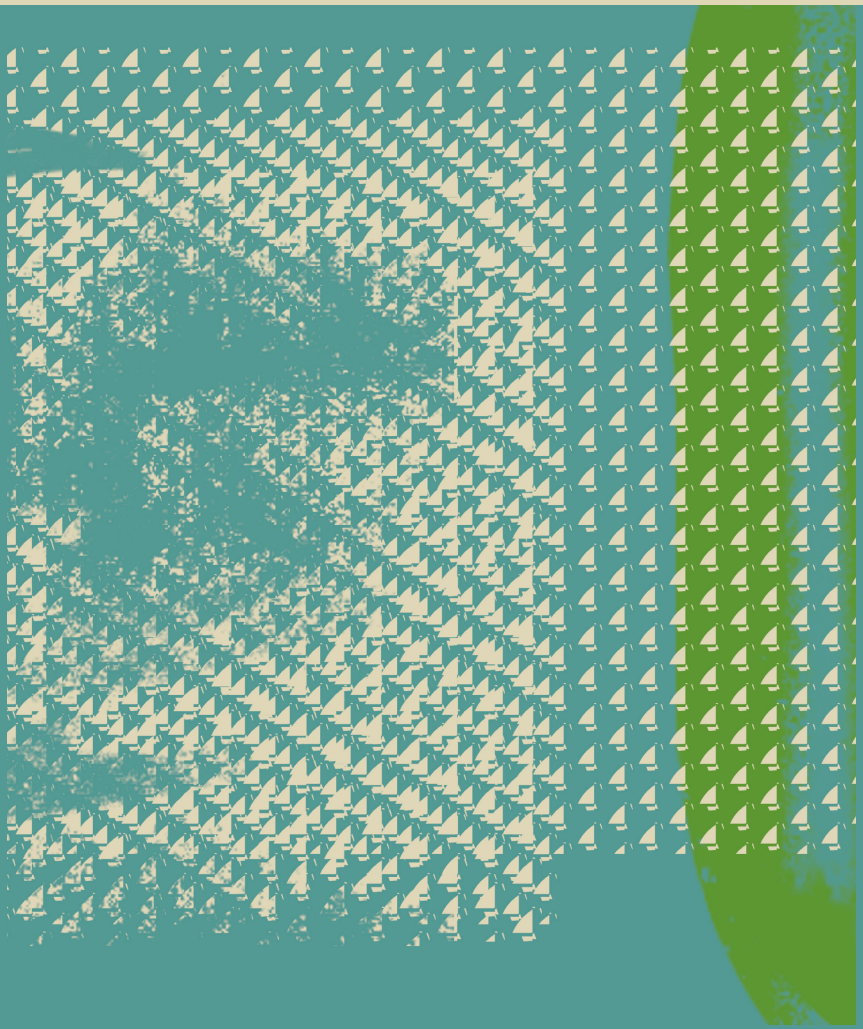
Treatment Manual

Quik FIX

A CANNABIS & Mental Health Resource



Engaging Young People in Treatment for Mental Health & CANNABIS or Alcohol Issues in a Primary Care Setting

ncpic national cannabis prevention and information centre

Orygen YOUTH Health

NCPIC is an Australian Government Department of Health and Ageing Initiative

Quik FIX

A brief motivational interviewing intervention for depression and cannabis or alcohol issues

A TREATMENT MANUAL FOR PRIMARY CARE SETTINGS

DR LEANNE HIDES

Clinical Psychologist & Senior Research Fellow

&

DR STEVE CARROLL

Clinical Psychologist

Orygen Youth Health Research Centre,

Centre for Youth Mental Health, The University of Melbourne.

ACKNOWLEDGEMENTS

Quik Fix was developed by the Orygen Youth Health Research Centre for the National Cannabis Prevention and Information Centre (NCPIC). NCPIC is funded by the Australian Government.

Project Writers:
Dr Leanne Hides
Dr Steve Carroll
Lisa McKay-Brown
Kathryn Elkins

Editor:
Dr Kate Hall
Zoe Shearer

Other contributors:
Associate Professor Dan Lubman
Professor Amanda Baker

Some of the content of this manual was adapted from the following treatment manuals:

Hides, L., Carroll, S., Kay-Lambkin, F., Baker, A. & Bucci, S. (June 2009) Self-help for Alcohol/other drug use and Depression for Young people - Youth Version (SHADEY), 2nd Edition. Orygen Youth Health Research Centre, University of Melbourne and Centre for Mental Health Studies, University of Newcastle

Hides, L., Baker, A., Bucci, S., Kay-Lambkin, F. & Cohen, M. (August 2006) Motivational intervention for substance use among young people with a vulnerability to psychosis, Version 14. Orygen Youth Health Research Centre, University of Melbourne and Centre for Mental Health Studies, University of Newcastle

Address for correspondence:
Dr Leanne Hides
Orygen Youth Health Research Centre
Centre for Youth Mental Health
University of Melbourne
Locked Bag 10
Parkville, Melbourne
Victoria, Australia 3052
Email: lhides@unimelb.edu.au

CONTENTS

PREFACE

Primary health settings are frequently the first point of treatment contact for young people with mental health and substance use issues [1]. It may be the young person's first experience of discussing their mental health issues or substance use with a health professional and they may be unsure or ambivalent about whether they really 'have a problem' or need treatment. Simply because a young person presents at a healthcare service, does not necessarily mean they are ready to engage in treatment or make a change. It is particularly common for young people to resist changing their substance use, particularly when they are unaware of the impact it may have on their mental health. Given this, it is imperative that practitioners in primary care settings have the skills to overcome resistance to change and engage young people in treatment. ***Quik Fix*** provides the framework and tools necessary to engage young people in treatment and motivate them to make changes in their mental health and substance use issues, in order to give them the best chance of achieving their full potential.

INTRODUCTION TO THE *QUIK FIX* INTERVENTION

Quik Fix is a brief motivational interviewing (MI) intervention targeting mental health and substance use issues in young people. The intervention also has a strong emphasis on engaging young people in treatment. ***Quik Fix*** follows best practice guidelines for the integrated treatment of co-occurring mental health and substance use issues, by simultaneously addressing both issues, and their interrelationship. It was designed for allied health professionals as an early intervention program for young people with emerging depression and substance use problems in primary care settings. However, the MI framework of ***Quik Fix*** enables the intervention to be used to address any presenting issue (e.g., peer difficulties, relationship break-up, family conflict, school issues) in any setting.

Quik Fix uses the spirit and principles of MI to: engage the young person; conduct a brief assessment; provide assessment feedback and psychoeducation; build readiness and commitment to make a change; assist the young person to develop a plan for making a change; and provide brief coping skills training to manage the presenting issues.

Quik Fix can be used as a stand-alone intervention but is ideally used as the first step in a stepped care model of treatment, where brief, low-intensity treatments are offered first, followed by more targeted and intensive treatments, contingent on the individuals response to the brief intervention [2]. Primary care settings present a unique opportunity for early interventions like ***Quik Fix*** to prevent the development of severe mental health and substance use disorders.

BACKGROUND LITERATURE

Substance use and mental disorders are the major source of disease burden in 15 to 24 year olds [3]. Epidemiological surveys have indicated that up to 40% of young people will experience a depressive and/or anxiety disorder, and alcohol and cannabis are the most commonly used licit and illicit substances by young people in Australia [4]. Frequent alcohol or cannabis use during early adolescence increases the risk of developing mental health and other psychosocial problems during late adolescence and early adulthood [5]. Conversely, symptoms of depression and/or anxiety during adolescence increase the risk of substance misuse in young adulthood. Prevention and early intervention programs targeted at young people are vital because of the high prevalence of mental health problems at this stage of life [6, 7]. Intervening early prevents the progression of these issues into chronic and severe disorders, as well as the adverse impact of these issues on the achievement of key educational and developmental milestones [8].

There is increasing evidence for the efficacy of face-to-face brief interventions (1-4 sessions) using motivational interviewing (MI) for reducing alcohol and drug use in young people [9], as well as a range of other problem behaviours including treatment compliance, mental health and physical health problems [10]. Most importantly, brief MI interventions have also been found to increase treatment engagement and attendance among individuals with co-occurring mental health and substance use issues [11-13]. Brief interventions can provide a large number of young people with access to cost-effective treatment, and are easily disseminated to a broad range of health professionals across a wide range of settings [14].

While brief MI interventions can successfully be delivered as a stand-alone treatment for clients with mild to moderate mental health symptoms and substance use, they are more likely to be used as a prelude to more intensive treatment for those with more complex or severe disorders, including those at risk of suicide or self-harming behaviours. In mild to moderate presentations, no further intervention may be required if an individual's response to MI is considered sufficient. Young people in need of further intervention can be 'stepped up' to the next level of more intensive interventions. Such stepped care models of intervention, require the treatment outcomes of all individuals to be monitored over a sufficient period of time to ensure they are maintained and booster sessions may be required.

OVERVIEW OF THE *QUIK FIX* INTERVENTION

This treatment manual describes ***Quik Fix***, a 1 to 3 session, 8 stage brief MI intervention for mental health and substance use issues in young people. This manual includes the theoretical framework, practical tools and worksheets necessary to engage the young person in treatment and deliver the intervention.

Quik Fix uses the spirit, principles and skills of MI to:

- Engage the young person
- Help them identify and develop an understanding of their presenting issue(s)
- Provide them with relevant information on the issue(s)
- Increase their motivation and commitment to make a change in their presenting issues(s)
- Develop a plan for making a change
- Enhance their ability to cope with their presenting issue(s)
- Motivate the young person to attend further treatment or follow-up (if necessary)

OVERALL AIMS OF QUIK FIX

1. To engage the young person in treatment
2. To increase motivation and commitment to make a change in the young person's presenting issue(s)
3. To decrease the severity of the young person's depression/anxiety symptoms and substance use and improve functioning
4. To increase the likelihood of the young person engaging in and attending future treatment

WHO CAN DELIVER *QUIK FIX*?

The ***Quik Fix*** treatment manual was written for allied health professionals with a minimum 3 year degree in an appropriate discipline (e.g., psychology, social work, nursing, occupational therapy, counselling), but could easily be used by general practitioners and other health professionals working in primary health care. It assumes clinicians have core engagement, assessment, counselling and crisis management skills and a thorough knowledge of the relevant professional codes of ethical conduct.

Quik Fix is designed to be implemented in a flexible way in order to meet the needs of the clinician, client and treatment setting.

The ***Quik Fix*** treatment manual is accompanied by a one-day training workshop, which covers the theoretical knowledge and skills necessary to deliver the intervention. Some background information is provided throughout this manual, however, it is recommended that clinicians without prior training in MI complete the background reading list in Appendix 1 prior to attending the training session. Clinicians interested in administering the screening tools recommended in this manual are also encouraged to access the background information on the administration, scoring and interpretation of these tools provided in Appendix 2.

This manual is not a stand-alone clinical resource and is not intended to be used by clinicians who have not attended the one-day training workshop. It is strongly recommended that clinicians implementing Quik Fix undergo supervision of their clinical practice to facilitate ongoing skill development. Clinical supervision should be conducted by an appropriately qualified senior clinician with expertise in MI and cognitive behaviour therapy (CBT). It is also recommended that they have experience in the treatment of co-occurring mental health and substance use issues and are familiar with the Quik Fix intervention.

WHAT PROBLEM BEHAVIOURS OR SYMPTOMS DOES *QUIK FIX* TARGET?

Quik Fix was developed as an early intervention program for emerging depression/anxiety and substance misuse in young people. It is suitable for young people presenting with:

- Mild to moderate depressive and anxiety symptoms
- Alcohol and/or cannabis misuse

Quik Fix is an integrated intervention, which simultaneously addresses the young person's mental health and substance use issues. If the young person does not wish to work on both their mental health and substance use issues, then this manual can be used flexibly to address either issue.

Quik Fix can also be used to address any other presenting issue (e.g. peer difficulties, relationship break-up, family conflict, school issues) of mild to moderate severity the young person presents with, as well as their readiness to engage with the therapist and attend treatment

HOW TO USE THE *QUIK FIX* MANUAL

The ***Quik Fix*** intervention is set out in 8 stages. An overview of these 8 stages is presented in the flowchart (figure 1). Rather than a series of sequential steps, the ***Quik Fix*** intervention is delivered in a flexible manner, and movement (back and forth) between these stages is dependent on the young person's treatment response.

The theoretical framework of the ***Quik Fix*** intervention is outlined in the Background Principles section of this manual (page 12). A brief summary of the relevant background principles and materials and preparation required to implement each stage, is provided at the beginning of each stage.

QUIK FIX FLOWCHART

FIGURE 1

Brief Motivational Interviewing (MI) Intervention

Quik Fix can be delivered over 1 to 3 sessions. It proceeds in the following 8 stages

STAGE 1 — **Conduct Brief Assessment & Provide Assessment Feedback**

STAGE 2 — **Provide Psychoeducation**
e.g.*'Feeling Good'*
ask permission first

STAGE 3 — **Explore Motivation to Change – Phase 1 MI Strategies**

If receptive: Explore ambivalence about change and complete a pros and cons balance sheet.

If not receptive: Explore life in general and how substance use and/or depression/anxiety fits in.

> Present strategies of change diagram and rate stage of change for substance use and for depression/ anxiety separately.

STAGE 4 — **Rate Importance & Confidence in Making a Change**

Importance Ruler Score* ≥ *7
If Important to make a change for substance use &/or depression/ anxiety **go on to STAGE 5.**

Importance Ruler Score* < *7
If not important to change substance use and/or depression/anxiety **return to STAGE 3 – Phase 1 MI Strategies.**

STAGE 5 — **Explore Options for Making a Change – Phase 2 MI Strategies**

Ready to Change substance use &/or depression/anxiety.
Go to STAGE 6.

Resistant to change substance use &/or depression/anxiety.
Return to STAGE 3 and offer Harm Reduction handouts.

