

**THE SUBSTANCES AND CHOICES SCALE  
BRIEF INTERVENTION MANUAL  
Complete Version**

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Workforce Development

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*The Substances and Choices scale (SACS) and the Substances and Choices Scale Brief Intervention (SACSBI) are available for use by researchers and health agencies that provide services to enhance the health and well-being of young people. They have been designed to be used by health professionals who have an active and ongoing relationship with the recipient of the questionnaire or intervention. This is so that issues around confidentiality can be discussed, and so that appropriate mental health support can be accessed if required. Those involved in developing the SACS do not accept any responsibility or liability for any direct or indirect loss, problems or consequences of any kind arising from the use or misuse of the SACS.*

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## **INTRODUCTION**

### *The SACS as a Brief Intervention*

The Substances and Choices Scale (SACS) is a youth AOD (alcohol and other drug) screening and outcome measurement instrument developed and tested in New Zealand. While researching the acceptability of the SACS, the young people who participated reported (unprompted) that completing the SACS gave them an opportunity to reflect on and consider their own (drug-taking) behaviour<sup>1</sup>.

What the young people reported is part of a brief intervention. Brief interventions involve gathering information about a person's substance use, giving them the opportunity to reflect on their behaviour and providing them with feedback and advice about changing<sup>2, 3</sup>. Potential outcomes from a brief intervention include increasing a young person's awareness of risks, a change in behaviour leading to harm reduction or successfully engaging a young person into longer-term treatment.

If just filling out a questionnaire makes young people think about their substance use behaviour and the harm related to it, then it follows that completing the SACS is an excellent opportunity to perform a brief intervention. A few minutes of targeted advice and support following completing the questionnaire is likely to have an impact in bringing about change.

This manual will give clinicians working with young people some basic skills and guidelines to assist them to perform a brief intervention using the SACS. With increasing familiarity and success with basic AOD treatment, clinicians will gain in confidence, develop their skills and provide more (and better) AOD interventions across a range of services.

### *The structure of this manual*

This manual is divided into ten sections. The first two are introductory and the final eight each cover key skills and knowledge required to conduct a brief intervention. At the end of each of the final eight sections is a summary of the key points covered. These summaries are collected together at the end of the document as a quick reference guide.

Those who already have experience and training in AOD assessment and treatment may want to skip the initial chapters and go ahead to chapter nine which provides a

step by step guide to the SACS Brief Intervention (SACSBI). Alternatively they may want to refer to the SACS Brief Intervention Manual Summary Version.

### *Limitations of this manual*

There are numerous ways to provide effective AOD interventions to young people. This manual describes just one type of intervention that is time limited and client focused. Clearly the SACSBI has limitations and will not be transferable to every clinical situation that presents. However, hopefully it is flexible enough such that clinicians, experienced in providing various treatments across the developmental spectrum, will be able to apply it in an individualized way to best suit the needs of the young person in front of them.

It may not be appropriate for some cultural groups and those using the manual need to use their judgment to assess this, and if necessary utilise cultural support and expertise to assist them in applying it to their young people.

Although the SACSBI is not a family based intervention, involving family in treatment is often the best way to optimize outcomes in young people. It may be possible for a skilled clinician, experienced in working systemically, to adapt the principles of the SACSBI to use within a family setting and this is certainly encouraged as long as confidentiality and safety issues are addressed appropriately along the way.

## **BACKGROUND**

### *Brief interventions*

Brief interventions are an efficacious<sup>4-7</sup> and low cost means to minimise substance related harm. They are designed to be delivered in an opportunistic way in primary and secondary care settings. In most cases they are recognised as a 10-40 minute therapeutic conversation targeting the harmful effects of substance abuse and the impact it is having on the individual. Advice and education (including self help materials) is provided that is personally relevant to the client<sup>8</sup>. Brief Interventions can be delivered by health workers who may have only limited AOD expertise (i.e. GP's, Child and Adolescent Mental Health Service (CAMHS) clinicians) and as such are an excellent starting point from which to upskill youth health workers in AOD interventions.

### *Adolescent development*

Key developmental tasks of adolescence include establishing independence and autonomy, forming identity, affiliating with peers and achieving legal permission to engage in adult activities such as driving, voting, drinking & smoking. Most adolescents will be exposed to alcohol and drugs at home, at school or at work, or in context of peer group experience. Navigating this exposure to intoxicating and addictive substances safely is a major developmental challenge that teenagers, unfortunately, are having to negotiate earlier and earlier<sup>9,10</sup>.

### *Substance use disorder in New Zealand young people*

The most up to date information about the rates of serious substance use problems (DSM-IV Substance Use Disorder or SUD) comes from Te Rau Hinegaro. This study of the prevalence of mental illness in the New Zealand population found that the 12-month prevalence of substance use disorders in 16 -24 year olds is about 9.5% with 7% fulfilling criteria for alcohol abuse and 3% having alcohol dependence. Nearly 4% had drug abuse (of this cannabis abuse accounted for 3.2%) and 2.1% had drug dependence (of this cannabis dependence accounted for 15%)<sup>11</sup>. The Dunedin Multidisciplinary Health and Development study found that in NZ 18 year olds the prevalence of alcohol dependence was 10.4% and cannabis dependence 5.2%<sup>12</sup>.

### *What is 'typical' substance use in teenagers?*

Categorizing young people's substance use as typical or otherwise is difficult as there is a very indistinct boundary between pathology and normal adjustment. It can be hard to tell the difference between problematic substance use and what might be regarded as typical teenage behaviour. Youth 2000, a cross-sectional survey of NZ secondary school students<sup>13</sup> found that 39% have used cannabis and 8% are using cannabis weekly or greater. 84% have drunk alcohol with 41% reporting having drunk more than 5 standard drinks in one session in the last month. 27% reported being a passenger in the car of a drunk driver in the last month. This shows us that not only is substance use pretty common in young people but much 'typical' teenage substance use behaviour is in itself inherently risky. It is for this reason that all health providers need capacity to deliver brief interventions that aim to minimize substance related harm opportunistically.

### *Co-occurring disorder*

Mental health (and health) services often do not recognise the level of SUD in the young people attending however chances are high that a youth presenting with mental health or health issues will also have substance use issues. At least 40% of adolescents attending mental health services will have a co-occurring SUD although only about 10% is identified by mental health services and even less is treated<sup>14, 15</sup>. The reasons mental health and health workers seldom perform addiction treatment are largely attitudinal and related to unfamiliarity with the work rather than lack of skills or knowledge. Any health worker who has reasonable experience working with young people will have the basic skills required to deliver a brief intervention. Any health worker who is working on a regular basis with young people should be doing brief interventions as a matter of course.

### *What does it take to do a Brief Intervention?*

Before embarking on conducting brief interventions in young people it is useful to examine your own values and attitudes about alcohol and drug use in young people. Should cannabis be decriminalised? Is drug use a health or justice issue? Do young people have too much freedom? Is it the parent's fault? What do you think of the



drinking age? Should young people be allowed to drink at all? Should young people be more discerning in their choice of adult activities to participate in? What's better; harm minimization or abstinence? Do young people act responsibly around alcohol and drugs? Is it realistic to expect young people to use substances responsibly when the adults around them clearly don't?

The point of asking these questions is not that there are right or wrong answers. Nor is it to suggest that you need a certain political stance to do brief interventions. Rather it is simply a reminder to be aware of your own belief systems and prejudices. A non-judgemental approach will be the most effective approach but it is not always easy to convey this, especially when you are talking to young people barely out of childhood who are doing potentially very harmful things. Keep in mind that your own opinion of what young people should and shouldn't do may have an effect on your ability to develop a therapeutic relationship (an interaction that has a positive effect) with a young person. If you want to get a message across, you need to connect in some way with the young person in front of you.

