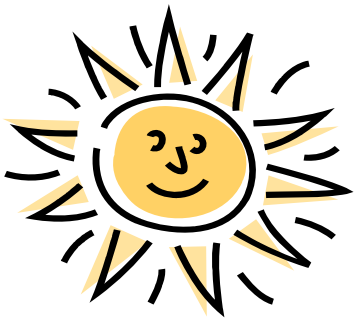

Florida
Brief Intervention and Treatment for Elders (BRITE)

Initial Training Manual

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This training manual was developed by Robert W. Hazlett, Ph.D, CAC, CCS, Florida's BRITE Quality Assurance/Training Manager, to provide training to site personnel for screening of potential substance use, abuse and dependence disorders in a hospital, primary care or clinic setting and how to apply brief intervention strategies matched to the patient's severity of use/abuse of alcohol and other drugs (AOD).

The material included in this manual comes from the research and data collected by the Florida's Department of Children and Families, Substance Abuse Programs Office, World Health Organization (WHO), Addictions Research Foundation, and the American Society of Addiction Medicine (ASAM), and the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol Manual (TIP 26) *Substance Abuse Among Older Adults.* Some material was extracted from the Brief Intervention and Screening Manuals, ASSIST manual, from the World Health Organization (WHO) and is included in this manual.

INTRODUCTION

Florida's Department of Children and Families, Substance Abuse Program Office (SAPO) is expanding its continuum of care to enhance brief intervention and treatment for elders (BRITE) in general medical and other community settings for older adult (i.e., ages 55 and above) patients with substance abuse and dependence disorders. These services shall be implemented in the Florida's Department of Children and Families circuits throughout the State of Florida. The BRITE will support clinically appropriate intervention for the target population and improve linkages among individual practitioners and community agencies participating in the BRITE project with specialist substance abuse and dependence treatment agencies within the above counties

The application of the BRITE approach in the proposed targeted areas and settings will utilize the oversight process of the Department of Children and Families Substance Abuse Programs Office. The treatment services infrastructure within the sub-recipient communities will administer a service delivery model consisting of science-based screening, assessment, and brief interventions, level of care determinations, and facilitated referrals to improve patient access and retention within both generalist and specialized settings. Specialized training of key staff within the targeted communities will be conducted by the Substance Abuse Programs Office, University of South Florida, and the Florida Mental Health Institute (FMHI).

The implementation of the BRITE model within the identified communities will improve the identification of substance misuse, decrease alcohol and drug use, increase the number of recommended treatment sessions within the recommended level of treatment, increase the lengths of stay in the level to which patients were referred, and increase the knowledge of clinical staff in a "one science" approach within both the generalist settings and specialized addictions treatment programs.

This manual was developed to provide professionals in the healthcare field, the skills and tools for screening potential substance abuse/dependence disorders in a hospital or clinic setting, how to apply brief intervention strategies matched to the patient's severity of use/abuse; assessment of patient's clinical placement, addiction treatment, application of screening, and brief intervention for special populations, and the provision of all aspects of care in a culturally competent manner.

Screening of Patients

OBJECTIVES:

At the conclusion of this component of the training, participants will be able to:

1) To integrate the seven pre-screening questions into the sites health assessment screening.
2) Identify the key components of the Alcohol, Smoking, and Substance Involvement Screening Tests (ASSIST) as well as their applications in a clinical setting;
3) Outline methods and goals for implementing these screening instruments in daily practice;
4) Demonstrate the ability to effectively use these screening instruments and respond to resistance from patients;
5) Describe appropriate follow-up procedures for patients who screen positively for drug or alcohol use, misuse, abuse, dependence, etc..
6) Identify key components of the Short version Geriatric Depression Scale as well as its application in a clinical setting.

One of the most difficult tasks of the health care professional is to approach a patient/consumer about the topic of drinking and abuse of other drugs. The research that is available references brief approaches to assessment and interventions that are effective and essential in order to succeed in preventing someone who is using or abusing alcohol or other drugs to the dependent or addictive stage. When professionals lack sensitivity, empathy, and patience, it is possible to alienate the patient, which in turn, frustrates the professional.

In order to foster the most positive results, it is essential to train all first line professionals in administering the appropriate screening tools. The training must include both verbal and non-verbal approaches.

We will begin with the screening tools that will be utilized for the BRITE project and then discuss, in detail, the approaches that can be utilized in administering the screening to a patient/consumer.

The first screening tool consists of a three-question screen developed by NIAAA which ask for quantity and frequency of alcohol.

The following questions are asked of the older adult patient. If their responses show that they drink more than 3 drinks per day for men and women 55 years of age and older, or if they drink more than 7 drinks per week , the ASSIST will then be administered to determine the level of risk and the type of brief interventions that will be implemented.

ASK	IF YOU RECEIVE THESE ANSWERS	THEN
Weekly Average Multiply the answers to the following two questions: **A. How often?** On average, how many **days a week** do you drink alcohol? ☐ **B. How much?**, On a typical day when you drink **how many drinks** do you have? ☐ **X** ☐ **=** ☐	**From Men and Women Age 55 and Older**  → more than **7** **or** more than → **3**	**From Women**  Your patient may be at **Risk** for developing alcohol-related problems. **Complete ASSIST and SGDS**
Daily Maximum **How much?** What is the **maximum number of drinks** you had on any given day in the past month? ☐		

If Below the cutoffs?

If scores are below the cutoff, screening can stop here *unless* patients who drink are frail or taking medication that interacts with alcohol (they may have problems at lower drinking levels and thus may need advice to cut down. Other drinkers below the cutoffs may benefit from reminders that no drinking level is risk free and any drinking can impair driving tasks.

For BRITE we added the two conjoint screening questions that were developed by Brown and colleagues. They found that a positive response to either of the two questions demonstrated a sensitivity of 80% in a random sample of adult primary care patients when compared to the CIDI-SAM, a reliable and validated diagnostic instrument based on the DSM criteria. The negative predictive value of 93% means that this screen will miss only 7% of patients with substance abuse disorders (SUD). These questions were:

"In the last year, have you ever drunk or used drugs more than you meant to?" and *Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?"* However, in order to simplify the decision to use the ASSIST , the questions were separated and the questions related to drugs are asked along with the NIAAA questions

along with two questions about patient's experience with depression. If the patient answers yes to any of the two drug questions and the depression question, both the ASSIST and Short Version Geriatric Depression Scale (S-GDS) is administered. If they answer no to alcohol and drug questions but yes to on of the questions on depression, only the S-GDS will be administered. The primary care provider's incorporation of the pre-screening questions would actually start the BRITE process.

Description and Background. The 2-question screen for depression is a modification of the depression module of the PRIME-MD® Patient Health Questionnaire. Whooley et al. (1997) compared the 2-question screen to the Quick Diagnostic Interview Schedule and reported a sensitivity and specificity of 96% and 57%, respectively.

Negative Pre-Screen

Whenever a participant screens negative on the pre-screen, you will receive credit for the screening by completing section A of the GPRA. This will be covered later and the procedures will be listed in the GPRA training manual for the BRITE project.

Using the ASSIST

The next screening tool is the "*Alcohol Smoking and Substance Involvement Screening Test (ASSIST).* The ASSIST was developed by the World Health Organization (WHO), as a brief screening questionnaire to find out about people's use of psychoactive substances. It was developed by the WHO and an international team of substance use researchers as a simple method of screening for hazardous, harmful and dependent use of alcohol, tobacco and other psychoactive substances. It can help in identifying excessive drinking as the cause of presenting illness. The questionnaire covers:

- tobacco,
- alcohol,
- cannabis,
- cocaine,
- amphetamine type stimulants,
- sedatives
- hallucinogens,
- inhalants,
- opioids, and
- other drugs.

The ASSIST is especially designed for use by health care workers in a range of health care settings. It may also be used for professionals who work with people in high risk of problems related to substance use.

Primary health care is the first level of contact that individuals, the family, and community have with their national health system and constitutes the first part of a continuing health

care process. Primary health care relies on a range of health workers, including physicians, nurses, midwives, social workers, psychologists, certain therapists, auxiliaries and community workers, as well as traditional practitioners, all who have been suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

The ASSIST provides information about:

- the substances people have ever used in their lifetime;
- the substances they have used in the past three months;
- problems related to substance use;
- risk of current or future harm;
- dependence;
- injecting drug use.

The ASSIST can help warn people that they may be at risk of developing problems related to their substance use in the future and it can provide an opportunity to start a discussion with a client about their substance use. It can identify substance use as a contributing factor to the presenting illness. The ASSIST can be linked to a brief intervention to help high risk substance users to cut down or stop their drug use and so avoid the harmful consequences of their substance use.

Problems related to substance use

Clinical staff should be aware that, in general, people use substances because they have pleasurable or desirable effects for the user. However, substance use problems can arise as a result of acute intoxication, regular use or dependence and from the way in which substances are used. It is possible for a person to have problems from all of these. Problems relating to acute intoxication can occur as a result of a single episode of drug use and may include:

- acute toxic effects including ataxia, vomiting, fever, confusion,
- overdose & loss of consciousness,
- accidents and injury,
- aggression and violence,
- unintended sex and unsafe sexual practices,
- reduced work performance.

A variety of different problems can occur from using substances regularly, ranging from physical problems to mental health and social problems. There is not always a clear distinction between these effects, and it is worth noting that mental health and social problems can be as debilitating as physical problems for some people. The kinds of problems relating to regular use and dependence develop over a period of time and may include:

- specific physical and mental health problems,
- decreased immunity to infection,

- anxiety and depression,
- sleep problems,
- withdrawal symptoms when use is reduced or stopped,
- financial difficulties,
- legal problems,
- relationship problems,
- work problems.

Withdrawal symptoms vary depending on the drug involved but generally include craving (strong desire for the psychoactive substance or its effects), anxiety, irritability, gastrointestinal upsets and problems sleeping. Symptoms are more severe for some drugs than others. Withdrawal from alcohol, benzodiazepines and opioids may require medical management while uncomplicated withdrawal from other drugs can usually be managed with supportive care.

Substance related problems can result from the way in which substances are used, for example, many of the harms associated with tobacco and cannabis occur because these substances are smoked and the smoke is harmful. Using substances by injection can cause serious health problems no matter which substance is injected (see below and Appendix D).

Use of illicit drugs places the user at particularly high risk of legal problems and the consequent social, financial and employment difficulties associated with having a criminal record. These problems cause stress which is also associated with an increased risk of health and family problems independently of the substances used.
Specific health problems from individual substances

Tobacco

- Use of tobacco products is the leading cause of drug related disease and death and is a major public health problem. Regular smoking of tobacco products is a risk factor for a number of serious long term health problems including:

    > heart disease, high blood pressure, stroke,
    > chronic obstructive airways disease (chronic bronchitis, asthma, emphysema),
    > cancers of the lung, bladder, breast, mouth, throat and esophagus.

- Smoking increases the severity or risk of complications of other health problems such as:

    > high blood pressure,
    > diabetes,
    > asthma.

- Children of people who smoke tobacco products are at increased risk of a range of health problems such as:

    > respiratory infections,
    > allergies and asthma.

• Pregnant women who smoke are at higher risk of:
> miscarriage,
> premature labor,
> having a low birth weight baby.

• Exposure to tobacco smoke in the environment (passive smoking) also increases the risk of these health problems among people who do not smoke themselves.
• Use of tobacco products by means other than smoking, such as chewing, or sniffing is also associated with increased risk of disease.
• Tobacco smoking is also associated with:
> premature ageing and wrinkling of the skin,
> bad breath,
> unpleasant body odor.

Alcohol

For some people, low level alcohol consumption is associated with health benefits, mainly due to a reduction in risk for heart disease from middle age onwards. The lowest risk is associated with an average of one standard drink per day for men and less than one drink per day for women. However, excessive alcohol consumption is a risk factor for a wide range of health and social problems and is a major cause of premature illness and death.

• Acute intoxication with alcohol is associated with:
> aggressive and violent behavior,
> increased risk of accidents and injury,
> nausea and vomiting,
> hangovers (headaches, dehydration, nausea, etc.),
> reduced sexual performance.

• Chronic excessive consumption can affect every part of the body and lead to long term health problems. High risk drinking is associated with:

> high blood pressure and stroke,
> anxiety, depression and suicide,
> liver disease,
> digestive problems, ulcers and inflammation of the pancreas,
> blackouts and hallucinations,
> difficulty remembering things and solving problems,
> premature ageing,
> impotence,
> permanent brain injury leading to memory loss, cognitive deficits and disorientation,
> impaired mobility as a result of osteoporosis, gout, and muscle and nerve damage,
> cancer of the mouth, throat and breast.

• Tolerance and dependence may develop after chronic excessive use of alcohol and dependent drinkers may suffer withdrawal symptoms if they reduce or stop their alcohol consumption. Severe alcohol withdrawal complicated by delirium tremens is a medical emergency. Withdrawal symptoms include:

> tremor,
> sweating,
> anxiety,
> nausea, vomiting and diarrhea,
> insomnia,
> headache,
> hallucinations,
> convulsions.

• Women who consume alcohol during pregnancy are at risk of having babies who suffer from fetal alcohol syndrome which is associated with deformities and impaired brain development.

Cannabis

Worldwide, cannabis is the most widely consumed illicit drug. Toxicity of cannabis is low and there have never been any reports of deaths due to cannabis intoxication alone. However, cannabis use is associated with numerous negative health consequences.

• Acute intoxication with cannabis is associated with increased risk of:

> anxiety,
> dysphoria,
> paranoia,
> panic,
> nausea,
> impairment of attention and memory,
> possible increased risk of accident and injury.

• People with a personal or family history of schizophrenia are at increased risk of experiencing psychosis as a result of cannabis use.

• Regular cannabis smoking shares many of the risks of tobacco smoking, increasing the risk of:

> respiratory diseases,
> lung cancer, upper respiratory and digestive cancers.

• Cannabis smoking also increases the severity and risk of complications of diseases such as:

> high blood pressure,
> heart disease,
> asthma,
> bronchitis,
> emphysema.

• Regular use of cannabis can lead to:

> decreased memory and problem solving ability,
> loss of motivation,
> reduced libido,
> depression,
> tolerance and dependence.

• Cannabis use in pregnancy has similar effects on mother and baby to tobacco smoking.

Cocaine

• Cocaine use is associated with a wide range of physical and mental health problems. Most common physical problems include:

> heart racing,
> headaches,
> weight loss,
> numbness/tingling,
> clammy skin,
> repeated scratching or picking of skin,
> increased risk of accidents and injury,
> exhaustion and reduced immunity to infection.

