

Brief Intervention Guide

**Addressing risk and harm related to
alcohol, tobacco, other drugs and gambling**

Matua Raki 2012

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Foreword

Greetings, Kia ora, Talofa lava, Malo e lelei, Kia orana, Fakalofa lahi atu, Ni sa bula vinaka, Namaste.

Brief interventions can encourage change for people who are at risk of harm or who are experiencing harm related to alcohol, tobacco, other drugs and gambling. A well conducted timely intervention can have a significant positive impact.

Matua Raki, the national addiction workforce centre, has produced this guide to respond to the needs of non-specialist addiction workforces. This includes professionals in other areas of health such as primary care and mental health as well as those in corrections/justice, education and social services. Staff in these settings often have ongoing relationships with the people using their services and this allows for the development of rapport and understanding of the issues service users face. They are therefore well placed to provide brief interventions to people who may be experiencing problems related to alcohol, tobacco, other drugs or gambling.

Our objectives in producing this resource were to clarify the purpose and content of brief intervention and to provide guidelines to support its implementation in a range of settings. We have also highlighted the role of organisational leaders, in recognition that successful brief intervention relies on a well-prepared and supported workforce operating within a well-managed organisational context.

Matua Raki recognises that every context for brief intervention is different and we emphasise that this Guide is not a simple recipe for providing brief intervention. Our aim is to outline the basic requirements to support workers and organisations so that they can tailor their own brief intervention approach to suit the needs of their service users and their service setting.

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Raine Berry
Director, Matua Raki
June 2012

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Introduction to the Guide

Who is the Brief Intervention Guide for?

The *Brief Intervention Guide* has been developed as a resource to assist workers to provide brief intervention to address risks and harms related to problematic alcohol, tobacco and other drug use and gambling. Additionally it is a resource to assist organisational leaders to set up and implement the processes necessary to support workers to provide brief intervention.

The *Brief Intervention Guide* is aimed at professionals who do not specialise in the treatment of alcohol, tobacco, other drug use and/or gambling problems. Within the terms of this Guide, the term “brief intervention” refers specifically to an intervention carried out by professionals not from the addiction sector.

The Guide aims to clarify what brief intervention is, where brief intervention sits in the spectrum of intervention and to address a lack of guidance available to those working in social and justice service settings, for example, social workers, probation officers, cultural workers, community workers, counsellors, nurses and psychologists. The Guide may also be useful for those working in primary and other health settings.

Sections within the Guide

The first six chapters of the *Brief Intervention Guide* focus on practical “how to” instruction aimed directly at the person (the worker) providing the intervention, building on their overall professional values, knowledge and skills. There is an assumption that the worker undertaking the intervention is bound by an appropriate code of ethics. It is also expected that workers have an appropriate level of cultural fluency to engage and work effectively with Māori and Pasifika people. See *Cultural considerations and brief intervention* (p 25).

The final chapter, *Brief intervention requirements at an organisational level*, outlines the key steps that organisations need to undertake in order to support brief interventions being implemented in a service. This section is aimed at managers, leaders and others who are responsible for an organisation.

Appendix 1 lists resources specifically developed for primary health care settings and Appendix 2 lists readily available alcohol, tobacco, other drug use and gambling screening tools.

What is brief intervention?

Brief intervention has many definitions in research literature and practice guidelines. For further information see Alcohol Education and Research Council Alcohol Academy (2010).

In this Guide brief intervention refers to:

A short, purposeful, non-confrontational, personalised conversation with a person about an issue related to alcohol, tobacco, other drug use and/or gambling (i.e. any or all of these).

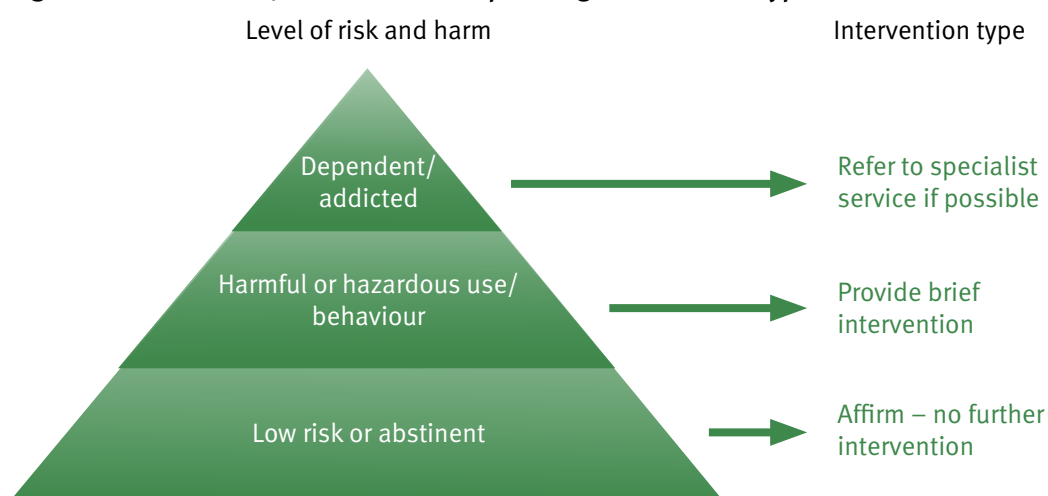
The purpose is to support the person to think about their behaviour, assisting them to make a connection between their behaviour and any associated risks and harms. (adapted from NHS Health Scotland, 2009, and Humeniuk, Henry-Edwards, Ali, Poznyak & Monteiro, 2010b).

From there the nature of the intervention depends on the level of risk and/or harm and the person's readiness to change.

The key word here is brief. Brief intervention generally takes as little as 5 – 15 minutes. This does not take into account the time that is needed to establish rapport and engagement with the person before a brief intervention is carried out. Failing to engage with the person will undermine the effectiveness of the brief intervention.

Brief intervention is most effective for people whose behaviour is hazardous or harmful, in other words people who are at risk of developing or people who are experiencing current harm related to alcohol, tobacco, other drugs and/or gambling. Brief interventions are not designed to treat people who are dependent or addicted although they are considered to be useful to improve motivation to seek more intensive treatment. Those people with more severe problems are likely to benefit from more comprehensive assessment and intervention and the role of the brief intervention worker is to refer this group of people to specialist treatment services for further assessment. Levels of harm and corresponding intervention types are shown in Figure 1 below.

Figure 1. Level of risk/harm and corresponding intervention types



Source: Adapted from *Substance Abuse and Mental Health Services Administration* (2006).

Why offer brief intervention?

Problematic drinking, smoking, other drug use and gambling often contribute to other problems such as legal, health, employment, family-related and financial issues etc. In other words, the issues people present with in social, justice and health service settings are often linked to alcohol, tobacco, other drugs and gambling. Brief intervention provided in these service contexts can have a significant positive impact for service users and can enhance the benefits of the services being provided.