### *Empathy and warmth*

There is good evidence that a warm, empathic and non-judgmental approach facilitates effective interventions. You will be less successful if you impose your own value system on the young person in an authoritative or judgmental way.

If your motivation is to improve the health and well-being of the young person in front of you then you will maximize the chance of this by being empathic and warm.

## THE CHALLENGE OF ENGAGING YOUNG PEOPLE

### *Why is it so hard to access young people?*

Providing AOD interventions for young people is a challenge as they are a diverse, heterogeneous group who usually present at a time of crisis or at the insistence of others (like parents or teachers)<sup>16</sup>. When they do present, they often aren't sure they even have a problem or may not want help for it<sup>17</sup>. If you combine this reluctance about accessing health services with the ambivalence about change that is a feature of most addictive disorders, it is easy to see why getting young people to access help for addictive disorders can be a formidable task.

### *Ambivalence and motivation*

People are usually ambivalent about changing their substance use. This is due to a number of things not least the powerful rewards that maintain substance abuse. If substance use only caused problems, and there was nothing pleasurable, or positive about using, then, obviously, no one would bother with it. It's for this reason that people continue to take substances even though it may be plainly dangerous or potentially fatal.

It is because of this ambivalence that young people are often reluctant about accessing treatment. When young people do present to services, rather than seeking help for personal distress (such as they might for low mood or anxiety or physical problems such as pain) they are likely to be there because of pressure from school, the law, or their parents. Because of this addiction (and other youth) services need to have an engagement focus.

Ultimately AOD treatment is about behaviour change and bringing about a decision to change behaviour is difficult without having individuals and families fully participating and involved in the process. An engagement focus means having a goal of retaining the young person in treatment (if only for a short period). This differs slightly from an assessment-focused process (working out what is wrong and why) that dominates in mental health and health services. Assessment is, of course, a key part of alcohol and drug treatment however a sophisticated assessment, formulation and diagnosis is of little use if the client never returns to the service for treatment. Bear in mind that the process of assessment is more likely to lead to engagement if it is experienced as *for* the young person rather than being *about* them.

*What kind of services should provide brief interventions?*

To access the young people who most need AOD interventions, services need to be flexible, have minimal barriers to access and be able to provide timely (within a few days of referral) interventions. Mobility (going to the young person) helps. Having specific services that can respond in this way is ideal, but not always possible. Working towards service delivery models that encourage engagement (rather than triage) should, however, be a goal of service providers.

Family-focused services offering systemic interventions will in many cases provide effective AOD treatment, however services with an engagement and client-focused approach are also essential and will often be more successful at accessing and engaging young people into a meaningful treatment process. Harmful substance use occurs, for the large part, independent of family life and the risk of family 'finding out' is often a reason that young people are reluctant to seek help. Services should always aim to involve the family in a young person's treatment but need to recognise that this is often best achieved via the young person, and on their terms.

All services (whatever their specialty) need to have the capacity to provide brief AOD interventions in an opportunistic way. If a range of services can provide brief interventions as and when the opportunity arises, this is likely to minimize harmful behaviour in some, build motivation for change in others and increase their chance of accessing longer-term treatments if required.

### ***The challenge of engaging young people***

*To access the young people who most need AOD interventions, services need to be flexible, have minimal barriers to access and be able to provide timely (within a few days of referral) interventions. All services (whatever their specialty) need to have the capacity to provide brief AOD interventions in an opportunistic way.*

*People are usually ambivalent about changing their substance use because of the powerful rewards that maintain their behaviour and young people are often reluctant about accessing treatment. Because of this, addiction (and other youth) services need to have an engagement focus.*

*An engagement focus means having a goal of retaining the young person in treatment (if only for a short period). Assessment is, of course, a key part of alcohol and drug treatment however a sophisticated assessment, formulation and diagnosis is of little use if the client never returns to the service for treatment.*

*Bear in mind that the process of assessment is more likely to lead to engagement if it is experienced as for the young person rather than being about them.*

## **GETTING YOUNG PEOPLE TO TALK ABOUT SUBSTANCE USE**

### *Where to start*

Remember that young people may have never spoken about substances to adults. It's generally useful to start with the assumption that young people will be ambivalent about their substance use. Establish rapport with discussion about 'easy' topics before rushing in and talking about substances. Normalize alcohol and drug use and don't worry about doing this, as substance use is pretty normal among young people. If you don't know the latest drug slang or 'lingo', then just ask the young person to describe in more detail what they are talking about. If in doubt, be yourself, and don't pretend you know about something if you don't. Make sure you have an open and non-judgmental approach.

### *Confidentiality*

Be clear about issues of confidentiality as until you do this, young people may not be totally honest and without a genuine history, you are unlikely to gain useful information. Safety issues, of course, limit confidentiality and you need to assess these from a developmental perspective.<sup>18</sup> Assessment of what is a safe level of parental supervision is likely to be different for a 13 year old compared to a 17 year old. Although family involvement is a worthwhile goal of treatment (as it is likely to improve outcome on a whole lot of levels), remember that in the initial stages of collecting information it may impact on the quality and veracity of the information you obtain.

### *Ask about the good things and less good things*

The useful first thing to ask a young person is 'What are the good things about using?' This helps build rapport and can give you a sense of their motivation or concern. It minimises resistance and will set the stage (and hopefully promote a more honest discussion) when you go on to ask what are the less good things about using? Another useful question is to ask about a typical session or day. Ask for specific details about their hourly routine over a day, the mundane aspects included. Be curious and interested. For example say, 'Tell me about what you do on a usual day/session and

how your drug use fits into this?' This helps keep things non-judgmental and facilitates discussion with a shut down client.

### *Ask open ended questions*

Some positive questions include:

- What are some of the good things about ...?
- People usually use drugs because they help in some way - how have they helped you?
- What do you like about the effects...?
- What would you miss if you weren't...?
- What else, what else...?

Questions about less good things might include:

- Can you tell me about the down side?
- What are some things you are not so happy about?
- What are the things you wouldn't miss?
- Do you have any concerns about?
- Does this stuff ever worry you?

Then you can move on and look back at past experiences

- When did you start using drugs?
- How did you get to now?
- How are things now, compared to then?

And from there, look forward to possible plans and goals

- How would you like things to be?
- If you had three wishes what would you wish for?

### ***Getting young people to talk about substance use***

*Establish rapport with discussion about 'easy' topics before rushing in and talking about substances. Make sure you have an open and non-judgemental approach.*

*Be clear about issues of confidentiality as until you do this, young people may not be totally honest and without a genuine history, you are unlikely to gain useful information. Safety issues, of course, limit confidentiality and you need to assess these from a developmental perspective.*

*A useful first thing to ask a young person is 'What are the good things about using?' This helps build rapport, minimises resistance and will set the stage (and hopefully promote a more honest discussion) when you go on to ask what are the less good things about using? Ask open ended questions.*

## **THE SUBSTANCES AND CHOICES SCALE (SACS)**

### *Screening tests*

AOD screening tests are brief questionnaires that attempt to identify people who are experiencing substance related problems or may be at risk of problems in the future. They can raise awareness of AOD concerns in young people and increase the focus onto AOD interventions. They provide young people with personal feedback about their behaviour and provide a benchmark against which they can measure themselves against their peers (usually a strong motivating factor in young people). Screening also provides information that a young person and health worker can plan change around<sup>19</sup>.