STAGE 6 — **Negotiate a Change Plan**

If receptive: Go on to STAGE 7.

If not receptive: Return to STAGE 5 – Phase 2 MI Strategies.

STAGE 7 — **Offer CBT Coping Strategies**
(include in change plan)

STAGE 8 — **Summarise the Change Plan and Rate the Young Person's Confidence in Implementing the Plan**

BACKGROUND PRINCIPLES OF THE QUIK FIX INTERVENTION

ENGAGEMENT

Engaging a young person in an effective therapeutic relationship, characterised by collaboration, empathy and genuineness, is instrumental to the achievement of any treatment goals. Often called a 'working alliance', the relationship between client and clinician is characterised by mutual agreement on the treatment goals and plan. Respect for the client's unique perspective on their presenting issues as well as their capacity to change is fundamental to an effective working alliance.

STAGES OF CHANGE MODEL

The stages of change model developed by Prochaska and DiClemente [15] offers a framework to understand the nature of behaviour change. In this model, successful change occurs when an individual progresses through a cycle of 5 stages of change outlined below:

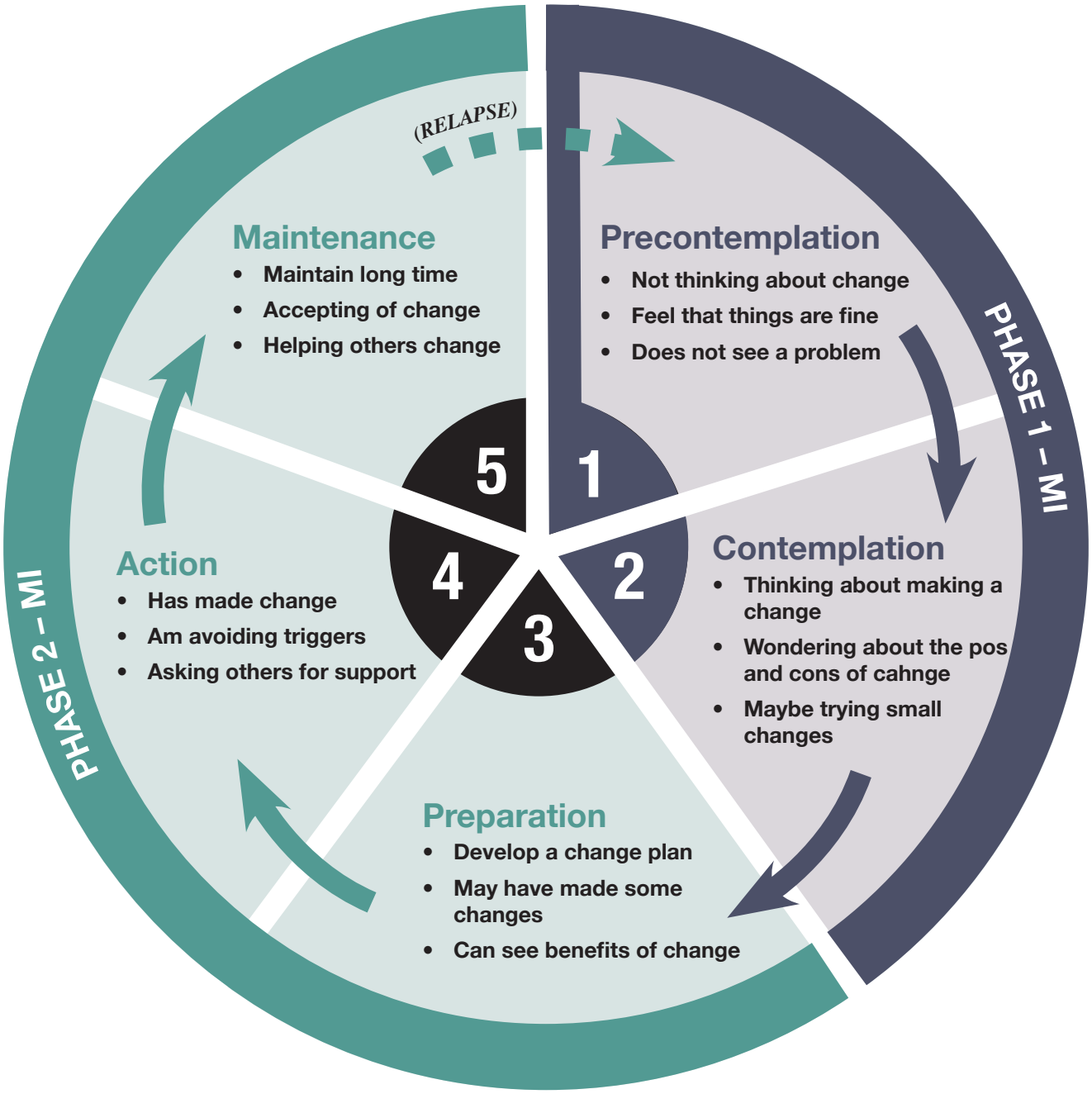
1. Pre contemplation: where the person is not considering change
2. Contemplation: where the person is considering the pros and cons of making a change
3. Preparation: where planning and commitment to change occur
4. Action: where specific action to change behaviour is taken
5. Maintenance: where work to maintain any change in the long term occurs

Rather than a series of sequential steps, this model posits that change occurs in a cycle and individuals move forward and backwards between the 5 stages of change. The stages of change model has played an integral role in the development of MI in terms of viewing change as a series of gradual steps that require different tasks and treatment strategies at each stage. A fundamental assumption of MI is that clinicians should tailor interventions to the clients' readiness to change, rather than assuming all clients are ready for action. The strategies and activities thought to be most effective in treatment differ according to the stage of change of the individual.

During any change attempt it is possible to move forward and backwards through the 5 stages of change (see Figure 2).

5 STAGES OF CHANGE

FIGURE 2



MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) was originally developed by W.R. Miller to enhance readiness and motivation to change substance use. It is a brief "client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" [16:25]. There is a strong evidence base for the use of MI in the treatment of alcohol and substance use [17] and a growing evidence base for MI applied to a range of mental heath problems including depression, anxiety, suicidality and physical health problems [10]. MI can be delivered as a stand-alone treatment or as a motivational prelude to other treatment [10].

MI occurs in two phases. Phase 1 MI focuses on building motivation to change and is designed for individuals in the first two stages of change (i.e., pre-contemplation and contemplation). This phase is dedicated to creating 'change talk' and focuses on increasing both the importance of change and the confidence to change. Phase 2 focuses on strengthening commitment to change and is designed for individuals in the final stages of change (i.e. preparation, action and maintenance). Phase 2 focuses on goal-setting and 'change plan' implementation. It is important to monitor a client's readiness to change throughout treatment as they may move both backwards and forward through the stages of change, requiring different MI strategies at different stages.

THE SPIRIT OF MI

Rather than simply being a series of strategies to enhance motivation, MI is underpinned by a spirit or relational style that has three components:

- Collaboration
- Evocation
- Autonomy

There has been increasing emphasis on the fundamental spirit of MI in recent years which is thought to account for 80% of MI's effectiveness.

Collaboration, means working in partnership with or alongside the client, where the therapist is supportive rather than persuasive. By working collaboratively with the client, the therapist creates a positive atmosphere conducive to change. A confrontational approach is the antithesis of the spirit of MI.

Evocation refers to the assumption that the resources and motivation for change reside in the client. The therapist's task is to elicit the client's own perceptions, goals and values, rather than imparting information or opinions. The key task is to do more listening rather than talking.

Autonomy refers to the concept that responsibility for change lies with the client. The therapist's role is to respect the client, for their resourcefulness and ability to make choices. The antithesis of autonomy is for the therapist to assume they know best and to take an authoritarian approach where they tell the client what to do.

The task of the therapist in MI is to create a set of conditions that will enhance the client's own motivation and commitment for change using the spirit and principles of MI throughout treatment (See Figure 3).

HARM REDUCTION

The ***Quik Fix*** intervention is underpinned by the principles of Harm Reduction. Harm Reduction aims to prevent or reduce the harms associated with the use of psychoactive drugs (licit and illicit) for both the individual and the community. This approach acknowledges that all drugs have the potential to cause harm, not just the illegal ones. The harm reduction handouts provided in the ***Quik Fix*** intervention provide practical strategies, aimed at reducing the physical and psychological harm of drug use to young people (See Appendix 3).

MI FRAMEWORK

FIGURE 3

STAGE 1: CONDUCT A BRIEF ASSESSMENT AND PROVIDE ASSESSMENT FEEDBACK

AIM

The first stage of the intervention aims to develop rapport, administer screening tools and provide assessment feedback. This stage is crucial in engaging the young person in treatment.

*It is assumed that prior to Stage 1, a thorough assessment of the young person's history and presenting issue(s) has been conducted. This should include information on substance use, anxiety and depressive symptoms. It is also strongly recommended that the following **Quik Fix** screening tools be administered.*

PREPARATION

You will need familiarise yourself with:

- Background Principles of the Quik Fix Intervention (page 12)
- Screening tools recommended by Quik Fix and the administration, scoring and interpretation of these measures (see Appendix 2)
- The principles of providing assessment feedback (see below)

Clinical Note: A suicide risk assessment should also be conducted due to the strong association between suicidality, drug and alcohol use and depression in young people [18-20]. See Appendix 2 for an example of a suicide risk screening tool.

MATERIALS

1. Recommended Screening Tools (see Appendix 2):
    - Kessler 10 [K10, 21]
    - Suicide Risk Screen [MINI International Neuropsychiatric Interview, 22]
    - Alcohol, Smoking and Substance Involvement Screening Test [ASSIST, 23]

BACKGROUND PRINCIPLES: PROVIDING ASSESSMENT FEEDBACK

The screening tools recommended by Quik Fix are not intended to replace a thorough assessment of the young person's history and presenting issues. Instead, they are simply tools that provide an opportunity to give the young person objective feedback about the severity of their mental health symptoms and substance use. The young person should also be provided with feedback on the initial assessment of their presenting issues and history. The provision of assessment feedback facilitates the development of a collaborative therapeutic relationship, increases the young person's understanding of their presenting concerns and helps them identify goals for treatment.

The principles of providing effective assessment feedback:

1. **Be Understandable**
    - Use clear language and brief sentences
    - Avoid overusing technical terms
2. **Be Accurate**
    - Give information within the limits of your assessment and your professional training and expertise
3. **Be Positive**
    - Reinforce that it is good to understand difficulties
    - Give hope
    - Include information on treatment
4. **Be Collaborative**
5. **Be Appropriate**
    - For age
    - For stage of engagement
    - For developmental stage
    - For symptoms/disorder under discussion
6. **Be Responsive**
    - To the need for further information or treatment

STAGE 1 EXERCISES

EXERCISE 1A: EXPLAIN QUIK FIX TO THE YOUNG PERSON

1. **Explain the aims of the intervention to the young person:**
    - to help decrease the severity of depression/ anxiety symptoms and substance use and improve functioning
    - to help identify a target symptom or behaviour and increase motivation and commitment to change
    - to increase the likelihood of engaging in and attending future treatment
2. **Outline the length of the Intervention:**
    - the intervention is delivered over one to three sessions that last about an hour
3. **Explain confidentiality:**
    - recap the limits of confidentiality with reference to your service's policy, government requirements and those consistent with your professional background

EXERCISE 1B: ADMINISTER SCREENING TOOLS

In the first stage of Quik Fix, the clinician's task is to engage the client in treatment while helping them to articulate their current concerns.

Step 1: Provide a rationale for administering the screening tools

Begin with a statement explaining the rationale for administering the screening tools and ask permission to proceed.

> *I'd like you to answer some brief questionnaires about your mental health and substance use. This will help us understand how severe your current symptoms are and how they compare to the general population. It will also help us track your progress during treatment. I will be able o give you some feedback about the results today. Does that sound ok?*
>
> *When I ask you each question it's easier and faster if you give me your first response. Please let me know if you don't understand any of the questions or if you don't want to answer any of the questions because they are making you feel uncomfortable. Do you have any questions before we begin?*

Step 2: Administer and score the screening tools (see appendix 2)

Administer and score the screening tools by following the instructions for each tool as outlined in the sources in Appendix 2.

EXERCISE 1C: REVIEW INITIAL ASSESSMENT & PROVIDE FEEDBACK

It is important to review your initial assessment with the young person to clarify any details and ensure that all essential information has been collected. Throughout this process reflect on your understanding of the young person's presenting problems to assist with rapport building.

If appropriate, provide the young person with some personalised, informal assessment feedback on their responses to the screening tools using the steps below.

Step 1: Provide a rationale for assessment feedback

Begin with a statement explaining the rationale for providing assessment feedback.

> *Thank you for completing the questionnaires. I am now going to spend some time giving you some feedback on how you did on the questionnaires and what that means. We won't be repeating any of your assessment, just having a closer look at your situation, what is working for you, what you are having trouble with.*

Step 2: Ask permission to provide information from screening tools

> *Would it be alright if I shared some of the information from the questionnaires you completed?*

Step 3: Provide feedback

Using the principles of providing assessment feedback (page 16), give the young person some feedback on what symptoms of depression and/or anxiety they reported and their severity in relation to the general population (if appropriate). Feedback on the frequency of substance use as well as any consequences of substance use the young person reported can also be provided. Try to establish links between the young person's substance use and depression/anxiety symptoms when giving feedback.

