon the completion of the brief intervention session. These are:

- client's ASSIST feedback report card;
- general information pamphlets on the substance(s) being used by the client (obtained from the relevant agency in your country);
- self-help strategies for cutting down or stopping substance use: a guide[30] booklet;
- risks of injecting card (if relevant).

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

The *'Self-help strategies for cutting down or stopping substance use: a guide'*[30] 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 5 years of education and is pictorial in nature. Health care workers could also 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 3 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 risks of injecting card can be found in Appendix D of Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V and Monteiro M (2010) The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Manual for use in primary care. Geneva, World Health Organization[1].

Injecting clients do require further intervention than Steps 1 through 10 outlined above, and this is covered in Chapter 8 on '*What to do with 'high risk' and injecting clients*'.

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 chose what they do about their substance use. Say something like:

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

Lower risk clients

Clients whose scores are all in the lower risk range do not need any intervention to change their substance use and treatment can continue as usual. However, it is good practice to reinforce that what they are doing is responsible and encourage them to continue their current lower risk substance use patterns. Moreover, if time permits provision of general information about alcohol and other drugs to lower 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 lower risk substance users to continue their lower risk substance use behaviour.
- It may remind clients with a past history of harmful or hazardous substance use about the risks of returning to harmful or hazardous substance use.
- Information they are given may be passed onto friends or family who do have substance use issues.

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

Clients who have been injecting drugs regularly over the last three months (see note below) and/or whose ASSIST scores are in the 'high' risk range ('27 or higher') for any substance, require more than just the brief intervention. However, 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. This may help the client understand that they may need treatment to change their substance use. Information on how to conduct a longer session with clients is discussed in Chapter 11 of this manual on *Giving longer or recurrent interventions – information, skills and techniques*.

At a minimum, high risk clients need further assessment, including taking their substance use history, and preferably referral for further treatment. Depending on the needs of the client, treatment can include: recurrent sessions with the primary care worker, specialist drug and alcohol counseling, pharmacotherapy, inpatient detoxification, residential rehabilitation, group counseling or a 12-step or similar program. There also are other treatment options available depending on availability in the client's country or culture. In addition, there may be underlying reasons associated with a client's substance use that may need to be addressed such as chronic pain, mental health issues, relationship difficulties, occupational demands or homelessness. All clients should be reviewed and monitored whenever they return to the health care facility, whether they agree to more intensive treatment or not. They should be invited to make an appointment to come back and talk about their substance use at any time in the future.

It is also very important that high risk and injecting clients undergo appropriate physical health checks including blood and other biological screening. For example, heavy drinking clients should have their liver enzymes checked, and injecting clients should be screened for hepatitis and HIV/AIDS and be given information about harm minimization associated with injecting as shown in the risks of injecting card.

Q8 on the ASSIST asks about the recency of injection of substances. While the score from Q8 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). However, 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. More information about assessment of injecting drug users can be found in *'The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): manual for use in primary care'*[1].

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 and C and HIV/AIDS.

Clients who choose to continue to inject should be informed of appropriate harm minimisation strategies. These may include: not sharing injecting equipment, hygiene around injecting, avoiding the use of other substances at the same time – especially alcohol and sedatives, letting a friend know when you are going to use in case of overdose, learning first aid and resuscitation techniques and having a small amount to start with to check the purity of the substance being used. Clients should also be informed of where they can access clean needles (or how to clean existing needles if unavailable) and how to safely dispose of their used needles.

9 Example of a brief intervention

The following is a scripted example of the suggested 10 step ASSIST-linked brief intervention for a 22 year old female client who just has been administered the ASSIST questionnaire by a health worker. This example is taken from a real clinical situation in which the ASSIST and brief intervention were administered to the client of an Australian STD clinic. The health worker has calculated the scores for the client and put them onto the ASSIST feedback report card. The client has scored in the moderate risk range for amphetamine-type stimulants, tobacco and cannabis. All other substances are in the lower risk range. For this example the health worker is focusing only on the client's amphetamine-type stimulant use which was speed (a powder form of amphetamine) in this example. A longer intervention could also address the client's other substance use (cannabis and tobacco).

The example below is divided into two parts. Part 1 comprises the script for a shorter 3 to 5 minute intervention while Part 2 comprises the second part of the script resulting in a longer 10 to 15 minute intervention.