### *The Substances and Choices Scale*

The Substances and Choices Scale is a validated screening test that is highly acceptable to young people and easy for clinicians to use and score<sup>1</sup>. It is a one-page pencil and paper instrument that takes about 5 minutes to complete. Its reliability and validity is equivalent or better than other available youth alcohol and other drug (AOD) instruments. It rates the number of occasions of substance use over the last month and yields a 'difficulties' score out of 20 that can be used to assess morbidity and track progress in treatment. It has been designed to be used in conjunction with The Strengths and Difficulties Questionnaire (SDQ), which is a similar consumer rated tool that measures psychiatric functioning in adolescents. Together the two instruments can provide a broad snapshot of a young person's psychosocial functioning. The SACS is free and easily accessible via the Internet (go to [www.sacsinfo.com](http://www.sacsinfo.com) for more information).

### *When should you use the SACS?*

For young people entering a health service it is recommended that the SACS is used at assessment, during their treatment and at the time of discharge. Even if a young person is accessing a service for reasons other than AOD treatment (diabetes or depression for example), it is still recommended that a screening instrument such as the SACS be used. Because young people access services so rarely (and even more rarely for substance related problems) it's important to use any opportunity that presents to screen for substance related problems.



Feedback from the SACS research included participants report that simply completing the questionnaire made them consider their own (drug-taking) behaviour in more depth. If just completing the SACS helps young people to think in more depth about their use and related behaviour, then taking this opportunity to further explore their use and plans goals around minimizing substance related harm (conducting a brief intervention) is essential. The SACS can be used as a motivational tool to assist young people to plan towards goals. It is not for use when a client is intoxicated, very distressed, or has active symptoms of severe mental illness.

### *Scoring the SACS*

The SACS is a screening instrument. It does not yield diagnoses and is a guide only. A high score should prompt the clinician to review the individual items on the SACS and is likely to indicate a need for further assessment in these areas. A low score does not rule out problems. Young people commonly under-report their substance use and may not answer the SACS honestly.

### *Section A - The SACS use scale*

Section A of the SACS looks at the number of occasions different types of substance have been used over the last month. Remember this is a record of the number of occasions of use but not of how much is used on each occasion. This scale has not been validated but is a useful guide to the young person's amount and range of use. It is often enlightening for a young person to see the extent of their use written down and described. This question can lead to further discussion about the patterns of use (such as bingeing), the amounts used and comparisons with recommended safe drinking levels (in the case of alcohol).

### *Section B - The SACS difficulties score*

Section B incorporates the SACS difficulties score and has been validated. As such it is a reliable and valid indication of a young person's current substance use issues compared to community norms. This part of the questionnaire is summed to yield a SACS difficulties score out of 20. Not true items are scored 0, somewhat true 1, and definitely true, 2. Try to score the SACS difficulties scale with the young person and use it to prompt discussion with them. Remember to refer back to the actual items on

the questionnaire as these indicate specific areas of concern (such as unsafe sex) and are much more meaningful than a number out of 20.

A SACS difficulties score of 2 and above likely indicates a need for further assessment and/or a brief intervention. Scores 4 and above usually signify problems that are clinically significant and require more in depth interventions. Remember however, that a brief intervention will often be a useful starting point for longer-term interventions and may be all that is possible in a precontemplative client. Scores 6 and above are usually indicative of serious problems requiring a specialist substance use service.

### ***The Substances and Choices Scale (SACS)***

*AOD screening tests are brief tests that attempt to identify young people who are experiencing substance related problems or may be at risk of problems in the future. The Substances and Choices Scale is a validated screening test that is highly acceptable to young people and easy for clinicians to use and score. It has been designed to be used in conjunction with The Strengths and Difficulties Questionnaire (SDQ) and is free and easily accessible via Internet (go to [www.sacsinfo.com](http://www.sacsinfo.com) for more information). The SACS can also be used as a motivational tool to assist young people to plan towards goals. Because young people access services so rarely (and even more rarely for substance related problems) it's important to use any opportunity that presents to screen for substance related problems.*

*The SACS is a screening instrument. It does not yield diagnoses and is a guide only. A high score should prompt the clinician to review the individual items on the SACS and is likely to indicate a need for further assessment in these areas.*

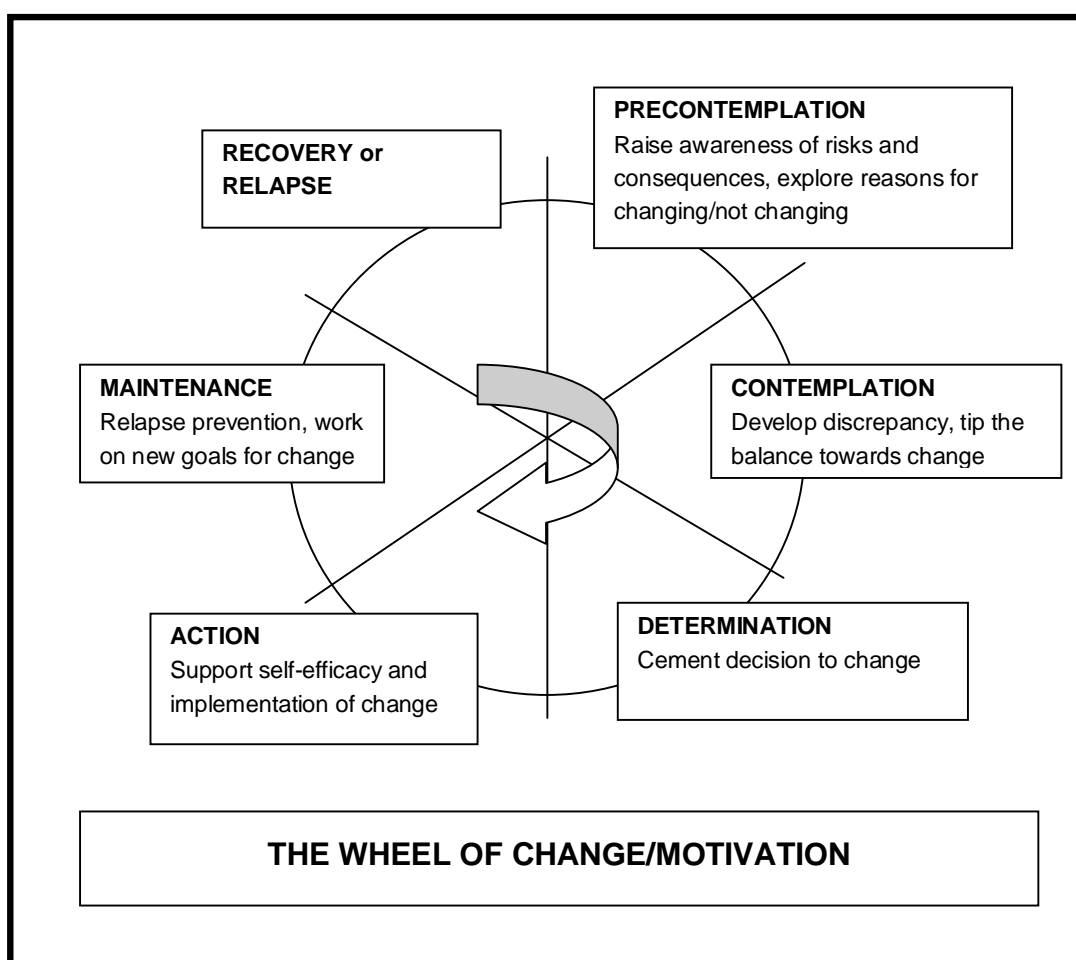
*Section A of the SACS looks at the number of occasions of use of different types of substance over the last month.*

*Section B is the SACS difficulties items and has been validated. As such it is a reliable and valid indication of a young persons current substance use issues compared to community norms.*

## MOTIVATION AND BEHAVIOUR CHANGE

### *Understanding motivation and behaviour change*

Prochaska and DiClemente developed a model of behaviour change that can provide a useful framework for understanding motivation and how people change<sup>20</sup>. Being able to assess a young person's motivation to change can help guide you in the approach you take with that young person. The stages of change are often described as a wheel. See diagram below.