> *The questionnaires you completed ask about ways people think and feel when they are depressed/ anxious. Your answers tell us you are experiencing [low/moderate/high] levels of psychological distress compared to the general population...(refer to interpretation instructions for these tools). They also tell us about how often you're using [substance] and the impact this may be having on your life…(refer to interpretation instructions for these tools).*
>
> *If appropriate, you may wish to provide the young person with some feedback on whether the assessment results indicate they may meet criteria for a current DSM-IV disorder according to your initial assessment and clinical judgement.*

STEP 4:
ENQUIRE ABOUT THE CLIENT'S REACTION TO THE FEEDBACK

- Check the accuracy of the information
  Does that sound right?
- Ask the young person to elaborate on the feedback
  Can you tell me a bit more about your depression/ anxiety and substance use?
- Offer the client a different perspective on their current issues
- Reframe difficulties as problems that can be effectively treated rather than a hopeless situation
- If the client resists the information provided roll with the resistance

Roll With Resistance

- *Avoid argumentation*
- *Avoid direct confrontation of resistance*
- *Resistance is a signal to respond differently*

Source: [16]

EXAMPLE 1:
How to give assessment feedback & explore the links between depression/anxiety and substance use

THERAPIST: This is a summary of your assessment results. You reported severe symptoms of depression compared to people in the general community; including a low mood, a loss of interest and enjoyment in things, a poor appetite, poor concentration and memory, as well as some ongoing suicidal thoughts. Does that sound correct?

PETER: Yes

THERAPIST: You also reported some pretty significant symptoms of anxiety, which are causing you high levels of distress. You also reported that you have been using cannabis daily in the past 3 months, and it has been having an impact on your relationship with your family as well as interfering with your ability to work.

PETER: Yeah, that's true - I mainly use pot when I'm upset, bored or can't sleep or when I just want to hang out with my mates.

THERAPIST: Has this always been the case?

PETER: No, originally I started smoking pot at parties on the weekends, but then I started smoking at night by myself.

THERAPIST: Were there times when you were more likely to smoke pot?

PETER: Yeah, when I was bored or really stressed at night, or if I had a fight with my girlfriend.

THERAPIST: Do you think the amount of stress you've been under lately might have had something to do with the amount you're smoking?

PETER: Yeah, but it's just made things worse because now I have to deal with that as well all of the other stuff.

THERAPIST: So, what you're saying is that while smoking pot initially seemed to help you cope with things, over time it become another problem to deal with on top of the other problems you already had.

STAGE 2: PROVIDE PSYCHOEDUCATION

AIM

The aim of Stage 2 is to provide the young person with psychoeducation about their depression/anxiety symptoms and substance use, as well as the relationship between them. This ensures the young person has accurate information on their presenting issues and can help to build their motivation to change. It is also important to give them harm reduction information on their drug of choice. The young person should be provided with take home resources they can review in their own time.

PREPARATION

You will need familiarise yourself with:

- Background Principles of the Quik Fix intervention (page 12)
- Background Principles of Psychoeducation outlined below
- The Worksheets in the Materials section

Quik Fix uses an information pamphlet called *Feeling good? answering your questions about alcohol, drugs and mental health* [24] (available for free download from **www.nationaldrugstrategy.gov.au**) to provide psychoeducation to young people. Other information resources, which provide information on depression, anxiety and/or substance use and the relationship between them, can also be used for this purpose. The same principles for providing assessment feedback apply to the provision of psychoeducation (page 19), so being familiar with these principles is essential.

MATERIALS

1. *Feeling good* brochure (available for free download from **www.nationaldrugstrategy.gov.au** search in publications)
2. Worksheets (see Appendix 3)
   a. Link between mental health and substance use ruler
   b. Harm reduction handouts

BACKGROUND PRINCIPLES: PSYCHOEDUCATION

Providing assessment feedback provides important opportunities for psychoeducation regarding depression/anxiety and substance use and the links between them. Research has shown that the more a person is aware of their illness and how it affects their own lives and that of others, the more control that person has over their illness. This means episodes of mental illness may occur less often and be less severe in intensity and duration.

It is important to ensure the information delivered is understandable and acceptable to the young person. It is often very useful to provide the young person with take-home materials including psychoeducation handouts, internet sites and other self-help materials. Keep in mind this may potentially be the only chance for intervention if they discontinue treatment.

STAGE 2 THERAPEUTIC EXERCISES

EXERCISE 2A: PROVIDE PSYCHOEDUCATION

Step 1: Acknowledge the young person's knowledge about their symptoms and substance use

- Begin by acknowledging the young person's knowledge about their symptoms and substance use

  You're the expert on your own mental health symptoms and substance use.

  Can you tell me about it?

  What do you know about the effects of substance on mental health symptoms and vice versa?

- Show the young person the Link between your substance use and emotional health ruler (See Appendix 3)
- Ask the young person to rate on a 10 point scale

  How much of a link is there between your substance use and depression/anxiety symptoms? Where 1 is no link at all and 10 is a very strong link?

Step 2: Ask permission to provide information

- Ask the young person for permission to provide advice and suggestions before proceeding

  Would it be OK if I gave you some information about substance use and mental health?

Step 3: Provide appropriate psychoeducation

- Work through the Feeling good brochure

  This brochure provides some information on the common symptoms of depression, anxiety and other mental health disorders and their relationship with substance use.

- Only provide information relevant to the young person's presenting concerns
- Preface advice with permission to disagree

  This may or may not apply to you, but"… or …"What happens to some people is that…

- Give a small amount of essential information on the common symptoms of depression/anxiety disorders and their relationship to substance use
- If the person is receptive, you can add some information about substance use and how their current levels of alcohol/other drug use compare to population standards

  While a lot of young people experiment with alcohol and drugs ,your current level of use appears to be above other young people in your age range. How does it compare with your friends?

- Consider providing information on how to reduce the harms associated with their substance use (see Harm Reduction Handouts in Appendix 3)
- It may also be useful to provide information on the physical, social and legal consequences of substance use with a focus on specific, short-term outcomes

  Anything above weekly use has been associated with increased levels of dependence and drug related harm.

Step 4: Enquire about the client's reaction to the information

- Ask them if the information fits with their ideas about the common symptoms of depression/anxiety

  Do any of these symptoms sound familiar?

- Enquire about whether the information on the relationship between depression/anxiety and substance use fits with the young person's ideas/ experiences

  What do you think?
  Is that how it might work for you?

- If the client resists the information provided 'roll with the resistance'
- Finally, it may be worth asking the young person to re-rate the 10 point scale on the link between their substance use and emotional health and reflect on the result. This can be done verbally or using the link between mental health and substance use ruler.

  How much do you agree or disagree that there is a link between your substance use and depression/ anxiety symptoms?

Step 5: Provide take home resources

- Provide the young person with a copy of the Feeling good brochure
- If you have internet access take the young person to the following websites or provide them with the addresses below:

  a. **www.beyondblue.org.au** Provides information about depression and its treatment for consumers, carers and health professionals.

  b. **www.ybblue.com.au** The youth version of the beyondblue website

  c. **www.moodgym.anu.edu.au** MoodGYM is an internet based therapy program designed to prevent depression in young people

  d. **www.reachout.com.au** Reach out youth friendly website for substance use and mental health

  e. **www.adf.org.au** Australian Drug Foundation site with fact sheets on different types of drugs

  f. **www.ncpic.org.au** National Cannabis Prevention and Information Centre (NCPIC) website

  g. **www.highsnlows.com.au** a website about cannabis and mental health

STAGE 3: EXPLORING THE YOUNG PERSON'S MOTIVATION TO CHANGE

AIM

The aim of Stage 3 is to explore the young person's motivation to change their substance use or depression/anxiety, to identify a target for change and to 'Elicit Change Talk'. This stage is consistent with the principles of Phase 1 MI.

PREPARATION

You will need familiarise yourself with:

- Background Principles of the Stages of Change Model (pages 12)
- Harm Reduction and MI (page 14)
- The Phase 1 MI principles and strategies outlined below
- The Worksheets in the Materials section

MATERIALS

1. Stages of Change Diagram (page 13)
2. Worksheets (see Appendix 3)
   a. Harm Reduction Strategies
   b. Pros and Cons Decisional Balance Sheet
   c. Readiness Rulers: Importance and Confidence Rulers

BACKGROUND PRINCIPLES: IDENTIFYING A TARGET FOR CHANGE

Depression/anxiety and substance use are the key targets for change in Quik Fix. If the young person is only willing to discuss one of these issues then this should be the initial focus of treatment. However, opportunities to discuss the relationship between depression/anxiety and substance use should always be sought, in order to increase the young person's awareness of the relationship between the two issues and (hopefully) increase their motivation to address both issues.

The most important point at this stage of treatment is to collaboratively identify a target symptom or behaviour to focus the MI strategies on. It may be useful to discuss change in general first, and then collaboratively identify the target symptoms/behaviours with the young person. If it is more pertinent to the young person to discuss a presenting issue (e.g., relationship break-up) not directly related to their mental health or substance use, the n this can be the focus of treatment, as long as the links between this presenting issue and the young person's depression/anxiety and substance use are explored.

In the rare case that a young person is not willing to address either their depression/anxiety or substance use then MI strategies can be used to target change in general or treatment engagement and attendance.

Once the target symptom/behaviour has been identified the focus of treatment shifts to eliciting self motivational statements or change talk aimed at increasing the young person's beliefs in the importance of making a change and their confidence to make a change [16].

SELF MOTIVATIONAL STATEMENTS

Self-motivational statements fall into four categories [16]:

- Problem recognition

  I guess there is more of a problem than I thought

  I never realised it was as serious as this

- Expression of concern

  I'm worried about this

  or nonverbal cues such as tears, gestures etc

- Intention to change

  This isn't how I want to be

  Maybe it's time to think about changing

- Optimism about change

  I think I can do it

In Stage 3, we focus on strategies to elicit change talk from the first two categories of statements.

BACKGROUND PRINCIPLES: 'ELICIT CHANGE TALK' IN PHASE 1 MI

OARS

There are four basic motivational skills used to 'Elicit Change Talk' [16]. These methods are used throughout treatment and can be remembered using the acronym OARS [16]:

1. Ask **O**pen Questions
2. **A**ffirm
3. Listen **R**eflectively
4. **S**ummarise

Ask Open Questions

This is a reminder that the person should do most of the talking. Closed-ended questions can only be answered with one or two word answers and, by their nature, do not encourage elaboration. Open-ended questions encourage an environment where the person feels comfortable and safe to discuss their feelings about an issue. Open-ended questions should be used to focus and redirect an individual onto a topic or explore a topic further.

Listen Reflectively

Reflective comments are statements that let the young person know you have heard and understood what they are saying. Clinicians should "turn down at the end" of the statement, meaning the inflection should reflect a statement NOT a question. While the repetition of client's words might keep the person moving, introducing new words, as a form of bridging, often facilitates in moving the person further along. Reflecting on how the person feels as they are speaking, e.g. You sound angry lets the person know that you are listening with an empathic ear. A recommended rule of thumb is that no more than three open ended question be asked in a series without a reflective comment.

Affirm

Direct affirmations, which can be as subtle as *"That's a good suggestion"* or *"I've enjoyed our visit today",* develop rapport and acknowledge the persons efforts to make a change in a respectful way.

Summarise

Periodic summaries show that you have been listening to the young person carefully and understood what they have said. They also reinforce what the young person has been saying and encourage them to elaborate further.

- Collecting summaries bring information together
- Linking summaries connect statements from one session with statements from another
- Transitional summaries herald shifts of focus, as is done between Phase 1 and 2, or the end of a session

During summaries, it is important to bring together as many reasons for change as possible, while still acknowledging the person's ambivalence. Ensure that the "good things about [target]" and "negatives about making a change" are mentioned first, and the "not so good things about [target]" and the "positives about making a change" are mentioned last to build motivation to change.

METHODS TO ELICIT CHANGE TALK

While the OARS skills are critical to Phase 1 MI, 'Eliciting Change Talk' also requires a focused effort by the clinician to tease out statements the young person makes that *argue against* the status quo. Miller and Rollnick [16] suggest several methods to do this, either as questions or activities during the interview.

Ask Evocative Questions

Evocative questions come from four categories:

1. Disadvantages of the Status Quo
2. Advantages of Change
3. Optimism about change
4. Intention to Change

Elaborate

Elaboration allows the therapist to press on in order to get more 'Change Talk'. This is done by asking the person to "clarify" or "further describe" or to present an example within the change topic.

Present Extremes

*Presenting extreme*s of possible consequences can be a helpful method when there is little expressed desire to change as it challenges the person to think of a worst case scenario.

What concerns you the most?

What are you fears about what might happen if you don't make a change?

Look Back

Looking back encourages the person to consider life prior to their presenting issue to create a contrast.

What was life like before _____ started?

When was life last enjoyable/not out of control?

Look Forward Or Explore Goals

Looking forward seeks to elicit the young person's goals, hopes and dreams and aids in developing disparity between the current situation and what they desire.

In three/six/twelve months, what do you hope life will be like? What would you like to be doing? What is in the way of these hopes?

Explore goals is similar to looking forward and is meant to explore what goals or values the person holds most dear, and look for inconsistencies with the problem issue.

STAGE 3 THERAPEUTIC EXERCISES

EXERCISE 3A: EXPLORING THE YOUNG PERSON'S MOTIVATION TO CHANGE

Focus on general change

How long have things been this way?

How would things be if you weren't feeling this way?

What do you think it would take for you to get better?

Raise mental health issues

Young people usually want to reduce their depression/anxiety symptoms. However, it is still worth exploring these issues to build motivation and commitment to change as they may still be resistant to discussing them or unsure how to address these issues.

Can you tell me more about your depression/anxiety?

How do you feel about being depressed/anxious?

What impact has depression/anxiety had on your life?

Raise the issue of substance use

Explore the issues of substance use.

Tell me about your substance use?

I wonder how you feel about your substance use?

How has it changed over time?

How does it fit into your life?

If the young person is receptive

The Pros and Cons 'Decisional Balance Sheet' is an important tool for building the young person's motivation to change [16].

EXERCISE 3B: DECISIONAL BALANCE

Use the Pros and Cons Decisional Balance Sheet to explore the young person's substance use and/or mental health issues further.