Each step of the brief intervention [Steps 1 through to 10] is indicated in square brackets at the end of each of the health care worker's scripts.

PART 1 | Brief intervention (3 to 5 minutes)

Health worker: *Would you like to see the results of the questionnaire you just did?* [Step 1. Asking]

Client: *Yes please.*

Health worker (points to scores on front page of ASSIST feedback report card): *These are your scores for each substance that we talked about. You scored a 21 for tobacco which puts you in the moderate risk range for that substance, a 6 for cannabis which also is in the moderate risk range and 14 for amphetamine-type stimulants which is also in the moderate risk range. You were in the lower risk group for all other substances. A score in the moderate risk range means that you are at risk of health and other problems from your current pattern of substance use. Even if you are not experiencing any problems now, a score in the moderate risk range means that you are at risk of developing health and other problems in the future.* [Step 2. Feedback]

Health worker (opens booklet and points to box relating to amphetamine-type stimulants): *Because your risk of experiencing harms from amphetamines is moderate, the kinds of things that are associated with your current pattern of use are things like: difficulty sleeping, loss of appetite, dehydration, jaw clenching, headaches and muscle pain. Mood swings – like feeling anxious, depressed and panicky or paranoid, particularly the day after using – which you mentioned when we were doing the questionnaire. Because speed is a central nervous system stimulant they stimulate you so you can get things like tremors, irregular heart beat and shortness of breath. Some people get aggressive and violent when they use amphetamines, and some people experience psychosis. At the serious end of things amphetamine-type stimulants can also cause permanent damage to brain cells, liver damage and stroke.* [Step 2. Feedback continued]

Health worker: *The best way you can reduce the likelihood of these things happening to you* (indicates to risks outlined in box) *is to either cut down or stop using amphetamines.* [Step 3. Advice]

Health worker: *What you do with this information is up to you. I'm just letting you know the relationship between your current pattern of use and the kinds of harms you might be experiencing.* [Step 4. Responsibility]

Health worker (Turns back to front of booklet and points to amphetamine score): *Does your score for amphetamines concern you? How?* [Step 5. Concern]

Client: *Well, yes it does concern me a bit. I didn't realise I would have such a high score for amphetamines and that I could be at risk of those kinds of health problems. I guess I have been thinking about cutting back for a while because they do make me feel really depressed and moody a couple days after I have used them, and it's getting to the point where maybe it's just not worth using them anymore. But they make you feel so good when you are using them – so I don't really know…*

End short intervention by giving client take-home materials according to Step 10.

PART 2 | Brief Intervention continued (10 to 15 minutes)

Health worker: *Well, what are the good things about using amphetamines for you personally?* [Step 6. Good things]

Client: *I enjoy it that I can stay up all night and party with my friends when I've used speed and that they just make you feel more lively and happy. We just have a really good time all together and it's a real buzz.*

Health worker: *What about the less good things about using amphetamines, what are they?* [Step 7. Less good things]

Client: *Definitely the come down. I feel really quite depressed and I get very irritable at work and at my boyfriend. He doesn't really like me using them and that's causing a few problems between us. I'm also worried about the effect that it might be having on my mood long term because I think I'm more irritable now than I used to be.*

Health worker: *So the good things about using speed are that it makes you feel up and active and you can party all night with your friends and have a really good time, but on the down side you get pretty depressed in the come down and you've noticed that you're feeling more moody and irritable in general than you have in the past, and that it has caused a few problems with your boyfriend, particularly because of your irritability and mood swings.* [Step 8. Summarise and Reflect]

Health worker: *Do the less good things about using amphetamines concern you? How?* [Step 9. Concern]

Client: *Yes, I suppose I am concerned about the effect that it is having on my mood in general and also those other things that were mentioned in the score sheet, I wasn't aware of them and they do sound scary. It also worries me if this effect on my mood might be an ongoing thing, because I really don't like feeling depressed.*

Health worker: *You can take this feedback report card home with you and I'll also give you this information sheet on amphetamines. I'll also give this booklet* (Self-help strategies for cutting down or stopping substance use: a guide[30]) *which people often find useful to help them decide whether or not they want to cut down on using substances. If you do decide that you want to cut down or stop using, then it provides some strategies that you might find helpful. Also you can feel free to make another appointment to talk about it if that's what you want – but it's completely up to you.* [Step 10. Take-home materials]

10 Longer interventions Addressing multiple substance use

A scenario in which health workers may wish to spend longer with their clients is to address multiple substance use. Some of the skills and techniques required for giving longer interventions are outlined in Chapter 11 of this manual.