• Mental health problems include:

> difficulty sleeping,
> intense craving,
> paranoia,
> anxiety,
> depression,
> exhilaration and mania,
> aggression,
> difficulty remembering things,
> severe stress resulting from the lifestyle.

• Repeated use of high doses can lead to psychosis.
• There is a significant risk of toxic complications and sudden death. Death is usually due to cardiovascular effects.

Cocaine use is associated with risky behavior including high risk injecting and unsafe sex putting users and their partners at significant risk of contracting a range of sexually transmitted diseases and blood borne viruses.

Amphetamine Type Stimulants (ATS)

Amphetamines (including dexamphetamine and methamphetamine) have similar effects to cocaine and can lead to a wide range of physical and mental health problems.

• Physical problems include:

> difficulty sleeping,
> loss of appetite and weight loss,
> dehydration,
> jaw clenching, headaches and muscle pain,
> shortness of breath,
> tremors and irregular heartbeat,
> reduced resistance to infections,
> sexual difficulties.

• Mental health problems associated with ATS use are a major area of concern and include:
    > psychosis after repeated use of high doses,
    > mood swings including anxiety, depression, exhilaration and mania,
    > agitation,
    > paranoia,
    > hallucinations,
    > aggressive and violent behavior,
    > difficulty remembering things.
• Long term high dose methamphetamine use is a risk factor for malnutrition and may cause permanent damage to brain cells.

• There is also a high prevalence of social problems including:
    > relationship problems with partners, friends and family,
    > financial problems,
    > work and study related problems.

• Ecstasy (MDMA) is also an amphetamine type stimulant. Some of its effects are similar to other ATS but ecstasy is also associated with a range of very rare but life-threatening conditions including:

    > hyperthermia (very high temperature),
    > disturbances of salt and water balance in the body,
    > liver damage,
    > brain hemorrhage.

• Ecstasy may also lead to ongoing mental health problems including:

    > difficulty remembering things,
    > depression,
    > panic disorders,
    > ‘flashbacks’ and delusions.

• There is growing evidence that ecstasy is neurotoxic and causes damage to nerves in the brain.

Inhalants
• Acute intoxication with inhalants can result in:

    > dizziness and hallucinations,
    > nausea,
    > drowsiness, disorientation, blurred vision,
    > loss of self control,
    > unconsciousness, delirium and fits,
    > accidents and injury,
    > death from heart failure.

• Chronic use is associated with:

> extreme tiredness,
> red, watery eyes, cough, runny nose, spots around the nose,
> trembling, tremor and slowed reactions,
> damage to the heart, lungs, liver and kidneys,
> chronic headaches, sinus problems and nosebleeds,
> indigestion and stomach ulcers,
> memory loss and confusion,
> depression and aggression.

Sedatives/sleeping pills

• Use of sedatives and sleeping pills may be associated with:

> drowsiness, dizziness and confusion,
> unsteady way of walking and falls,
> depression,
> sleeping problems,
> headaches,
> skin rash,
> nausea.

• Tolerance and dependence on sedatives or sleeping pills can develop after a short period of use. Withdrawal symptoms include:

> severe anxiety and panic,
> insomnia,
> headache,
> sweating and fever,
> nausea and vomiting,
> convulsions.

• If sedatives are used with other depressant drugs such as opioids or alcohol they can increase the effects of those drugs which increase the risk of overdose and death.

Hallucinogens

• Effects of hallucinogens are unpredictable and may be different for different users or on different occasions. They may cause:

> hallucinations which may be pleasant or unpleasant,
> difficulty sleeping,
> mood swings, anxiety, panic, paranoia or exhilaration,
> numbness, muscle weakness, twitching, tremor or seizures,
> increased heart rate and blood pressure,
> changes in temperature and sweating,
> nausea and vomiting.

• In the long term, use of hallucinogens may increase the effects of mental illness such as schizophrenia. Users may also experience flashbacks – spontaneous recurrences of the effects of hallucinogens use in the past.

Opioids

• Opioids slow down the central nervous system and reduce pain. Short term effects include:

> nausea and vomiting,
> shallow breathing,
> drowsiness,
> constipation,
> itching.

• Long term effects may include:

> tooth decay,
> severe constipation,
> irregular menstrual periods,
> impotence and reduced libido.

• Opioid overdose occurs when the amount of opioids or other depressant drugs leads to respiratory depression and the person can slip into a coma and die. The risk of overdose is greatly increased if they have also used alcohol or sedatives.
• Regular heroin users may develop tolerance and dependence and suffer withdrawal symptoms when they stop using opioids or cut down the amount. Withdrawal symptoms can make the person feel very ill and include:

> sweating, goose-bumps,
> yawning, runny nose and tears,
> diarrhea, vomiting and stomach cramps,
> restlessness, leg cramps and muscle pain,
> high blood pressure and rapid pulse,
> racing thoughts.

• There is also a high prevalence of social problems including:

> relationship problems with partners, friends and family,
> work and study related problems.

Risks of Injecting

Injecting of any drug is a significant risk factor for contracting blood borne diseases such as HIV/AIDS and Hepatitis B and C. Injectors are also at risk of infection and damage to the skin and veins as a result of poor injection technique, repeated injections, and dirty equipment. People who inject drugs have a higher risk of dependence and are likely to have more severe dependence than those who do not inject.

Injecting of stimulant drugs such as amphetamines and cocaine increases the risk of drug related psychosis. Vein problems are very common among people who inject cocaine because cocaine causes numbness and makes the veins smaller. This makes it very difficult to inject correctly and increases the risk of subcutaneous injection (injecting just under the skin), abscesses and cellulites.

Benefits of screening for substance use

Screening for problematic substance use provides an opportunity for education about the risks of substance use and can be used as a health promotion strategy to encourage communities, groups and individuals to reduce the risks associated with their substance use behaviors. Screening can improve the health of populations and of individuals.
For those people whose substance use is not risky or harmful, screening can be used to reinforce that what they are doing is responsible and encourage them to continue their current low risk substance use patterns.

Screening is most effective for those found to be at risk when it is combined with a brief intervention. There is strong evidence for the effectiveness of screening and early intervention in reducing excessive alcohol use and growing evidence for the effectiveness of brief intervention for other forms of high risk substance use.

At the population level, screening and brief intervention is a cost effective method to reduce the burden of disease due to substance use. World Health Organization estimates suggest that a 25% reduction in alcohol consumption world wide would lead to a 33% reduction in disease burden due to alcohol, while the benefits of reducing tobacco consumption would be even greater.

Screening for hazardous or harmful substance use can also help in the management of individual patients. Many common health problems seen in primary care may be related to substance use or may be made worse by substance use. Screening provides important information for the primary health care worker that can help in the diagnosis and treatment of the patient's health problems. Psychoactive substances can interact with medicines prescribed by the health worker to cause health problems and so information about substance use is very important for safe treatment.

CONTEXT OF SCREENING.

The ASSIST has been specifically designed for use in primary health care settings to help practitioners identify patients who would benefit from cutting down or stopping their substance use. Primary health care settings are ideal places to undertake screening and prevention activities for a number of reasons.

- Primary health care settings are generally the first contact with the health system for people seeking care and most people attend a general practice or other primary health care facility at least once per year.
- There is evidence that the rate of alcohol problems is higher among people seeking health care and this may also be true for some other substances such as amphetamines.
- Primary health care workers are a trusted and credible source of information and advice about health matters, and most people expect them to ask about lifestyle risk factors such as psychoactive substance use, especially if they are related to the presenting complaint.
- Many common health problems seen in primary health care settings may be made worse by psychoactive substance use, and screening provides an opportunity to educate patients about the risks of excessive alcohol or other substance use.
- There is an opportunity for repeated contact and the development of an ongoing

relationship with patients which enables primary care workers to monitor progress and provide ongoing support.

For most people, the ASSIST can be completed in about five or ten minutes and can be incorporated into the normal consultation. Alternatively, it may be administered by another staff member while the patient is waiting to see the health worker. In the future, it is likely that the patient will be able to complete the ASSIST alone but it has not yet been validated for self completion.
Considering the Patient

Using the ASSIST in other settings

While this manual is primarily focused on using the ASSIST to screen for substance abuse in primary care settings, the ASSIST can also be used in many other contexts and with other target groups where substance use may be an important issue. This might include general hospital patients, especially those whose illness is known to be associated with substance abuse, patients attending emergency departments, psychiatric patients, particularly those who are depressed or suicidal, prisoners and those charged with drug and alcohol related offences, and any other groups considered to be at high risk of substance related problems.

Information about possible settings, target groups and personnel for a screening programm using the ASSIST is shown in Box 2.

Box 2: Settings, groups and personnel suitable for an ASSIST screening programms

Setting	Target Group	Screening Personnel
Primary Care Clinic community health worker	Medical Patients	Nurse, social worker
Emergency department	Accident victims Intoxicated patients Trauma patients	Physician, nurse, other staff
Doctors Rooms Surgery	Medical Patients	General Practitioner Physician, other staff
General hospital wards Outpatient clinics	Patients with disorders possibly related to substance use	Physician, nurse, other staff
Psychiatric clinic Psychiatric hospital	Psychiatric patients particularly those who are suicidal	Psychiatrist, nurse, other staff
Antenatal clinic Postnatal ward	Pregnant women New mothers	Midwife, General Practitioner, Obstetrician
Court, jail, prison	Offenders	Officers, counselors, Corrections Health workers
Other health/welfare Facilities	People with impaired social or occupational functioning	Health and welfare workers

Introducing the ASSIST to the Patient

The ASSIST should be introduced carefully with a brief explanation of the reasons for asking and instructions for responding. The ASSIST questionnaire comes with a card which includes sample instructions on one side and a list of the drugs covered by the questionnaire on the other (the drug card). The following is an example introduction which can be used as it is or modified to suit local circumstances.
"*Many drugs and medications can affect your health. It is important for your health care provider to have accurate information about your use of various substances, in order to provide the best possible care. The following questions ask about your use of alcohol, tobacco products and other drugs. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills. (Show the patient the drug card). Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs; please be assured that information on such use will be treated as strictly confidential.*"

For patients whose drug use is prohibited by law, culture or religion it may be necessary to acknowledge the prohibition and encourage honest responses about actual behavior. For example:

"*I understand that others may think you should not use alcohol or other drugs at all but it is important in assessing your health to know what you actually do.*"

The Response Card for Patients
During the introduction and instructions for the ASSIST the health worker should clarify which substances are to be covered in the interview and ensure that they are referred to by names which are familiar to the patient.

The Response Card for Patients contains a list of the substance categories covered by the ASSIST together with a range of names associated with each category. It also contains frequency responses for each question. The drug names on the card are those which are most commonly used in the countries in which the ASSIST was tested, but the interviewer should use the most culturally appropriate names for their location. Check with patients what names they use to describe particular drugs and use the names that they use (See Appendix B).

Interview versus self administration
Currently the ASSIST is only validated for use in an interview. Further research is needed to determine if it is suitable for self administration.

The interview format has a number of advantages. The ASSIST can be used even when patients have low levels of literacy. The health worker can explain questions which are poorly understood and can ask probing questions to clarify inconsistent or incomplete responses. The ASSIST can be administered as a normal part of the consultation.

Confidentiality is assured by conducting the interview in a private place and by keeping the ASSIST results as part of the confidential patient record.

However, a few patients may be uncomfortable revealing their substance use directly to a health worker and may be more likely to under-report their drug use in an interview than if they are able to complete the questionnaire by themselves. While there are currently no data to confirm this, there is no reason to suspect that self administration of the ASSIST would be less reliable or less valid than interview.

Administration of the ASSIST

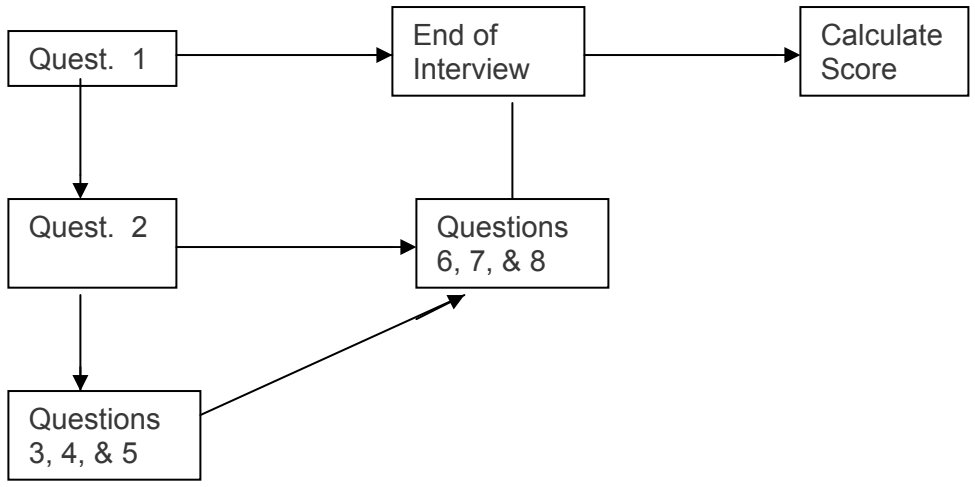
The ASSIST questionnaire (Appendix A) contains some prompts and instructions to guide interviewers during the interview. Some of these instructions enable the interviewer to leave out some questions for some patients and so shorten the interview. Others remind the interviewer to probe for more detail to obtain accurate responses. While some flexibility is possible when asking the questions, it is important to make sure that all the relevant questions have been asked and that the answers have been recorded.

Question 1 asks about lifetime use of substances, i.e., those drugs the patient has ever used, even if it is only once. Every patient should be asked this question for all the substances listed. If the patient answers 'No' to every substance the interviewer should ask a probing question "Not even when you were in school?". If the response is still 'No' to all the substances then the interview should be stopped.

If the patient answers 'Yes" to Question 1 for any of the substances listed then move on to Question 2 which ask about substance use in the previous three months. Question 2 should be asked for each of the substances ever used. If the response is 'Never' to all of the items in Question 2, move on to Question 6. If any substances have been used in the past three months then continue with Questions 3, 4 and 5 for each substance used. It should be noted that Q5 is not asked for tobacco because it is unlikely that failure to fulfill role obligations would be experienced by tobacco users.

All patients reporting ever having used any substance in their lifetime in Question 1 should be asked Questions 6, 7 and 8. Questions 6 and 7 should be asked for each substance endorsed in Question 1.