Harms from use of alcohol, tobacco other drugs and gambling

Significant harms to individuals, families, whānau, communities and society arise from the use of alcohol, tobacco, other drugs and gambling. Harms can be health related, social, legal and financial. Examples include:

- Alcohol-related harm in New Zealand is estimated to cost \$5.3 billion per year, or \$14.5 million per day (Alcohol Healthwatch, 2009). Approximately 25% of people who drink alcohol typically drink large quantities when they drink (Law Commission, 2009). A recent NZ report noted that in the previous year one in six adults experienced harm from someone else's drinking (Law Commission, 2010). Alcohol is also closely linked with crime (Wilkins, et al., 2010; New Zealand Police, 2009).
- Tobacco use is the single largest preventable cause of death in New Zealand (Ministry of Health, 2002, cited in Health Sponsorship Council, 2009). On average a regular tobacco smoker in New Zealand will lose 13 years of quality life (Peto, Lopez, Boreham, & Thun, 2006). There are immediate health benefits from stopping for those who are already experiencing harm from smoking and for those who are at risk of harm (Ministry of Health, 2007).
- Cannabis is New Zealand's most widely used illicit drug (Wilkins, Girling & Sweetsur, 2006). A recent survey indicated that 67.1% of cannabis users reported driving under the influence of cannabis in the past year (New Zealand Drug Foundation, 2009).
- New Zealand has the third highest reported proportion of the population using methamphetamine (P) in the world (United Nations Office on Drugs and Crime, 2009). Research indicates that 3.4% of the population (aged 15-45 years) uses methamphetamine, with significant negative impacts on individuals, families, whānau and communities (Wilkins & Sweetsur, 2008).
- Gambling affects one in eight New Zealanders. Each person with a gambling problem affects at least seven others, making this a significant social issue (National Committee for Addiction Treatment, 2010).
- Gambling can be related to criminal activity e.g., a recent New Zealand study suggested that 10,000 people committed illegal activities within the previous year because of gambling (Centre for Social and Health Outcomes Research and Evaluation, 2008). Gambling related crimes can include: illegal gambling, criminal activity to support gambling and family-related offending (Problem Gambling Foundation of New Zealand, 2011).

- Every day in New Zealand \$5.2 million is lost to gambling (Problem Gambling Foundation of New Zealand, 2012).
- In all of the surveys of the harms associated with the use of alcohol, tobacco and other drugs and gambling Māori and Pasifika people are proportionally over represented.

People who have severe substance dependence or who are problem gamblers only make up a small proportion of these statistics. The following quote from the Law Commission illustrates this point:

One-in-five drinkers typically drink enough to double their risk of injury; nearly one-in-three drink over the daily recommended maximum so face a greater than 1:100 risk of dying of an alcohol-related disease or injury.

(Law Commission, 2010, p. 72)

Brief intervention is part of the spectrum of effective responses

The risks and harms arising from alcohol, tobacco, other drugs and gambling go undetected for many people despite their contact with health and social services. For example, in approximately three-quarters of patients presenting to general practice with alcohol related problems the problems are not detected (bpacnz, 2010).

Brief intervention provided in generalist (non-addiction) settings is a key component within an effective spectrum of responses. It is particularly important in those settings where the prevalence of problems is known to be high, for example in criminal justice service settings. To effectively tackle the risks and harms these problems must become the business of all social, justice and health services.

Social workers, youth workers, Probation Officers as well as GPs and practice nurses... have an important part to play in identifying and working to curb risky or hazardous behaviour that might progress to become more problematic. Further, people who have a severe problem but who do not see themselves as having a problem and/or who are not presenting at specialist addiction services may present before these generalists

(Matua Raki, 2012, p. 11)

Brief intervention evidence base

Research indicates that brief intervention can be both effective and efficient for those with hazardous or harmful substance use and/or gambling problems.

The evidence supporting brief intervention is strongest in relation to primary health settings and alcohol use.

Evidence to support the effectiveness of brief intervention for other drugs and gambling is emerging and beginning to provide guidance for further development (National Committee for Addiction Treatment, 2007). There is growing support for brief intervention to be provided in other non-health settings, such as criminal justice and social work settings (Bliss & Pecukonis, 2009; Brown, Newbury-Birch, McGovern, Phinn & Kaner, 2010; Hopkins & Sparrow, 2006; McGovern, Newbury-Birch, Deluca & Drummond, 2012). Additionally more guidance and tools are emerging which focus on providing brief intervention to address a wider range of issues.

Key concepts in screening and brief intervention

Screening as a basis for brief intervention

Brief intervention is generally provided after a screening process has been undertaken. The results of a screening process provide an opportunity for a service user to consider the effects of alcohol, tobacco, other drugs and/or gambling on their lives, depending on the scope of the screening.

Screening is not assessment or diagnosis. It is a structured process that provides an indication that a problem may exist and, depending on the tool or questions used, an indication of the potential severity of the problem. The results of a screening process assist the worker to determine whether intervention is required and the level of intervention that is likely to be of most benefit to the person (see Table 1 below).

A screening result that indicates a potential problem must be followed up with a brief intervention, referral to a specialist service or with a more detailed assessment of the problem potentially identified (Matua Raki, 2012).

Table 1: Screening result and level of intervention

Screening result	Level of intervention
No problem indicated	Provide positive affirmation. Offer information to support continued no/low risk
Hazardous or harmful use/behaviour indicated	Provide brief intervention
Possible dependence or addiction indicated	Advise need for specialist treatment and refer to specialist

Screening can occur in variety of ways, from asking simple questions to administering a screening tool. The selection of screening method depends on the purpose or focus of the brief intervention, the population being screened and the setting in which screening takes place. Some screening tools can be self-administered, others are administered by the worker in a collaborative interview style. A standardised screening tool provides more accurate information for the person being screened and can be particularly useful for a generalist who does not have specialist knowledge. A list of commonly used screening tools is provided in Appendix 2. For further information on screening tools refer to Matua Raki (2012) **Screening, Assessment and Evaluation: alcohol and other drug, smoking and gambling** available at: <http://www.matuaraki.org.nz/>

Most screening tools and brief intervention resources have been designed for use within a specific context. For example, in a general health setting it may be feasible to screen opportunistically for a range of potential health issues and to provide brief intervention or further assessment for those issues that the service user is willing to discuss further. Another example is a probation service setting where a screening tool that identifies a range of substances may be a more appropriate tool. Alternatively an organisation may decide to screen for one issue such as alcohol or tobacco smoking as this is more likely to be prevalent within the population served and/or is more feasible in the service context. Information to guide selection of screening tools is provided in the *Brief intervention requirements at an organisational level* chapter of this guideline.

Before offering brief intervention

Preparation

For the worker embarking on brief intervention it is essential to ensure that approval and support from the organisation is in place. Commitment at organisational governance and management levels is essential to support workers to provide brief intervention.