Polydrug use, particularly that of tobacco, alcohol and cannabis is fairly common among clients who are using illicit substances such as amphetamine-type stimulants, cocaine or opioids. A suggested variation of the 10 main steps to address multiple substance use is outlined below. While feedback would be given on all substances scoring in the moderate or high risk range, the focus of the intervention should be directed toward the substance(s) that are creating the most problems for the client or is of most concern to the client. It is also worth noting that while an intervention may focus around one predominant substance, clients can get information about the risks associated with other substance use in the take-home materials given at the end of the intervention.

Suggested 10 steps variation for dealing with multiple substance use

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:
   - general feedback as per scores on the front page;
   - specific feedback for substance 1 (highest scoring or most problematic substance) as outlined in the individual boxes inside the feedback report card;
   - specific feedback for substance 2;
   - specific feedback for substance 3, etc.
3. Giving **advice** about how to reduce risk associated with substance use:
   - general advice statement which covers all of the substances.
4. Allowing clients to take ultimate **responsibility** for their choices:
   - general responsibility statement which covers all of the substances.
5. Asking clients how **concerned** they are by their scores:
   - Take the client's lead regarding the substance(s) of most concern to them and pursue that with steps 6, 7, 8 and 9.
6. Weighing up the **good things** about using the substance against the;
7. **Less good things** about using the substance.
8. **Summarize and reflect** on clients' statements about their substance use with emphasis on the 'less good things'.
9. Asking client how **concerned** they are by the 'less good things':
   - repeat steps 5, 6, 7, 8 and 9 with substance of next concern.
10. Giving clients **take-home materials** to bolster the brief intervention.

11 Giving longer or recurrent interventions – Information, skills and techniques

All clients screened using the ASSIST should receive feedback regarding their scores and level of risk and should be offered information or advice about the substances they use, as per the short 3-5 minute intervention example above. This is the minimum level of intervention for all clients. However, there may be opportunity for some health workers to give longer or ongoing interventions, in which case health workers would most likely require some level of further training concerning best practice for treatment of drug and alcohol clients. This resource manual outlines **some** of the Motivational Interviewing and FRAMES techniques required to give longer interventions, or to help contemplator clients who want to change but lack the confidence or knowledge, or clients who have moved into the action stage of change and are ready to change their substance use behaviour.

Techniques and skills for change also are outlined in the '*Self-help strategies for cutting down or stopping substance use: a guide*' [30] and while directed at clients, is a useful tool for health workers to facilitate understanding of the battery of strategies used.

Taking a substance use history

It is recommended that the client's substance use history be taken with longer or ongoing sessions. While there will be variability between clients, frequency and quantity generally are a good indicator of the severity of health and other problems experienced by clients. Frequency of use in the past three months is determined in Q2 of the ASSIST which contributes to the resulting ASSIST risk score. A more detailed history would include:

- **Quantity** – how much, in standard or comparable units, is being consumed.
- **Frequency of use** – detailing frequency over the past 3 to 6 months.
- **Pattern of use** – is the pattern of use consistent, does the client binge, or has there been any periods of abstinence, and why.
- **Duration of use** – how long has the client been using the substance including age of first use.
- **Route of administration** – how is the substance used: swallowing, smoking, snorting, injecting, inhaling, etc.
- **Form of the substance** – in what form is the substance used: pills, syrup, crystals, powder, plant product (leaf, bud, sap, etc) and any preparation thereof.

Determining a substance use history is another way of monitoring a client's substance use over a period of time, and consolidates the information that is provided by the ASSIST questionnaire. The information can be used to communicate with other health care providers and to determine the best treatment course for the client, particularly for high risk and dependent users.

More on Stages of change

Contemplation

Much of this manual provides information and techniques for dealing predominantly with precontemplators and some contemplators. However, as outlined in Chapter 4 above, some contemplators may be willing to make a change but may not know how, or may lack the confidence to do so. Importance, readiness and confidence need to be assessed in interventions to encourage clients to change their behaviour; and use of the readiness ruler (Figure 2) and the confidence ruler (Figure 3) as outlined below may be a useful visual tool to help clients.