Figure 1: Administering the ASSIST



Scoring and Interpretation

Each question on the ASSIST has a set of responses to choose from, and each response has a numerical score. The interviewer simply circles the numerical score that corresponds to the patient's response for each question. At the end of the interview these scores are added together to produce an ASSIST score.

A number of different scores can be calculated for the ASSIST

- **Specific Substance Involvement score**
  sum of responses to Questions 2-7 within each drug class

- **Total Substance Involvement score (global continuum of risk)**
  sum of responses to Questions 1-8 for all ten drug classes

The most useful score for screening and clinical purposes is the Specific Substance Involvements score for each drug class. This provides a measure of use and problems over the three months prior to the interview for each substance covered by the ASSIST and warns of the risk of future substance related problems. Each patient may have up to 10 Specific Substance Involvement scores depending on how many different types of substance they have used.

The Specific Substance Involvement score is calculated by adding together the responses to Questions 2-7 for each of the following drug classes: tobacco, alcohol, cannabis, cocaine, amphetamine type stimulants, inhalants, sedatives/sleeping pills, hallucinogens, opioids and 'other drugs' (see Box 5 for an example).

Box 5: Example
Calculating a Specific Substance Involvement Score for Cannabis

A patient has given the following answers on the ASSIST for Cannabis

Q2c	Weekly	Score = 4
Q3c	Once/twice	Score = 3
Q4c	Monthly	Score = 5
Q5c	Once/twice	Score = 5
Q6c	Yes, but not in past 3 months	Score = 3
Q7c	No, Never	Score = 0

Specific Substance Involvement Score (Cannabis) Total = 20

(similar scores are calculated for all other substances used in the past 3 months with the expectation of tobacco which does not include Q5 in the calculation)

The score for each substance should then be recorded on the ASSIST report card (see below) and noted in the patient record.

What do the scores mean?

Box 6: What do the Specific Substance Involvement Scores Mean?

Alcohol		All other substances	
0 – 10	Low Risk	0 -3	Low Risk
11 – 19	Moderate Risk	4 -19	Moderate Risk
20 – 26	Moderate/High Risk	20-26	Moderate/High Risk
27+	High Risk	27+	High Risk

Patients with ASSIST Specific Substance Involvement scores three or less (10 for alcohol) are at a lower risk of problems related to the use of the substance involved. While they may use substances occasionally, they are not currently experiencing any problems related to their use and are at low risk of developing health problems related to their substance use in the future if they continue their current pattern of use.

Mid range scores between 4 (11 for alcohol) and 19 for any substance are an indication of hazardous or harmful use of that substance. Patients with scores in this range are at moderate risk of harm from their current pattern of substance use. Risk is increased for those with a past history of problems or dependence.

Scores of 20 through 26 are to be considered moderate to high risk and are provided brief treatment.

A score of 27+ or higher for any substance suggests that the patient is at high risk of dependence on that substance and is probably experiencing health, social, financial, legal and relationship problems as a result of their substance abuse and patient should be referred to appropriate substance abuse program for complete drug and alcohol assessment.

Question 8 on the ASSIST asks about the recency of injection of substances. While the score from question 8 is not included in the calculation of the ASSIST Specific Substance Involvement score, injection of any substance in the last 3 months (a score of ‘2’ on Q8) is a risk factor and these patients should be assessed further for their risk levels and pattern of injecting in the last three months.

Patients who are injecting more than once a week, or have injected drugs three or more consecutive days in a row are at very high risk of harms, including dependence, infection and blood borne virus contraction, and will require more intensive treatment. Patients injecting less frequently than this are at a reduced risk, and may be given a brief intervention.

These are guidelines for the most appropriate treatment based on risk and are 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.

While the ASSIST provides an indication of the degree of substance-related risk, it is worth noting that there are limitations of making risk assessments based only on the

ASSIST, as there are with any kind of psychometric tool. Substance-related problems are multifaceted, and there are many factors which modify the risk of health consequences of substance use including family history of substance use problems, psychiatric comorbidity, age, gender, socio-economic status etc. Health care practitioners should keep these factors in mind when estimating the actual individual risk for each patient.

The ASSIST Feedback Report Card
The ASSIST Feedback Report Card is completed at the end of the ASSIST interview and is used to provide personalized feedback to the patient about their level of substance related risk. The report card is a four page folder with space to insert scores on the front page and information about risk level and potential problems for each substance on the remaining pages. A formatted copy of the report card appears in Appendix C.

Record the Specific Substance Involvement Scores for each substance in the boxes provided on the front of the card. On the other pages record the level of risk indicated by the specific substance involvement score for all substances used in the past three months by ticking the relevant box.

The report card is used during the consultation to provide feedback and is given to the patient to take home as a reminder of what has been discussed.
The Risks of Injecting - Information for Patients
The risk of injecting card is a one page sheet that provides information and personalized feedback to individuals who are injecting drugs about the risks and problems associated with injecting. The card is used during the brief intervention to provide advice and information, and is given to the patient to take home as a reminder of what has been discussed.

HOW TO HELP PATIENTS

All patients screened using the ASSIST should receive feedback regarding their scores and level of risk and be offered information about the substances they use. This is the minimum level of intervention for all patients. Box 7 links ASSIST scores with the most appropriate level of intervention. For patients whose ASSIST score indicates that they are at low risk of substance related harm for all substances this level of intervention is sufficient. Patients who are at low risk or abstainers should be congratulated and encouraged to remain that way.

Patients who's ASSIST score indicates that they are at moderate risk of harm (Specific Substance Involvement score between 4 and 19 for alcohol, and 11 through 19 for other substances) should be offered a brief intervention. Scores 19-26 are provided brief treatment. People who are injecting less than once a week, and have not injected drugs three or more times in a row during the last three months also could be given a brief intervention by the health professional including the "*Risks of Injecting*" card. A brief intervention suitable for use with these patients is described in detail in the companion document "*Brief Intervention for Problematic Substance Use. A Manual for Use in Primary Care."*

Patients who's Specific Substance Involvement score is 27 or more for any substance, and/or have regularly injected drugs in the last 3 months are likely to be at high risk and substance dependent and require more than just a brief intervention. These people require further assessment and more intensive treatment. This may be provided by the health professional(s) within that primary care setting, or, by a specialist drug and alcohol treatment service if these agencies exist and are accessible for the patient within a reasonable period of time.

If specialist treatment agencies exist, clinic staff should be aware of the waiting lists and the procedures involved in making appointments, and referring high risk patients to specialist agencies. If drug treatment facilities are not easily accessible or heavily stigmatized, every effort should be made to treat the patient within the clinic.

More detailed information about how to help patients following screening with the ASSIST can be found in the companion document *"Brief Intervention for Problematic Substance Use. A Manual for Use in Primary Care."* Patients receiving a brief intervention should also be given *"The substance user's guide to cutting down or stopping"* booklet and specific drug information to take home with them.

Box 7: Linking ASSIST Scores to Appropriate Interventions for BRITE Project

Tobacco

SSI Scores 0-3 >> information
SSI Scores 4-19 >> brief intervention
SSI Scores 20-26 >> brief treatment
SSI Scores 27+ >> referral for intensive treatment

Alcohol

SSI Scores 0-10 >> information
SSI Scores 11-19 >> brief intervention
SSI Scores 20-26 >> brief treatment
SSI Scores 27+ >> referral for intensive treatment

Other Substances

SSI Scores 0-3 >> information
SSI Scores 4-19 >> brief intervention
SSI Scores 20-26 >> brief treatment
SSI Scores 27+ >> more intensive treatment

Recent injecting drug use QB

If participant is positive for injecting illegal drugs an automatic referral to a substance abuse treatment program is made for a full drug and alcohol assessment.

NB: SSI = Specific Substance Involvement

BRITE SCREENING INSTRUMENTS

POST-TEST

Name: _____ Date: _____

Agency: _____ Position: _____

Circle the correct answer.

1. BIRTE stands for one of the following:

    a. Screening, Briefing, Initial Referral to Treatment
    b. Skill Building Initial Resources to Treatment
    c. Brief Interventions and Treatment for Elders

2. The primary reason for using the ASSIST for screening is to identify patient who are dependent on alcohol or other drugs.

    a. True
    b. False

3. The ASSIST screens for :

    a. Dependency and addiction
    b. Use and abuse of drugs
    c. Substance use misuse that puts person at risk, and those with current problems, and those at risk of developing dependency

4. The initial pre-screening questions that will lead into the use of the ASSIST identify quantity and frequency of alcohol and use of other drugs . You will continue screening using the ASSIST whenever a patient 55 yrs. old and above, answers reflect the following:

    a. They drink 5 drinks in one day, or 15 drinks per week
    b. They drink 3 drinks in one day, or 7 drinks per week
    c. They drink 4 drinks in one day, or 14 drinks per week

5. If the patient is slightly below maximum number of drinks that would put them into the risky range with the NIAAA screening instrument for risky use, you would provide the following services;

    a. Tell them that they are not at risk and just send them home and just a screening GPRA (Section A) is completed.
    b. Explain to them that they are close to the level of consumption that would put them into possible risk for potential alcohol problems. Provide them the handout that explains what the acceptable daily number of drinks that represent a low risk level. Administer a brief intervention GPRA.
    c. Explain to them that they are very close to being considered “at risk” for possible dependency and then call your supervisor for further instructions.

6. Alcohol Dependence is defined as using alcohol every day.

    a. True
    b. False

7. An example of harmful use is that you drink in excess and then find out that you are having liver problems.

    a. True
    b. False

8. An example of hazardous drinking is drinking 4 drinks in one hour and then driving home.

    a. True
    b. False

9. After administering the ASSIST, you administer a Brief Intervention GYPRA prior to providing a brief intervention.

    a. True
    b. False

10. The ASSIST stands for Drug Abuse Screening Test

    a. True
    b. False

11. For the BRITE project, the ASSIST is self-administered.

    a. True
    b. False

12. If a patient scores an 11 for Alcohol and a 5 on other substances on the ASSIST they are at a moderate risk level and you would provide brief counseling to assist them in reducing their substance intake.

    a. True
    b. False

13. When the score is 1-2 which means a low level of risk and they reveal that their drug of choice is injecting heroin, you will:

    a. Will provide brief counseling with a plan for them to abstain on their own and schedule a follow-up appointment.
    b. Use motivational techniques to assist the patient in consenting to a referral to a professional for further assessment.
    c. Both A and B are appropriate.

Using the Short Version Geriatric Depression Scale (S-GDS)

OBJECTIVES:

At the conclusion of this component of the training, participants will be able to:

1) To integrate the Short Version Geriatric Depression Scale (S-GDS) questions into the sites health assessment screening.
2) Identify the key components of S-GDS as well as its applications in a clinical setting;
3) Outline methods and goals for implementing these screening instruments in daily practice;
4) Demonstrate the ability to effectively use the S-GDS and respond to resistance from patients;
5) Describe appropriate follow-up procedures for patients who screen positively for depression.

The Florida BRITE Project's Screening Tool for depression was designed to alert staff members to such problems and ensure that people are referred to the appropriate mental health services. The Workbook does not provide specific interventions for addressing depression or suicide risk, but rather offers the following instructions for interviewers.

Identification of Depression:

The purpose of conducting the Short-Geriatric Depression Scale (S-GDS) (attachment E) is to identify the need for further assessment or referral for treatment by a mental health professional. There are suggested interpretations of a total score as follows:

0 to 4 suggests either no depression or mild depression
5 to 9 suggests moderate depression and warrants a follow-up interview
10 to 15 highly indicative of depression and requires referral for appropriate follow-up and treatment.

If signs of depression are observed, consider the following actions:

- Determine if the individual is under the care of a physician or mental health professional.
- Contact the appropriate mental health provider for further assessment if required.
- Be supportive, not confrontational, when interacting with people who appear depressed.

Suicide Risk:

If a client indicates that suicide is being considered or if there are any obvious signs or statements suggesting that there is a suicide plan, the interviewer should:

- inform their supervisor about the situation and actions taken.
- contact the appropriate individuals to formally assess the situation. This might be a law enforcement officer, an adult protective services case manager, physician, psychiatrist, psychologist, clinical social worker, to name a few professions eligible to participate under Florida's "Baker Act" law (see next section).
- stay with the client until assistance arrives.
- follow-up by contacting the client to ensure that he/she received the appropriate services.

Brief Interventions

OBJECTIVES

At the conclusion of this component of training, participants should be able to:

1) Identify the goals of a brief intervention;
2) Match interventions to risk levels identified in brief screening;
3) Conduct a patient advice session using prepared health education materials;
4) Adapt a brief counseling element to the individual's readiness to change;
5) Utilize methods for addressing resistance to interventions.

Active Listening and Administering Brief Interventions

One of the hardest things to do, when you are overwhelmed with work or if you are in a hurry due to time constraints, is to actually listen to others. Even as professionals there are times that projection takes over and we just can't wait for the other person to stop talking in order that we can just make "our point."

It is very important in administering brief interventions that we must be able to listen and hear what is actually being said. Below are a few steps in becoming an active listener:

1. Listen to what the client/patient says.
2. Form a reflective statement. To reflect your understanding, repeat in your words what the client said.
3. Test the accuracy of your reflective statement. Watch, listen and/or ask the client/patient to verify the accuracy of the content, feeling, and/or meaning of the statement.

Skilled active listeners perform these three steps automatically, naturally, smoothly, and quickly. Active listening saves time by reducing or preventing resistance, focusing the client, focusing the clinician, encouraging self-disclosure, and helping the client/patient remember what was said during the intervention.

Brief interventions have actually been performed by professionals outside of the Substance Abuse Treatment arena, but at the times that they did so they were not aware that they did. The reason for this is that brief interventions could be just one statement that could bring about changes in a person's behavior. An example is a "coach" that a player confides in about a drinking problem and the coach just simply states, "It sounds like you may have a problem, but I am not an expert in this area. But do me a favor and stop by the guidance counselor's office, Ms. Ames, I heard that she knows about these kinds of things. Promise me that you will stop."

The following is a list of other professionals who can administer brief interventions:

- Primary care physicians
- Substance abuse treatment providers
- Emergency department staff members

- Nurses
- Social Workers
- Heath educators
- Lawyers
- Mental health workers
- Teachers
- EAP counselors
- Crisis hotline workers, student counselors
- Clergy

Brief interventions are those practices that aim to identify a real or potential alcohol or drug problem and to motivate an individual to do something about it. Brief interventions have become increasingly important in the management of individuals with drug/alcohol related problems. During the past 20 years, there have been numerous randomized trials of brief interventions in a variety of healthcare settings. Results from these studies show that there is clear evidence that appropriately-designed brief intervention strategies are effective, low-cost and easy to administer.