Once organisational policy, systems and processes are in place minimum preparation requirements for the worker include:

- Familiarity with the selected screening process or processes.
- Understanding of the selected brief intervention systems and processes, including those for referring to specialist assessment and treatment.
- Having the resources needed to support brief intervention, these include self-help materials, handouts, reference materials and a list of local providers for when referral is indicated. (See Box 1).
- Practice screening and providing brief intervention.
- Knowing who to consult regarding any problems that are encountered, e.g. Māori and Pasifika cultural support where appropriate.

Box 1. Resources for brief intervention

Alcohol: The Alcohol Advisory Council's resources such as information brochures, booklets and dvds are of high quality and freely available. It is recommended that workers keep a stock of these on hand to give to people who have issues related to alcohol. Web based self-help material on the ALAC website may also be useful. There is also material aimed to support family and friends concerned about someone else's drinking. The ALAC website is available at: www.alac.org.nz.

See also Kina Families and Addiction Trust, **Living Well**, for families seeking help for alcohol and other drug issues. Available at: <http://www.kinatrust.org.nz>.

Tobacco: The Quitline website, <http://www.quit.org.nz/>, provides excellent resources to support people to quit smoking. It may be useful to print out or order resources such as **The Quit Book** (available on line at <http://www.quit.org.nz/file/new-quit-book.pdf>) which has tips for quitting and staying quit. This book can be the basis for a discussion and tips most relevant to the person can be highlighted for quick reference. Quitline also has the **4Ds** card which people can order and take with them to remember the 4Ds: Delay, Deep Breathe, Do something Else, Drink water. The Quitline website also has a free quit smoking service and a texting service that sends people motivational messages and tips. These can be used in addition to face-to-face services.

Box 1. Resources for brief intervention *(continued)*

ADANZ, www.adanz.org.nz or 0800 787797, provides information, assessment, brief intervention and ongoing support to people who use alcohol and other drugs and their family and whānau members. ADANZ also maintains an up to date online database of specialist addiction services across Aotearoa New Zealand

Other drugs: The New Zealand Drug Foundation website provides information on drug effects and harm reduction for a range of drugs, including cannabis and methamphetamine. The website is available at: <http://www.drugfoundation.org.nz/drug-information/about-drugs>

Gambling: The Gambling Helpline website has helpful information and a range of self-help material, including printable leaflets targeted at identifying a problem, preparing to change, gambling triggers, warning signs etc. More substantial self-help booklets are also available. There is also material aimed to support family and friends concerned about someone else's gambling. This material is available at: http://www.gamblinghelpline.co.nz/Self-help--resources--links_356.aspx

The knowledge base

It is not necessary to be an expert in alcohol, tobacco, other drugs and gambling to provide brief intervention. A basic understanding of risks and harms and a working knowledge of simple interventions to reduce harm, including referral options, are the essential requirements. For example, those providing brief intervention for harmful use of alcohol need to know basic facts and effects about alcohol, standard drink measures, low risk drinking advice for men and women, basic tips for cutting down and stopping and knowledge of specialist agencies to refer people with significant problems to.

Key information is available at the websites listed in Box 1 above.

Training

Training in brief intervention is recommended. Evidence consistently suggests that training increases the rate at which brief intervention is provided (Johnson, Jackson, Guillaume, Meier & Goyder, 2010). There are a number of training providers offering short courses in brief intervention and motivational interviewing. Addiction studies courses at graduate and postgraduate level include screening, brief intervention and motivational interviewing. There are also online training courses and videos available. It is important to check out whether the training offered is sufficiently aligned with the workers and/or organisation's aims and approach.

How to provide brief intervention

Elements of brief intervention: FRAMES

Regardless of the approach to brief intervention, there are key elements that apply in all contexts. These can be summarised by the acronym FRAMES:

Feedback: about personal risk or level of current harm, as indicated by the screening process.

Responsibility: responsibility for choices and change sits with the person. It is not the role of the professional to confront or persuade. Respect the person's autonomy.

Advice: increase the person's awareness of the costs and consequences of their behaviour and provide advice to support positive change.

Menu: outline options or strategies to support positive change; help with goals and action planning if appropriate to the person.

Empathy: listen and reflect; maintain rapport; use an empathic communication style.

Self efficacy: convey optimism and strengthen the person's self belief in their ability to change.

FRAMES does not describe stages of brief intervention. The elements in FRAMES are not presented in order. Rather, **F**, **A**, and **M** describe WHAT is provided in brief intervention; **R**, **E** and **S** describe HOW brief Intervention is provided (NHS Scotland, 2009).

The elements in FRAMES can be applied to working with young people (Christie, 2008a).

Motivation and brief intervention

It is useful to have an understanding of the 'stages of change' model and motivational interviewing as a background to providing brief intervention (Prochaska & DiClemente, 1983). However it is important not to be overly concerned with assigning people to a stage of change and applying specific motivational techniques. Having a general understanding of the stages of change can help the worker listen for readiness to change and ensure that their response is in step with the person.

Applying the broad principles of motivational interviewing (see Box 2 below) can enhance motivation to change. Attempting to persuade and argue for change can be ineffective and counter-productive. A person who doesn't see their behaviour as

problematic is unlikely to respond to ideas about changing the behaviour. When the worker is out of step with the person resistance is a likely outcome. While responsibility for change sits with the person the worker is responsible for engaging the person and maximising their opportunity to consider change.

There are three broad elements of motivational interviewing that are helpful in brief intervention:

- **Collaboration** (rather than confrontation): the process is undertaken in partnership. The views and experiences of the person are central. Both the person and the worker have expertise to share. The process involves mutual understanding. The person is a primary resource in finding answers and solutions.
- **Evocation** (drawing out rather than imposing ideas): the worker's role is to draw out the person's ideas, goals, plans and skills to make positive change. These are not imposed. The person presents the arguments for change.
- **Autonomy** (rather than authority): the power for change rests with the person. The person determines what and how change will occur.

Box 2. Key principles of motivational interviewing

Express Empathy: show acceptance and develop rapport. Ambivalence to change is normal. The worker listens to and accepts what is important to the person. Empathy and rapport make space for gentle challenge.

Develop Discrepancy: Change is motivated by a perceived discrepancy between a person's current behavior and their important personal goals and values.

Roll with Resistance: Resistance is a signal for the worker to respond differently. Avoid arguing for change.

Support Self-efficacy: If a person believes they can change, the likelihood of change occurring is greatly increased. A person's belief in the possibility of change is an important motivator.

Source: Adapted with permission from Miller and Rollnick (2002).

NB: a revised publication from B. Miller and S. Rollnick, which updates some of the key principles of motivational interviewing, is expected in late 2012.

Bring together the stages of change and a motivational response

A guide to the stages of change (adapted from NHS Scotland, 2009) and associated motivational responses is provided in Table 2 below. Brief intervention is usually focused on people who are in Pre-contemplation, Contemplation and Preparation.