Begin asking questions that explore the young person's beliefs about their presenting issues and record what they say in the relevant quadrant of the 'Decisional Balance Sheet':

- Explore ambivalence about depression/anxiety and/or substance use by asking:

  What are the good things about your _____?

  What are the less good things?

  (Record info on Pros and Cons Decisional Balance Sheet)

- Explore the relationship between substance use and mental health symptoms by asking:

  How does your use of [substance] affect your depression/anxiety symptoms?

- If time allows and the young person is receptive to the discussion ask permission to look at their issues more closely:

  So, perhaps there are some good things and some not so good things about your _____.

  (Summarise with a subtle emphasis on less good things)

  Can we take a look at what it would mean to make a change in your _____ at this time more closely?

- Explore ambivalence about making a change by asking

  What are the less good things about making a change in your _____?

- Repeat this exercise about the good things about making a change in _____ by asking:

  What are the good things about making a change?

- Continue working with the Pros and Cons Decisional Balance Sheet until you are able to tip the balance in favour of the good things about making a change.

- NB: Avoid the use of terms such as "problem", "abuse" etc. as these can elicit resistance from the client at this early stage.

- Explore experience of previous mental health and/or substance use treatment. Explore both positive and negative ideas about treatment as well as experiences with other services, including the role of treatment in making a change and the young person's hopes and fears about treatment:

  What do you hope will happen to you with treatment? Do you think coming along to treatment will be helpful? What would be helpful? What would be unhelpful?

  What did you hope your therapist/counsellor would be like?

  What do you want from your therapist?

If the young person is not receptive

- It is important to raise the issue in a way that minimises resistance, and opens the door to constructive conversation. Begin by asking generally about the person's lifestyle.

  The information we have talked about in this session has given me a bit of an idea about what is going on in your life at the moment. Can you spend a bit more time telling me about this?

- If the person does not volunteer information about drinking or using substances, try asking the following:

  Can you tell me where your drinking/using fits in?

- If the young person is then receptive to discussing their substance use begin exploring the young person's ambivalence about substance use.

  What are the good things about using?

  What are the less good things?

- If the young person remains resistant about discussing their substance use, explore the impact of their mental health symptoms on the young person's functioning.

  Can you tell me about your depression and anxiety and what effect they are having on your life?

  What would things be like for you if your depression and anxiety improved?

  What do you think it would take for your depression and anxiety to get better for you?

- If the person is receptive to a discussion about mental health symptoms, explore how they believe their substance use affects their mental health symptoms.

  Can you tell me about how your substance use impacts on your depression?

- If the young person is receptive to discussing substance use issues at this point *MOVE TO STAGE 4.* However, if the young person continues to show resistance towards discussing substance use issues but is receptive towards addressing their mental health issues these should be the target for change and CONTINUE TO STAGE 4.

If the young person remains resistant

- If the young person remains resistant about change in general, present the stages of change model (see Figure 2 on page 13) and discuss what stage you believe the young person is at for their substance use and depressive/anxiety symptom separately.

- Explain to the young person that it is common to move back and forth between the different stages. After presenting the stages of change model, offer to provide the young person information on harm reduction strategies for their substance use.

  It seems you are not interested in discussing your substance use or depression/anxiety at this time. Would you like some information on how to minimise the potential harms associated with your substance use? (See Exercise 3C)

EXERCISE 3C: HARM REDUCTION & TIPS FOR CUTTING DOWN SUBSTANCE USE

Quik Fix aims to reduce the harms associated with substance use by providing the young person with information on how they can reduce drug related harm, as well as tips for cutting down substance use. This information can be provided to the young person regardless of their readiness or commitment to make a change.

- Read over the general Harm Reduction Strategies handout and the Harm Reduction handouts for Alcohol and Cannabis in Appendix 3

- Provide a copy of the relevant handout(s) for the young person to take home

STAGE 4: ASSESS IMPORTANCE AND CONFIDENCE TO MAKE A CHANGE AND ATTEND TREATMENT

AIM

The aim of Stage 4 is to assess how important it is to the young person to make a change in their substance use and depression/anxiety, as well as their level of confidence in making this change. The young person is also asked to consider how willing they are to attend further treatment (if required/ after completing ***Quik Fix***.

PREPARATION

You will need familiarise yourself with:

- Background principles of MI (page 14) and Phase 1 MI strategies (page 22)
- Background principles using the readiness rulers outlined below
- The Worksheet in the Materials section

MATERIALS

Worksheet: *Confidence, Importance and Treatment Readiness Rulers* (See Appendix 3)

BACKGROUND PRINCIPLES: USING THE READINESS RULERS

Miller and Rollnick [16] suggest using "Readiness Rulers" to assess a person's belief in the importance of change and their confidence in their ability to change. The *Importance Ruler* can be used to gauge the importance of change to the young person, and the *Confidence Ruler*, their confidence in making a change.

High scores (8 or higher) on both the importance and the confidence "Readiness Rulers" are a good indication that the person is "willing and able" to move on to Phase 2 MI: *GO TO STAGE 6.*

Lower scores (7 or below) on either or both "Readiness Rulers" are a reason to *GO BACK TO STAGE 3: Phase 1 MI,* revisit the Pros and Cons Decisional Balance and continue eliciting 'Change Talk'. It may also be appropriate to introduce paradoxical discussions as outlined in the therapeutic exercises below.

Ask the person to rate on a scale of 1 to 10, the importance of changing their substance use, then ask them to separately rate the importance of changing their depression/anxiety symptoms. Then ask them to rate on a scale of 1 to 10, their confidence in being able to change their depression/anxiety and substance use.

Why are you not a 1?

NB: It is less helpful to ask "Why are you not a 10?" as this may lead to increased resistance.

Exploring the reasons for the scores will often lead to insight into the person's Stage of Change, providing further 'Change Talk' and an accurate gauge of where to focus MI.

STAGE 4 THERAPEUTIC EXERCISES

EXERCISE 4A: IMPORTANCE AND CONFIDENCE FOR MAKING A CHANGE

Step 1: Assess and explore the importance of making a change

Assess and explore importance in making a change for both anxiety/depression and substance use separately.

On a scale of 1-10, how important is it for you to make a change in your depression/anxiety symptoms?

How about your substance use?

Record answer on the scale. Then further explore the importance of making a change.

Why are you not a 1?

If the importance of making a change is:

LOW:

OK, so it's not that important to you at this time. I wonder if I can provide you with a little information about _____?

Even if you don't want to make a change in your substance use there is some information I can give you on how to reduce the harms associated with use.

MEDIUM:

So, about the middle. But I'm wondering, why did you say a '4' and not a '1'? So, one reason it's important is… What else?

HIGH:

So, it's very important for you to do something about your cannabis use. Why is that? So, one reason it's important is… What else?

Step 2: Assess and explore confidence to change

Assess and explore the young person's confidence in making a change for both anxiety/depression and substance use separately.

> *On a scale of 1 – 10 how confident are you that you could make a change if you wanted to?*

Record answer on the scale. Then further explore the young person's confidence in making a change.

> *Why are you not a 1?*

If the importance of making a change is:

LOW:

> *Pretty low. What would it take to raise that '1' up to, say a '5'? Tell me about a change you made in the past. How did you go about it?*

MEDIUM:

> *So, about in the middle. But why a '4' and not a '1'? What else? What would it take to raise your confidence to say, an '8'? How would you go about it? How can I be of help?*

HIGH:

> *So, you're quite confident. How would you go about it? What would it look like? What else? How can I be of help?*

Step 3: Assess and explore readiness to attend treatment

Explore the young person's views on the utility of treatment.

> *Do you think attending further treatment will help you make these changes?*

Assess the young person's readiness to attend treatment.

> *On a scale of 1 – 10 how likely is it that you will attend further treatment [after completing Quik Fix] to help you make this change*?

Further explore the young person's readiness to attend treatment.

> *Why are you not a 1?*

If the importance of making a change is:

LOW:

> *Pretty low. What would it take to raise that '1' up to, say a '5'? What would make you more willing to attend treatment?*

MEDIUM:

> *So, about in the middle. But why a '4' and not a '1'? What would make you more willing/able to attend treatment?*
>
> *What would need to happen?*
>
> *Is there anything I can do that will make it more likely you will attend?*

HIGH:

> *So, you're quite confident you will attend further treatment. How would you go about it?*
>
> *How do you think it will help?*
>
> *Is there anything that might get in the way of you attending?*
>
> *Is there anything I can do that will make it more likely you will attend?*

Step 3: When the young person has low scores (7 and below)

GO BACK to Phase 1 MI in Stage 3 and continue eliciting 'Change Talk'. You may need to revisit the Pros and Cons Decisional Balance or it may also be appropriate to introduce paradoxical discussions in the following way [16].

> *One thing I find helpful is to clarify the real reasons for a change. We have started to do this a little bit already last session, but I've heard from you some reasons why you are reluctant to think about changing your substance use. So, now I have a suggestion. I want to have a little debate with you. I will defend the position that you don't really have a problem and don't need to change, and I want you to do your best to convince me otherwise. I'm going to be you, and your job is to persuade me that there really is a problem here that I need to examine and do something about.*

STAGE 5: EXPLORE OPTIONS FOR MAKING A CHANGE

AIM

Stage 5 heralds the move from Phase 1 to Phase 2 MI. The strategies used in Phase 2 MI are used to summarise the issues raised so far and explore options for making a change in depression/anxiety symptoms and substance use.

PREPARATION

You will need familiarise yourself with:

- Background principles of MI (page 14), and Phase 1 MI (page 22)
- Background principles of 2 MI strategies outlined below
- The Worksheets in the Materials section (below)

MATERIALS

Stages of Change Diagram (page 13)

Worksheets: Harm Reduction Handouts for the relevant substance/s (see Appendix 3)

BACKGROUND PRINCIPLES: PHASE 2 MI STRATEGIES

Miller and Rollnick [16] list signs indicating a readiness to move from Phase 1 MI strategies to Phase 2 strategies. These include:

- Decreased resistance
- Decreased questions about the problem
- Resolve (may seem more peaceful or settled, a resolution has been reached)
- Self-motivational statements
- Increased questions about change
- Envisioning (client talks about what life might be like after a change)
- Experimenting (client may have begun experimenting with possible change approaches)

Phase 2 MI consolidates all the issues raised in Phase 1 and develops a plan for change. Be aware that ambivalence, possibly presenting as resistance will still be present, and when encountered, strategies from Phase 1 should be used (e.g. reflective listening, open-ended questions, affirming, summarising).

Miller and Rollnick [16] explain that the key components of Phase 2 are: recapitulation, key questions, information and advice, negotiating a plan and eliciting commitment.

RECAPITULATION

Recapitulation serves to consolidate all the issues to close out Phase 1 and addresses both the reasons for change while acknowledging ongoing ambivalence. It may include the following:

- Summary of the person's perceptions of the problem (using their self-motivational statements)
- Summary of the person's remaining ambivalence, including what remains positive (mention positives first followed by the negatives)
- Summary of the person's statements about their intention and optimism for change
- Your own assessment of the client's situation

KEY QUESTIONS

The goal of this is to elicit what the person wants to do, now that they have this information in front of them. A danger here is to assume that the person is simply going to jump in to a change plan. To avoid this, continue with open ended questions, exploring what they think might be next.

> *What do you make of all this?*
>
> *Where does this leave you in terms of your [target symptom/behaviour]?*
>
> *I wonder what you're thinking about your [target symptom/behaviour] at this point.*
>
> *Now that you're this far, I wonder what you might do about these concerns.*
>
> *Of the things I have mentioned, which are the most important reasons for a change to you? How are you going to do it?*

INFORMATION AND ADVICE

At this point, the person may ask you for information or ideas about how to bring about change. Remember that the person must feel ownership when planning an intervention.

As Miller and Rollnick [16] caution, wait for a direct invitation to provide advice, and do not be too eager to provide solutions.

> *I'll be happy to give you some ideas, but I don't want to get in the way of your own creative thinking. You are the expert on you.*
>
> *I can give you ideas and strategies as part of this program of treatment, but I want to stress that you'll have to try them out to see if they work for you.*

There are many self-help booklets available to provide a range of options, which the person may find helpful. Be prepared to give them options.

Negotiating a change plan and eliciting a commitment are covered in Stage 6.

STAGE 5 THERAPEUTIC EXERCISES

EXERCISE 5A: EXPLORE OPTIONS FOR MAKING A CHANGE

Recapitulate/Summarise all the issues raised so far while acknowledging ongoing ambivalence. Summarise the issues for both substance use and depression/anxiety separately. Explore substance use alternatives and prepare for change:

> *What do you make of all this?*
>
> *What do you think would happen if your [substance] use increased? …Stayed the same? …Reduced?*
>
> *What do you think?*
>
> *Would you like to make a change in your substance use?*
>
> *How would you like it to change?*

Explore alternatives for addressing depressive/anxiety symptoms:

> *What do you think it would take for your symptoms to improve?*
>
> *What would things be like for you in the future if your symptoms stayed the same?*
>
> *Would you like to make a change in your depression/ anxiety?*
>
> *How would you like it to change?*

When the young person is receptive to change

If the young person is receptive to making a change to their depression/anxiety and/or substance use *GO TO STAGE 6.*

When the young person is not receptive to change

If the young person is not receptive to making a change, evocative questions may help.

> *You seem a bit stuck at the moment. What would have to change to fix this?*
>
> *The fact that you are here indicates that at least a part of you thinks it is time to do something. What are the reasons you see for making a change?*

If the young person REMAINS RESISTANT ABOUT CHANGE IN GENERAL, present the Stages of Change diagram (Figure 2 on page 13) and discuss what stage the young person is at for depressive/anxiety symptoms and substance use, separately. Advise the young person that it is common to move back and forth between stages. Offer harm reduction information to the young person.