Because research has shown that brief interventions are low in cost and have proven to be effective across the spectrum of alcohol problems, health workers and policy-makers have increasingly relied on them as tools to fill the gap between the primary prevention efforts and more intensive treatment of persons with serious drug/alcohol dependence, which generally requires greater expertise and more clinical management. However, they might serve well as an initial treatment for severely dependent patients seeking extended treatment. Along with the ASSIST, brief interventions are administered to persons whose alcohol or other drug consumption has become hazardous or harmful to their health.

As you familiarize yourself with the screening tools, it will become apparent that the type of intervention that you will use must coincide with the results of the screening scores. Using the appropriate dialogue, and providing essential educational handouts, is an important factor in successful interventions. Therefore the next component of this training manual will provide guidelines and possible interventions.

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 Organisation26. It is estimated that tobacco is responsible for 9% of all deaths and for 4.1% of the global burden of all disease, which is measured as the number of years spent living with a disease (Disability Adjusted Life Years - DALYs), while alcohol is responsible for 3.2% of deaths and 4.0% of DALYs. Illicit drugs are responsible for 0.4% of deaths and 0.8% of DALYs. Excessive alcohol use and other substance abuse are also 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 patients whose substance use is hazardous or harmful to their health and wellbeing. Health promotion

and prevention is important parts of the role of primary care and primary care workers are engaged in many preventive activities including immunization, and screening and early intervention for high blood pressure, obesity, smoking and other lifestyle risk factors. Patients view primary care 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 clinician at least once per year. Patients whose tobacco, alcohol and other substance use is hazardous or harmful 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 interventions for substance use. The intervention then forms part of the management of the presenting complaint.

Primary care workers often have an ongoing relationship with patients which enable them to develop rapport and demonstrate genuine concern for the welfare of patients. Patients 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 or that patient can be invited to make a specific appointment to discuss substance abuse.

There is substantial evidence of the benefits of screening and brief intervention for alcohol problems in Primary Health Care settings.· Senft et al. 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[15] 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[14].

Research suggests that brief interventions may also be effective in primary care settings for substance use other than alcohol, if culturally appropriate intervention procedures are developed. Evidence to date suggests that brief interventions can work for cannabis[6, 9, 21,] benzodiazepines[4], amphetamines[3], opiates[19], and cocaine[22].

MODEL OF BEHAVIOR CHANGE

The model of stages of behavior change developed by Prochaska and DiClemente[16] provides a useful framework for understanding how people change their behavior and for considering how ready they are to change their substance use or other lifestyle behavior. The stages and processes by which people change seem to be the same with or without treatment and the model describes these natural processes13. 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.

The model includes four stages and is shown below:

The Stages of Change and Associated Brief Intervention Elements

Stage Elements	Definition	Brief Intervention to be Emphasized
PRECONTEMPLATION	The hazardous or harmful substance user is not considering change in the near future and may not be aware of the actual or potential health consequences of continued substance use at this level	**Feedback** about the results of the screening, and **Information** about the hazards of drinking
CONTEMPLATION	The substance user may be Aware of substance use Related consequences but Is ambivalent about changing	Emphasize the benefits of changing, give **Information** about substance use problems, the risks of delaying, and **discuss** how to choose a **Goal**
PREPARATION	The substance user has already decided to change and plans to take action	***Discuss how to choose a*** **Goal**, and give **Advice** and **Encouragement**
ACTION	The substance user has begun to cut down or stop using and change has not become a permanent feature	Review **Advice**, give **Encouragement**
MAINTENANCE	The substance user has achieved Moderate use or abstinence on a relatively permanent basis	Give **Encouragement**

***** *Relapse* can occur during maintenance phase and should be discussed as well as information about support systems available to assist patient.

Stage 1 Not really thinking about changing (Pre-contemplation)

Many people seen in primary care who score positive on the ASSIST are likely to be in this stage.

• They are 'happy-users'.
• They do not have any worries about their use of psychoactive substances, and do not want to change.
• They may not know or accept that their substance use is risky or problematic.

People in this stage are unlikely to respond to advice to change their behavior but may be receptive to information about the risks associated with their level and pattern of substance use. Providing information may encourage them to recognize the risks of substance use and to think about cutting down or stopping their substance use.

Stage 2 Thinking about cutting down or stopping substance use (Contemplation)

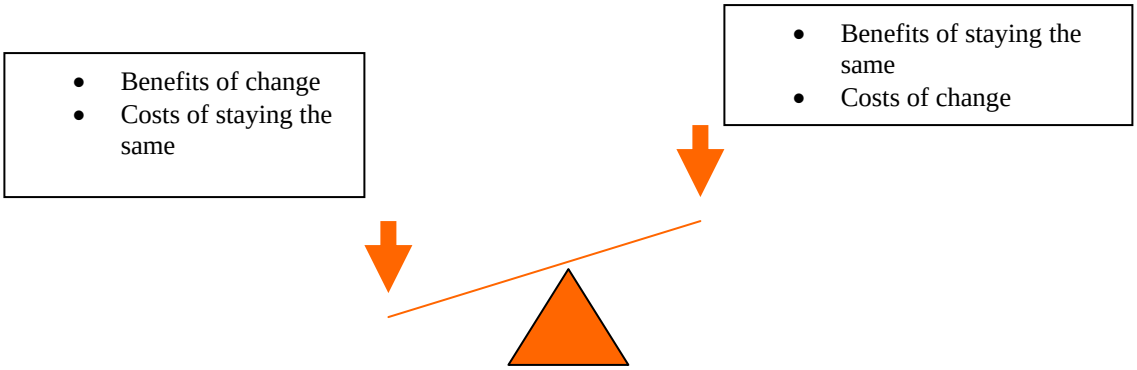
People in this stage are likely to:

• be ambivalent about their substance use. They can see both the good things and the not so good things about their substance use.
• 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.
• Others may be willing to make a change but them:
> may not know how to make a change.
> may not be confident that they are able to change.

Interventions for people in this stage focus on providing information about their substance related risks, advice to cut down or stop, and helping them to talk about the good and not so good things about their current substance use pattern. The aim is to encourage them to find and talk about their own reasons to cut down or stop their substance use.

A helpful tool at this stage is to see ambivalence about substance use as a balance. On one side of the balance is the benefits to the patient of their current substance use behavior 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 (See figure 2).

Figure 2 Decision Balance



Another way of encouraging the patient 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. It can be helpful to ask the patient to talk first about what they like about their substance use, the good things, and then to ask about the not so good things.

	Benefits	Costs
Short Term		
Long Term		

Interventions for this stage may also include:

helping the patient to recognize their strengths and ability to change.
Suggesting a range of strategies the patient could choose to help them cut down or stop their substance use.

Stage 3 Doing something about changing their behavior (Action)

People in the action stage:
• have made the decision that their use of substances needs to change.
• may be abstaining or cutting down, or have decided to change their established behavior.

People in this stage are likely to continue to feel ambivalent about their substance use and to need encouragement and support to maintain their decision. Interventions for this stage also include:

• negotiating aims and goals for changing risky substance use behaviors together.
• suggesting a range of strategies the patient could choose to help them cut down or stop their substance use.
• helping them to identify situations where they might be at risk of relapse.
• discussing with the patient their plan for action to reduce or stop their substance use.

Stage 4 Keeping on with the new behavior (Maintenance)

• The person is attempting to maintain the behavior changes that have been made.
• Long-term success means remaining in this stage.

People who are trying to maintain behavior 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 patient's strategies for avoiding situations where they are at risk of relapse or helping them to move on after a small lapse.

Relapse

- Most people who try to make changes in their substance use behaviors will go back to substance use, at least for a time. This should be expected. 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 or action.
- For many people, changing their substance use gets easier each time they try until they are eventually successful.

Ready, willing and able

In order for people to actually change their behavior they need to be ready, willing and able to change13. The stages of change model discussed above is a way of understanding how ready and willing a patient is to make changes in their substance use.
Being ready and willing to reduce or stop substance use is related to how important the patient thinks it is to make the change. However, thinking a change is important is not always enough for a person to move into the action phase. Sometimes a person 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 patients to change their behavior.

Importance
A simple way to find out how important the patient thinks it is to reduce their substance use is to use the 'readiness ruler'[16]. This is just a scale with gradations from 0 to 10 where 0 is not at all important and 10 are extremely important. Patients can be asked to rate how important it is for them to change their substance use.

Figure 3 'The Readiness Ruler'

"How important is 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

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 as a way of encouraging the patient to talk about reasons for change.

Confidence
The same sort of scale can also be used to assess how confident patients are that they are able to cut down or stop their substance use[13]. The confidence ruler can be used with patients who have indicated that it is important for them to make a change or it can be used as a hypothetical question to encourage patients to talk about how they would go about making a change.

Figure 4 '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 as confident										Extremely confident

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

COMPONENTS OF BRIEF INTERVENTIONS THAT WORK

Research into effective brief interventions for substance use have found that they include a number of consistent features which appear to contribute to their effectiveness. These have been summarized using the acronym FRAMES:- Feedback, Responsibility, Advice, Menu of options, Empathy and Self efficacy (confidence for change)[5, 14, 15]. A number of these features (empathy, self efficacy, responsibility and menu of options) are also associated with motivational interviewing which is a style of intervention aimed at helping people move through the stages of change[16]. Examples of FRAMES techniques are given in Boxes 3 & 4 and in the section "Brief Intervention with moderate risk users" on page 43 of this manual. Motivational interviewing is discussed later in this guide.

FRAMES

Feedback
The provision of personally relevant feedback is a key component of brief intervention and generally follows a thorough assessment of drug use and related problems. Feedback can include information about the individual's drug use and problems from a screening instrument such as the ASSIST, information about personal risks associated with current drug use patterns, and general information about substance related risks and harms. If the patient's presenting complaint could be related to substance use, it is important to inform the patient about the link as part of feedback. Feedback may also include a comparison between the patient's substance use patterns and problems and the average patterns and problems experienced by other similar people in the population.

Responsibility
A key principle of intervention with substance users is to acknowledge that they are responsible for their own behavior and that they can make choices about their substance use. The message that "What you do with your substance use is up to you" and that "nobody can make you change or decide for you" enables the patient to retain personal control over their behavior and its consequences. This sense of control has been found to be an important element in motivation for change and to decrease resistance[5].

Advice
The central component of effective brief interventions is the provision of clear advice regarding the harms associated with continued use. Patients are often 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 behavior.

Menu of alternative change options
Effective brief interventions and self help resources provide the patient with a range of alternative strategies to cut down or stop their substance use. This allows the patient 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 patient's motivation for change. Giving patients the "Substance users guide to cutting down or stopping" is a good first start because it contains strategies for helping them change their behavior, and can be used alone or in conjunction with several options. Examples of options for patients to choose could include:

> Keeping a diary of substance use (where, when, how much, who with, why)
> Helping patients 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 patient 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 patient 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 counselors that specialize in drug and alcohol problems
> Putting aside the money they would normally spend on substances for something else

Empathy
A consistent component of effective brief interventions is a warm, reflective, empathic and understanding approach by the person delivering the intervention. Use of a warm, empathic style is a significant factor in the patient's response to the intervention and leads to reduced substance use at followup[13].

Self efficacy (confidence).
The final component of effective brief interventions is to encourage patients' confidence

that they are able to make changes in their substance use behavior. 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 behavior13. It is particularly helpful to elicit self efficacy statements from patients as they are likely to believe what they hear themselves say.

MOTIVATIONAL INTERVIEWING

Motivational interviewing is a directive, client centered style of interaction aimed at helping people to explore and resolve their ambivalence about their substance use and move through the stages of change. It is especially useful when working with patients in the precontemplation and contemplation stages but the principles and skills are important at all stages[13].

Motivational interviewing is based on the understanding that:

- effective treatment assists a natural process of change,
- motivation for change occurs in the context of a relationship between the patient and the therapist, and
- the style and spirit of an intervention is important in how well it works, in particular, an empathic style is associated with improved treatment outcomes[13].

The brief intervention approach adopted in this manual is based on the motivational interviewing principles developed by Miller12 and further elaborated by Miller and Rollnick[13].

Principles of motivational interviewing

Express empathy
In the clinical situation empathy involves an accepting, non judgmental approach which tries to understand the patient'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 patient. 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 patient responds to the intervention[13].

Develop discrepancy
People are more likely to be motivated to change their substance use behavior when they and the way they would like their life to be. The greater the difference between their important goals and values and their current behavior, the more important it is likely to be to patients to change. Motivational interviewing aims to create and amplify a discrepancy between current behavior and broader goals and values from the patient's point of view. It is important for the patient to identify their own goals and values and to express their own reasons for change.

Roll with resistance (avoid argument)

A key principle of motivational interviewing is to accept that ambivalence and resistance to change is normal and to invite the patient to consider new information and perspectives on their substance use. When the patient expresses resistance, the health worker should reframe it or reflect it rather than opposing it. It is particularly important to avoid arguing in favor of change as this puts the patient in the position of arguing against it.

Support self efficacy (confidence)
As discussed above patients need to believe that reducing or stopping their substance use is important and be confident that they are able to do so. Using negotiation and confidence building to persuade patients that there is something that they can do is an important part of motivational interviewing. The therapist's belief in the patient's ability to change their behavior is also important and can become a self fulfilling prophecy.

Specific skills

Motivational interviewing makes use of five specific skills. These skills are used together to encourage patients to talk, to explore their ambivalence about their substance use and to clarify their reasons for reducing or stopping their substance use[13]. The first four skills are often known by the acronym OARS – Open ended questions, Affirmation, Reflective listening and Summarizing. The fifth skill is 'eliciting change talk' and involves using the OARS to guide the patient to present the arguments for changing their substance use behavior.

OARS

<u>*O*pen ended questions</u>
Open ended questions are questions which require a longer answer and open the door for the person 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 ….?

<u>*A*ffirmation</u>
Including statements of appreciation and understanding helps to create a more supportive atmosphere, and helps build rapport with the patient. Affirming the patient'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."

*R*eflective listening

A reflective listening response is a statement guessing at what the patient means. It is important to reflect back the underlying meanings and feelings the patient 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 patient that the therapist understands what is being said or can be used to clarify what the patient means. Effective reflective listening encourages the patient to keep talking and you should allow enough time for that to happen.

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

<u>Summarize</u>

Summarizing is an important way of gathering together what has already been said and preparing the patient to move on. Summarizing adds to the power of reflective listening especially in relation to concerns and change talk. First patients 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 emphasizing 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 has 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 patient to resolve ambivalence and is aimed at enabling the patient to present the arguments for change.