Table 2. Stages of change and motivational responses

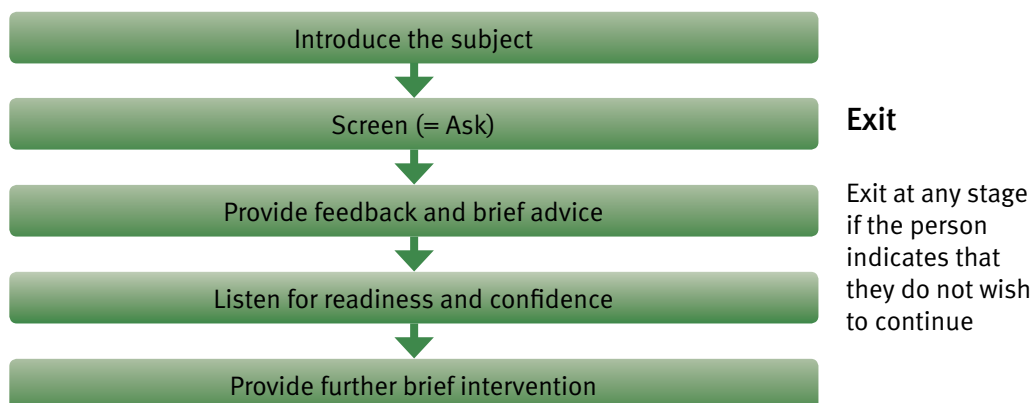
Stage	Response
Pre-contemplation – not thinking about change; don't see a problem <i>"My grandmother smokes and she's 85 and fit as. Smoking is no big deal."</i>	Work towards engendering motivation Provide information and advice (with permission) on the benefits of change
Contemplation – thinking about change; maybe I have a problem; ambivalent <i>"Sometimes I think about all the money I spend on smokes."</i>	Enhance motivation Explore concerns, explore benefits of change
Preparation/decision making – actively planning change <i>"I want to quit."</i>	Provide menu of options Build confidence
Action – making changes, new behaviour not yet established <i>"I haven't had a smoke for eight days. The patches are helping."</i>	Build confidence Affirm success
Maintenance – new behaviour established <i>"I get nervous when I go out with my friends, I might just have a drink and then light up without even thinking."</i>	Build confidence Assist with problem solving and planning
Relapse – return to patterns of old behaviour <i>"I blew it."</i>	Build confidence Enhance motivation

For further information on Motivational Interviewing the Motivational Interviewing website is a good start. This is available at: <http://www.motivationalinterview.org/>

Stages of brief intervention at a glance

The key stages of brief intervention are shown in Figure 2 below.

Figure 2. Stages of brief intervention



Source: Adapted from Center for Substance Abuse Treatment (1999).

Each stage of brief intervention is outlined in some detail below. Objectives, actions and examples corresponding to each action are provided. Relevant elements of FRAMES are shown for each stage.

Examples are provided as simple scripts that the worker can adapt to suit their own style and context. Most of the examples focus on alcohol and tobacco as these are the drugs most widely used in New Zealand. This is not intended to convey that brief intervention should be limited to these issues.

The stages, objectives and actions are provided as a guide only. In practice some may blend and overlap. It may not be necessary to follow each action or stage for every person.

Tips are provided for each stage as a further aid.

Where appropriate, specific tips are provided for working with young people. A comprehensive guide to screening and brief intervention with young people is provided in *The Substances and Choices Scale Brief Intervention Manual* (Christie, 2008a). Those working within youth service settings or within youth focussed roles are encouraged to use this resource which is tailored specifically for working with young people.

Introduce the subject

In a general setting, where a person is not expecting to talk about alcohol etc., introducing the subject can be the biggest hurdle for the worker. Several examples are provided below to cover a range of options for different circumstances. The key is for the worker to be clear, confident and relaxed in talking about these issues and to normalise the process.

Objectives

- › To respectfully obtain consent to explore specific behaviour/s
- › To maintain rapport and convey empathy, regardless of the person's decision to consent or not

Responsibility sits with the person

Empathy: listen and reflect; maintain rapport

Actions	Examples
Ask permission to talk about the behaviour	<p><i>"Would it be ok to have a quick discussion about alcohol? We like to cover this with all of our clients. It's an opportunity to have a think about how alcohol fits in to your life. Do you drink at all?"</i></p> <p><i>"While we're discussing what you like to do with your free time, could we talk about alcohol and smoking?"</i></p> <p><i>"You've mentioned that you were drunk when you got arrested. Could we talk a bit more about where drinking fits in for you?"</i></p> <p><i>"You sound a bit worried about how much you've been drinking lately? Could we talk a bit more about that?"</i></p> <p><i>"We're trying to improve our service and offer people a bit more. We're offering screening for a range of things - alcohol, smoking, cannabis, gambling - we can cover them all or you can choose what interests you. Are you interested in finding out more, it only takes a few minutes?"</i></p>
Explain your role in relation to the behaviour/s to be explored	<p><i>"If you are interested we can work through a few quick questions. We use a process called an alcohol screen. The screen provides you with your personal result. What you do with that information is your choice."</i></p>
Clarify confidentiality issues	<p><i>"We have already discussed confidentiality but I just want to restate that this discussion will be confidential, in the same way as any other information about you."</i></p>
Reinforce and respect the person's choice	<p><i>"It's up to you."</i></p> <p><i>"What do you think you might want to do next?"</i></p> <p><i>"It is your choice whether you want to take up this opportunity."</i></p>

Tips

Your own values and behaviour are not the focus and should not interfere with your efforts to support people to reduce harm from alcohol, tobacco, other drugs and gambling.

When working with people of cultures other than your own ensure that you convey respect for cultural difference. Use cultural support and expertise to assist in providing an effective service. Pay attention to cultural norms in relation to rapport building. Taking the time to effectively engage with Māori and Pasifika people and building a trusting relationship will increase the likelihood of being able to provide an effective intervention.

With young people: It is generally important to develop rapport before you introduce the issues i.e., by talking about topics other than substance use or gambling. Clarity about confidentiality is especially important to develop trust.

Screen

Objectives

- › To gather personalised information about potential levels of risk or harm resulting from selected behaviours
- › To determine whether intervention could be useful
- › To determine the level of intervention that is indicated

Responsibility sits with the person

Empathy: listen and reflect; maintain rapport

Action	Example
Administer the screening tool	<i>“This is the screening questionnaire. Shall we work through the questions together?”</i>
OR	<i>“This is the gambling questionnaire. It will give you an indication about whether gambling might be causing problems for you.”</i>
Ask screening questions	<i>“Do you smoke cigarettes?”</i> <i>“How soon after you wake up do you usually have your first cigarette?”</i>
Score the screening tool	<i>“What we do now is look at your responses and total them up. One of the good things about this is that it’s an objective measure – a bit like a blood test.”</i>

Tips

Be familiar and comfortable with the screening questions and/or tools.

Defer screening when other needs are clearly more immediate, for example, the person is intoxicated, highly agitated, in need of urgent medical attention etc.

Emphasise the objective nature of the tool.