Helping clients see their ambivalence about substance use as a balance can be another helpful tool at this stage. On one side of the balance are the benefits to the client of their current substance use behaviour and the costs associated with changing it (reasons for remaining the same), while on the other side are the costs of current substance use and the benefits of change (reasons for change). Change is unlikely to occur until the reasons for change outweigh the reasons for staying the same. A decision balance (Figure 4) is a useful visual tool that can assist the health worker to further discuss with the client the pros and cons of substance use and to create discrepancy (or ambivalence). Another way of encouraging the client to consider the costs and benefits of their current substance use is to help them to draw up a table similar to the one below (Table 2). It can be helpful to ask the client to talk first about what they like about their substance use, the good things, and then to ask about the not so good things. These strategies are used directly with clients in their take-home manual *'Self-help strategies for cutting down or stopping substance use: a guide'*[30].

In order for people to actually change their behaviour they need to be ready, willing and able to change[7]. The stages of change model discussed above is a way of understanding how ready and willing a client is to make changes in their substance use.

Being ready and willing to reduce or stop substance use is related to how important the client thinks it is to make the change. However, thinking a change is important is not always enough for a client to move into the action phase. Sometimes a client is willing to make a change but is not confident that they are able to do so. Both importance and confidence need to be addressed in interventions to encourage clients to change their behaviour.

A simple way to find out how important the client thinks it is to reduce their substance use is to use the readiness ruler[7] (Figure 2). This is a scale, or ruler, with gradations from 0 to 10, where 0 is 'not at all important' and 10 is 'extremely important'. Clients can be asked to rate how important it is for them to change their substance use.

The readiness ruler can be used at the beginning of a brief intervention to help target the intervention at the appropriate stage of change or it can be used during the intervention. It can also be used in ongoing sessions as a way of encouraging the client to talk about reasons for change.

FIGURE 2 | The readiness ruler

"How important is it to you to cut down or stop your substance use? On a scale of 0 to 10, where 0 is *'not at all important'*, and 10 is *'extremely important'*, how would you rate yourself?"

0	1	2	3	4	5	6	7	8	9	10

Not at all important **Extremely important**

FIGURE 3 | The confidence ruler

"How confident are you that you could cut down or stop your substance use if you decided to do it? On a scale of 0 to 10, where 0 is *'not at all confident'* and 10 is *'extremely confident'*, how would you rate yourself?"

0	1	2	3	4	5	6	7	8	9	10

Not at all confident **Extremely confident**

FIGURE 4 | Decision balance

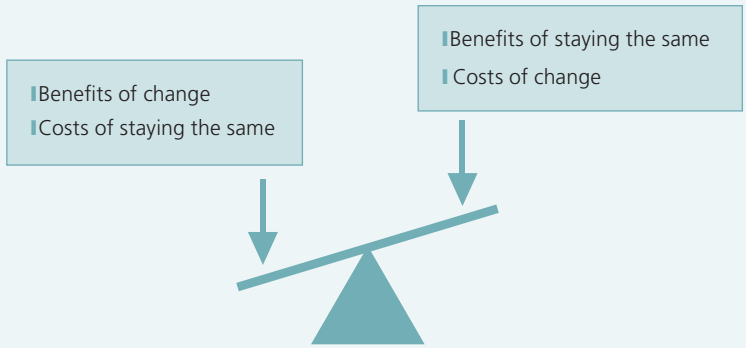


TABLE 2 | Decision table

	Benefits	Costs
Short term		
Long term		

Miller and Rollnick[7] suggest using the ruler to obtain the client's rating and then asking the following two questions.

- *"Why are you at a (e.g. 3) and not a 0?"* This gets the client to verbally justify, or defend, their position which can act to motivate the client to change.
- *"What would it take for you to go from a (e.g. 3) to a (e.g. 6) (a higher number)?"* This gets clients to verbalise possible strategies for change and gets them to start thinking more about change.

The same sort of scale can also be used to assess how confident clients are that they are able to cut down or stop their substance use[7]. The 'Confidence Ruler' can be used with clients who have indicated that it is important for them to make a change or it can be used as a hypothetical question to encourage clients to talk about how they would go about making a change.

It is not necessary to actually show the client a ruler, but it may be helpful, especially for clients with low literacy and numeracy. For some clients it may be enough to just describe the scale using words like those in the examples given above.