There are four main categories of change talk:

- Recognizing the disadvantages of staying the same
- Recognizing 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 patient.

- Asking direct open questions; for 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 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?"

- Use the importance and confidence rulers (see figure 3 and figure 4). Miller and Rollnick[13] suggest using the ruler to obtain the patient's rating and then asking the following two questions.

> "Why are you at a (eg. 3) and not a 0?" This gets the patient to verbally and, their position which can act to motivate the patient to change.
> "What would it take for you to go from a (eg. 3) to a (eg. 6) (a higher number)?". This gets patients to verbalize possible strategies for change and gets them to start thinking more about change.

- Probe the decision balance (see figure 2) by encouraging the patient to talk about the benefits of change and the costs of staying the same.
- Ask the patient to clarify or elaborate their statements - for example, a person who reports that one of the less good things about using cocaine is having panic attacks could be asked:

> "Describe the last time this happened."
> "What else?"
> "Give me an example of that"
> "Tell me more about that?"

- Ask the patient to imagine the worst consequences of not changing or the best consequences of changing.
- Explore the patient's goals and values to identify discrepancies between the patient's values and their current substance use. For example, ask:
"What are the most important things in your life?"

Linking Screening to Appropriate Interventions

The ASSIST can be linked to an appropriate intervention for each patient depending on their Specific Substance Involvement Scores (see the companion manual "*The Alcohol, Smoking and Substance Involvement Screening Test: Guidelines for use in Primary Care")* for details of how to calculate Specific Substance Involvement Scores). Box 1 shows the level of risk of substance related harm associated with different score ranges. People who report injecting any drug with high frequency in the previous three months (a score of '2' on ASSIST Q8) are also considered to be at high risk.

Box 1: What do the Specific Substance Involvement Scores Mean?	
Alcohol	**All other substances**
0-10 Low Risk	0-3 Low Risk
11-19 Moderate Risk	4-19 Moderate Risk
20-26 Moderate-High Risk	20-26 Moderate-High Risk
27+ High Risk	27+ High Risk

- People who score in the low risk range on the ASSIST for all substances should receive brief feedback of their results and be asked if they require any further information about drug use.

- People whose scores are in the moderate risk range for any substance should receive feedback of their results and a brief intervention, which includes at a minimum, Feedback, Responsibility and Advice. Risk is increased for those with a past history of problems or dependence.

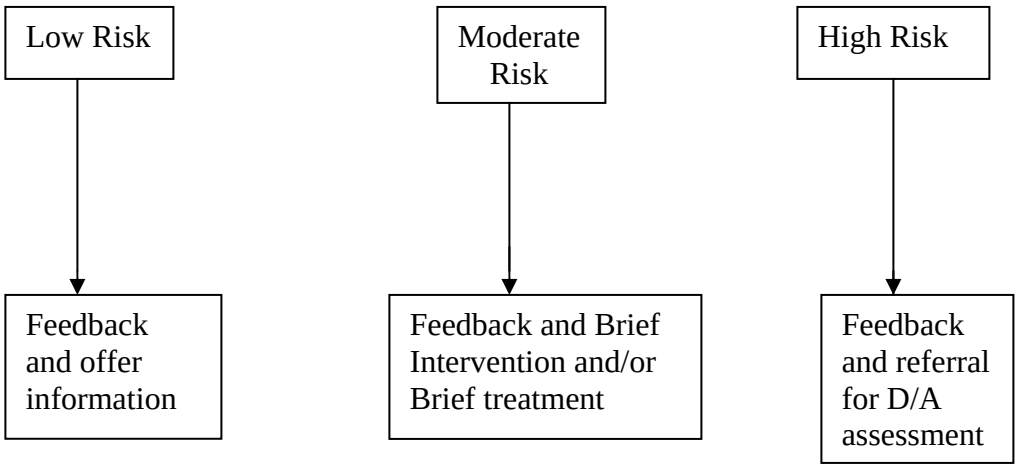
- Those whose score indicates that they are at high risk (including frequent injectors) should receive more intensive treatment which may commence with feedback of their results and brief intervention. More intensive treatment may be provided by the health care professional(s) within your health care setting, or, by specialist drug and alcohol treatment service when available.

Question 8 on the ASSIST asks about the recency of injection of substances. While the score from question 8 is not included in the calculation of the ASSIST Specific Substance Involvement score, patients who are injecting more than once a week, or have injected drugs three or more consecutive days in a row are at very high risk of harms, including dependence, infection and blood borne virus contraction, and will require more intensive treatment. Patients injecting less frequently than this are at a reduced risk, and may be given a brief intervention.

These are guidelines for the most appropriate treatment based on risk and are 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.

Linking ASSIST Score to Appropriate Intervention

Feedback of ASSIST Results



All patients screened using the ASSIST should receive feedback regarding their scores and level of risk and be offered information or advice about the substances they use. This is the minimum level of intervention for all patients.

The ASSIST Feedback Report Card provides a useful framework for giving feedback and can also serve as an introduction for providing advice. Specific Substance Involvement Scores for each substance are recorded in the boxes provided on the front of the card. The other pages contain information about specific risks associated with each substance included in the ASSIST. There is provision for the therapist or the patient to tick a box indicating the patient's risk of experiencing these harms for each substance.

The way that feedback is given can affect whether the patient really hears the feedback and takes it in. Feedback should be given in a way that takes account of what the patient 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 patients feel they have understood the feedback.

A simple and effective way of giving feedback which takes account of the patient's existing knowledge and interest, and is respectful of their right to choose what to do with the information involves three steps: Elicit – Provide – Elicit.

• Elicit readiness/interest for information. i.e.: ask the patient what they already know and what they are interested in knowing. It may also be helpful to remind the patient that what they do with the information is their responsibility.

> "Would you like to see the results of the questionnaire you completed? What you do with this information is up to you."
> "What do you know about the effects of amphetamines on your mood?"

• Provide feedback in a neutral and non-judgmental manner.

> "Your score for opiates was 6, which means that you are at risk of experiencing

Health and other problems related to your opiate use at your current levels"

> "Amphetamines affect the chemicals in your brain that regulate mood and regular use can make you feel depressed, anxious and in some people angry and violent"

• Elicit personal interpretation. i.e.: ask the patient what they think about the information and what they would like to do. You can do this by asking one of the following key questions:

> "How do you feel about that?"
> "Where do we go from here?"
> "What would you like to do about that?"
> "How concerned are you by this?"
> "What concerns you most?"

Feedback and information for low risk users

Most patients screened with the ASSIST will have scores in the low risk range for all substances (see Box 1 for cut off scores for each substance). These people do not need any intervention to change their substance use. However, provision of general information about alcohol and other drugs to low risk users is appropriate for several reasons:

• It increases the level of knowledge in the community about alcohol and other substance use and risks.
• It may act as a preventive measure by encouraging low risk substance users to continue their low risk substance use behavior.
• It may remind patients with a past history of risky substance use about the risks of returning to hazardous substance use.

What to do with patients whose ASSIST Scores indicate they are at low risk

• Provide feedback about their ASSIST scores and risk level.

Box 2: Example of feedback of ASSIST scores in low risk range

"This card shows the results of the ASSIST questionnaire you completed a substance use and whether you have experienced any problems in connection with your substance use. (*Show the patient the front page of the ASSIST report card*) You can see that your scores fall into the low risk range for all substances. (*Turn the page of the report card to show the patient the lists of* few minutes ago. If you remember, the questions asked about your *substance related problems.*) This means that you are unlikely to develop any of these problems if you continue your current behavior."

• Ask if they would like any additional information about drugs for themselves or Their family. Give the patient the report card to take home, along with any other information resources they are interested in receiving.
• Reinforce that what they are doing is responsible and encourage them to continue their current low risk substance use patterns.

Brief Intervention with moderate risk users

People whose ASSIST score for any substance indicates moderate risk of substance related problems should be offered a brief intervention (see Box 1 for cut-off scores for each substance). Brief interventions should be flexible and take account of the patient's level of risk, specific problems, and readiness to change as well as the time available. If it seems appropriate you can ask the patient to come back for a further appointment to discuss their substance use in more detail. This may occur if time is short, or if you are particularly concerned about the patient's substance use and related problems, or if the patient really wants to do something about their substance use. If necessary, the intervention could be implemented over a number of consultations.
The main components of a brief intervention are:

- Provide feedback (FRAMES) of ASSIST results and risk levels (page 1 of the ASSIST Report Card). Discuss the meaning of the results and link to the specific problems listed on pages 2-4 of the Report Card.
- Provide clear advice (FRAMES) that the best way to reduce the risk of substance related problems are to cut down or stop substance use. At the same time it is important to emphasize that the patient is responsible (FRAMES) for their own substance use behavior.

> "The best way to reduce your risk of experiencing these problems is to cut down or stop your substance use but nobody else can make that decision for you. It is up to you to decide. If it is alright with you I'd like to talk with you about that"

- Take a brief history of drug use over the past week.
- Discuss perceived benefits of drug use:

  > "What are the good things about using…(substance)?"

- Discuss negative consequences of drug use.

  > "Can you tell me about some of the *less* good aspects of using…(substance)?"
  Encourage the patient to consider both long term and short term consequences. Refer back to the problems listed on pages 2-4 of the ASSIST report card. If the presenting complaint, or a problem in the medical history may be related to substance use, it is important to discuss this with the patient.

- Encourage the patient to weigh up the positives and negatives. You can use the decision balance or the table of benefits and costs on page 7 to help the patient think about this.
- Discuss the patient's level of concern about their drug use. You can use the

  importance ruler on page 9 to help the patient show you how important they believe it is to change their substance use.

If the patient is not concerned about their drug use, or is not ready to consider change (pre- contemplator):

- Provide the ASSIST Report Card to take home
- Offer additional written information about the specific substances they use, and available services in their area.
- Invite them to return to discuss their substance use if they become concerned at any time in the future.
- End the current session. Review substance use whenever they return to see you about other health problems.

EXAMPLE OF A SHORT BRIEF INTERVENTION FOR CANNABIS (BOX 3)

Box 3:
Feedback and advice only – 3 minutes

After completion of the ASSIST questionnaire with Dr Y, Mr X, a 33 year old man who lives with his girlfriend and their young child, has scores in the low risk range for all substances except cannabis for which he has scored a 20, placing him in the moderate risk category.

FRAMES Techniques and MI strategies used are in brackets.

Dr Y. Ok, thanks for going through this questionnaire with me (affirmation). Would it be fair to say that marijuana is the drug that you use the most at the moment?

Mr X. Yeah, pretty much.

Dr Y. How much would you smoke, say, on an average day after work? (taking brief history)

Mr X. Um, usually about 3 or 4 cones throughout the evening, maybe a bit more on the weekends.

Dr Y. Would you like to see the results of the questionnaire that you did? (Elicit)

Mr X. Yes

Dr Y. 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 patient the front page of the ASSIST Report Card).* It really is up to you would you like to do with this information. (responsibility)

From your answers it appears that your scores for most of the substances we asked about are in the low risk range so you are unlikely to have any problems from those substances if you keep on with your current pattern of use. However, your score for marijuana was 20, which means that you are at risk of experiencing health and other problems related to your marijuana use by smoking dope at your current levels. (provide feedback)

(*shows the patient pages 2-4 of the ASSIST Report Card*). This box shows some of the problems that are caused by risky use of cannabis - problems with attention and motivation, anxiety, dysphoria, panic, paranoia, decreased memory and problem solving ability, high blood pressure, asthma and bronchitis, heart disease and lung disease. (provide advice)

Dr Y. How concerned are you about dope affecting you? (open ended question, elicit selfmotivating statement)

Mr X. Yeah…I don't know, I never thought about it…..I mean….I suppose it is a bit worrying that it could cause all these problems. I don't know. (dissonance)

Dr Y. Can I give you some pamphlets about smoking dope that you can take home with you? They just explain more about the effects that marijuana can have and provide information about how to cut down, if that's what you want to do (hands Mr X written materials). Have a read, and if you want to talk about it more I'm happy to talk to you about it at our next appointment (Menu, written advice).

Mr X. Ah….OK….thanks…I'll have a think about it.

If the patient is concerned or is ready to consider change (contemplator) then further intervention should be offered. Key components of this intervention could include:

- Further feedback linking substance use with current and potential health problems.
- Further discussion aimed at eliciting change talk (see page 22).
- Discuss the patient's level of confidence that they can change their substance use if they want to. Use the confidence ruler on page 9 to help the patient tell you how confident they feel. If confidence is low, encourage the patient to tell you about other changes they have made or the personal qualities which would help them to make changes in their substance use.
- Discuss specific options to assist change (Menu of options). Examples include:
  - > Keep a diary of substance use including:
  - > Time and place of using
  - > Other people present when using
  - > What substances were used, and how much
  - > How much money was spent.
  - > Identify high risk situations and strategies to avoid them or to reduce use in those situations.
  - > Identify other activities instead of drug use.

- Help the patient decide on their goals.
- Encourage the patient to identify people who could provide support and help for the changes they want to make.
- Provide self help resources and written information to reinforce what has been discussed in the consultation.
- Invite the patient to return to discuss their substance use if they need further help or information. Review how they are going with changing their substance use

whenever they return to see you about other health problems.

- Help the patient decide on their goals.
- Encourage the patient to identify people who could provide support and help for the changes they want to make.
- Provide self help resources and written information to reinforce what has been discussed in the consultation.
- Invite the patient to return to discuss their substance use if they need further help or information. Review how they are going with changing their substance use whenever they return to see you about other health problems.

EXAMPLE OF A SHORT BRIEF INTERVENTION FOR CANNABIS (BOX 4)

Box 4:Feedback and exploring pro's and con's of use ~5 minutes

After completion of ASSIST questionnaire with Dr Y, Mr X, a 33 year old man who lives with his girlfriend and their young child, has scored low risk for all substances with the exception of cannabis for which he has scored a 20, placing him in the moderate risk category.

Techniques and MI strategies used are in red in brackets at end of sentence.

Dr Y. 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)

Mr X. Yeah, pretty much.

Dr Y. What do you enjoy about smoking dope – I mean what are the good things about it? (open ended question – exploring pros and cons)

Mr X. 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 mates or at a party or something on the weekend because you enjoy yourself more.

Dr Y. How much would you smoke, say, on an average day after work? (taking brief history)

Mr X. Um, usually about 3 or 4 cones throughout the evening.