### *Not worried or concerned (Pre-contemplation)*

This is when the client doesn't see that they have a problem or is not concerned. Many young people are likely to be precontemplative about their substance use. They have possibly never considered the potentially harmful aspects of their substance use

and are fairly happy with their level of use. They may see their use as not particularly different from that of their peers and are unconcerned by potential risky behaviour or health risks. They are unlikely to want to change or see any need to do so.

Telling young people in this stage, to suddenly change what they are doing is likely to be ineffective. More useful is providing information about potential risks and problems associated with their use. For example letting a young person know that sharing cannabis is, in the eyes of the law, 'supply' and a serious criminal offence is usually news to young people. If this kind of information is delivered in a non-judgmental manner, it creates awareness of the risks of substance use and helps 'develop discrepancy' which is the first step on the way to changing behaviour.

### *Thinking about change (Contemplation)*

This is where the client is concerned or worried and is thinking about or considering changing. Young people in this stage may have some awareness of the problems associated with using substances and can see both the good things and the not so good things about their substance use. They may be contemplating changing but may not know how to, or may feel they are incapable of changing.

When working with young people in this stage you are aiming to 'tip the balance' in favour of them deciding that changing is worthwhile and that they are capable of change. Interventions might include providing information about their substance related risks or exploring the good and not so good things about their use with the aim that they find out their own reasons to cut down or stop their substance use. The idea is that you elicit (from them) their own reasons for change. Providing young people with reasons why *you* think it would be worthwhile changing are less likely to be persuasive. It's really important that you reinforce to the young person that they are in control and are able to do it.

### *Planning change (Determination) and making change (Action)*

Some young people will be presenting at a time when they want to change and are actively seeking help and assistance around how to achieve this. They may be abstaining or cutting down, or are trying to work out ways to do this. Remember that young people in this stage are still likely to feel somewhat ambivalent about changing, and will perhaps miss things about their substance use or regret some aspects of their

decision. They will need lots of encouragement and support to maintain their decision to change.

Strategies for young people in this stage might include deciding on goals for changing risky substance use behaviours and looking at different strategies to help with cutting down or abstaining from substance use.

### *Keeping the change (Maintenance)*

In this stage the young person is attempting to maintain the changes that they have already made. In young people who have been dependent on substances (addicted) and are trying to stop using, this can be very difficult, however this may not be so for other kinds of change. For example the young person may make a decision to no longer drive drunk, which is a largely an issue of convenience, rather than battling against the reward and reinforcement of addiction.

When someone is in the maintenance stage it is useful to try and get the young person to identify situations where they might be at risk of relapse and strategise around how best to manage these situations safely. Young people in this stage will need encouragement in their efforts and affirmation that they are doing well.

### *The worker's task*

Consider where the young person is in terms of their motivation when planning treatment goals.

For those who are precontemplative or contemplative you should aim to:

- Increase their awareness of the risks and consequences of their behaviour
- Explore reasons for change
- Explore the problems associated with not changing

For those who are in the determination and action stages you can be more ambitious and aim to:

- Cement their decision to change
- Enhance their belief they are capable of change
- Provide options for change
- Help set goals and promote commitment to change

## ***Motivation and behaviour change***

*Being able to assess a young person's motivation to change can help guide you in the approach you take with that young person. The stages of change are often described as a wheel with people moving back and forth depending on their current circumstances.*

- *Precontemplation is when the client is not worried or concerned about their substance use or don't see they have a problem.*
- *Contemplation is when the client has some concerns and is thinking about change.*
- *Determination and Action stages reflect when a client is planning or making change.*
- *Maintenance is when a client has made healthy change and is trying to keep it.*

*For those who are precontemplative or contemplative your need to aim to:*

- *Increase their awareness of the risks and consequences of their behaviour*
- *Explore reasons for change*
- *Explore the problems with not changing*

*For those who are in the determination and action stages you can be more ambitious and aim to:*

- *Cement their decision to change*
- *Enhance their belief they are capable of change*
- *Provide options for change*
- *Help set goals and promote commitment to change*

## **A MOTIVATIONAL APPROACH**

### *Motivational interviewing*

Motivational interviewing is a practical skill that can be used in a range of settings for therapeutic situations where a person is ambivalent about changing a behaviour<sup>8, 21</sup>. It is a tool that promotes change and as a rule it is best utilised for people who are either precontemplative or contemplative (and sometimes for those in the determination stage)<sup>22</sup>. Although a motivational approach may be, at times, useful for those in action and maintenance stage, the most useful therapeutic approach for people who have already decided to change will be cognitive behavioural strategies.

### *A motivational approach*

It is beyond the scope of this resource to provide information about how to do motivational interviewing and in any case there are plenty of excellent resources that can be accessed for further reading<sup>8</sup>. It is, however, important to know that one doesn't have to be an expert in motivational interviewing to conduct a brief intervention. Indeed it is possible to perform one with no knowledge of a motivational approach whatsoever. But a brief intervention is much more likely to be successful if a motivational approach is used. Some of the key principles (as they might be practically applied within a brief intervention setting) are detailed below.

#### **1. Be warm and empathic**

Be accepting and respectful. Don't judge or preach. Be understanding and encouraging. Do your best to make the young person feel comfortable and at ease. Make sure you are doing no more than 50% of the talking. If you find yourself doing all the talking, ask yourself whether your young person is just 'going through the motions' of agreeing with you.

#### **2. Challenge gently**

In a brief intervention you are likely to only have a limited amount of time with your young person and you need to make the most of the opportunity with them. This may mean challenging them, especially if their use is harmful. The skill in a motivational approach is doing this in a non-threatening and gentle manner. This can be particularly difficult with adolescents who may not be used to talking about substance use with adults and may be defensive.

While increasing the young person's awareness of risks and consequences, aim to give them an experience of evaluating the pros and cons of a behavior (or even better, of changing a behavior). One way to do this is to play the role of a detective who is trying to solve a mystery but is having a difficult time “Hmm... Help me figure this out. Sometimes when you smoke cannabis during the week you find it really hard to concentrate at school. But you also want to do well at school so you can get that apprenticeship?” In doing this you are highlighting the discrepancy between important value and their behavior. Showing this to young people, or even better, getting them to realize it and show it to you, is a cornerstone of changing motivation.

### **3. Avoid argument and 'roll with resistance'.**

Challenging a young person about their behaviour is different from arguing with them, which will almost certainly be unhelpful. Remember that there is a significant power imbalance in the relationship between the two of you. This is related to the fact that you are an adult and a professional, and the young person is 'just' a teenager who may or may not be in trouble. Whatever the situation, the chances of a young person arguing with a health worker are very low, thus you need to be aware of more subtle signs of 'resistance'. If your young person starts agreeing with everything you say, or stops talking, or their body language suggests they are withdrawing from the interview, then you need to back off and shift the focus of the interaction. Acknowledge that they are ultimately the ones who will make decisions about their health and well-being and that you can't do this. Emphasising personal choice & control is likely to bring about change. Confrontation, on the other hand, will increase defensiveness & resistance, make them even more wary of health professionals, and jeopardise future interventions around substance use and other aspects of their healthcare

### **4. Support self-efficacy**

This essential component of a motivational approach is about reinforcing to young people the fact that they are capable of change and indeed responsible for it. At the same time it is important to be optimistic. Show belief in their capacity to change. For adolescents, who may be using substances as a means to assert their individuality and/or rebel against authority, the value of this can not be overemphasized. Although young people may feel they have unreasonable restrictions on their lives or freedom, their substance use is most likely to be



occurring beyond the touch of any societal or parental controls. Acknowledging self-responsibility in their substance use is acknowledging reality, as in the end they are the only ones who can control it.