Action

As discussed previously, clients in the action stage have made the decision that their use of substances needs to change, or may already be in the process of abstaining or cutting down. Clients in this stage may continue to feel ambivalent about their substance use, and need encouragement and support to maintain their decision. Building on the 10 step intervention outlined above, techniques that are useful for clients who want to take action include:

- negotiating aims and goals for changing substance use behaviours together;
- suggesting a range of strategies from which the clients could choose to help them cut down or stop their substance use (Menu of options);
- helping them to identify situations where they might be at risk of relapse;
- discussing with the clients a plan for action to reduce or stop their substance use.

These strategies are detailed further below in '*More on FRAMES*'.

Maintenance

Clients in this stage are attempting to maintain the behaviour changes that have been made and long-term success means remaining in this stage. While clients in this stage have made lots of changes, they will still experience ambivalence and desires to return to substance use. Accordingly, clients who are trying to maintain behaviour changes need affirmation that they are doing a good job and encouragement to continue. Primary health care workers can assist people in this stage by providing praise for successes and reinforcing the client's strategies for avoiding situations where they are at risk of relapse or helping them to move on after a small lapse.

More on Motivational Interviewing

Feedback

As discussed in Chapter 6 on Motivational Interviewing, giving feedback to clients is an important part of the intervention process. However, the way that feedback is given can affect whether the client really hears the feedback and takes it in. Feedback should be given in a way that takes account of what the client is ready to hear and what they already know. Using the empathic style and specific skills described earlier in the manual can have a large effect on how well clients feel they have understood the feedback.

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:

- elicit readiness/interest;
- provide feedback;
- elicit personal interpretation.

1. **Elicit the client's readiness/interest for information. That is, ask the client what they already know and what they are interested in knowing. It may also be helpful to remind the client that what they do with the information is their responsibility. For example:**
   - *"Would you like to see the results of the questionnaire you completed?"*
   - *"What do you know about the effects of amphetamines on your mood?"*
2. **Provide feedback in a neutral and non-judgmental manner. For example:**
   - *"Your score for opioids was 18, which means that your current level of opioid use puts you at risk of experiencing health and other problems."*
   - *"Amphetamines affect the chemicals in your brain that regulate mood, and regular use can make you feel depressed, anxious and make some people angry and violent."*
3. **Elicit personal interpretation. That is, ask the client what they think about the information and what they would like to do. You can do this by asking key questions. For example:**
   - *"How concerned are you by your score for opioids?"*
   - *"How concerned are you by the effect of amphetamines on your mood and mental health?"*
   - *"How do you feel about that?"*
   - *"Where do we go from here?"*
   - *"What would you like to do about that?"*
   - *"What concerns you most?"*

Specific skills

Motivational interviewing makes use of five specific skills. These skills are used together to encourage clients to talk, to explore their ambivalence about their substance use and to clarify their reasons for reducing or stopping their substance use[7]. The first four skills are often known by the acronym OARS: Open ended questions, Affirmation, Reflective listening, and Summarising. The fifth skill is 'eliciting change talk' and involves using the OARS to

guide the client to present the arguments for changing their substance use behaviour.

Open ended questions

Open ended questions are questions which require a longer answer and open the door for the client to talk. Examples of open ended questions include:

- *"What are the good things about your substance use?"*
- *"Tell me about the not so good things about using… (drug)?"*
- *"You seem to have some concerns about your substance use; tell me more about them."*
- *"What concerns you about that?"*
- *"How do you feel about … ?"*
- *"What would you like to do about that?"*
- *"What do you know about … ?"*

Affirmation

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

- *"Thanks for coming today."*
- *"I appreciate that you are willing to talk to me about your substance use."*
- *"You are obviously a resourceful person to have coped with those difficulties."*
- *"I can see that you are a really strong person."*
- *"That's a good idea."*
- *"It's hard to talk about … I really appreciate your keeping on with this."*

Reflective listening

A reflective listening response is a statement guessing at what the client means. It is important to reflect back the underlying meanings and feelings the client has expressed as well as the words they have used. Using reflective listening is like being a mirror for the person so that they can hear the therapist say what they have communicated.

Reflective listening shows the client that the health worker understands what is being said or can be used to clarify what the client means. Effective reflective listening encourages the client to keep talking and the health worker should allow enough time for that to happen.