Be sensitive to literacy levels and adjust accordingly e.g. work through the tool with the person.

Be sensitive to language issues where English is not the person’s first language. Ensure this does not become a barrier.

If the person says no or changes their mind mid-way through the process respect their choice and exit the brief intervention process. Consider whether it could be an option to revisit the issue at a later date and if so flag this as your systems allow.

With young people: Use a screening tool or process that has been validated for use with young people, for example The Substances and Choices Scale (SACS) available at www.sacsinfo.com.

Provide feedback and brief advice

Objectives

- › To provide personalised information about levels of risk and harm (the screening results and interpretation of these)
- › To facilitate reflection and review of behaviour
- › To provide tailored advice to assist with reducing risk and/or harm

Feedback: about personal risk or level of current harm, as indicated by the screening process

Responsibility sits with the person

Advice: provide advice

Empathy: listen and reflect; maintain rapport

Actions	Examples
Review screening data in collaboration with the person	<i>“The ASSIST score shows that your drinking is unlikely to cause problems. If your circumstances change, say you are planning to get pregnant, then it would be important to stop drinking. As with many other things, its best to avoid all alcohol during pregnancy to keep the baby safe.”</i>
Check for level of risk/harm: hazardous, harmful or dependent	<i>“The screening test suggests that you are smoking at a harmful level. This means there are risks for your health and the best thing you can do for your health is to stop smoking. There would also be other immediate benefits. I know it is not an easy thing to do. There are a number of options that could help you to quit.”</i>
Give personalised brief advice (as appropriate)	<i>“Given your result, there would be significant benefits if you were to cut down on alcohol.”</i>
Note: encourage referral to specialist service where there is a need for further assessment	<i>“Your score shows that your drinking is well above recommended limits. This is worth getting checked out further and it’s likely to be linked to some of the issues you’re facing right now. I recommend that you see a specialist for an assessment to find out more. I can arrange an appointment for you at CADS, there is no charge for the appointment. At a minimum you will get some more information. What you do with it will be up to you.”</i>

Tips

Brief intervention can stop at this point if there is insufficient time to provide any further intervention.

Check in with the person about how they are finding the process. Make space for them to ask questions.

If the person becomes withdrawn, argumentative or resistant take this as a sign to back up. Avoid arguing and/or persuading, avoid presenting reasons for change, maintain rapport and simply reflect back what the person is saying to you.

If there are indications of dependence or addiction recommend and support referral for further assessment or more intensive assistance.

If there are indications of other health problems, including mental health problems, recommend and support referral to appropriate services.

With young people: look for opportunities to provide positive feedback, focus on their strengths and achievements as much as possible. Avoid the discussion becoming overly problem-saturated (Christie, 2008a).

Listen for readiness and confidence

Objectives

- › To check out the person's readiness to change their behaviour
- › To support consideration of the connection between behaviour, risk and/or harm

Feedback: *about personal risk or level of current harm*

Responsibility sits with the person

Empathy: *listen and reflect; maintain rapport*

Self efficacy: *convey optimism about their ability to change.*

Action	Example
Check out how the person is responding	<p><i>"What are your thoughts about the screening result?"</i></p> <p><i>"It's a lot to take in. Are you surprised about your score?"</i></p> <p><i>"I know you weren't necessarily expecting to be looking at this today, but I wonder what you think about how drinking fits in with some of the other issues that have brought you here today?"</i></p>
Explore readiness to make changes: <ul style="list-style-type: none"> › Does change seem to be worthwhile to the person › Are they confident about their ability to change › Try to elicit change talk 	<p><i>"What are your thoughts at this point? Are there any concerns that you have?"</i></p> <p><i>"Have you considered cutting down on your drinking?"</i></p> <p><i>"Can you think of any benefits if you were to stop smoking?"</i></p> <p><i>"What connections do you see between your drinking and the stresses in your life right now?"</i></p> <p><i>"On a scale of 1-10, if 1 is not ready at all and 10 is totally ready, how ready are you to make changes in your drinking?.... What are some of your reasons for giving this rating?" OR "why did you rate 5 instead of 3?"</i></p>

Action	Example
Reflect the person's views on change back to them	<p>Person is not indicating readiness to change <i>"Thanks for agreeing to check out your drinking. It sounds like right now you can't see any benefits in cutting back on your drinking? If you decide you want to talk about this again, you can let me know. Would it be all right if we talk about it again in a few months time to see if anything has changed for you?"</i></p> <p><i>"From what you're telling me, it sounds as though you are not interested in cutting down your drinking right now. Would it be useful to talk about some ways to make you safer while you are drinking?"</i></p> <p>Person is ambivalent about change <i>"So, if I'm hearing you correctly, you can see that cutting back on drinking would help keep you out of trouble but you can't see your friends letting you get away with it. How do you think things will turn out for you?"</i> <i>"What are the pros and cons with your drinking?"</i> <i>"On balance would it be worth having a go at cutting down?"</i> <i>"What are some things that could help you cut down?"</i> <i>"What are some of the barriers that might prevent you from cutting down?"</i></p> <p>Person wants to change, lacks confidence <i>"You want to stop smoking but you've tried many times and it hasn't worked out. You just don't think you can manage to do it. Would you be interested in looking at some strategies to help with this?"</i> <i>"What would need to happen for you to become more confident to make a change?"</i> <i>"What would be helpful to you at this point?"</i> <i>"You said that you stopped smoking about a year ago? How did you achieve that? Could you use some of the same strategies that were successful then to help with cutting down on drinking now?"</i></p>

Tips
Avoid arguing, persuading and/or presenting reasons for change and maintain rapport.
Respect the person's views and don't assume that the intervention has not been helpful if they choose to close the subject.
Remember responsibility for change sits with the person themselves.
Encourage the person to explore and articulate their own reasons for change.
Listen carefully for what the person is prepared to work on at this time and focus on that.
Use the readiness scale/ruler to quickly elicit change talk. Available at http://www.adultmeducation.com/downloads/Readiness-to-Change_TOOL.pdf
With young people: don't discount or minimise the young person's experiences of the good things about using substances or gambling. Let them talk about the good things before gently guiding/inviting them to explore the downsides. Avoid coming up with the downsides, let the young person tell you from their own experience.