#### *A motivational approach - Do's*

- Use the language of the young person, don't put words in their mouth
- Explore the young person's expectations/concerns about change
- Let the young person think up their own reasons for change
- Emphasise personal choice and self-responsibility for deciding future behaviour
- Reflect concerns, feelings and statements that support change and minimisation of harm
- Reflect by summarising and paraphrasing

#### *A motivational approach - Don'ts*

- Lecture or assume an authoritarian role
- Talk too much, get into debates or prescribe solutions
- Tell clients they have a problem

#### *How to give advice*

- Offer relevant new information in a neutral, non-judgmental manner
- Ask permission to talk about their behaviour 'Do you mind if we talk about ...?'
- Say... 'What do you know about the effect of cannabis on concentration?' rather than 'Do you know cannabis can impair your concentration?'
- Explore the personal significance 'I don't know if you are concerned about...'

### ***A Motivational Approach***

*A brief intervention is much more likely to be successful if a motivational approach is used. Some of the key principles of a motivational approach (as they might be practically applied within a brief intervention setting) are:*

- 1. Be warm and empathic*
- 2. Challenge gently.*
- 3. Avoid argument and 'roll with resistance'.*
- 4. Support self-efficacy*

## **BRIEF INTERVENTIONS**

### *Background*

Brief interventions are well recognised in the addiction field as an efficacious and cost-effective means to minimise substance related harm<sup>3, 6</sup>. They help to identify current or potential problems and can motivate young people to change their behaviour.

Brief interventions are designed to be delivered in an opportunistic way in primary and secondary care settings. Although brief interventions are usually not intensive or comprehensive enough to treat young people with serious substance use problems, they can help motivate young people into considering more appropriate treatments, especially if their experience of brief intervention is a positive one.

There is good evidence for the effectiveness of brief interventions for alcohol and tobacco dependence in adults and there are promising results from studies into the effectiveness of brief interventions for other substances. The evidence for the effectiveness of brief interventions in young people is developing but also promising.

Brief interventions cost little to administer and are easily learned by health workers. They are designed to be used opportunistically, as and when the need and opportunity arise. As such they are an ideal way to access youth populations who tend to access health care reluctantly and are difficult to engage into longer-term treatments.

### *What is a brief intervention?*

In most cases a brief intervention is recognised as a 10 - 40 minute therapeutic conversation targeting the harmful effects of substance abuse and the impact it is having on the individual. Advice and education (including self help materials) is provided that is personally relevant to the client. Brief interventions are flexible however and can range from 10 minutes of discussion to a number of sessions of therapy.

How a brief intervention proceeds will vary depending on the circumstances however one example of a process that might occur is as follows:

1. A clinician asks a young person about the positive aspects (of their substance use)
2. Then asks about 'not so good' things

3. Together they weigh up the pros and cons of change and the pros and cons of not changing
4. The clinician then asks the young person for a decision
5. And together they plan a short-term realistic goal

In the next chapter we will demonstrate how you can perform a brief intervention using the SACS.

### *What is it about a brief intervention that works?*

The central components of a brief intervention that research has shown to be effective<sup>3, 8</sup> are summarized by the acronym **FRAMES** as follows:

- **F**eedback about risk
- **R**esponsibility is with the individual
- **A**dvice and educate
- **M**enu (provide a) of strategies and options
- **E**mpathic approach
- **S**elf-efficacy and optimism are emphasized

## **FRAMES**

### **Feedback about risk**

Feedback about risky behaviour or levels of use needs to be personally relevant and resonate with concerns the young person might have. Lecturing a young person about a behaviour you find concerning but they don't is unlikely to be helpful. Feedback needs to be based on information you have collected about the young person's drug use and associated problems. This might come from a formal mental health assessment, from another assessment such as a HEADSS assessment, from questions you ask or from a screening instrument such as the Substances and Choices Scale (SACS). For the purposes of this manual we will be concentrating on how to conduct a brief intervention in conjunction with the use of the SACS screening instrument.

### **Responsibility is with the individual**

A key principle of effective individual substance use interventions involves acknowledging that young people are responsible for their own behaviour. Although this is often not the underlying philosophy of many youth services (who see parents,

caregivers or agencies assuming some of this responsibility) in the case of substance use, this is usually something the young person does with their peers and out of view of 'responsible adults'. As such, young people are making choices about whether or not to use substances and it is essential to acknowledge this. Reinforcing the fact that people are in control of their use and they can make choices about what they do, has been shown to be a key part of a motivational approach and helps induce behaviour change as well as reducing resistance to change.

### **Advise and educate**

Provide clear advice about the harms associated with continued use in a way that is developmentally appropriate. Young people are surprisingly oblivious to many of the risks that health workers and adults may think are common knowledge. They may be unaware that substance use can lead health or other problems and a conversation about safe-sex, for example, is often extremely informative for a young person and has the potential to minimizing harm substantially. Your approach to providing advice should differ for a thirteen year old compared to an eighteen year old. For example complex abstract concepts are less likely to be understood by a younger teenager. Education for different ages may involve different modalities (drawing versus talking) and be focused on different things. Provide information that is pertinent to the young person's problems at that time and be conscious of over-informing young people about substances they may not already be aware of. Keep to what is relevant in their life as blindly providing 'drug education' can increase young people's interest and curiosity about substance use.

### **Menu (provide a) of strategies and options**

Effectiveness studies have identified providing a range of treatment options as a key part of a brief intervention. Providing choices about different ways to change can make problems seem less overwhelming, help people gain a sense of control, increase their self-responsibility and increase their motivation to change. It helps personalize the intervention for the young person, in that they can choose the intervention that is most relevant for them. It is useful to have written information and self help resources available to facilitate this. Examples of options for young people to choose are discussed later.

### **Empathy**

A non-judgmental approach is essential for engagement of young people and effective interventions. The expectation of young people is likely to be that you, the

adult health worker are going to admonish them or at least be disapproving of their use and tell them to 'Stop!' Fulfilling this expectation is unlikely to create a platform for an honest conversation but will give them permission to make other assumptions about you and get them on the defensive. On the other hand, being understanding, curious (but not prying), warm and empathic is likely to lead to better quality information about their use and associated risks, and will impact on the intervention in a positive way. A warm and empathic style has been shown to lead to reduced substance use at follow-up.

### **Self-efficacy and optimism are emphasised**

Work hard at instilling in young people the belief that they are able to make changes. Achieving self-responsibility and autonomy are key tasks of adolescent development and giving young people confidence in this area is essential. For young people who may be battling against parental or societal boundaries substance use can assume (to them) importance as a statement against authority (i.e. I will do what I want). A health worker needs to work with this and provide the young person with reasons to want to change their substance use (for them). In many cases however, addiction becomes another factor that restricts a young person's freedom, in that their substance use starts to control their life, and this can contribute to a sense of powerlessness. If you believe that a young person can make changes to their substance use behaviour and communicate this to the young person, you will be more likely to elicit change. Research shows that people who believe that they can make changes are much more likely to do so than those who feel powerless or helpless.