In motivational interviewing, reflective listening is used actively to highlight the client's ambivalence about their substance use, to steer the client towards a greater recognition of their problems and concerns, and to reinforce statements indicating that the client is thinking about change. Examples include:

- *"You are surprised that your score shows you are at risk of problems."*
- *"It's really important to you to keep your relationship with your boyfriend."*
- *"You're feeling uncomfortable talking about this."*
- *"You're angry because your wife keeps nagging you about your substance use."*
- *"You would like to cut down your substance use at parties."*
- *"You really enjoy your substance use and would hate to give it up, and you can also*

see that it is causing some financial and legal problems."

Summarise

Summarising is an important way of gathering together what has already been said and preparing the client to move on. Summarising adds to the power of reflective listening especially in relation to concerns and change talk. First clients hear themselves say it, then they hear the therapist reflect it, and then they hear it again in the summary. The therapist chooses what to include in the summary and can use it to change direction by emphasising some things and not others. It is important to keep the summary succinct. An example of a summary appears below.

"So you really enjoy using speed and ecstasy at parties and you don't think you use any more than your friends do. On the other hand you have spent a lot more money than you can afford on drugs, and that really concerns you. You are finding it difficult to pay your bills and your credit cards have been cancelled. Your partner is angry and you really hate upsetting him. As well, you have noticed that you are having trouble sleeping and you're finding it difficult to remember things."

Eliciting change talk

The fifth skill '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 substance use?"*
- *"What do you think will happen if you don't make any changes?"*
- *"What would be the good things about cutting down on your substance use?"*
- *"How would you like your life to be in five years 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?"*

More on FRAMES

Clinical experience and research into brief interventions for substance use have found that effective brief interventions comprise a number of consistent and recurring features. These features have been summarised using the acronym FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy[8, 9, 10]. Feedback, Responsibility and Advice were discussed in Chapter 5 of this manual, and empathy has been discussed in Chapter 6 of this manual on *'Motivational Interviewing*'. This chapter provides more detail on Menu of Options and Self Efficacy.

Menu of alternative change options

Effective brief interventions and self help resources provide the client with a range of alternative strategies 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: a guide'*[30] is a good way to start because it contains strategies for helping clients change their behaviour, and can be used alone or in conjunction with several options. Examples of options for clients to choose could include:

- keeping a diary of substance use (where, when, how much used, how much spent, with whom, why);
- helping clients to prepare substance use guidelines for themselves;
- identifying high risk situations and strategies to avoid them;
- identifying other activities instead of drug use – hobbies, sports, clubs, gymnasium, 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 and to work through the substance users guide to cutting down or stopping together;
- providing information about other groups or health workers that specialise in drug and alcohol problems;
- putting aside the money they would normally spend on substances for something else.

Self efficacy (confidence)

The final component of effective brief interventions is to encourage clients' confidence that they are able to make changes in their substance use behaviour. People who believe that they are likely to make changes are much more likely to do so than those who feel powerless or helpless to change their behaviour[7]. It is particularly helpful to elicit self efficacy statements from clients as they are likely to believe what they hear themselves say.

Example of a longer brief intervention

The following is an example of a longer intervention which has built on the 10 step ASSIST-linked brief intervention and utilizes some of the specific skills and techniques outlined above. The FRAMES and Motivational Interviewing techniques used are included in square brackets after the script. The client is a 33 year old man who lives with his girlfriend and their young child and is employed full time in a factory. He smokes cannabis after work and on the weekend and has obtained ASSIST scores in the lower risk range for all substances except cannabis for which he has scored a 23, placing him in the moderate risk category.

EXAMPLE | Longer brief intervention

Health worker: *OK, thanks for going through this questionnaire with me. Would it be fair to say that marijuana is the drug that you use the most at the moment?* [Affirmation]

Client: *Yes, pretty much.*

Health worker: *How much would you smoke, say, on an average day after work?* [Taking brief history].