> *It seems you are not interested in discussing your substance use or depression/anxiety at this time. Would you like some information on how to minimise the potential harms associated with your substance use?*

Continue to use Phase 1 MI strategies to build motivation to change.

STAGE 6: NEGOTIATE A CHANGE PLAN

AIM

The aim of Stage 6 is to continue using Phase 2 MI strategies to set some change goals and develop a plan for implementing them.

PREPARATION

You will need familiarise yourself with:

- Phase 2 MI strategies (page 28)
- Worksheet in the Materials section

MATERIALS

Change Plan Worksheet (see Appendix 3)

STAGE 6 THERAPEUTIC EXERCISES

EXERCISE 6A: DEVELOP A CHANGE PLAN

If the young person is receptive to making a change in their depression/anxiety and substance use, use the Change Plan Worksheet to work through the following steps:

Step 1: Set some change goals

Try to include goals targeting the young person's depression/anxiety and substance use as well as any other goals the young person wishes to pursue. In setting formal goals for the young person, make sure that they are specific, realistic and achievable.

What goals would you like to achieve?

Substance Use Goals may include setting some limits on the frequency, quantity, timing and/or amount of money spent on substance use. They may commence a process of gradual tapering down toward abstinence, or commence a trial period of moderation with the longer term goal of abstinence. While others choose to begin with abstinence.

1. *I will allow myself to drink/use only on these days of the week (start by cutting out 1 day and build from there).*

   Sun Mon Tues Wed Thurs Fri Sat

2. *I will not drink/take more than _____ drinks/ _____ in 1 day.*
3. *I will not start drinking/using before _____.*
4. *I will stop drinking/using by _____.*
5. *I will not spend more than $_____ on alcohol/drugs in any 1 day.*

Finally, identify the main reasons for making a change.

What are the main reasons you'd like to achieve these goals?

List these on the Change Plan Worksheet.

Step 2: Brainstorm change options

Brainstorm as many possible options to attain the young person's goals and encourage them to pick one based on consideration of the advantages and disadvantages.

How do you think you might go about making a change?

What people in your life could help you make these changes?

If attending further treatment is identified as an option, explore further *treatment options* available and explore the young person's *expectations for treatment.*

What have your previous experiences of treatment been like?

What do you expect this therapy will achieve?

Do you have any concerns about this treatment?

How do you feel about seeing a counsellor/mental health clinician?

Identify possible *obstacles to treatment* including:

- External obstacles

  Many people find that, even when they want to seek help, it can be hard to do so. What might make it hard for you to come?

- Psychological obstacles

  If we could magically solve these practical issues, what else could keep you from coming?

- Cultural obstacles

  Sometimes it is difficult for clients to get to therapy if other family members do not believe in getting that kind of help. What kind of concerns do you have about that?

Work through solutions to the obstacles to attending treatment

Thinking about all of these issues together, how confident are you that you will make the changes?

Step 3: Arriving at a plan

Help them formulate a step by step plan for achieving the goal. Again refer to the principles of these steps being specific, realistic and achievable. Explore any barriers or problems that may potentially impact on the achievement of the chosen goal.

> *You have said that you would like to cut down, so let's make that a goal. What can you think of that might go wrong with this plan? What might be good, and what might be not so good about reaching this goal?*

Step 4: Offer coping strategies

Offer to provide some coping strategies that the young person can include in their Change Plan Worksheet.

> *How would you feel about me providing you with some other strategies that other people have found helpful in managing their substance use and depression/anxiety?*

If the person *is receptive* to being taught coping strategies to help them manage their depressive/anxiety symptoms and substance use: GO TO STAGE 7

If the young person *is not receptive* to coping skills training continue Phase 2 MI.

STAGE 7: OFFER COPING STRATEGIES

AIMS

The aim of Stage 7 is to offer some brief behavioural, affective and cognitive coping skills training to help the young person manage their presenting problems.

PREPARATION

You will need familiarise yourself with:

- Background principles of coping skills training outlined below
- The Worksheets in the Materials section

It is useful to practice the strategies prior to implementing them if you are not already familiar with the techniques.

MATERIALS

The following worksheets are in Appendix 3

1. Coping Styles
2. Good Vibes
3. Stress Less
4. Belly Breathing
5. Be Mindful NOT Mindless
6. How to Improve you Sleep (Optional)

BACKGROUND PRINCIPLES: BRIEF COPING SKILLS TRAINING

This stage of ***Quik Fix*** focuses on providing the young person with brief coping skills training to increase their capacity to cope with their presenting problems and everyday problems. The young person's current coping skills repertoire or "Coping Styles" are first discussed, and a distinction is made between helpful (or adaptive) coping, which actively addresses problems and emotions and unhelpful (or maladaptive) coping which does not address problems or emotions. Young people are encouraged to use a combination of adaptive problem focused coping (addressing the practical aspects of problems) and emotion-focused coping (expressing and managing emotions) [25]. They are also encouraged to consider the context of the problem or emotion when determining which coping skills are most appropriate.

EXERCISE 7A: COPING STYLES

Use the Coping Styles worksheet in Appendix 3.

Provide the young person with information using the handout.

> *Everybody experiences day-to-day life problems (e.g. relationship problems) and negative emotions (e.g. sadness, anger) and need to identify and work through them. Problems can also be substance specific (e.g. being in a group where drugs and alcohol are freely available), can arise from thoughts or feelings (e.g. depressing/intrusive thoughts), or in interactions with others (e.g. arguments). COPING STYLES are typical or habitual ways of approaching or dealing with problems or emotions.*
>
> *How do you usually use when you're dealing with problems or difficult emotions?*
>
> *Coping styles that are helpful, actively deal with problems (e.g. make telephone calls, seek help, visit services) and emotions (e.g. relaxation, schedule distracting activities) as they occur. Coping styles that are unhelpful tend to be passive and do not address problems or emotions. These include denial and avoidance. Denial means ignoring the problem or emotion, pretending it's not happening or that it's not as bad as it seems. Avoidance means doing other things to avoid dealing with the problem (e.g. wagging school), taking drugs or binge drinking, getting aggressive and hostile or being impulsive (e.g. driving fast, gambling).*

Ask the young person,

> *Which of your coping styles are helpful and which are unhelpful?*

The following questions may assist with this.

> *How effective is it in helping me manage my problems or emotions?*
>
> *Does it actually help me solve my problems?*
>
> *How long does it work for?*
>
> *Does it solve my problems in the long-term*?

If the young person is using unhelpful coping skills such as avoidance or denial, discuss the impact of this coping strategy.

> *The more you attempt to avoid or deny problems or emotions the more you'll think about them and the more upset you'll feel, as avoiding or delaying problems or emotions just makes them worse. While these coping styles may make you feel better in the short term, they do little to resolve the problem. Pressure from unresolved problems easily leads to negative emotions (e.g. anxiety/worry, anger, sadness) and substance use.*

If the young person is receptive to discussing their coping skills continue.

> *Coping skills training is an important part of cognitive behaviour therapy (CBT), which teaches you how to recognize problematic situations and emotions and the most appropriate ways of coping with them. We recommend you attend CBT treatment in the future to develop more helpful ways of coping with problems and emotions and can provide you with [further treatment/referral options for seeking further treatment] if your interested.*
>
> *In the mean time, would you be interested in learning a few simple ways of helping you cope with [presenting problem/emotions]?*

Behavioural Coping Skill: Looking After Yourself & Pleasant Event Scheduling

Young people are first taught that the most important coping skill for reducing negative thoughts, emotions and behaviours is to look after themselves by trying to eat a more balanced healthy diet, sleeping regularly, treating physical illnesses, and exercising[26].

Increasing the young person's activity levels, particularly pleasant events helps to improve their mood, distract them from substance use and restore them to higher levels of functioning [27]. Young people are taught that when we feel bad we're less likely to do things we enjoy, and our emotions spiral downward and we feel even worse (see Figure 3). However, when we're enjoying or are successful at doing something, we feel good and our emotions spiral upward and we are more likely to do more things in the future.

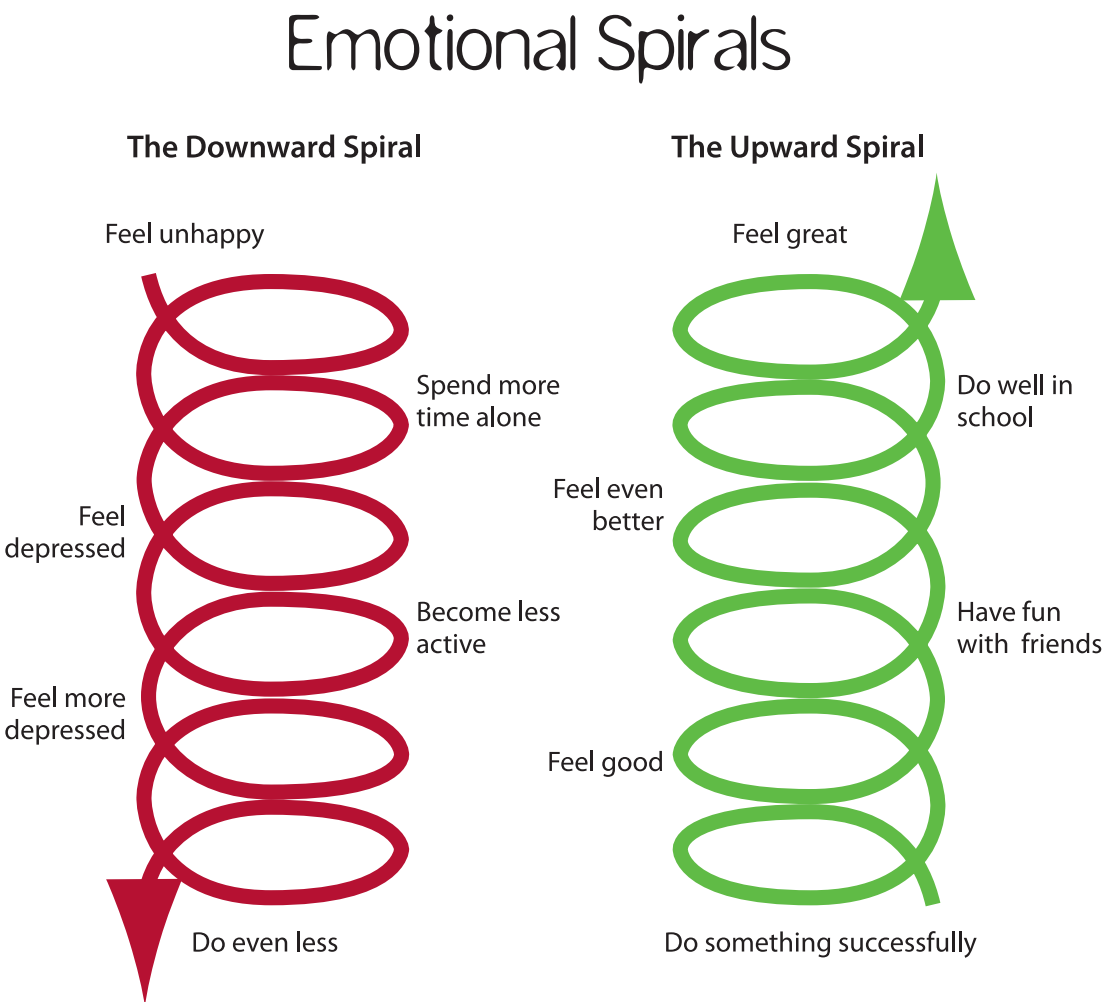


Figure 4: Emotional Spirals

They are then asked to generate a small list of activities they currently enjoy or have enjoyed in the past. These can be everyday (e.g., eating, reading), social (e.g., go see a friend), creative (e.g., drawing, painting, playing music), fun (e.g., movies, playing games, go to a shopping centre, playing or watching sport, visit a place you like) or physical activities (e.g., go for a walk, gym, yoga/meditation). To keep it simple we ask young people to do at least one thing a day that makes them feel good and to try and schedule the days they will do these pleasant activities in advance.

EXERCISE 7B: INCREASING POSITIVE FEELINGS

Use the Good Vibes worksheet in Appendix 3.

Go through each of the points in the LOOK AFTER YOURSELF section.

> *It is important to look after yourself to help increase your mood. This includes eating a balanced diet with regular meal times, keeping active and going to see a doctor if you're feeling physically unwell.*

If the young person reports concerns about their sleep pattern, spend some time going over each of the points and go through the sheet titled "How to Improve you Sleep".

Go through the INCREASE POSITIVE FEELINGS section of the handout.

Explain the relationship between activity and mood to the young person.

> *We have also found that keeping active and doing things you enjoy also helps to improve your mood.*

Using the emotional spirals diagram (Figure 4) or by drawing the spirals on a piece of paper to assist in explaining the relationship between activity and mood.

> Negative emotional spiral:
>
> *When we feel bad we're less likely to do things we enjoy, and our emotions spiral downward and we feel even worse.*
>
> Positive emotional spiral:
>
> *When we're doing something we enjoy we feel good and our emotions spiral upward and we are more likely to do more things in the future.*
>
> *To lift your mood it is important to do at least 1 thing a day that makes you feel good.*
>
> *It can be helpful to write a list of things that make you feel good.*

Work through the INCREASE POSITIVE FEELINGS section of the handout.

Ask the young person about their preferred activities and write them in the Pleasant Activities I Enjoy section of the handout.

> *Can you think of 3 things that you currently enjoy or have enjoyed doing in the past?" It can be anything you like*.

Work your way through the questions on the handout to increase the number of pleasant activities on the list.

> *We have found that figuring out what days we will do activities makes us much more likely to do them. Can you tick which days you'll be able to do the activities.*

Remember to do at least one thing a day that makes your feel good.