Dr Y. Would that be the amount you'd have when you smoke on the weekends? (taking brief history)

Mr X. Yeah…probably a bit more actually…maybe 5 or 6, I don't know, sometimes I lose track (laughs)

.

Dr Y. What are the less good things about smoking dope? (open ended question – exploring pros and con's)

Mr X. Ask my girlfriend – she always nagging me about it (laughs). 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.

(shows the patient pages 2-4 of the ASSIST Report Card). This box shows some of the problems that are caused by risky use of cannabis - problems with attention and motivation, anxiety, dysphoria, panic, paranoia, decreased memory and problem solving ability, high blood pressure, asthma and bronchitis, heart disease and lung disease. (provide advice)

You said you've experienced some of these problems with your memory and concentration and motivation……..

Mr X. (interrupts) yeah, but that could be because I'm always tired because I don't always sleep well if the baby cries at night. (resistance)

Dr Y. So it seems to you that the only 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)

Mr X. Well, that's part of it anyway. I guess part of it could be from smoking too much.(ambivalence)
Dr Y. How concerned are you about the way smoking dope affects you? (open ended question, elicit self-motivating statement of concern)

Mr X. 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)

Dr Y. Listen Mr X, you do have many options available, and it's up to you to decide what is best for you. Can I give you some pamphlets about smoking dope that you can take home with you? They just explain more about the effects that marijuana can have and provide information about how to cut down, if that's what you decide to do (hands

Mr X written materials). If you want we could talk about your options more at another time. (written advice, menu, emphasis on personal choice and control)

Mr X. Ah….OK….thanks…I'll have a think about it.
(A longer session could focus on the importance of the relationship between Mr X. and his girlfriend and child)

Mr X. Ask my girlfriend – she always nagging me about it (laughs). 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.

Dr Y. So smoking dope 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, refocus, open-ended question)

Mr X. 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….

Dr Y. And it's hard for you because smoking dope helps you relax but at the same time you're not lending a hand around the house because you're stoned and sometimes you forget to do things that she is relying on you to do. (summary, empathy)

Mr X. Yeah.

Dr Y. Would you like to see the results of the questionnaire that you did? (Elicit)

Mr X. Yes.

Dr Y. If you remember, the questions asked about your drug and alcohol use and whether you have experienced any problems related to your substance use (s*hows the patient the front page of the ASSIST Report Card*). It really is up to you what you would like to do with this information. (responsibility)

From your answers it appears that your scores for most of the substances we asked about are in the low risk range, so you are unlikely to have any problems from those substances if you keep on with your current pattern of use. However, your score for marijuana was 20, which means that you are at risk of experiencing health and other problems related to your marijuana use by smoking dope at your current levels. (provide feedback)

Choosing the substance of most concern.
Some patients will have Specific Substance Involvement ASSIST scores indicating hazardous or harmful use of more than one substance. A sub-group of these patients may also be injecting one or more types of drug. For these patients it may be necessary to choose one substance only to be the focus of the intervention. Trying to change a number of behaviors at the same time can be difficult and may lead to the patient feeling overwhelmed and discouraged. It is better to focus on one behavior at a time. Patients will be more likely to respond to an intervention if they are involved in choosing which substance is of greatest concern to them. It is likely that the substance of most concern will be the substance that is being injected (where relevant) and the substance for which they have received the highest Specific substance Involvement ASSIST score, however, some patients may be more concerned about a lower scoring substance. The intervention should therefore focus on either:

- The substance with the highest ASSIST Specific Substance Involvement Score OR
- The substance of most concern to the patient OR
- The substance that is being used intravenously.

What to do with high risk users or frequent injectors

Patients who have been injecting drugs regularly over the last three months and/or whose ASSIST scores are in the high risk range for any substance may require more intensive

treatment. This may take the form of treatment within the primary care agency, such as pharmacotherapy or on-going counseling, or may be referral to a specialist drug and alcohol treatment agency if available.
Some patients who are at high risk may not be concerned about their substance use or may not be willing to accept intensive, higher-level treatment. Elements of the brief intervention may be used to motivate such patients to accept further treatment.

- Provide feedback of ASSIST results and risk levels (page 1 of "*The ASSIST Feedback Report Card*"). Discuss the meaning of the results and link to the specific problems listed on pages 2-4 of the Report Card (and the "*Risks of Injecting*" card if relevant).
- Provide clear advice that the best way to reduce the risk of substance related problems and to manage existing problems is to cut down or stop substance use. If the patient has tried unsuccessfully to cut down or stop their substance use in the past, discuss these past attempts. This may help the patient understand that they may need treatment to change their substance use.
- Link the results to specific problems the patient is already experiencing.
- Take a brief history of drug use over the past week.
- Encourage the patient to weigh up the positives and negatives. You can use the decision balance or the table of benefits and costs on page 7 to help the patient think about this. Asking open ended questions is also an effective technique;

    > "Tell me about the good things about using…(substance)."
    > "Can you tell me about some of the less good things about using …(substance)?"

- Encourage the patient to consider both long term and short term consequences. Refer back to the problems listed on pages 2-4 of the ASSIST report card.
- Discuss the patient's level of concern about their drug use. You can use the importance ruler on page 9 to help the patient show you how important they believe it is to change their substance use.
- Provide information about what is involved in treatment and how to access treatment.
- Provide encouragement and reassurance about the effectiveness of treatment.
- Provide written materials on problem substances and strategies for reducing use.

Review and monitor all patients, whether they agree to more intensive treatment or not, whenever they return to see you about other health problems. Invite them to make an appointment to come back and talk to you about substance use at any time.

BRIEF INTERVENTIONS
POST-TEST

Name: _____ Date: _____

Agency: _____

Circle the correct answer below:

1. It is very important in administering brief interventions that you must be able to:

    a. tell the patient what is really needed.
    b. provide solutions and ask them to choose one.
    c. listen and hear what is actually being said.

2. Brief Interventions can only be used in a generalist medical setting.

    a. True
    b. False

3. When a patient scores between a 27+ on the ASSIST , you would give them simple advice and congratulate them on being at low risk for substance use problems and then send them home.

    a. True
    b. False

4. ASSIST scores below 8 for alcohol generally indicate low-risk drinking. Although no intervention is required, for many individual's alcohol education is appropriate.

    a. True
    b. False

5. As a BRITE professional you will be able to diagnose the problem using the screening instruments and then you will refer the patient to a treatment provider for treatment.

    a. True
    b. False

8. Whenever a patient's response to one of the questions on the preliminary drug screen is yes, and then you administer the ASSIST and they score a 3-5 and they are using heroin you would:

    a. Access their readiness to change, provide results of screens, provide information on health issues utilizing BRITE handouts, and recommend a referral for further assessment based on the seriousness of heroin and addiction.
    b. See if they are willing to quit on their own.
    c. Develop a goal plan for reduction of intake.

9. If after exhausting all motivational techniques, sharing of all information, the patient states that they do not want to change and they will continue to use cocaine or heroin and does not want the literature that you are willing to provide you would:
    a. Due to the fact you are a healthcare provider or educator you have an ethical obligation to once again just state the seriousness of their problem and related to their health. Invite

them to think about it and then offer to schedule another appointment to talk about their use and that you do want to monitor them for health reasons. If they refuse, there is nothing else you can do.

b. You would inform the police that the patient is a heroin addict.
c. If you are a healthcare educator and think that the physician could possibly make a difference, you would go and inform the physician and ask them to assist in the intervention.
d. Both a. and c. are appropriate.

10. Prior to providing any intervention you must assess the patient's readiness to change and if they indicate that they are not ready, you will:

a. You will tell them that there is nothing that you can do for them and you will tell them to come back when they are ready.
b. You will utilize the motivational techniques such as the Pro-Con scale to assist them in moving to the next level of change.
c. You will share your concern as a (healthcare specialist, physician, med. Asst., nurse) and that the effects to their health using the BRITE handouts. Encourage a dialogue. Then again assess their readiness to change along with their confidence to change. If they are not ready, you will encourage them to read the literature that you have provided and to digest the material, and that you are scheduling another appointment for them to come back based on your concern for their health and well-being.
d. Both b and c.

11. Other important factors to remember are:

a. It is important to get the patient to see things your way.
b. Change is easy and they should realize that you are the expert and they need to listen to what you say.
c. To deflect denial, facilitate change, and follow-up with each patient.
d. None of the above.

12. The stages of change in order are:

a. Contemplations, Precontemplation, Maintenance, Preparation, Action
b. Precontemplation, Maintenance, Contemplation, Preparation, Action
c. Precontemplation, Contemplation, Preparation, Action, Maintenance
d. None of the above.

13. Precontemplation is when the hazardous or harmful substance user is not considering Change in the near future, and may not be aware of the actual or potential health consequences of continued drinking at this level.

a. True
b. False

14. Brief interventions elements to be emphasized for Precontemplation are:
a. Feedback about the results of the screening, and information about hazards of their substance use.
b. Emphasize the benefits of changing, give information about substance related problems, the risks of delaying, and discuss how to choose a goal.
c. Discuss how to choose a Goal, and give Advice, and Encouragement.
d. Review advice, give encouragement
e. Give encouragement.

15. Brief interventions elements to be emphasized for Contemplation are:

    a. Feedback about the results of the screening, and information about hazards of substance use.
    b. Emphasize the benefits of changing, give information about substance related problems, the risks of delaying, and discuss how to choose a goal.
    c. Discuss how to choose a Goal, and give Advice, and Encouragement.
    d. Review advice, give encouragement
    e. Give encouragement.

16. Brief interventions elements to be emphasized for Preparation are:

    a. Feedback about the results of the screening, and information about hazards of drinking.
    b. Emphasize the benefits of changing, give information about alcohol related problems, the risks of delaying, and discuss how to choose a goal.
    c. Discuss how to choose a Goal, and give Advice, and Encouragement
    d. Review advice, give encouragement
    e. Give encouragement.

17. Brief interventions elements to be emphasized for Action are:

    a. Feedback about the results of the screening, and information about hazards of drinking.
    b. Emphasize the benefits of changing, give information about alcohol related problems, the risks of delaying, and discuss how to choose a goal.
    c. Discuss how to choose a Goal, and give Advice, and Encouragement.
    d. Review advice, give encouragement
    e. Give encouragement.

18. Brief interventions elements to be emphasized for Maintenance are:

    a. Feedback about the results of the screening, and information about hazards of drinking.
    b. Emphasize the benefits of changing, give information about alcohol related problems, the risks of delaying, and discuss how to choose a goal.
    c. Discuss how to choose a Goal, and give Advice, and Encouragement.
    d. Review advice, give encouragement
    e. Give encouragement.

19. The following elements are important to providing interventions.

    a. Establish a rapport, empathic listening, using open-ended questions, and use of reflective statements.
    b. Confidence, authoritative, patience, and compassionate.
    c. Effective, being able to manipulate, establishing control
    d. Self-disclosure, closed questioning, directive, time-limited
    e. Both a. and b.

20. When a patient share a concern about someone else in the family possibly having an alcohol or other drug problem you would:

    a. Tell them that you can't help them unless the other family member is present.
    b. Diagnose the family member's problem based on the patient's information.
    c. Listen Sympathetically, Provide information, Encourage Support and Joint Problem-Solving
    d. Both a. and c.

BRIEF TREATMENT

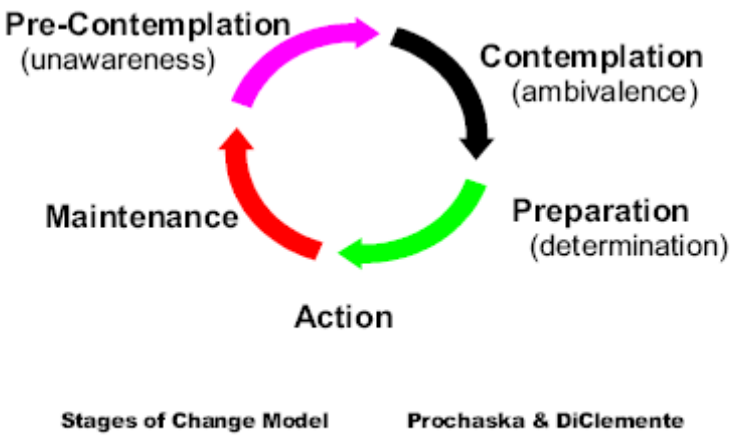
Primary care settings deliver extended risk- education interventions through multiple sessions of motivational counseling termed "brief treatment"

Some patients produce screening scores that indicate their excessive use is already causing adverse consequences for them. For example, individuals with ASSIST scores that falls into the category of "harmful use" where there is acknowledgement of the negative effects of heavy drinking in personal, social or vocational areas. A brief intervention, consisting of 3-5 minutes of feedback and simple advice, may be inadequate to motivate these patients to change their behavior. At the same time, these individuals may resist the suggestion that they seek treatment for a substance use disorder. Often, they may not even meet the placement criteria for treatment, although their excessive or hazardous use still creates a variety of problems for them. Other nondependent patients acknowledge their substance-related problems but have difficulty implementing a plan to change their risky behavior and require assistance with their efforts.

The Florida BRITE initiative provides a level of intervention that falls between simple advice and specialty treatment. It is termed "brief treatment" although it is really an extension of preventive medicine through risk reduction counseling at the primary care level. It is tailored to the patient's readiness to change the harmful behavior, and focuses on two elements central to risk reduction, ambivalence about change and the resolution of barriers to making a change. This level of service is not designed to replace traditional substance abuse treatment. Instead, it provides an opportunity to help at-risk individuals clarify their problematic use, find positive motivation to commit to change, and discover ways to reduce their harmful situation.

The Stage-directed process of Brief Treatment

Individual motivation has been shown to correspond to a theoretical model of change that through which individuals pass in the process of modifying their behavior. Under this Stage of Change model, individuals in a **Pre-Contemplation** stage are not yet considering change; those in **Contemplation** are considering change but not taking action; others are in **Preparation** or taking **Action** to change their behavior; while others, in the **Maintenance** stage, have changed their lifestyle to maintain new behavior. According to this model, patients in the pre-contemplation stage are more likely to deny that they have a problem or to accept the relevance of health risk information in their personal situation; those in the contemplation stage are more likely to be weighing the relative costs and benefits of a change in their behavior; those in the preparation or action stage initiating coping skills to reduce their risks; and those in the maintenance stage are likely to be concerned with ways to preserve the new behaviors.