Client: *Usually 1 or 2 joints throughout the evening.*

Health worker: *Would that be the amount you'd have when you smoke on the weekends?* [Taking brief history]

Client: *Yeah… probably a bit more actually… maybe 3 or 4, I don't know, sometimes I lose track.*

Health worker: *And how long have you been smoking marijuana for – I mean, how many years?* [Taking brief history]

Client: *I started in my late twenties, so probably about 5 years in total.*

Health worker: *OK. Would you like to see the results of the questionnaire that you did?* [Elicit]

Client: *Sure.*

Health worker: *If you remember, the questions asked about your drug and alcohol use and whether you have experienced any problems related to your substance use* (shows the client the front page of the ASSIST Feedback Report Card). *Your score for marijuana was 23 which is in the moderate risk range. Your score for all other substances was in the lower risk range. Moderate risk means that you are at risk of health and other problems from your current pattern of marijuana use, not only now, but also in the future if you continue smoking at your current levels* (opens ASSIST feedback report card and points to Box C detailing cannabis risks). *Because your risk of harms from cannabis is in the moderate risk range, the kinds of things associated with your current pattern of use are problems with attention, concentration and motivation, anxiety, depression, panic, paranoia, decreased memory and problem solving ability, high blood pressure, asthma and bronchitis, heart disease and lung disease.* [Provide feedback]

Health worker: *The best way you can reduce the likelihood of these things happening to you* (indicates to risks outlined in box) *is to either cut down or stop using marijuana.* [Provide advice]

Health Worker: *What you do with this information is up to you. I'm just letting you know the relationship between your current pattern of use and the kinds of harms you might be experiencing.* [Responsibility]

Health worker: *How concerned are you about your score for marijuana?* [Open ended question, elicit self-motivating statement of concern]

Client: *Yeah… I don't know… I mean… I suppose it is a bit worrying that it's doing this to my brain… I don't know.* [Dissonance]

Health worker: *Well, what do you enjoy about smoking marijuana – I mean what are the good things about it?* [Open ended question – exploring pro's and con's]

Client: *Well, it makes me relax, especially after coming home from work. It really helps me to unwind and forget the day. It's also good when you're out with friends or at a party on the weekend because you enjoy yourself more.*

Health worker: *What are the less good things about smoking marijuana?* [Open ended question – exploring pro's and con's]

Client: *Ask my girlfriend – she always nagging me about it! I guess probably the worst thing about it for me is that it seems to affect my memory and concentration at work. Sometimes after a big binge session the night before, the next day at work I'm a bit hazy and I feel really tired. If I feel really bad sometimes I won't go into work that day.*

Health worker: *So smoking marijuana helps you to relax and unwind after work, but it also makes you forgetful and tired and sometimes you miss work because of it. You also said your girlfriend doesn't like you smoking it – why do you think that is?* [Reflective listening, re-focus, open-ended question]

Client: *She doesn't like me getting stoned all the time because she says I don't do anything except sit around and watch TV and that I'm always forgetting to do stuff. She says I don't do enough around the house and that she's always left to do all the work and look after the baby. But, I mean, I work and bring home a wage every week…*

Health worker: *And it's hard for you because smoking marijuana helps you relax, but at the same time you're not lending a hand around the house because you're getting stoned, and that affects your memory and concentration and sometimes you forget to do things that your girlfriend is relying on you to do.* [Reflection, summary, empathy]

Client: *Yeah, but that could be because I'm always tired because I don't always sleep well if the baby cries at night.* [Resistance]

Health worker: *So the reason you're forgetting things and finding it hard to concentrate and help your girlfriend after work is because you don't get enough sleep?* [Roll with resistance – amplified reflection]

Client: *Well, that's part of it anyway. I guess part of it could be from smoking too much.* [Ambivalence]

Health worker: *How does smoking too much impact on your ability to concentrate and remember things at work? Do you have a specific example?* [Open-ended question]

Client: *Actually the other day I did nearly have an accident using one of the forklifts at work. It was early on a Monday morning and I really wasn't concentrating because I'd had a fair bit to smoke on the week-end. I nearly ran into one of my workmates – he was pretty shaken up by it, and so was I.*

Health worker: *What would happen if you did have an accident at work because you weren't concentrating?* [Open-ended question, eliciting change talk]

Client: *That's a horrible thought. Well, I would probably lose my job and that would certainly cause hardships at home because I'm the only one working at the moment, so we wouldn't have an income. I'd also have to live with the knowledge that I had hurt someone, and I'd feel really guilty about that. I guess I would also be in big trouble if they found out I had been smoking marijuana before the accident.*

Health worker: *So if you had an accident at work because you weren't concentrating it could have long term implications for your workmates, and also for you financially and for your home life, and perhaps even legally. Does that concern you?* [Reflection, summarise, open-ended question]