Provide further intervention (as appropriate)

Objectives

- › To facilitate reflection and review of behaviour
- › To support change if the person is seeking change

Feedback: *about personal risk or level of current harm*

Responsibility *sits with the person*

Empathy: *listen and reflect; maintain rapport*

Menu of options: *outline options or strategies*

Self efficacy: *convey optimism about their ability to change*

Action	Example
<p>For people who are considering change or wanting support to change, select an appropriate approach (one or more):</p> <ul style="list-style-type: none"> › Provide information › Goal/s and Menu of options › Build confidence › Enhance motivation 	<p>Provide information: focus on the benefits of change: <i>“Would you like more information? I have a dvd here that you could take home. It might be interesting to hear about some of the benefits other people have experienced after cutting back.”</i></p> <p>Facilitate goal setting and explore menu of options: <i>“Could you consider setting yourself a goal in relation to smoking?”</i> <i>“What are some changes that you are interested in trying out?”</i> <i>“Would it be helpful to look at some options that have been helpful for other people? There are some very effective nicotine replacement therapies available to help people quit smoking, they really improve your chances of successfully quitting. It could be helpful to look at whether any of these are worth trying for you.”</i> <i>“There are lots of options for cutting down on gambling, you are the best judge of what is likely to work for you. Would it be helpful to talk about some ideas and then, if you want to, set a goal for yourself to try out?”</i> <i>“It sounds like the Friday night drinking is your main concern because it is impacting on your performance at Saturday sport. We could explore some practical options and you could make a plan, then if you think it’s worth a go you could try it out. If it doesn’t work out we could look at some other ideas next time we meet.”</i></p>

Tips

Keep it personalised, relevant and achievable. The change goal must be something that is worthwhile and “doable” for the person. Avoid the lure of encouraging goal setting that does not meet these criteria.

Encourage the person to come up with their own strategies and/or explore in detail how strategies will fit into the person’s situation. People are more likely to try things out if they come up with their own ideas.

Spend time looking at a range of options. It is important to convey that there is more than one way to address issues and improve situations. This helps generate self-efficacy.

Listen carefully for what the person is prepared to work on at this time and focus on that.

Important considerations

Cultural considerations and brief intervention

Throughout the process of screening and brief intervention workers are encouraged to be mindful of the social and cultural context of the people they are working with. Effective engagement, assessment and goal setting may be affected by a person's 'ethnocultural identity'. The way a person might identify themselves and 'see the world' may impact on the ways they might express distress; the way in which they might perceive problems or solutions and/or their communication styles. Workers have an important role in ensuring that the people they are working with understand information well enough to be able to make informed choices or decisions. Many New Zealanders have poor health literacy – particularly Māori and Pacific peoples (Ministry of Health, 2010). This may well mean giving some thought to how screening information is interpreted and communicated. Comprehension may be improved by putting it into a relevant context as well as considering the content of any message.

Working with Māori

Engaging with Māori, even briefly (15 minute consultations with GPs for instance), can be enhanced if practitioners apply basic processes which are consistent with mihimihi (introduction) and pōwhiri (engagement) or hui (meeting). The intent of these processes are to structure communication so roles, protocols and the negotiation of a safe space can occur. Within these processes Māori beliefs, values and experiences can be acknowledged and enhance the nature of the relationship.

Whakawhanaunga processes emphasise the establishment of shared connections – perhaps something personal. While this can be quite challenging the benefits can be significant.

Māori participants in a number of studies (e.g. Pitama, Ahuriri-Driscoll, Huria, Lacey & Robertson, 2011) have articulated the benefit of practitioners (including doctors) using Te reo Māori when this has first been initiated by the client, as they saw this use of Te reo Māori as an acceptance of them being Māori.

It is important for practitioners to eliminate jargon. Use common terms to explore the experience of any condition or view of the future – this might clarify what is being communicated.

The importance of mihi whakamutunga (closing) is that it transitions the discussion so that it lays out what are the shared understandings and agreed actions and closes off the spiritual pathways opened at the start.

See: <http://www.matuaraki.org.nz/Takarangi/>, Faatoese, et al. (2011) and Ministry of Health (2010).

Working with Pasifika

Engaging positively with Pasifika people and their families at the first point of contact is critical. Research into best practice for working with Pasifika people in relations to talking therapies indicated that: *“It is likely that unless cultural considerations are addressed at the first point of contact, then effective assessment and therapy are unlikely to eventuate.”* Te Pou. (2010).

It is also important to acknowledge the concept of the tapu space or ‘va’ which is shared among many Pacific cultures and refers to a ‘space that relates’ between people (Ka’ili, 2005). It is the ‘space between’ or ‘relationship that connects’, rather than divides. This relationship should be paramount when working with Pasifika people and their families.

See: <http://www.leva.co.nz/>

Overcoming potential barriers to brief intervention

There are a number of well identified barriers to the provision of brief intervention in generalist settings. The more prevalent of these are outlined below along with some suggestions as to how these barriers can be overcome or managed. These barriers and potential solutions relate to both the organisational level and the worker.

Causing offence: Both workers and organisational leaders are often concerned that service users, who are generally not expecting to be talking about these issues, may be annoyed or offended if they are asked about them. The evidence suggests that this is rarely the case (NHS Health Scotland, 2009).

Within the approach presented in this Guide all issues are raised with empathy and respect for the autonomy of the person and if a person does not want to engage in brief intervention then that choice should always be respected. Such an approach minimises perceptions of judgment and intrusiveness.

Workers are more likely to overcome their concern by actually providing brief interventions, seeing that service users are not offended and seeing the benefits brief intervention can provide. Organisational leaders can support and encourage workers to overcome any initial reservations by ensuring staff have access to training to build their skills and confidence. Leaders can also ensure that staff have access to ongoing supervision and support. Additionally, it is useful to set realistic targets for brief intervention in the early stages, recognising that it may take some time for staff to become sufficiently comfortable to more routinely introduce the subject etc.

The issue of coercion: In settings where service users are facing or undergoing legally imposed sanctions e.g. justice and some social service settings, workers can be concerned about imposing screening and brief intervention.

It is important to note that the principles and stages of brief intervention do not change in these contexts. Respect for the autonomy of the person, empathy and collaboration are integral to brief intervention and help to ensure the intervention is not imposed.

Own behaviour and values: It is not uncommon for a worker who drinks and smokes cigarettes to feel open to being judged as hypocritical in talking with others about these issues.

In this circumstance it is important that workers and organisational leaders are mindful that brief intervention is provided to assist service users to make informed choices. The worker's own patterns of use and behaviour are not relevant and should not be a barrier to providing brief intervention.

Using standardised screening tools and a structured approach to brief intervention will help to ensure that the worker's own values and choices do not prevent them from providing effective brief intervention to service users.

Outside of the scope of worker's role: Some generalists believe that providing brief intervention is outside of the scope of their role. This is understandable as many are not well informed about brief intervention or trained in providing it.

Organisational leaders have a role to play in overcoming this barrier by ensuring that workers are well informed and supporting them to learn about their potential role in brief intervention. It is important to stress that many people who are at risk of or experiencing harm will never see a specialist and brief intervention provided by a generalist may be of huge benefit to them. Increasingly it is recognised that the substantial harms that can arise from alcohol, tobacco, other drugs and gambling make these issues everybody's business. However it is important to consider professional boundaries carefully and to ensure that there is organisational support with approved processes, training and ongoing back up for the provision of brief intervention.

Competing priorities: The demands on time within a service environment may present one of the most significant barriers to brief intervention. It is common to hear workers and leaders comment on the burden of expectations placed on them to address a wide range of issues. This is a challenge for both the worker and the organisation and there is no simple answer. However, focus and commitment at all levels are required to implement and maintain brief intervention.