The goals of brief treatment can be adapted to outcomes that correspond to each stage of change. For example, patients are ready to move from the pre-contemplation to contemplation stage when they have had the opportunity to examine their substance use in relation to norms for quantity, frequency and consequences, so that they recognize a problem for themselves as a result of that feedback. Transition from the contemplation stage to preparation or action occurs when individuals have resolved their ambivalence and have adopted a personal commitment to change. Patients are ready to move to maintenance when they have established the skills and behaviors and are seeking to sustain them.

How Brief Treatment Incorporates a Readiness to Change Model
The effectiveness of brief treatment depends on the congruity between the patient's readiness to change and the process of intervention.

Intervention programs often fail because of the mismatch between the individual's readiness to make changes and the intervention program's focus on action. When people are not ready to commit to a change in their behavior, they ordinarily react to being pressured or pushed into change by becoming resistant and defensive, or they become even more ambivalent about change and view the message as irrelevant to their personal situation. Efforts to persuade those who might be contemplating but aren't yet ready to make changes are seldom as effective as opportunities to assist them to resolve their ambivalence or strengthen their own motivation. Brief treatment is rooted in this paradigm of change. **In the Florida BRITE model, brief treatment is based on a style of clinical interaction that respects the patient's ambivalence about maintaining or changing at-risk behavior, and uses a motivational interviewing approach for eliciting determination to change by helping clients to explore and resolve ambivalence.** In the words of Dr. William Miller, an originator of this approach, "It is inappropriate to think of motivational interviewing as a technique or set of techniques that are applied to or (worse) "used on" people. Rather, it is an interpersonal style… a subtle balance of directive and client-centered components, shaped by a guiding philosophy and understanding of what triggers change. If it becomes a trick
or a manipulative technique, its essence has been lost (Miller, 1994)."

In BRITE Brief Treatment, the spirit of motivational interviewing should transcend any techniques that are adapted from it.

In the model of brief treatment, an open and nonjudgmental, reflective approach to patient interaction is central to the process of motivating and facilitating change while minimizing resistance. The core features of this approach include:

- Seeking to understand the person's frame of reference, particularly via reflective listening
- Expressing acceptance and affirmation
- Eliciting and selectively reinforcing the client's own self motivational statements expressions of problem recognition, concern, desire and intention to change, and ability to change
- Monitoring the client's degree of readiness to change, and ensuring that resistance is not generated by jumping ahead of the client.
- Affirming the client's freedom of choice and self-direction

This approach can be illustrated in a set of principles that have been proposed by the developers of motivational interviewing to express the spirit motivational interviewing.

1. ***Motivation to change is elicited from the client, and not imposed from without.*** Coercion, persuasion, and constructive confrontation are different in spirit from an approach that relies on identifying and mobilizing the patient's intrinsic reasons for change, and are not a part of the BRITE brief treatment paradigm.

2. ***It is the patient's task, not the interventionist's, to articulate and resolve his or her ambivalence.*** Ambivalence reflects the decisional conflict between the perceived benefits and costs of a behavior change. The interventionist's job is to help the patient express both sides of the conflict and resolve it in a manner that facilitates change, rather than to formulate the arguments on behalf of the patient.

3. ***Direct persuasion is not an effective method for resolving ambivalence.*** Tactics that attempt to persuade the patient about the urgency of the problem or the benefits of change generally increase client resistance and diminish the probability of change.

4. ***The intervention style is generally a quiet and eliciting one.*** The BRITE model of brief treatment avoids a "hard sell" approach, direct persuasion, aggressive confrontation, and argumentation. More assertive intervention strategies, sometimes guided by a desire to "confront denial," easily slip into pushing patients to make changes for which they are not ready and provoking more resistance.

5. ***The interventionist helps the patient to examine and resolve ambivalence before barriers to change or coping strategies are addressed.*** Rather than begin with action-oriented strategies to reduce at-risk substance use, the BRITE brief treatment model starts by examining the patient's readiness to change and resolving ambivalence about taking the steps to reduce risk. Further efforts to address methods to change are ineffective without the patient's commitment to make them.

Given these core attributes, it is essential to note that a brief treatment session would not be following the BRITE motivational approach when the interventionist:

- argues that the person has a problem and needs to change
- offers direct advice or prescribes solutions to the problem without the person's permission or without actively encouraging the person to make his or her own choices
- uses an authoritative/expert stance leaving the client in a passive role
- does most of the talking, or functions as a unidirectional information delivery system
- imposes a diagnostic label
- behaves in a punitive or coercive manner

Such techniques violate the essential spirit of motivational interviewing.

Steps in Brief Treatment
There are three phases to the BRITE brief treatment approach:

1. **Assess the patient's substance use problem, the patient's attitudes about change, and self-efficacy**

2. **Provide motivational interviewing to assist clients to explore their feelings about change**

3. **Reinforce the patient's change efforts through encouragement and feedback.**

Step 1: Assess the patient's substance use problems, attitudes about change, and beliefs about self-efficacy

Brief treatment begins with a comprehensive look at the patient's at-risk substance use to change to a less harmful pattern. In order to set the stage for this g the first session the interventionist must foster a positive, collaborative relationship with the patient so that trust and confidence are created as conditions for self-examination and deliberation. Central to this effort is the interventionist's ability to convey unconditional positive acceptance of the patient as a person, skillful use of reflective listening to understand accurately the client's perspective and convey that understanding back to the patient, and the ability to patiently draw out the patient's perspective rather than "installing" the interventionist's knowledge, insights and advice.

Collect Supplementary information for patients who screen positive

Although the brief pre-intervention screening is useful to determine risk, it provides limited detail about the nature or extent of the patient's substance-related problems, his or her motivation to change or beliefs and expectations about the ability to change. During the first session of brief treatment, the interventionist must include a collaborative assessment of the patient's substance use and its consequences in greater depth. This assessment should include the following elements:

- Current use patterns and associated problems
- Information about major medical problems and health status
- Information about housing, education and employment, and alcohol-related problems
- Support mechanisms and social connectedness

If the patient's substance misuse is other than alcohol, it is appropriate to include the ASSIST in order to augment the patient's consumption measures gathered on the GPRA Section B interview with information about the extent of substance-related problems. Generally, scores in the high risk area of the questionnaire suggest significant substance use problems that warrant referral for specialized assessment and possible treatment rather than the brief treatment protocol.

In the Florida BRITE model, much supplementary information is gathered by means of the Government Performance Results Act (GPRA) baseline data collection tool. The intent of the GPRA questions is to assess the impact of the person's substance use on various aspects of health status and living situation.

Answers to GPRA Sections A and B, the demographics and use inventory questions, should have been collected during the patient's primary care appointment and should be available to the interventionist. Additional sections of the GPRA tool, Sections C-G, should be collected through a face-to-face interview, preceded by an introduction that frames the inquiry into an effort to learn more about the patient's situation:

Suggested introduction to GPRA questions:

Now I am going to ask you some questions to help me learn more about you and to help us examine the impact of your substance use. I am going to use a standard approach with this interview tool so that I don't miss any important areas.

Assess readiness to change

In addition to information collected through the GPRA intervention, the intervention should assess the patient's readiness to change. A quick method to determine three stages of change, pre-contemplation (P), contemplation (C), and action (A) is accomplished with a brief readiness to change questionnaire. The University of Rhode Island Change Assessment Scale (URICA) is a brief survey that provides a quick view of the patient's relative Stage of Change. It should be administered as a self-report tool during the initial Brief Treatment session. The URICA tool is presented below, adapted to the BRITE brief treatment model and a population that has not presented for treatment.

University of Rhode Island Client ID#_____

Change Assessment Scale (URICA) : Date: _____/_____/_____

EACH STATEMENT BELOW DESCRIBES A HOW A PERSON MIGHT FEEL WHEN APPROACHING SITUATIONS IN THEIR LIVES. PLEASE INDICATE THE EXTENT TO WHICH YOU TEND TO AGREE OR DISAGREE WITH EACH STATEMENT. IN EACH CASE, MAKE YOUR CHOICE IN TERMS OF HOW YOU FEEL RIGHT NOW, NOT WHAT YOU HAVE FELT IN THE PAST OR WOULD LIKE TO FEEL. FOR ALL STATEMENTS THAT REFER TO YOUR "PROBLEM", ANSWER IN TERMS OF PROBLEMS RELATED TO YOUR SUBSTANCE USE. THE WORDS "HERE" AND "THIS PLACE" REFER TO THIS SESSION.

THERE ARE FIVE POSSIBLE RESPONSES TO EACH OF THE ITEMS IN THE QUESTIONNAIRE:

CIRCLE THE NUMBER THAT BEST DESCRIBES HOW MUCH YOU AGREE OR DISAGREE WITH EACH STATEMENT.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1) I don't have a problem. It doesn't make much sense for me to consider changing.	1	2	3	4	5
2) I am finally doing some work on my problem.	1	2	3	4	5
3) I've been thinking that I might want to change something about myself.	1	2	3	4	5
4) At times my problem is difficult, but I'm working on it.	1	2	3	4	5
5) Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5
6) I'm hoping that I will be able to understand myself better.	1	2	3	4	5
7) I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5
8) I am really working hard to change.	1	2	3	4	5
9) I have a problem and I really think I should work on it.	1	2	3	4	5

10) I'm not following though with what I had already changed as well as I had hoped, and I want to prevent a relapse of the problem.	1	2	3	4	5
11) Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5
12) I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
13) I wish I had more ideas on how to solve my problem.	1	2	3	4	5
14) Maybe someone or something will be able to help me.	1	2	3	4	5
15) I may need a boost right now to help me maintain the changes I've already made.	1	2	3	4	5
16) I may be part of the problem, but I don't really think I am.	1	2	3	4	5
17) I hope that someone will have some good advice for me.	1	2	3	4	5
18) Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5
19) All this talk about change is boring. Why can't people just forget about their problems?	1	2	3	4	5
20) I'm struggling to prevent myself from having a relapse of my problem.	1	2	3	4	5

21) It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5
22) I have worries but so does the next guy. Why spend time thinking about them?	1	2	3	4	5
23) I am actively working on my problem.	1	2	3	4	5
24) After all I had done to try and change my problem, every now and then it comes back to haunt me.	1	2	3	4	5

SCORING The URICA – 24- item version

	Precontemplation	Contemplation	Action	Maintenance
Enter	1	3	2	10
the value	5	6	4	12
of the	7	9	8	15
corresponding	16	13	11	20
Items--	19	14	18	21
	22	17	23	24
Total:				
Divide by	6	6	6	6
Mean:				

In order to obtain a Readiness to Change score, first sum items from each subscale and divide by 6 to get the mean for each subscale. Then sum the means from the Contemplation, Action, and Maintenance subscales and subtract the Precontemplation mean (C + A + M – PC = Readiness).

Step 2: Adapt a motivational interviewing approach to facilitate a readiness to change

Because at risk individuals differ in their readiness to change and their stage of change, it is impractical to impose a "one size fits all" limit on the required number of brief treatment sessions. Generally, brief treatment should consist of an introductory meeting with the Interventionist to learn more about the patient and his or her substance-related issues, and additional sessions to resolve ambivalence, address barriers to change and reinforce risk-reducing efforts. Ordinarily, brief treatment can be accomplished within six patient encounters, some of which might be telephone contacts to discuss progress and reinforce accomplishments.

The Florida BRITE model employs motivational interviewing to increase a patient's readiness to change. This approach serves the goal of resolving a patient's ambivalence about substance use patterns and moving the patient to a more determined state of mind about making these changes.

The BRITE model incorporates a basic approach to Interventionist-patient interactions which is captured by the acronym OARS: **(1) Open-ended questions, (2) Affirmations, (3) Reflective listening and (4) Summaries.** PABRITE subscribes to the definition of this style of interaction. The OARS approach has been summarized from the literature by Chris Wagner, Ph.D. and Wayne Conners, M.Ed. of the Mid-Atlantic Addiction Technology Transfer Center (Mid-ATTC). Their detailed discussion can be found at http://motivationalinterview.org/clinical/interaction.html

Motivational interviewing is, more precisely, an interpersonal style of counseling rather than a discrete set of methods, although effective behavior change techniques have been derived from this approach. Certain strategies are suited to the goals of brief treatment within the BRITE model. As suggested in the Mid-ATTC's website--(http://motivationalinterview.org/clinical/strategies.html) the strategies include:

Good Things and Less Good Things
This strategy is simply to review what is "good" about substance use alongside a review of what is "not-so-good" about the use of substances. Steve Rollnick developed this phrasing for a particular purpose; namely, he wanted to avoid labeling a behavior as a problem when the client was not using that language. Failure to do this may lead to arguments with clients where they state adamantly the behavior is not a problem. Conversely, clients are often willing to acknowledge that there are less good things about a behavior. behavior. The technique also provides the therapist an opportunity to explore what "positives" may be sustaining a behavior. This is often a very fruitful inquiry and typically quite surprising to clients. They are often confronted with why they need to change a behavior, but only rarely asked what benefits they are receiving. This often serves to reduce resistance and allows inquiry into the Less Good things to be more acceptable to the client. We start this technique with a prefacing comment, then follow with a question about the Good Things. We follow up until all the Good Things have been exhausted. We summarize, then ask about the Less Good Things. These are then explored in more detail with requests made for examples of Less Good behavior. For example, *"You said that your use had affected your children. Tell me about a time that happened."* Once this area is fully explored, we summarize, emphasize any change talk that emerged, and then ask the client what their

take on this material might be. The most important part of this strategy is to avoid labeling things as a problem.

Looking Forward
Looking Forward has a similar focus to Looking Back. It has the client envision two futures. The first is if they continue on the same path without any changes where they might be five or ten years from now. The second future is if - and the emphasis is on if - they decided to make a change in their behavior, what that future might look like. The therapist's job is not argue one position or another, but rather just elicit the information and then ask the client to comment on these imaginings.

Exploring Importance and Confidence
A recent strategy developed by Rollnick and colleagues (Rollnick, Mason, & Butler, 1999) involves the dimensions of importance and confidence. This strategy essentially explores the client's impressions of how important is to make a change and how confident he or she is that he or she can succeed in changing. The therapist explores the client's impressions of what it is that makes the change important, how this change fits in with other aspects of his or her life, and what events may transpire to make this change seem more important than it currently does. The issues around a person's confidence in changing are explored in a similar way, and the therapist may guide the client to review past change attempts and determine how the therapist and significant others could help the person succeed in making a change.

Decisional Balance
The decisional balance exercise is a values exercise similar to good things/less good things, except with a focus on future behavior. Counselors ask clients to identify the anticipated "pros" and "cons" of changing a behavior, then compare this with the pros and cons of not changing the behavior. Once the pros and cons have been identified, counselors may ask clients to consider which of these options best meet clients' ideals while also tending to their preferences for experiences. Counselors may reflect that clients have the opportunity to create different lifestyles and to choose in part who they will become in the future through the course of action they choose.