### *When do you do a Brief Intervention?*

Whether or not you try to do a Brief Intervention will depend on the motivation and situation in which you are seeing a client. Although there are likely to be any number of different scenarios, many will fit into the following three:

- On those occasions that a client is likely to return - i.e. they have self-referred for assistance with their substance use and have insight and motivation to make change;

*Conduct a comprehensive assessment and plan treatment from that point.*

- On those occasions that it is unclear whether the client is going to come back or not;  
*Conduct a brief intervention but use a motivational approach and focus on engagement. In these cases a brief intervention will be more relevant to the young person (a comprehensive assessment in someone who doesn't see they have a problem is less so), promote engagement and hopefully this will lead to a more comprehensive assessment later.*
- On those occasions that it seems likely that you won't see young person again, for example they are attending purely on account of pressure from outside agencies;  
*Conduct a brief intervention, provide psychoeducation and focus on harm minimisation.*

## ***Brief Interventions***

*Brief interventions are well recognised in the addiction field as an efficacious and cost-effective means to minimise substance related harm.*

*Brief interventions cost little to administer and are easily learned by health workers. They are an ideal way to access youth populations who tend to attend health care reluctantly and are difficult to engage into longer-term treatments.*

*In most cases a brief intervention is recognised as a 10 - 30 minute therapeutic conversation targeting the harmful effects substance abuse and the impact it is having on the individual. Advice and education (including self help materials) is provided that is personally relevant to the client. Brief interventions are flexible and can range from 10 minutes of discussion to a few sessions of therapy.*

*The central components of a brief intervention that research has shown to be effective are summarized by the acronym FRAMES as follows:*

- 1. Feedback about risk*
- 2. Responsibility is with the individual*
- 3. Advise and educate*
- 4. Menu (provide a) of strategies and options*
- 5. Empathic approach is essential*
- 6. Self-efficacy and optimism are emphasized*



## **THE SACS BRIEF INTERVENTION (SACSBI)**

*Ten steps (not twelve)*

To follow are 10 steps that you can take with a young person to perform a brief intervention with the SACS. You may need to adapt them to suit various clinical situations. The key aspects of the SACSBI include providing positive feedback (to avoid the exercise becoming too problem saturated) and choosing one thing to change. If the young person experiences success in changing one thing, this will hopefully generalize to other risky behaviours identified in the SACS. On the other hand, setting a number of goals runs the risk of overwhelming the young person.

### **1. Do the SACS**

Ask the young person if they'd like to do a questionnaire that looks at their substance use, how much they are using and whether it is safe or not. Tell them it is easy to do and that it takes no more than 5 minutes to fill out. Reiterate issues of confidentiality; that it will be going in their confidential client file and is not something that will be publicly available. Encourage them by saying sometimes it is easier to answer questions by writing them down than by just talking. Offer to answer any questions they might have about the SACS.

### **2. Check in**

When they have completed the SACS, check in with the young person how it was filling it out. The questions may have brought up specific matters or questions for them and it's important to address these, or at least note them down so they can be discussed later. Give the young person a time-line so that they have a sense of what you will be doing over the rest of the session. Tell them that you will score the SACS quickly, discuss what the score means in general and then take some time to go over any particular items or questions that they scored in more detail. Let them know that if the SACS brought up any sensitive issues, which they don't want to talk about, that is okay too.

### **3. Score the SACS**

Explain to the young person how the scoring system works and then score the questionnaire with them. The more involved they can be in this process the better. If they become involved in what is a fairly non-threatening process, they are more likely feel comfortable with a discussion about harder issues later. The SACS difficulties score will yield a score out of 20. It may be useful feedback for a young person that scores above 2 usually mean further assessment and intervention may be required, and that scores above 4 usually indicate difficulties that are serious enough to warrant specialist treatment.

### **4. Review and discuss the individual items**

#### *SACS use scale*

Firstly look at the first section of the SACS, which lists the number of occasions of use over the last month. Ask whether the last month was typical for them or whether they have used other substances in differing amounts at other times. Any response indicating use 'nearly every day' needs to be explored in detail. Likewise, responses that show use of a range of substances (more than 1) probably warrant further exploration. When looking at the responses to the alcohol question, make sure you ask further about how much they use on each occasion. Young people usually use alcohol in a binge pattern and even if they are only using once in the weekends, they may be drinking to states of severe intoxication and/or blackout, which is extremely serious and an important area in which to minimize harm.

#### *SACS difficulties scale*

After looking at the first series of items, move on to the SACS difficulties scale. Any positive responses here warrant discussion, however be mindful of the time and try and keep time at the end for setting goals. Ask for elaboration or further information. Are they concerned or do they want to change? Have they considered what they might do? If there are a number of scoring items then try and concentrate on the ones that the young person seems most concerned about, or those that are most concerning. For example if your young person reports unsafe or unwanted sexual contact, this will likely be an important focus.

## **5. Provide positive feedback**

At this point it is useful to provide some positive feedback for the young person, especially for those who have scored reasonably highly. It's unlikely that they will have ticked a box for every risky behaviour, thus you may want to focus briefly on something that they are not doing, or doing well. For example you may note that they are not drinking alone. You may want to reflect on this response and note that for young people using substances is largely a social thing, and those who drink or smoke cannabis alone may be at risk, or in the process of developing problems. If there is little from the questionnaire to feel positive about, you may want to praise them for their honesty in answering the questions.

Review the young person's strengths with them. Remind them of those things in terms of their family and peer relationships, spiritual world, emotional and physical health that make them strong. The important thing is preventing the discussion from becoming too problem saturated. Talking about problems all the time runs the risk of making the interaction a negative one, contributing to feelings of hopelessness about their situation. Remembering to provide some positive feedback during the process of discussing the SACS keeps the focus on supporting self-efficacy and increases confidence to change.

## **6. Choose one thing to change**

Next, try to summarise as best you can the issues you have discussed and then suggest that they choose one of the items, or something else that has come up during the discussion, to change. It might be a risky or harmful behaviour, how they are using or the amount they are using. Ideally it should be their concern rather than yours, however if there is a finding on the SACS that is particularly harmful or of concern then you may want to use a motivational approach to steer the conversation in the direction that you feel would be most strategic. On the other hand, trying to influence a behaviour that they young person has absolutely no concern or awareness of, is unlikely to be successful.

## **7. Brainstorm possible strategies for change**

Once you have chosen something to change, explore different ways that the young person might achieve this. Again, the most successful strategies are likely

to be the ones that the young person thinks of or agrees with, so do your best to elicit ideas from the young person. If this proves difficult, then it is okay to suggest some of your own, however make sure that you make them personally relevant to the young person. So if you are talking about drinking and driving, the conversation needs to be about who in their group of friends would be supportive of taking turns at being a designated driver rather than talking abstractly about the issue. Having a 'menu' of options for change has been shown to be a key part of successful brief interventions so spend some time on this. The process is about more than just finding the right strategy. In doing it, you are promoting self-efficacy, showing the young person that they have a number of options and modelling how to problem solve.

#### **8. Choose a strategy for change**

Once you have come up with a few ideas about how to change or at least some safer choices, ask the young person to decide on which would suit them best, and which they would most likely be able to achieve. Explore the pros and cons of this strategy if possible and look at what are the factors that are likely to increase the chances of it being successful. Likewise you may want to look at those things that increase the risk of it not being successful and plan ahead for this.

#### **9. Agree and commit to a goal**

This step is essentially a summary of the conversation that you have just had with the young person. Revisit the initial thing that the young person wanted to change and why. Then connect it to the strategy that the young person decided they would employ to achieve it. If possible, reformulate this as a specific goal and discuss how the young person might measure their success or otherwise at it. Try to put the goal down on paper if possible and give it to the young person to take away.

#### **10. Emphasize self-efficacy**

Although this should have been occurring throughout the brief intervention, this is an excellent way to wrap things up. Express your confidence in the young

person achieving the goal that you have just set and also in the other challenges that they are likely to face.

### *The SACS Brief Intervention Worksheet*

You may find it useful to keep track of the young person's goal using the SACS Brief Intervention Worksheet – a copy can be found on the SACS website. Using this print out can help with orienting the session and keeping to task. It is also a tangible reminder of the young person's goal that can be given to the young person to take away.