It is up to the organisation and the worker to determine what services can be provided within resource constraints.

Responding to family and whānau

Resources for family and whānau

Many people are adversely affected by others' alcohol, tobacco, other drug use and/or gambling. Sometimes these effects are identified in the course of health and social service delivery.

There is a range of resources available to assist families including self-help resources such as:

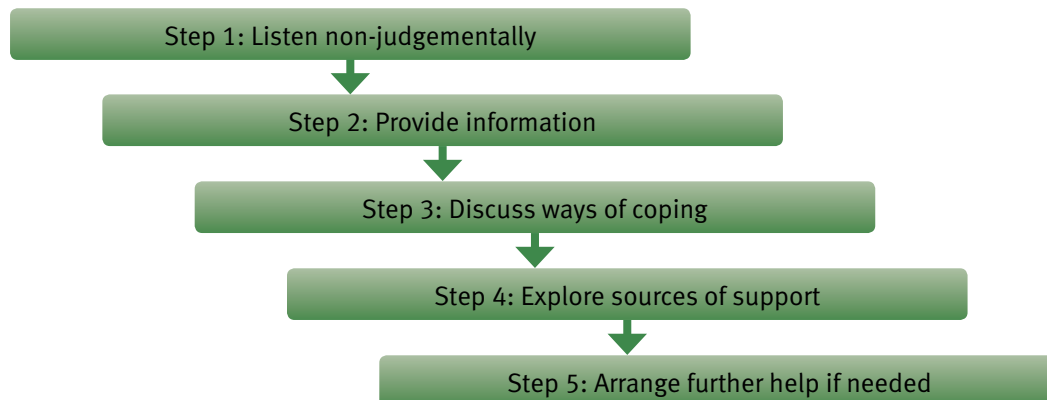
- *Living Well*, for families seeking help for alcohol and other drug issues. Produced by the Kina Families and Addiction Trust.
Available at: <http://www.kinatrust.org.nz>
- *Concerned About Someone Else's Drinking*. Produced by ALAC.
Available at: http://www.alac.org.nz/sites/default/files/useruploads/Resourcepdfs/02209_ALAC_Concerned_About_Someone%27s_Drinking_FA.pdf
- *Concerned About Someone Else's Gambling*. Produced by the Gambling Helpline for families seeking help with gambling issues.
Available at: http://www.gamblinghelpline.co.nz/data/media/documents/Concerned_about_someones_gambling.pdf
- The Quitline has a page for friends and family, containing tips for people wanting to support family and friends to give up smoking.
This is available at: <http://www.quit.org.nz/65/helping-others-quit/friends-and-family>

The 5-Step Method

The 5-Step Method (Orford, Templeton, Patel, Velleman & Copello, 2007) for helping affected family members offers a simple and effective approach for responding to family members. It is a non-blaming approach to working with families and whānau affected by substance use or gambling. It can be delivered by a range of workers in a range of settings. The approach is designed to assist families to develop effective coping strategies and access effective social support.

The 5 steps are shown in Figure 3 and further explained below.

Figure 3 The Five-Step method



1. Listen carefully to the experience of the family member/s to develop an understanding of how they are affected. Explore their concerns. Provide reassurance that others also have these experiences. Convey empathy and non-judgement.
2. Provide relevant information about substance use/gambling/addiction as relevant. Provide information about other relevant issues tailored to the concerns raised e.g. child care, financial assistance etc. Targeted information helps family members to gain a sense of having some control in their lives.
3. Explore coping responses. Research associated with the model has identified three broad coping responses:
 - Engaged – Standing up to
 - Tolerant – Putting up with
 - Withdrawn – WithdrawingExplore the current responses and discuss what is effective and what is less effective? Explore alternatives.
4. Explore social support. Draw a network diagram to determine current support. Work on strategies to increase positive support and decrease negative support.
5. Explore further options for help and support. Check out further needs, provide information, refer as necessary and arrange follow up if required.

Research indicates that families from a range of cultures have found that brief intervention provided within the 5-Step model in a range of settings has helped them to:

- Focus on their own needs.
- Be assertive in communication.
- Calm down and find different ways of dealing with frustration and anger.
- Have a better understanding of the drinking /drug taking behaviour and the links with their own health.

(Orford et al., 2007).

Brief intervention requirements at an organisational level

This section offers guidance to support effective planning, set up, implementation and monitoring of brief intervention within an organisational context. The guidance provided here is generic and will need to be tailored and adapted to the specific conditions within each organisational context.

Evidence suggests that organisational factors can limit or enable implementation of brief interventions (Johnson et al., 2010). Successful implementation of brief intervention programmes is more likely when the programme is championed at management and/or leadership level (McGovern et al., 2012). Commitment at organisational governance and management levels is essential to support workers to provide brief intervention.

The implementation of brief intervention within an organisation is best approached as a project.

Key steps in planning and implementing brief intervention for a large organisation are outlined below. The steps are set out in a chronological order, however in practice they are likely to overlap, particularly the second and third steps. In summary the steps are:

- Project initiation
- Consulting within the organisation
- Project planning
- Implementation
- Ongoing improvement

Project initiation

Key actions at the outset include:

- Developing a project brief (or charter) specifying goals, key objectives, deliverables, resources available, costs, risks and benefits of the project.
- Assigning a project leader to manage and coordinate the implementation of brief intervention.
- Determining if a project team is required to assist implementation (usually this is best, particularly in medium to large organisations) and if so assigning membership and roles.
- Preparing an information sheet on brief intervention (see Box 3 below for suggestions on what to include).

Once these actions above are completed, the implementation of brief intervention should be announced within the organisation. Preferably the announcement is made by a senior person to indicate the importance of the project within the organisation. The announcement can be made via email, staff bulletin, team meeting etc., depending on the organisational communication systems already in place and the size of the organisation.

After the project is announced provide an information sheet to all staff to begin the process of developing a shared understanding of brief intervention and fostering enthusiasm for the initiative.

Box 3. Inform and educate

Provide an information sheet for staff outlining the intention to develop a brief intervention initiative within the organisation, explaining what brief intervention is and why it is a worthwhile activity for the organisation i.e. how it will benefit service users. Ideally, this information is tailored to your organisation and sector.

The information sheet should cover the following:

- › A brief description of brief intervention (as provided in this Guide):
 - › A clear definition, how brief intervention is delivered and who it is most effective for.
 - › A statement emphasising the brevity of the intervention and that it is not addiction treatment.
- › The key reasons for offering brief intervention in your organisation, for example:
 - › Information on the harms associated with substances and/or gambling (depending on the scope of brief intervention in the organisation) as these relate to the service user population.
 - › Evidence for the effectiveness of brief intervention.
- › Information promoting the role of the generalist:
 - › A clear message that brief intervention does not require significant or in-depth understanding of the issue/s and that the issues are everybody's business.
 - › A statement emphasising that brief intervention will potentially provide significant benefit to service users who might otherwise miss out on assistance for their issues.
 - › A brief statement regarding training and support.
- › Contact details of the project leader
 - › Encouragement of questions, comments and ideas.