Step 3: Reinforce the patient's efforts to modify at-risk behavior and encourage efforts to sustain the changes

In the BRITE model, the other half of brief treatment consists of facilitating change once the patient has a commitment to it. The paradigm of facilitated behavior change has been acronym **FRAMES.**

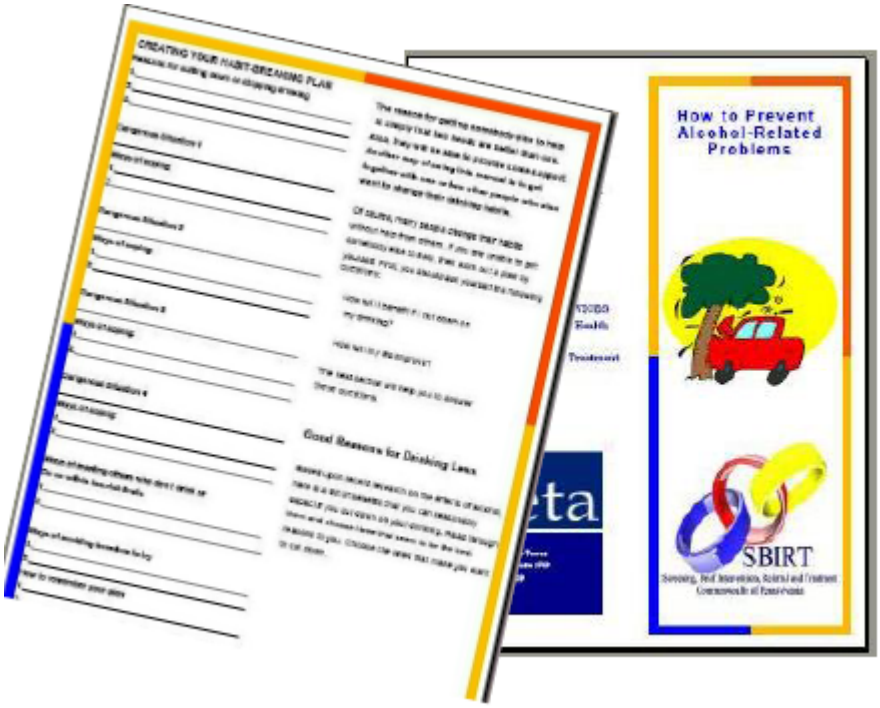
- **F**eedback: about personal risk or impairment
- **R**esponsibility: emphasis on personal responsibility for change
- **A**dvice: to cut down or abstain if indicated because of severe dependence or harm
- **M**enu: of alternative options for changing drinking pattern and, jointly with the patient, setting a target; intermediate goals of reduction can be a start
- **E**mpathic interviewing: listening reflectively without cajoling or confronting; exploring with patients the reasons for change as they see their situation
- **S**elf efficacy: an interviewing style which enhances peoples' belief in their ability to change.

This work will have begun in the initial stages of brief treatment through feedback and motivational interviewing to resolve ambivalence. The process continues when the patient is helped to set goals for change and adopt a plan to make them succeed. It is essential to remember that the patients are the experts on their own behavior, and that success is greatest when they are helped to discover their own solutions rather than being made to adopt the interventionist's.

It is helpful to maintain a flexible and creative attitude when helping patients discover their risk. One of the reasons people avoid changes in their behavior is that they overestimate the effort that is required. Risk reduction can begin in small steps and gain momentum through a provider's encouragement.

Encourage the patient to set realistic goals, and to keep a daily record of accomplishments. A visual reminder of change can be a powerful reinforcer. Encourage e a calendar or chart to record their daily performance, and use the
tool to reinforce change.

The BRITE project provides a workbook to help patients set personal goals. This workbook should be used during this phase of brief treatment.



Periodic telephone contact with a patient is a valuable way to provide brief treatment once the preliminary steps of assessment and goal setting have been addressed. The BRITE initiative recognizes telephone counseling as a viable method of monitoring patient progress and providing encouragement for efforts to change at-risk behavior.

Setbacks are not failures. They are opportunities to explore additional barriers to success and to discover solutions around them. Patients should be assured that change is difficult but that they can succeed. Some setbacks are caused by goals that are set too high. Use a setback to help the patient adjust expectations and set more attainable goals. When the new goals are sustained, they can be revised upward.

Consider referral for assessment and possible treatment if the patient reports consistent difficulty attaining goals, or when a more severe substance-related problem is uncovered.

A few patients who have been initially referred for brief treatment will actually have a serious substance use disorder. Fortunately, the motivational counseling process can increase an individual's determination to obtain treatment for an alcohol or drug problem by reducing the stigma of treatment and resolving ambivalence. Because risk-reduction counseling/brief treatment and traditional addiction treatment are intended for different populations, individuals who are suspected drug or alcohol dependent should have the opportunity to be formally assessed for substance use disorder and placed at the correct level of treatment when the interventionist suspects that the patient has a more serious problem, or when the patient requests it.

Six Month Follow-Up Procedures

Whenever a patient is determined to be a positive screen and their social security number ends in a 20 through 29, a six month follow-up health survey will be administered. This information is shared with the patient as well as informing them that they will receive a $20.00 gift certificate upon completion of the follow-up health survey. The BRITE DCF manual for follow-up procedures is provided to each provider to be followed. Below are the steps to be taken when a patient has agreed to participate in the follow-up. If thy refuse, this is annotated during the GPRA process under section A of the GPRA.

Six Month Follow-Up Procedures

- If screen is positive and participants last 2 digits of ss# ends in 20-29, script for completion of 6 month health follow-up survey will be given requesting their participation. If participant agrees, consent for follow-up and locator information completed and a tentative appointment scheduled.
    - An appointment card will be given with a $20.00 incentive that participant will receive upon completion of health survey. *(Attachment F)*
- 6 months follow-up health survey interview is to be completed 6 months from initial interview, but can be scheduled 5 months from initial interview. A thank you card for agreeing to participate with 6-month follow up health survey will be sent within 7 days of screening.
- Agency has 3 months window for completion of follow-up data. *(1 month prior to follow-up date but not more than 2 months post follow-up date)*
- BRITE staff will contact participant within seven (7) days post screening (or first BRITE activity) if appointment was not scheduled at initial session.
- Agency will send out reminder notification to BRITE participant of date of 6 month follow-up appointment 2,3, and 4 months prior to 6 months appointment *(Attachment G)*
- If no response an attempt to contact letter will be sent. *(Attachment H)*
- Agency will follow processes and procedures as specified in manual provided with this training.

(Agencies will offer $20.00 gift certificates, etc. as motivation for participants attendance at follow-up interview to assist in achieving 80% positive contact rate.)

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Script for 6 Month Follow-Up Survey

Mr./Ms/Mrs. _____ I would like to request your permission to contact you and find out how you are doing by completing a health study follow-up survey six months from today's date. I will give you an appointment card with a tentative date six months from today. I will also be contacting you via mail or telephone to remind you of the appointment. Upon your completion of the six-month follow up health survey, you will receive a $20 gift (cash, gift certificate, gift card, travel voucher, etc) as a token of our appreciation for your participation. If you agree to this, I have a consent form for you to complete that include names, addresses and telephone numbers of individuals that I may contact if I am unable to reach you at your current phone number. By signing this form you will give us permission to speak with those that you list in order to inquire about any forwarding phone numbers or addresses where you may be reached. I would like for you to add your address and telephone number of your home up north if you are just renting or staying here for the winter. That way we can contact you by phone and mail your $20 gift upon completion of your six-month follow up health survey.

Below is an example of the appointment card to be given to the patient at time of scheduling the 6 month health follow-up survey:

Health Study Survey

Has An Appointment On

Date: *Time:*

Thank you for your participation in our Health Survey Project. Upon Completion of the six-month follow-up survey, you will be issued your $20.00 gift card for participation. Offer expires 60 days after scheduled appointment date.

BRITE Project

Phone: 352-751-7089
1317 Winewood Avenue
Tallahassee, FL 32399

Below is the Script letter that is to be mailed at 2, 3, and 4 months prior to patients 6-month appointment

Script for Letter

Dear _____,

This is a reminder about your sixth month health study follow-up survey that you agreed to complete on Date and time. If you are unable to meet with me, or be available on this date, please contact me at phone number. Upon completion of your health survey you will receive your $20.00 gift certificate.

Sincerely,

Your Name

Script for Social Security Number Refusal

Mr./Ms/Mrs. _____ I appreciate that you are unwilling to provide me with your Social Security number. I understand that you are concerned about your privacy and the possibility of identity theft. Let me assure you that your personal information will not be shared with anyone outside of this program.

On the other hand, if you are willing to provide me with just the Last Two Digits of your Social Security Number, that will help us determine if you are eligible for participation in our six-month follow up health survey. If you are eligible, upon your completion of that survey, you will receive a $20 gift from us (cash, gift certificate, gift card, travel voucher, etc) as a token of our appreciation for your participation.

Are you willing to share the last two digits of your Social Security number with me at this time?

(If the client agrees, then the Health Care Educator should refer to Attachment 2 to complete the follow up participation process.

If the client refuses, then the Health Care Educator should thank the client and use "0000" as the client's Social Security Number.)

Below is the letter script for attempt to contact. If you do not get a response to this letter it is returned, you are to begin using locator form and the internet to try to locate participant.

Attempt to Contact Letter

Date:

Client Name:

Client Address:

Dear Mr./Ms. _____,

I am writing this letter to follow up on the recent attempts that have been made to contact you.

Please call me at (904) _____ so that we can make sure you're continuing to do well. If a response is not received within one week, we will contact the person listed as your Locator so that we can make sure you're continuing to do well. Your health is our concern. I would also like to remind you that if you complete the six-month health survey, you will receive a $20.00 gift.

I look forward to hearing from you.

Sincerely,

Staff Name
Healthcare Educator

Guidelines for Tracking Patients

The BRITE provider staff has a number of strategies at their disposal to locate and track clients for the follow-up interviews. Strategies include web-searches, telephone contacts, mailings, and possibly home visits or field work if the client cannot be located by other contact methods. The methods for contact may include:

All mailings to clients should contain “Request Forwarding Address” on the envelope or outside cover

Directory Assistance/Telephone Book

Reverse or Cross-Reference Directories

Tracking By Computer Search Engines

http://www.google.com/
http://www.411.com/

Web-based White Pages

Zip Code Look-Up

. Tracking Clients in the Field

When the above locating methods produce no results, the next step (when applicable and practical) is a personal visit to the client's home or neighborhood. If an address appears to be good but there is no response, BRITE provider staff will on occasion prepare to conduct a home visit. The BRITE provider staff member will take along extra interview forms in case he/she comes across one or more of the clients he/she is seeking.

NOTE: BRITE staff must always protect client confidentiality. Stationery will be Neutral and will not mention drugs, alcohol, treatment, or the name of a treatment agency. Business cards will also be neutral. These materials may mention “BRITE and they may contain the “BRITE” logo.

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A. WHO - ASSIST V3.0

INTERVIEWER ID		**COUNTRY**		**CLINIC**	
PATIENT ID			**DATE**		

INTRODUCTION ***(Please read to patient)***

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

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

Question 1
(if completing follow-up please cross check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you ever used? *(NON-MEDICAL USE ONLY)*	**No**	**Yes**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

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

If "No" to all items, stop interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

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

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

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

Question 3

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

Question 4

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

Question 5

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

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

Question 6

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

Question 7

Have you ever tried and failed to control, cut down or stop using *(FIRST DRUG, SECOND DRUG, ETC.)?*	**No, Never**	**Yes, in the past 3 months**	**Yes, but not in the past 3 months**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you <u>ever</u> used any drug by injection? ***(NON-MEDICAL USE ONLY)***	0	2	1

IMPORTANT NOTE:

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

PATTERN OF INJECTING		INTERVENTION GUIDELINES
Once weekly or less **Fewer than 3 days in a row**	or	**Brief Intervention including "risks associated with injecting" card**
More than once per week **3 or more days in a row**	or	**Further assessment and more intensive treatment***

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

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

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

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

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

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

B. WHO ASSIST V3.0 RESPONSE CARD FOR PATIENTS

Response Card - substances

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

Response Card (ASSIST Questions 2 – 5)

Never: not used in the last 3 months

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

Monthly: 1 to 3 times in one month.

Weekly: 1 to 4 times per week.

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

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

C. ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (WHO ASSIST V3.0) FEEDBACK REPORT CARD FOR PATIENTS

Name_____ **Test Date** _____

Specific Substance Involvement Scores

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

What do your scores mean?

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

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

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

Are you concerned about your substance use?

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

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

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

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

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

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

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

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

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

D. RISKS OF INJECTING CARD – INFORMATION FOR PATIENTS

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

This harm can come from:

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

❖ **It is safer not to inject**

❖ **If you do inject:**

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

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

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

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

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

E. SHORT-GERIATRIC DEPRSSION SCALE

II-2. Short-GDS Scale

Think about how you have felt over the <u>past</u> <u>week</u> and respond yes or no to the following:	
1. Are you basically satisfied with your life?	Yes ☐ **NO** ☐
2. Have you dropped many of your activities and interests?	**YES** ☐ No ☐
3. Do you feel that your life is empty?	**YES** ☐ No ☐
4. Do you often get bored?	**YES** ☐ No ☐
5. Are you in good spirits most of the time?	Yes ☐ **NO** ☐
6. Are you afraid that something bad is going to happen to you?	**YES** ☐ No ☐
7. Do you feel happy most of the time?	Yes ☐ **NO** ☐
8. Do you often feel helpless?	**YES** ☐ No ☐
9. Do you prefer to stay at home, rather than going out and doing new things?	**YES** ☐ No ☐
10. Do you feel you have more problems with memory than most?	**YES** ☐ No ☐
11. Do you think it is wonderful to be alive now?	Yes ☐ **NO** ☐
12. Do you feel pretty worthless the way you are now?	**YES** ☐ No ☐
13. Do you feel full of energy?	Yes ☐ **NO** ☐
14. Do you feel that your situation is hopeless?	**YES** ☐ No ☐
15. Do you think that most people are better off than you are?	**YES** ☐ No ☐

Scoring: Score 1 point for each CAPITALIZED YES or NO response above.

0-4 points - Suggests None or mild depression

5-9 points - Suggests moderate depression warrants a follow-up interview

10-15 - Highly indicative of depression. Requires referral for appropriate follow-up and treatment.