Client: *Yes, when I start thinking about it like that of course it concerns me. But I just don't know if I could actually cut down smoking marijuana, I don't really know where to begin.*

Health worker: *OK – how important is it for you to cut down or stop smoking? Imagine a scale of 0 to 10, where 0 is 'not at all important that you cut down' and 10 is 'extremely important that you cut down', how would you rate yourself on that scale? [*Readiness ruler, eliciting change talk]

Client: *I'd say maybe a 6 or a 7.*

Health worker: *OK – think of that same scale again, but this time rate your confidence where 0 is 'not at all confident I could cut down' and 10 is 'extremely confident I could cut down', where would you place yourself?* [Confidence ruler]

Client: *Probably about a 3.*

Health worker: *So it seems that cutting down on smoking marijuana is fairly important to you right now, but perhaps you're not really sure how you could do that. Can I tell you about this booklet that we sometimes give to people to help them cut down?* [Summarise, elicit]

Client: *Sure.*

Health worker: *This is a booklet* (shows client Self-help strategies for cutting down or stopping substance use: a guide[30]) *which people often find useful to help them decide whether or not they want to cut down on using substances. If you do decide that you want to cut down or stop using marijuana, then it provides some strategies that you might find helpful. These are strategies that have been proven to be very effective for helping people who want to cut down. For example* (opens booklet), *one way to help you keep track of your substance use is to keep a diary, that way you can get a good idea of how much you are using, when you are most likely to use and how much you spend. You can also use this diary to identify when you are most likely to smoke marijuana and then plan strategies around avoiding those situations. It also helps you to weigh up the pros and cons of your marijuana use and how it fits in with your other goals in life. I'll give you this booklet to take home, and if you want you can come back for another appointment and we can talk about it some more.* [Menu of options]

Health worker: *Do you think that any of these things could work for you, or is there some other way that you think might be better? Perhaps you have used another strategy in the past to help you make changes in your life?* [Elicit, encourage self efficacy]

Client: *Actually my girlfriend kept a food diary when she was on a diet and it seemed to help her a lot. She lost a lot of weight. I haven't done anything like that before, but if it worked for her it could probably work for me. That makes me feel like I might be able to at least cut down on smoking marijuana if I read that booklet and do a diary.*

Health worker: *Well that's very good that you've identified something that could work for you and learnt from the experience of others. Good luck with it and if you want to catch up again in a few weeks to talk about how it is going for you please feel free to make another appointment.* [Affirmation]

12 How to include the ASSIST-linked brief intervention in every day practice

Detailed information concerning the implementation of the ASSIST screening into every day practice is outlined in *'The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): manual for use in primary care'*[1]. The procedures detailed under the four main headings of 'Planning', 'Training', 'Monitoring' and 'Feedback' in the ASSIST manual also are relevant for implementing a brief intervention linked to ASSIST screening. In particular, the kinds of implementation questions that need to be addressed relate to access to resources and services for clients who score moderate or high risk on the ASSIST. These clients will need to access the take home materials including the manual "*Self-help strategies for cutting down or stopping substance use: a guide*"[30] and health practices need to ensure ready availability of these materials.

Another important consideration is the follow-up of clients with regards to ongoing assistance for substance use problems. Health workers and clients should be made aware of the options available to clients for support, such as further assessment and counseling (either within that practice or at a specialised practice), self-help groups, pharmacotherapy (eg. methadone, buprenorphine, acamprosate etc.), peer support groups and services, inpatient and out-patient detoxification and residential rehabilitation. Access to clean needles and injecting equipment also needs to be considered (according to policy within each country and jurisdiction), as well as where to access testing for communicable diseases.

Finally, equipping health workers with the skills to deal with substance users on a regular basis is also important. This may include access to some level of counseling or debriefing when required. Adequate training of health workers is also paramount and apart from reading the two manuals, health workers should be encouraged to attend ASSIST training and Motivational Interviewing training if available.

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The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed for the World Health Organization (WHO) by an international group of researchers and clinicians as a technical tool to assist with early identification of substance use related health risks and substance use disorders in primary health care, general medical care and other settings.

The WHO ASSIST project aims to support and promote screening and brief interventions for psychoactive substance use by health professionals to facilitate prevention, early recognition and management of substance use disorders in health care systems with the ultimate goal of reducing the disease burden attributable to psychoactive substance use worldwide.

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