#### ***The SACSBI***

- 1. Do the SACS*
- 2. Check in*
- 3. Score the SACS*
- 4. Review and discuss the individual items*
- 5. Provide positive feedback*
- 6. Choose one thing to change*
- 7. Brainstorm possible strategies for change*
- 8. Choose a strategy for change*
- 9. Agree on a goal*
- 10. Emphasise self-efficacy*

## **SOME NOTES ON HARM REDUCTION**

### *Background*

“Harm reduction is a common sense approach to drug issues which recognises that people do use drugs, and that some people will continue to use drugs no matter what we do to discourage them.”

*(Australian Drug Foundation, 1993)*

“The NZ National Drug Policy’s goal, as far as possible within available resources, is to minimise harm caused by tobacco, alcohol, illicit and other drug use to both individuals and the community.”

*(Ministry of Health, 1998)*

Harm Reduction is a pragmatic approach that accepts that some use of mind-altering substances is a common feature of human experience that carries risks and benefits. No moralistic judgment made in favour or against substance use, rather the key issue is minimising the risk of harms that result i.e. health, social, economic, or many other factors to the individual and wider community. The dignity and rights of the user are respected and strategies to reduce harm include anything that is effective such as reduction or alteration in use and ideally abstinence if possible.

### *Harm reduction in young people*

Harm reduction in young people includes a wide range of strategies and information, much of which might appear to be (and is) common sense. However don't assume that because something is obvious to you, it will be obvious to the young person you are talking to. Providing basic information, for example discussing the risk of sexually transmitted infections (STI's) or potential criminal charges for possession of cannabis, may make a significant impact on the young person's behaviour.

### *Areas of harm reduction to focus on*

To follow are a number of areas in which simple advice or discussion can lead to minimisation of harm.

### **1. Reducing levels of use and abstaining**

Have a discussion about safe levels of use

- 21 standard drinks for men/week (6 at 1x)
- 14 standard drinks for women/week (4 at 1x)
- > 6 joints week = heavy use

Look at the amount they are using on each occasion of use and how they might reduce it. Perhaps reduce the number of occasions of use or time of day of use (postponing use). Have they tried reducing the potency of the substance used i.e. cannabis leaf vs. skunk or beer vs. spirits.

### **2. Changing to a safer mode of use**

Talk about decreasing the intensity of their binges, how they can drink more slowly, or space drinks with water, eating while drinking etc. Discuss the health risks of spotting or bongs as opposed to joints. If they are injecting it is crucial to spend time discussing safe injecting practices or if you don't know about this then encourage (arrange) them to see someone who does. Use of clean needles and a *no sharing ever* policy could literally save their life. Safe cooking up and using wheel filters to remove unwanted debris from a 'fix' (injection) is important information to decrease the risk of infections and other serious blood borne problems.

### **3. Education around decreasing health risks**

Young people will likely know much less about this than you, so even if you don't feel qualified it is essential that you raise the issue and start the process of exploring it with young people, especially those who are injecting drugs. Hepatitis (liver infection) and HIV or AIDS are potential killers that need to be prevented. STI's (sexually transmitted infections) are embarrassing, stigmatising and serious illnesses that can affect young people's fertility later in life. Encourage and support your young person to have an STI check if they have had unprotected sex. Other discussions about health risks might look at the fact that drugs are often cut (diluted) with a variety of inert and dangerous substitutes and having a reliable 'own' supplier can decrease the risk of taking something that is more dangerous than the drug itself. Discuss the dangers of mixing drugs and alcohol, especially in terms of the additive effect of combining sedatives and the risk of becoming unconscious. Simple things like making sure users have adequate hydration and eat healthily may also make a big impact.

#### **4. Environmental factors - planning ahead**

Get your young person to work out ways they can stick with friends when they go out. There is safety in numbers; elect a minder to keep everyone together. Tell someone (preferably an adult - a responsible one) where they going and what the plans are for the night. Make sure they have money for taxi & phones and they keep it separate from the rest of their funds. Discuss the importance of buying their own drinks and the reality of date/drug rape. Encourage them to eat before they go out, as chances are they will forget once they are already out.

#### **5. Environmental factors - driving**

Discuss limits legal (and safe) limits for driving which vary depending on age and license. Plan for use of taxis (i.e. programming a number into your phone, leaving money at home to pay for the taxi when you arrive). Dial a driver services are very helpful for some. Having a designated driver is often the cheapest and easiest way to be safe, so discuss how could your young person could make this work for them. Discuss the issues around avoiding getting into car with drunk driver - it is much harder to get out of a car, or ask a drunk driver to stop once they are on the road.

#### **6. Safe sex**

Provide education around STI's and safe sex and make sure the young person knows how to get further information and free sexual health. If they are sexually active, discuss how they can make sure they always carry condoms and provide them ways to access these. Discuss how to avoid getting into situations that might be risky sexually, and be aware of drug rape and what to do if, while out, they think they might have been drugged (get help immediately before they become too sedated.)

#### **7. Legal information**

Provide information about the legal ramifications of their use including the difference between personal use and supply (giving drugs away is 'supply' and has much more serious consequences than personal use.) Discuss drug charges and the impact of criminal charges on future goals related to overseas travel, university study and future employment. Do they have awareness around drug classifications and the difference between being caught with class A versus class B drugs?



## **8. Mental health problems**

You may want to discuss 'comedown' effects, especially if the young person is using amphetamines or ecstasy and this may also lead into a conversation about anxiety and depression as 'up and down moods' are frequently caused or exacerbated by substances. It can be useful to explore whether the young person has experienced any paranoia or psychotic symptoms while intoxicated by substances and it is essential to warn young people that they are increasing their risk of developing a psychotic illness if they are heavy cannabis users. Make sure they know how to seek help if they have any concerns about their own or a friend's mental health especially if they have had suicidal thinking in the past. If it becomes clear that they are suffering from low mood, suicidal thinking or other mental health symptoms during your assessment then you need to address this urgently.

## **9. Overdose**

The risk of overdose, particularly from combining sedative drugs and alcohol should be discussed. Of specific concern are opiates, solvents, GHB and alcohol. Make sure the young person is aware of how serious it can be, how to be careful about it with regard to themselves and how to recognise it in others. Discuss what to do if they are concerned that someone might be unconscious (i.e. recovery position and call an ambulance) and its useful to debate the pros and cons of getting help versus 'not wanting to get into trouble'. Young people have died in the past because their friends have feared calling 111 and their parents finding out.

## **10. Risks to personal reputation**

Although 'getting out of it' is unfortunately sometimes regarded as acceptable behaviour among young people, teenagers are also usually very sensitive to negative comments and very conscious of their reputation among peers. Talking about the potentially harmful nature of gossip and rumours amongst peers can be motivating especially when a young person's substance use is out of control and leading to embarrassing or shameful activities. Discuss the potential negative impacts of placing potentially incriminating or embarrassing material on the internet via Bebo, Myspace for your young person, especially the effects of having this placed in perpetuity.

## **11. Risks to relationships**

Families often bare the brunt of an individual's substance use problems, increasingly so as the problems become more serious and established. However most young people will still have strong links with their family and their substance use may or may not yet be disrupting it. Exploring the possible ramifications of their substance use on future relationships within their family may be somewhat abstract for many young people, but for those for which is already causing arguments and conflict, this will be something that is on their mind. Likewise peer relationships are very important and substance use that is impacting on these may be seen as harmful for the young person. Personally relevant issues are most likely to lead to change and family and friends are always going to be important issues for teenagers.