RELAXATION COPING SKILL: REDUCING PHYSICAL AND MENTAL TENSION

Relaxation is another important skill for learning how to cope with negative feelings such as depression, anxiety, stress and anger as well as cravings for substance use. There are many ways to relax and reduce physical and mental tension. Some people feel more relaxed after high energy activities while others feel more relaxed after gentler activities. Not all forms of relaxation work for everyone. The key to relaxation is finding which activity or combination of activities works best for an individual.

The first exercise focuses on a range of activities to reduce stress.

The second exercise focuses on "belly breathing" or deep breathing, which is an important skill for reducing negative feelings such as depression, anxiety, stress and anger as well as cravings for substance use. It is designed to be used at the first sign of negative feelings to assist the young person to stay calm and prevent the negative feelings from developing into intense panic, anger or sadness [28]. Young people should be encouraged to practice these skills regularly, particularly when they are not feeling anxious, to build mastery in these skills.

EXERCISE 7C: STRESS LESS

Use the Stress Less Worksheet in Appendix 3.

Explain about reducing stress techniques.

> *There are many ways to relax and reduce physical and mental tension. Not all forms of relaxation work for everyone. The key to relaxation is finding which activity or combination of activities works best for you.*
>
> *Some people feel more relaxed after high-energy activities while others feel more relaxed after gentler activities.*
>
> *What kind of things make you stress less and feel more relaxed*?

Work your way through the STRESS LESS handout.

There is no need to work your way through all of the strategies listed. First ask the young person which strategies they are interested in using and only focus on those.

1. Exercise 3+ times a week

High energy exercise such as swimming, running, martial arts or going to the gym can release pent-up tension.

What kind of activities have you found have helped you release tension and stress less?

Gentler activities like walking or yoga can have a soothing effect and reduce tension.

Have you ever tried any of these activities?

Discuss the activities with the young person and how it has helped them feel relaxed and relieve tension. Encourage the young person to do the activities at least 3+ times a week.

2. Ssttrreettcchh your body

Stretching the parts of your body where we commonly hold tension like your neck and shoulders reduces muscle tension by increasing blood flow to these muscles. The following stretches can be used to release muscle tension

Ask the young person to stand up and work your way through the following stretches.

Whole body:

Stretch as tall as you can, hold your arms up tall and stand on your tippy toes!!!

Neck:

Stretch your neck as long and tall as you can – make if feel like a swans neck. Now turn your head to the right side – to elongate the stretch push your left shoulder and arm down as you exhale extend the stretch even more. Now repeat for the other side. Once you've done this a few times slowly rotate your head down, to the left, the back to the right and to the front again a few times.

Shoulders:

Rotate your shoulders forward 5 times and backwards 5 times. Give yourself a bear hug. Cross your arms over your chest and grab a shoulder with either hand. Squeeze each shoulder and release three times.

3. Give yourself a mini massage

Massage improves your mental energy and reduces muscle stiffness and tension by increasing blood flow to your muscles. You have your very own massage therapist with you at all times -- your hands!!

You might even find you are already giving yourself mini massages without thinking about it. This includes things like rubbing your forehead when you have a headache or rubbing your feet when they are tired. There are many simple mini-massage techniques you can try that only take seconds!!

Brief neck and shoulder massage:

Clasp your fingers behind your neck, pressing the heels of your palms into your neck on either side of your spinal column. Slowly massage the heels of your hands up and down your neck. Then place the fingers of your right hand on your trapezius muscle along the left side of your neck just below the base of your skull. Press into that muscle, tilt your head to the left, and rub downward until you reach your shoulder. Repeat three times, then switch sides.

Finish by stretching your head back and look at the ceiling to stretch the front of your neck. Hold for 20 seconds.

Roll on a tennis ball:

You can also try lying on your back and placing a tennis ball wherever you feel muscle tension. Try the base of your neck, between your shoulder blades and the small of your back.

4. Self soothe

Relax by soothing each of your 5 senses: look at old photos, take a bath, smell your favourite perfume, eat your favourite food, listen to music.

5. Take a brief vacation

Take a brief vacation. Go to bed and pull the covers up over your head for 20 minutes, read a book in bed, lie in a park, sit on the beach.

6. Listen to music mindfully

Take some music and listen carefully to every beat, notice the sounds of the instruments as well as the lyrics. Focus on the music. It your mind wanders off, this is ok it's what minds do. Just notice this and gently bring your focus back to the music.

Highlight to the young person that it is important for them to do something to STRESS LESS as they are the only person who can help them stress less.

EXERCISE 7D: BELLY BREATHING

Use the Belly Breathing Worksheet in Appendix 3.

During the in-session practice ensure the young person is breathing correctly by watching their breathing and/or counting aloud through each 6-second cycle.

Invite the person to practice this technique in session using the following instructions:

> *We call this type of breathing 'Belly Breathing' as it uses your diaphragm rather than your chest. Your diaphragm is a muscle located across your belly, just underneath your ribcage. It serves as a kind of plunger to move air in and out of the lungs. When you are relaxed, your diaphragm is doing most of the work in breathing, while your chest should remain relatively still – your chest should not really move much at all – that's why we call it 'Belly Breathing'.*

Work your way through the Belly Breathing instructions on the Worksheet.

Allow the person to continue breathing for a few minutes and then gently bring them back to the here-and-now, opening their eyes.

Ask for feedback on whether the technique had any impact on their levels of anxiety, stress or tension. Highlight that it is important to practice this skill to build mastery.

As young people are unlikely to spend a long period of time practicing this skill tell the young person that like all exercises, the greatest benefits come from regular practice.

> *It is important to **REPEAT the belly breath at least 3 times** to reduce your feelings of anxiety or anger. This can be used as a quick fix to calm yourself down in stressful situations.*

COGNITIVE COPING SKILL – MINDFULNESS

People who are feeling depressed or anxious tend to think in a negative way about themselves, others, the world, and their future. The CBT model teaches us that it's not the situation that makes us feel depressed, but the way we interpret the situation.

There is insufficient time in Quik Fix to teach the young person thought catching and challenging. However, if the young person identifies negative thoughts during the Quik Fix intervention that are causing them distress, it may be helpful to teach them some simple skills for managing these thoughts.

Rather than trying to prevent or avoid negative thoughts or mindlessly doing or feeling whatever our minds tell us, we have found just tuning into and increasing awareness of negative thoughts can help to reduce negative feelings and behaviours [29]. We encourage young people to change their relationship with their thoughts by focusing on accepting and allowing thoughts and feelings to happen without feeling the need to change them [29]. They are first taught to 'STOP & SLOW DOWN' and observe their thoughts non-judgementally. Explain that thoughts are just thoughts – events in the mind – and that negative thoughts are just like any other thought (e.g., my shoe lace is undone) [30]. Nothing more. Negative thoughts are not facts, but we tend to pay too much attention to them and it is often difficult to see them as just thoughts [30].

In the following exercise the young person is taught to be receptive to and observe their thoughts in a non-judgmental way - as events in the mind and not facts. This technique in itself can be useful for reducing the impact and influence of negative thoughts or feelings on the individual. This is just one way of managing negative thoughts and there is a range of other strategies available.

EXERCISE 7E: BE MINDFUL NOT MINDLESS

Use the Be Mindful NOT Mindless worksheet in Appendix 3.

We generally find when people are feeling depressed or anxious they tend to think in a negative way about themselves, others and the world.

You've mentioned a number of negative thoughts including [……..].

Using one of the young person's negative thoughts as an example, work through the following thought management steps:

1. NOTICE the thought
2. OBSERVE the thought in a non-judgemental way
3. Remind yourself:

   'This is just a thought'; 'Thoughts are just thoughts, they are not facts"

   OR say to yourself: *'I've had the thought that……..'*

   Whatever works for the young person
4. Refocus your attention on what you are doing in the present moment
5. Finally, take a moment to see if your feelings change

   We've found that just tuning into and increasing awareness of your thoughts can help to reduce negative feelings and behaviours rather than trying to prevent or challenge them.

   This is just one way of managing negative thoughts and there are a range of other strategies available you can learn if you come back for further treatment.

STAGE 8: SUMMARISE THE CHANGE PLAN AND RATE THE YOUNG PERSON'S CONFIDENCE IN IMPLEMENTING THE PLAN

AIM

The aim of Stage 8 is to summarise the change plan and elicit commitment to change. You also rate the level of confidence in implementing the plan during this stage.

PREPARATION

This stage builds on:

- Principles and Use of Phase 2 MI Strategies (page 28)
- Use of the Readiness Rulers
- The person's completed Change Plan Worksheet

MATERIALS

Completed Change Plan Worksheet

Contact list of appropriate help-lines or telephone counselling services

STAGE 8 THERAPEUTIC EXERCISES

EXERCISE 8: CHANGE PLAN SUMMARY

Use the 'Change Plan Worksheet' in Appendix 3 for the following exercises.

Summarise the change plan and elicit the young person's level of support for the plan.

Is this what you want?

Is this what you will do?

Encourage the young person to identify support people, which may include family, friends, support workers, or telephone counselling services and how they may assist with the implementation of the plan.

Ask the young person to rate on a 10-point scale their confidence in implementing the change plan.

How confident are you that you will implement the change plan over the next few weeks?

If low (less than 7), use Phase 1 MI techniques to explore why the young person is not confident they can implement the plan and revise appropriately.

Encourage the young person to have a go at implementing the plan over the next month. If you are able, ask the client to nominate when they would like to start the modification process, and/or a date by which they are aiming to be abstinent (if this is their goal). Record this in the goals section of the Change Plan Worksheet.

Thank the young person for attending and let them know you will contact them in 1 month to see how things are going. Make the young person aware they can contact you in the meantime if they have any concerns or if things get worse.

ABBREVIATIONS

ASSIST	Alcohol, Smoking, and Substance Involvement Screening Test
BI	Brief Intervention
CBT	Cognitive Behavioural Therapy
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
K10	Kessler 10
MH	Mental Health
MI	Motivational Interviewing
QF	QuikFix
SU	Substance Use
YP	Young person/people

APPENDIX 1: BACKGROUND READING LIST FOR MOTIVATIONAL INTERVIEWING

Arkowitz, H., Westra, H.A., Miller, W.R., & Rollnick, S. (2008). *Motivational Interviewing in Health Care: Helping Patients Change Behavior,* New York: Guildford Press.

Arkowitz, H., Westra, H.A., Miller, W.R., & Rollnick, S., 2008. *Motivational Interviewing in the Treatment of Psychological Problems.* New York: Guilford Press.

Baker, A. & Velleman, R. (2007). *Clinical Handbook of Co-existing Mental Health and Drug and Alcohol Problems.* East Sussex: Routledge

Graham, H. L. (2004). *Cognitive-Behavioural Integrated Treatment (C-Bit): A Treatment Manual For Substance Misuse In People With Severe Mental Health Problems.* West Sussex: John Wiley & Sons.

Miller, W. R., & Rollnick, S. 2002. *Motivational Interviewing: Preparing People for Change (2nd ed.)*. New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2009). *Ten Things That Motivational Interviewing Is Not. Behavioural and Cognitive Psychotherapy,* 37(2), 129-140.

Miller, W. R., & Rose, G. S. (2009). *Toward a Theory of Motivational Interviewing.* American Psychologist, 64(6), 527-537.

Mueser, K. T., Noordsy, D. L., Drake, R. E. & Fox, L. (2003). *Integrated Treatment for Dual Disorders: A Guide for Effective Practice.* New York: Guilford.

Rollnick, S., Mason, P., & Butler, C. (1999). *Health behaviour change: A guide for practitioners.* Churchill Livingstone, Edinburgh.

For further information see www.motivationalinterview.org/

APPENDIX 2: SCREENING AND OUTCOME MEASURES

1) Mental Health Screens
   a) Kessler 10 (K10)
   b) Suicide Screen
   c) Self Harm Screen
2) Drug & Alcohol Screen
   a) Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
3) Useful measures for monitoring progress in treatment
   a) Readiness to Change Questionnaire (RTCQ)
   b) Social & Occupational Functioning Scale (SOFAS)
   c) Readiness Rulers

1. MENTAL HEALTH SCREENS

K10

The Kessler 10 (K10) Scale is a 10-item self-report measure of psychological distress [21]. A K10 cut-off score of ≥ 17 has been found to reliably detect the presence of depression and anxiety disorders in an Australian community sample [31]. We found a higher cut-off score of ≥ 27 was most reliable and valid among a sample of adult injecting drug users [32]. The K10 is yet to be validated among young people with co-occurring depression/anxiety and substance use issues. As the Quik Fix intervention is an early intervention program, a cut off score of ≥ 17 was used to identify young people with psychological distress in clinical and research settings to ensure even those with low levels of distress were provided with access to the ***Quik Fix*** treatment, despite the chance of false positive screens.

A copy of the K10 and information on its administration, scoring and interpretation is provided on page 63.

Translations of the K10 into 14 different languages are available at: **www.healthtranslations.vic.gov.au**

Online administration of the K10 is available at **www.gpcare.org**

A training manual and further information on the administration, scoring and interpretation of the K10 see: **www.amhocn.org/static/files/assets/2c63fca6/Kessler_10_Manual.pdf**

A K10 training DVD, IdentifyABLE has been developed by Kathryn Elkins, and produced by the Orygen Youth Health Design and Digital Media.

SUICIDE SCREEN & SELF HARM SCREEN

The suicidality section of the Mini International Neuropsychiatric Interview [MINI, 33] is a 6-item measure of current suicide risk. The total score of this scale provides an indication of whether the young person is at no risk, low, moderate or high suicide risk. An additional measure of self-harm in the past month was also added. This suicide risk screen is intended to be used as screening tool only and any young person reporting moderate to high levels of suicide risk requires further risk assessment and management by a mental health professional. A safety plan needs to be put into place for any young person reporting low levels of risk.

A copy of the Suicide Screen and information on its administration, scoring and interpretation is provided on page 64.