Consulting within the organisation

Ensure key people within the organisation are informed and involved as necessary. This is a process of both informing and gaining information from various perspectives about the organisational barriers and enablers to implementing brief intervention. Early input from key people can foster engagement and help identify both snags and shortcuts.

It is important that key people and groups within the organisation develop a common understanding of the project including what is likely to be expected of them, how they can contribute and how they will be supported to make their contribution.

Consulting can happen via meetings, telephone and email discussions, providing documents for feedback etc.

It is likely that the following people will need to be consulted with: team leaders, supervisors, trainers (if you have these in your organisation), front line staff likely to be providing brief intervention, human resources staff, IT people, administration staff etc.

In determining who to consult the following could be considered:

- Who is most likely to be delivering brief intervention? Who are the leaders and supervisors of this group?
- Is HR input needed?
- Are there specific IT requirements?
- How will records be kept? Who manages records for the service?
- Will administrative processes need to be adjusted?
- Are there any policy changes required?
- Are there any accounting requirements e.g. invoicing for services provided?

Project planning

Develop a detailed project plan including objectives, structure, processes, milestones, key responsibilities, reporting and costs. A communications plan may be required as part of the overall plan.

The planning should incorporate the following key requirements specific to brief intervention:

- The brief intervention approach and pathway: define this thoroughly i.e. the scope.
- The screening tools (See Box 4 for further guidance on selecting screening tools).
- The steps in the intervention and the timing of these within the business of the organisation.
- Referral sources and resources that the organisation will use.
- The population to be screened and any exclusions.
- Policy and procedures for confidentiality and consent.

Box 4. Key considerations in selecting screening methods

- › **The make-up of the population/group** to be screened: what are the issues that this population may be experiencing?
- › **Whether to screen for single issues or multiple issues:** what is optimal given the needs of service users and the expertise and resources available within the service?
- › **Setting:** what is realistic in the service setting i.e. if office based then computer-based or pen and paper and more in-depth screening may be possible. If in the field (e.g. working with homeless population) there may only be opportunity to ask a couple of key questions with record keeping occurring at a later time.
- › **Systems for responding to screening results:** the level at which the organisation can respond to those whose screening results are positive and in particular those whose results indicate the potential for a significant problem is an important consideration in selecting a tool. Where workers have time and an ongoing relationship with the service user it may be optimal to use a tool that provides information about presence and levels of problem (e.g. AUDIT or ASSIST); where there is limited time a short screen such as AUDIT-C which focuses on the presence/absence of a problem may be more appropriate.
- › **The time available to screen and provide intervention and any associated costs:** what can the service optimally provide?
- › **The expertise of the staff:** what level of knowledge and skill is required to screen and respond appropriately based on the screening result?
- › **The level of management support:** is there management approval for the process? Do management support staff training and ongoing staff support?

- The personnel delivering brief intervention: key considerations will include feasibility within the role i.e. are service users likely to accept brief intervention from those in this role, time available, workload, knowledge, skills and attitudes.
- Training and support requirements: specify requirements to enable personnel to understand and deliver brief intervention and integrate this into their role.
- Administrative systems and IT requirements.
- Data requirements (see Box 5 below) including reporting, monitoring and ongoing quality improvement processes.

Box 5. Data considerations for organisational monitoring

The following measures are suggested for monitoring brief intervention:

- › Number of service users in the brief intervention target population: i.e. the number of people that would be expected to be screened.
- › Percentage screened: i.e. the number of service users screened divided by the number in the target population. It is recommended that a realistic target is set initially.
- › Number and percentage of “positive” screens: i.e. the percentage of service users whose screening results indicate that intervention is required.
- › The percentage of “positives” receiving an intervention (including a subset of those who are referred for specialist intervention).

Source: Adapted from Higgins-Biddle, Hungerford, & Cates-Wessel (2009).

- Review the plan with others in the organisation as relevant. Ensure sign off by senior management.

Implementation

- Ensure the roll out of brief intervention is well notified to all relevant people in the organisation.
- Provide regular communication to encourage, remind and support people at this early stage; for example, thanking people for their work in getting the project off the ground.
- Ensure that help and support is readily available during the early implementation stage to increase uptake.
- Actively monitor implementation and address any issues that arise.

Ongoing improvement

- Gather and provide feedback regarding progress. It is useful to do this on an ongoing basis to keep up the momentum and embed the change in practice.
- Review data and other feedback to determine improvements. Manage the requirements for embedding improvements.

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Appendix 1

Brief intervention guides for primary health care

Primary health care brief intervention guides: alcohol

Anderson, P., Gual, A., & Colom, J. (2005). *Alcohol and Primary Health Care: Clinical Guidelines on Identification and Brief Interventions*. Barcelona: Department of Health of the Government of Catalonia.

American Public Health Association and Education Development Center, Inc. (2008). *Alcohol screening and brief intervention: A guide for public health practitioners*. Washington DC: National Highway Traffic Safety Administration, U.S. Department of Transportation.

Babor, T., & Higgins-Biddle, J. (2001). *Brief Intervention for Hazardous and Harmful Drinking: A Manual for use in Primary Care*. Geneva, World Health Organization.

Primary health care brief intervention guides: alcohol, tobacco and other drugs

Humeniuk, R., Henry-Edwards, S., Ali, R., Poznyak, V., & Monteiro, M. (2010a). *The alcohol, smoking and substance involvement screening test (ASSIST) manual for use in primary care*. Geneva: Switzerland: World Health Organization.

Humeniuk, R., Henry-Edwards, S., Ali, R., Poznyak, V., & Monteiro, M. (2010). *Brief intervention: the ASSIST-linked brief intervention for hazardous and harmful substance use manual for use in primary care*. Geneva: Switzerland: World Health Organization.

Other helpful guides

Center for Substance Abuse Treatment. (1999). *Brief interventions and brief therapies for substance abuse*. Treatment Improvement Protocol (TIP) Series, No. 34. Rockville MD: Substance Abuse And Mental Health Services Administration.

Christie, G. (2008a). *The substances and choices scale brief intervention manual: Complete version*. Werry Centre: Auckland, New Zealand.

Appendix 2

Screening Tools

Further information on all of these screening tools is available from Matua Raki (2012).

- Alcohol Use Disorders Identification Test (AUDIT)
- Alcohol Use Disorders Identification Test – C (AUDIT – C)
- The Cannabis Use Disorder Test – Revised (CUDIT-R)
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- Case-finding and Help Assessment Tool (CHAT)
- Early Intervention Gambling Health Test (EIGHT)
- Problem Gambling Severity Index (PGSI)
- Concerned Others Gambling Screen (COGS)
- Heaviness of Smoking Index (HSI)
- Substances and Choices Scale (SACS)