## **12. Risks to future life goals**

Although some young people with substance use difficulties may appear unmotivated or aimless, and may be performing poorly academically, remain optimistic. Find out what their aspirations are, promote them and help them reflect on how their substance use might interfere with where they want to be. Discuss the impact of substance use on educational and training opportunities including the fact that criminal charges may interfere with their aspirations. Does their substance use conflict with their value systems in anyway? What is the impact on their family, religion and cultural values?

### *Self-help materials*

Provision of written educational materials is a key part of effective brief interventions and if performing them, do your best to have something on hand to provide for young people to read and take away. You need educational materials that have been designed for young people and generally it is useful if they are pocket/wallet sized as young people are unlikely to carry around large sheets of paper for any length of time. Be careful not to give young people information about drugs that they have not used as this could potentially increase their interest.

## ***Harm Reduction***

*Harm reduction includes a wide range of strategies and information. It's actually anything that aims to minimise the harmful effects of substance use on young people's lives.*

*Potential areas to focus on when trying to reduce harm include:*

- 1. Reducing levels of use and abstaining*
- 2. Changing to a safer mode of use*
- 3. Education around decreasing health risks*
- 4. Environmental factors - planning ahead*
- 5. Environmental factors - driving*
- 6. Safe sex*
- 7. Legal information*
- 8. Psychiatric problems*
- 9. Overdose*
- 10. Risks to personal reputation*
- 11. Risks to relationships*
- 12. Risks to future life goals*

## **COLLATED SUMMARIES**

### **The challenge of engaging young people**

To access the young people who most need AOD interventions, services need to be flexible, have minimal barriers to access and be able to provide timely (within a few days of referral) interventions. All services (whatever their specialty) need to have the capacity to provide brief AOD interventions in an opportunistic way.

People are usually ambivalent about changing their substance use because of the powerful rewards that maintain their behaviour and young people are often reluctant about accessing treatment. Because of this, addiction (and other youth) services need to have an engagement focus.

An engagement focus means having a goal of retaining the young person in treatment (if only for a short period). Assessment is, of course, a key part of alcohol and drug treatment however a sophisticated assessment, formulation and diagnosis is of little use if the client never returns to the service for treatment.

Bear in mind that the process of assessment is more likely to lead to engagement if it is experienced as *for* the young person rather than being *about* them.

### **Getting young people to talk about substance use**

Establish rapport with discussion about 'easy' topics before rushing in and talking about substances. Make sure you have an open and non-judgemental approach.

Be clear about issues of confidentiality as until you do this, young people may not be totally honest and without a genuine history, you are unlikely to gain useful information. Safety issues, of course, limit confidentiality and you need to assess these from a developmental perspective.

A useful first thing to ask a young person is 'What are the good things about using?' This helps build rapport, minimises resistance and will set the stage (and hopefully promote a more honest discussion) when you go on to ask what are the less good things about using? Ask open ended questions.

### **The Substances and Choices Scale (SACS)**

AOD screening tests are brief tests that attempt to identify young people who are experiencing substance related problems or may be at risk of problems in the future. The Substances and Choices Scale is a validated screening test that is highly acceptable to young people and easy for

clinicians to use and score. It has been designed to be used in conjunction with The Strengths and Difficulties Questionnaire (SDQ) and is free and easily accessible via Internet (go to [www.sacsinfo.com](http://www.sacsinfo.com) for more information). The SACS can also be used as a motivational tool to assist young people to plan towards goals. Because young people access services so rarely (and even more rarely for substance related problems) it's important to use any opportunity that presents to screen for substance related problems.

The SACS is a screening instrument. It does not yield diagnoses and is a guide only. A high score should prompt the clinician to review the individual items on the SACS and is likely to indicate a need for further assessment in these areas.

Section A of the SACS looks at the number of occasions of use of different types of substance over the last month.

Section B is the SACS difficulties items and has been validated. As such it is a reliable and valid indication of a young persons current substance use issues compared to community norms.

## **Motivation and behaviour change**

Being able to assess a young person's motivation to change can help guide you in the approach you take with that young person. The stages of change are often described as a wheel with people moving back and forth depending on their current circumstances.

- Precontemplation is when the client is not worried or concerned about their substance use or don't see they have a problem.
- Contemplation is when the client has some concerns and is thinking about change.
- Determination and Action stages reflect when a client who is planning or making change.
- Maintenance is when a client has made healthy change and is trying to keep it.

For those who are precontemplative or contemplative your need to aim to:

- Increase their awareness of the risks and consequences of their behaviour
- Explore reasons for change
- Explore the problems with not changing

For those who are in the determination and action stages you can be more ambitious and aim to:

- Cement their decision to change
- Enhance their belief they are capable of change

- Provide options for change
- Help set goals and promote commitment to change

## **A Motivational Approach**

A brief intervention is more likely to be successful if a motivational approach is used. Some of the key principles (as they might be practically applied within a brief intervention setting) are:

1. Be warm and empathic
2. Challenge gently.
3. Avoid argument and 'roll with resistance'.
4. Support self-efficacy

## **Brief Interventions**

Brief interventions are well recognised in the addiction field as an efficacious and cost-effective means to minimise substance related harm.

Brief interventions cost little to administer and are easily learned by health workers. They are an ideal way to access youth populations who tend to attend health care reluctantly and are difficult to engage into longer-term treatments.

In most cases a brief intervention is recognised as a 10 - 30 minute therapeutic conversation targeting the harmful effects substance abuse and the impact it is having on the individual. Advice and education (including self help materials) is provided that is personally relevant to the client. Brief interventions are flexible and can range from 10 minutes of discussion to a few sessions of therapy.

The central components of a brief intervention that research has shown to be effective are summarized by the acronym FRAMES as follows:

1. Feedback about risk
2. Responsibility is with the individual
3. Advise and educate
4. Menu (provide a) of strategies and options
5. Empathic approach is essential
6. Self-efficacy and optimism are emphasized

## **The SACS Brief Intervention**

1. Do the SACS
2. Check in
3. Score the SACS
4. Review and discuss the individual items

5. Provide positive feedback
6. Choose one thing to change
7. Brainstorm possible strategies for change
8. Choose a strategy for change
9. Agree on a goal
10. Emphasise self-efficacy

## **Harm Reduction**

Harm reduction includes a wide range of strategies and information. It's actually anything that aims to minimise the harmful effects of substance use on young people's lives.

Potential areas to focus on when trying to reduce harm include:

1. Reducing levels of use and abstaining
2. Changing to a safer mode of use
3. Education around decreasing health risks
4. Environmental factors - planning ahead
5. Environmental factors - driving
6. Safe sex
7. Legal information
8. Psychiatric problems
9. Overdose
10. Risks to personal reputation
11. Risks to relationships
12. Risks to future life goals

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# The SACS BRIEF INTERVENTION Worksheet

## MY GOAL

### Stuff I could change

- 1.
- 2.
- 3.
- 4.



### ONE THING I REALLY WANT TO CHANGE

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### Possible ways to change

- 1.
- 2.
- 3.
- 4.



### I AM GOING TO DO THIS BY

---

---

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### My strengths and supports

- 1.
- 2.
- 3.
- 4.



### Things that might trip me up...

- 1.
- 2.
- 3.
- 4.

I'll try and overcome these by...

Family - Whanau

Spiritual - Wairua



Physical - Tinana

Emotional - Hinengaro

## **The SACS BRIEF INTERVENTION Worksheet**

**To follow are 10 steps that you can take with a young person to perform a brief intervention with the SACS. You may need to adapt them to suit various clinical situations.**

- **Do the SACS**
- **Check in**
- **Score the SACS**
- **Review and discuss the individual items**
- **Provide positive feedback**
- **Choose one thing to change**
- **Brainstorm strategies for change**
- **Choose a strategy for change**
- **Agree on a goal**
- **Emphasise self-efficacy**