MENTAL HEALTH SCREEN (K10)

DATE _____

The following questions ask about how you have been feeling during the past 4 weeks.
During the **past 4 weeks**, on a scale of "none of the time" to "all the time", about how often did you feel…

KESSLER 10 Scale	None	A Little	Some	Most	All
a. tired out for no good reason?	1	2	3	4	5
b. nervous? (if none, go to 'd')	1	2	3	4	5
c. so nervous nothing could calm you down?	1	2	3	4	5
d. hopeless	1	2	3	4	5
e. restless or fidgety? (if none, go to 'g')	1	2	3	4	5
f. so restless that you could not sit still?	1	2	3	4	5
g. depressed? (if none, go to 'i')?	1	2	3	4	5
h. so depressed that nothing could cheer you up?	1	2	3	4	5
i. That everything was an effort?	1	2	3	4	5
j. worthless?	1	2	3	4	5

SCORING: TOTAL (add all numbers circled): _____ *(score 1 on skipped items)*

❑ Low (10 – 16) ❑ Moderate (17 – 29) ❑ High (30 – 50)

(If ≥ 17 client is experiencing psychological distress)

Suicide Screen		
In the ***past month*** did you:		
a. Think that you would be better off dead or wish you were dead?	0	1
b. Want to harm yourself?	0	2
c. Think about suicide?	0	6
d. Have a suicide plan?	0	10
e. Attempt suicide?	0	10

SCORING: TOTAL (add all numbers circled): _____

❑ No current risk (0 points) ❑ Low (1 – 5 points) ❑ Moderate (6 – 9 points) ❑ High (≥ 10 points)

Self Harm Screen		
Have you deliberately harmed or injured yourself in the past month (e.g. cut, burned or scratched) when not feeling suicidal?	NO	YES

How *difficult* have any of these problems made it for you to do your work, take care of things at home, or get along with other people?

❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

2. DRUG & ALCOHOL SCREEN

ASSIST

Alcohol, Smoking and Substance Involvement Screening Test [ASSIST, 23] is an 8-item measure of lifetime and recent (past 3 months) use of 10 substances, including tobacco, alcohol, cannabis, cocaine, amphetamines (including speed and ecstasy), inhalants, sedatives, hallucinogens, opioids and 'other drugs' [34]. Questions 3 to 7 provide measures of symptoms of substance abuse (e.g., how often has your use of substance led to health, social, legal or financial problems) and dependence (e.g., how often have you had a strong desire or urge to use substance) in the past 3 months. Items 2 to 5 are rated on a 5-point Likert scale (ranging from "never" = 0 to "daily or almost daily" = 4) and items 6, 7 and 8 are rated on 3-point scale ("never" = 0, "yes in/but not in the past 3 months" = 2 and 1 respectively). Item 8 asks about lifetime injecting drug use. A specific substance involvement score (SSI) is derived for each substance (sum of response weights to items 1 to 7) suggests the level of intervention needed, as well as a total substance involvement score (TSI; sum of response weights for items 1–8 across all substances) [34].

The ASSIST was developed by the World Health Organisation (WHO) as a screening instrument for all psychoactive substances, and the reliability and validity of the scale was established in a large study of 1047 participants recruited from drug treatment and primary care settings [34]. The ASSIST was recently found to be reliable and valid screening measure for cannabis, alcohol and amphetamine use disorders among individuals with first episode psychosis [35].

A copy of the ASSIST and information on its administration, scoring and interpretation is available on page 65.

Translations of the ASSIST into 8 different languages are available at: **http://www.who.int/substance_abuse/activities/assist/en/**

Online administration of the ASSIST is available at **www.drugabuse.gov/NIDAMED/screening/**

Guidelines for using the ASSIST in primary care settings as well as further information on the

administration, scoring and interpretation of the ASSIST is available at: **http://www.who.int/substance_abuse/activities/assist/en/**

A. WHO - ASSIST V3.0

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

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

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

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

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

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

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

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

If "No" to all items, stop interview.

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

Question 2

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

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

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

Question 3

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

Question 4

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

Question 5

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

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

Question 6

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

Question 7

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

Question 8

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

IMPORTANT NOTE:

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

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

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

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

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

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

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

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

B. WHO ASSIST V3.0 RESPONSE CARD FOR PATIENTS

Response Card - substances

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

Response Card (ASSIST Questions 2 – 5)

Never: not used in the last 3 months

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

Monthly: 1 to 3 times in one month.

Weekly: 1 to 4 times per week.

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

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

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

Name_____ **Test Date** _____

Specific Substance Involvement Scores

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

What do your scores mean?

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

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

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

Are you concerned about your substance use?

3. USEFUL MEASURES FOR MONITORING TREATMENT PROGRESS AND OUTCOMES

The following measures may be useful clinical tools to monitor treatment progress both during and after ***Quik Fix***:

1. Readiness to Change Questionnaire [RTCQ, 36]: a 12-item measure of an individuals motivation and confidence to change their drug related behaviours. This measure has demonstrated high levels of internal consistency, test-retest reliability and predictive validity among alcohol users.

INSTRUCTIONS

2. Social and Occupational Functioning Scale [SOFAS, 37]: a clinician rated assessment of the participant's current level of social and occupational functioning.
3. It can also be useful to readminister the client rated readiness rulers completed as part of the Quik Fix intervention to monitor treatment progress (Appendix 3).

READINESS TO CHANGE QUESTIONNAIRE

The following questionnaire is designed to identify how you personally feel about your drug use [MOST PROBLEMATIC/FREQUENTLY USED DRUG] right now. Please read each of the questions below carefully, and then decide whether you agree or disagree with the statements. Please tick the answer of your choice to each question. Your answers are completely private and confidential.

		Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	For Clinician Use
1.	I don't think I use drugs too much	❑	❑	❑	❑	❑	❑ P
2.	I am trying to use less drugs than I used to	❑	❑	❑	❑	❑	❑ A
3.	I enjoy using drugs, but sometimes I use too much	❑	❑	❑	❑	❑	❑ C
4.	Sometimes I think I should cut down on my drug use	❑	❑	❑	❑	❑	❑ C
5.	It's a waste of time thinking about my drug use	❑	❑	❑	❑	❑	❑ P
6.	I have just recently changed my patterns of drug use	❑	❑	❑	❑	❑	❑ A
7.	Anyone can talk about wanting to do something about drug use, but I am actually doing something about it	❑	❑	❑	❑	❑	❑ A
8.	I am at the stage where I should think about using less drugs	❑	❑	❑	❑	❑	❑ C
9.	My drug use is a problem sometimes	❑	❑	❑	❑	❑	❑ C
10.	There is no need for me to think about changing my drug use	❑	❑	❑	❑	❑	❑ P
11.	I am actually changing my drug using habits right now	❑	❑	❑	❑	❑	❑ A
12.	Using less drugs would be pointless for me	❑	❑	❑	❑	❑	❑ P

READINESS TO CHANGE QUESTIONNAIRE

SCORING THE READINESS TO CHANGE QUESTIONNAIRE
Quick Method

The precontemplation items are numbers 1, 5, 10 & 12, the action items are 3, 4, 8, & 9 and the contemplation items are numbers 2, 6, 7 & 11.
All items are to be scored on a 5 point rating scale ranging from:

-2 Strongly disagree
-1 Disagree
0 Unsure
+1 Agree
+2 Strongly agree

To calculate the score for each scale, simply add the item scores for the scale in question. The range of each scale is -8 through 0 to +8. A negative scale score reflects an overall disagreement with items measuring the stage of change, whereas a positive score represents overall agreement. The highest scale score represents the Stage of Change Destination.

Note: If two scale scores are equal, the scale farther along the continuum of change (Precontemplation - Contemplation - Action) represents the subject's Stage of Change Designation. For example, if a subject scores 6 on the Precontemplation scale, 6 on the Contemplation scale and -2 on the Action scale, then the subject is assigned to the Contemplation stage.

Note that positive scores on the Precontemplation scale signify a lack of readiness to change. To obtain a score for Precontemplation which represents the subject's degree of readiness to change, directly comparable to scores on the Contemplation and Action scales, simply reverse the sign of the Precomtemplation score (see below).

If one of the four times on a scale is missing, the subject's score for that scale should be pro-rated (i.e. multiplied by 1.33). If two or more items are missing, the scale score cannot be calculated. In this case, the Stage of Change Designation will be invalid.

Scale Scores		**Readiness to Change**	
Precontemplation	❑	Precontemplation	❑ (reverse score)
Contemplation	❑	Contemplation	❑ (same score)
Action score	❑	Action	❑ (same score)

STAGE OF CHANGE DESIGNATION
(P,C OR A?)

Readiness to change source:

Readiness to Change Questionnaire. Rollnick, S., Heather, N., Gold, R. & Hall, W. (1992).
Development of a short 'readiness to change' questionnaire for use in brief, opportunistic interventions among excessive

SOFAS

Consider social and occupational functioning along a continuum from excellent functioning to grossly impaired functioning. Include impairments in functioning due to physical limitations as well as those due to mental impairments. To be counted, impairment must be a direct consequence of mental health and physical health problems, the effects of lack of opportunity and other environmental limitations are not to be considered.

100 ↓ 91	**Superior function in a wide range of activities**
90 ↓ 81	**Good functioning in all areas, occupationally and socially effective**
80 ↓ 71	**No more than a slight impairment in social, occupational or school functioning (eg. infrequent interpersonal conflict, temporarily falling behind in schoolwork)**
70 ↓ 61	**Some difficulty in social, occupational or school functioning, but generally functioning well, has some meaningful interpersonal relationships**
60 ↓ 51	**Moderate difficulty in social, occupational or school functioning (e.g. few friends, conflicts with peers or co-workers)**
50 ↓ 41	**Serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job)**
40 ↓ 31	**Major impairment in several areas, such as work or school, family relations (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing school).**
30 ↓ 21	**Inability to function in almost all areas (e.g. stays in bed all day; no job, home, no friends).**
20 ↓ 11	**Occasionally fails to maintain minimal personal hygiene; unable to function independently.**
10 ↓ 1	**Persistent inability to maintain minimal personal hygiene. Unable to function without harming self or others or without considerable external support (e.g. nursing care and supervision).**
0	**Inadequate information**

Sofas Source:

Goldman HH, Skodol AE, Lave TR: "Revising Axis V for
DSM-IV: A Review of Measures of Social Functioning." American Journal of Psychiatry 149:1148–1156, 1992.

APPENDIX 3: QUIK FIX WORKSHEETS

1. Link between Substance Use and Emotional Health Ruler
2. Harm Reduction Handouts
   a. Harm Reduction Strategies
   b. Harm Reduction for Alcohol (3 pages)
   c. Harm Reduction for Cannabis
3. Pros and Cons Decisional Balance Sheet
4. Readiness Rulers:
   a. Importance Ruler
   b. Confidence Ruler
   c. Treatment Ruler
5. Change Plan Worksheet
6. Coping Styles
7. Good Vibes
8. Stress Less
9. Belly Breathing
10. Be Mindful NOT Mindless
11. How to improve your sleep (Optional)

LINK BETWEEN SUBSTANCE USE AND EMOTIONAL HEALTH RULER

How much of a link is there between your substance use and emotional health?

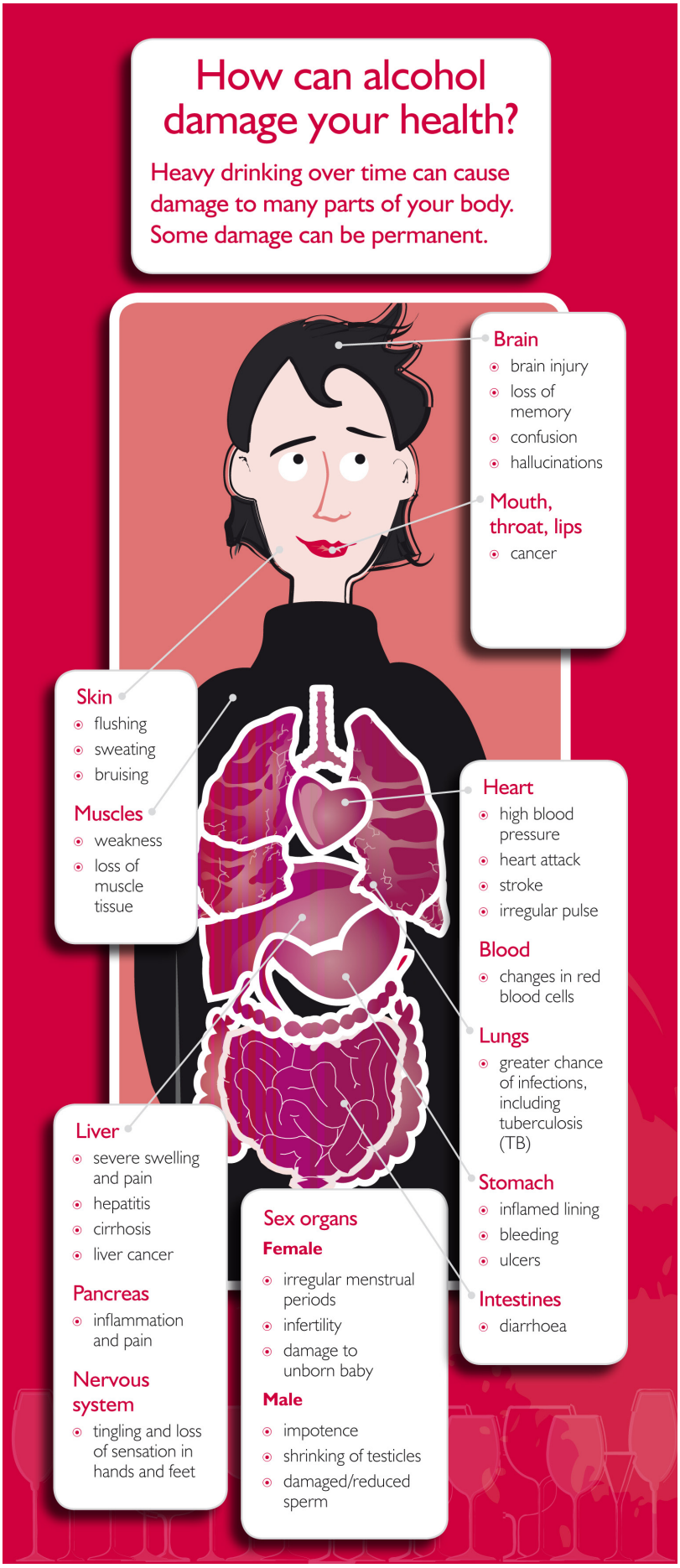
No link at all	Weak link	Moderate link	Strong link	Very Strong link

HARM REDUCTION STRATEGIES

Have a minder	➜ **Avoid using substances alone** – have someone as minder in case of overdose, allergic reactions or 'bad trips'.
Use is a safe place	➜ **Use in environments where emergency support can be easily accessed**
Don't mix	➜ **Avoid combining substances** – the effects of mixing substances are unpredictable and potentially dangerous.
Be safe	➜ **Use safer methods for administrating** the substance (e.g. orally instead of IV).
'Taste test' first	➜ **Have a 'taste test' first** – especially if the drugs have been obtained from new sources or if your tolerance has dropped (if you haven't used in a while).
Know the source	➜ **Buy from a known source** and be aware of the purity of the substance and the cutting agents used.
Watch your mood	➜ Alcohol and other drugs can negatively affect the way you feel, think and/or behave – **be aware of taking drugs when angry, anxious, depressed, vulnerable etc.**
Don't drive under the influence	➜ **Avoid using substances when driving a vehicle** or when involved in any other potentially dangerous activities. Substance use reduces a person's ability to concentrate, slows reflexes and impairs judgement and perception.

Source: Substance Use & Mental Illness Treatment Team (SUMITT)

HARM REDUCTION – ALCOHOL



Source:
Alcohol and Your Body,
Australian Drug Foundation

HARM REDUCTION – ALCOHOL

Switch drinks	➜ **SWITCH DRINKS** – Some drinks are much stronger than others, so switch from a strong drink to a weaker one. If making your own drinks use more mixer and less alcohol.
Drink spacers	➜ **DRINK SPACERS** – Soft drink "spacers" between drinks can help to pace an evening.
Avoid top-ups	➜ **TOP UPS** – Avoid top ups so that you can keep track of your drinking.
Avoid rounds	➜ **QUIT THE ROUNDS** – Avoid rounds, they encourage you to drink more than you would like out of loyalty to your friends.
Choose your company	➜ **CHOOSE YOUR COMPANY** – If you know you will drink a lot with some people, try and avoid always going out with them.
Pace yourself	➜ **PACE YOURSELF** – Drink slowly. Take a break of 1 hour between drinks. Drink soda, water, or juice between drinks.
Say NO	➜ **LEARN HOW TO SAY NO** – You do not have to drink when other people drink. You do not have to take a drink that is given to you. Practice ways to say no politely. For example, you can tell people you feel better when you drink less. Stay away from people who give you a hard time about not drinking.
Stay active	➜ **STAY ACTIVE & REWARD YOURSELF FOR ACHIEVING YOUR GOALS** – What would you like to do instead of drinking? Use the time and money spent on drinking to do something fun with your family or friends. Go out to eat, see a movie, shop or play/watch sports.
Get support	➜ **GET SUPPORT** – Cutting down on your drinking may be difficult at times. Ask your family and friends for support to help you reach your goal. Get the help you need to reach your goal.
Avoid temptations	➜ **WATCH OUT FOR TEMPTATIONS** – Watch out for people, places, or times that make you drink, even if you do not want to. Stay away from people who drink a lot or bars where you used to go. Plan ahead of time what you will do to avoid drinking when you are tempted. Do not drink when you are angry or upset or have a bad day.

HARM REDUCTION – ALCOHOL

Monitor the amount you drink

➜ **MONITOR THE AMOUNT YOU DRINK** – A 'standard drink unit' (SDU) contains 10 grams of alcohol, the following servings are 1 SDU

STANDARD DRINKS

Avoid drinking excessively

➜ **AVOID DRINKING EXCESSIVELY** – The following are guidelines for 'low risk drinking'.

'Low Risk Drinking' For MEN	'Low Risk Drinking' For WOMEN
No more than 2 standard drinks in the 1st hour and 1 per hour after that	No more than 1 standard drink per hour
An average of no more than 4 standard drinks a day, and no more than 21 standard drinks over a week	An average of no more than 2 standard drinks a day, and no more than 14 standard drinks over a week
Not more than 6 standard drinks during any one occasional heavy drinking day	Not more than 4 standard drinks during any one occasional heavy drinking day
One or two alcohol-free days per week	One or two alcohol-free days per week

Don't mix drugs

➜ **MIXING DRUGS** – Avoid combining alcohol with other substances – the effects of mixing substances are unpredictable and potentially dangerous.

Drink water

➜ **WATER** – Alternate your drinks with water to stay refreshed, and drink water before you go out so that you are not so thirsty.

Eat food

➜ **FOOD** – Having a bite to eat before or whilst drinking slows alcohol absorption.

Designate a driver

➜ **DRIVING** – Think about how you're going to get home before you leave home – take a licensed cab or designate a driver.

Set limits

➜ **If you're going out, before you go out SET LIMITS or decide:**

a. How much you are going to drink &/or
b. How much money you're going to spend &/or
c. How long your going to stay out

HARM REDUCTION – CANNABIS

Avoid hashish and hashish oil	➜ **Use CANNABIS instead of hashish or hashish oil**
Smoke 'leaf'	➜ **Smoke the plants 'LEAF' instead of 'heads' or 'hydro'**
Eat cannabis instead of smoking	➜ **EAT CANNABIS INSTEAD OF SMOKING IT** – this reduces the physical consequences of it. Remember the effects can take 1 – 2 hours to come on.
Avoid holding smoke in lungs	➜ **AVOID HOLDING SMOKE IN THE LUNGS** – The effects of a 'drag' occur within seconds so there is no need to hold smoke in the lungs – it just allows more opportunity for tar to coat the lungs.
Use tips instead of filters	➜ **USE TIPS INSTEAD OF FILTERS** – Filters will filter out much of the THC so you will suck harder or smoke more to get the same effects
Use plain cardboard	➜ **USE PLAIN CARDBOARD** rather then coloured or laminated card as inks can be toxic
Limit papers	➜ **USE AS FEW PAPERS AS POSSIBLE WHEN SMOKING JOINTS**
Use ceramic or glass bongs	➜ **USE CERAMIC OR GLASS BONGS INSTEAD OF 'HOME MADE' ONES.** Plastic bottles, rubber hoses and aluminium cones contain harmful toxins that are released when heated. Alternatively, if smoking a pipe use glass, stainless steal or brass pipes rather then wood or plastic pipes.
Don't smoke seeds or stems	➜ **DON'T SMOKE THE SEEDS OR STEMS** as they burn at a higher temperature

Source: Substance Use & Mental Illness Treatment Team (SUMITT)

HARM REDUCTION – CANNABIS

Avoid mixing drugs	➜ **AVOID COMBINING CANNABIS WITH ALCOHOL AND OTHER DRUGS** – the effects of mixing substances are unpredictable and potentially dangerous.
Take care of yourself	➜ **DRINK PLENTY OF WATER** – and have a bite to eat before you have a smoke.
Don't smoke and drive	➜ **AVOID VEHICLES AND MACHINERY WHEN SMOKING** –If you're going out think aboout how you're going to get home - take a licensed cab or designate a driver.
Set Limits	➜ **DECIDE ON YOUR OWN REASONABLE LIMITS** Before you smoke: a. How much you smoke &/or b. How much money you're ging to spend &/or c. How long your going to stay out
Pace Yourself	➜ **TAKE A BREAK BETWEEN SMOKES** - Plan to do other things, especially things that involve leaving the house to slow you down.
Avoid Shouts	➜ **SET YOUR USE INDEPENDENT OF YOUR FRIEND** - Friends may encourage you to smoke more cannabis than you planned.
Select Activity Wisely	➜ **SOME ACTIVITIES OR FRIENDSHIPS INCREASE THE LIKELIHOOD OF SMOKING** - If you know you will smoke a lot of cannabis with some people, try and avoid always hanging out with them, or plan smoke-free activities.
Say 'NO'	➜ **LEARN TO SAY NO** - You do not have to smoke pot when other people do. Practice ways to say no assertively. For example, you can tell people you've got a sore throat. Stay away from people who give you a hard time about not smoking pot with them.

PROS & CONS DECISIONAL BALANCE

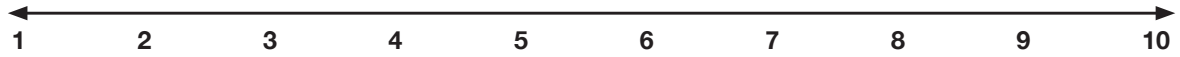
Good things about:	Not so good things about:

Good things about CHANGE	Not so good things about CHANGE

CONFIDENCE, IMPORTANCE AND TREATMENT READINESS RULERS

IMPORTANCE Ruler

How *important* would you say it is for you to make a change in your depression / anxiety symptoms? On a scale of 1 – 10, where 1 is not at all important and 10 is extremely important, where would you say you are? Mark scale with an X.
How about your substance use? Mark scale with a 0.



Not important	Somewhat important	Most important

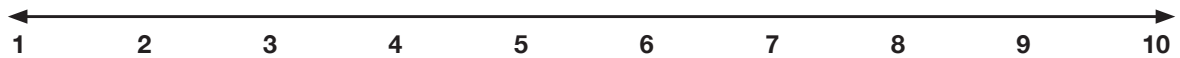
CONFIDENCE Ruler

How *important* would you say it is for you to make a change in your depression / anxiety symptoms? On a scale of 1 – 10, where 1 is not at all important and 10 is extremely important, where would you say you are? Mark scale with an X.
How about your substance use? Mark scale with a 0.

Not confident	Somewhat confident	Highly confident

TREATMENT Ruler

On a scale of 1 – 10, how likely is it that you will attend further treatment (once you have completed Quik Fix) to help you make this change?
Where 1 is not at all important and 10 is extremely important, where would you say you are?



Not confident	Somewhat confident	Highly confident

CHANGE PLAN WORKSHEET

What are my change goals? What are my emotional health and/or substance use goals?

1. _____
2. _____
3. _____

The MOST important reasons why I want to change are:

1. _____
2. _____
3. _____

What would help me achieve these goals?

1. _____
2. _____
3. _____

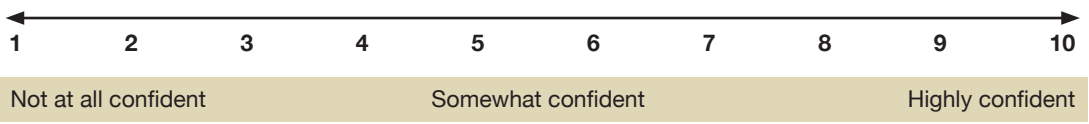
Other people who could help me in changing these ways are:

Person	***Possible ways they could help:***
1. _____	_____
2. _____	_____
3. _____	_____

I'll know my plan is working if I have the following positive results:

1. _____
2. _____
3. _____

How confident are you that you will make these changes in the next few weeks? *(please circle)*



COPING STYLES

Everybody experiences day-to-day life problems and negative emotions (e.g. anger, sadness). Problems can relate to drug use (e.g. being in a group where drugs are freely available), can arise from thoughts or feelings (e.g. depressing/intrusive thoughts), or from interactions with others (e.g. arguments).

COPING STYLES are typical or habitual ways of approaching or dealing with problems or emotions."

"What coping skills do you usually use when you're dealing with problems or negative emotions"?

COPING STYLES:

HELPFUL Coping Skills actively deal with problems and emotions as they occur. Examples include: making telephone calls, seeking help, visiting services, relaxing, challenging thoughts, scheduling activities.

UNHELPFUL Coping Skills that do not address the problem or emotion. They include:

➜ **Denial:** ignoring the problem or emotion, pretending it's not happening or that it's not as bad as it seems

➜ **Avoidance:** doing other things to avoid dealing with the problem (e.g. wagging school) or emotion (e.g., taking drugs or binge drinking)

➜ **Aggressive or hostile behaviour:** yelling and swearing at others, hitting someone

➜ **Acting impulsively:** doing things without thinking first (e.g. drive fast, gamble, drug and alcohol use)

The more you attempt to avoid or deny problems or emotions the more you'll think about them and the more upset you'll feel, as avoiding or delaying problems or emotions just makes them worse. While these coping styles may make you feel better in the short term, they do little to resolve the problem. Pressure from unresolved problems easily leads to negative emotions (e.g. anxiety/worry, anger, sadness) and substance use.

For each of the coping skills you've identified, ask yourself *"Which of your coping styles are helpful and which are unhelpful".*

The following questions may assist with this:

- **How effective is it in helping me manage my problems or emotions?**
- **Does it actually help me solve my problems?**
- **How long does it work for?**
- **Does it solve my problems in the long-term?**

Now, circle the coping skills (above) which best help you manage problems or emotions.

Coping skills training is an important part of cognitive behaviour therapy (CBT), which teaches you how to recognize problematic situations and emotions and the most appropriate ways of coping with them. We recommend you attend CBT treatment in the future to develop more helpful ways of coping with problems and emotions and can either provide you with further treatment/or referral options for seeking further treatment if your interested.

In the mean time, here are a few simple ways of helping you cope with problems or emotions.

GOOD VIBES

LOOK AFTER YOURSELF

1. **Balance Eating:** Make healthy choices with the food you eat and have regular mealtimes.

2. **Drink lots of water.**

3. **Get Exercise:** Do something active 3+ times a week. Exercise such as walking, swimming or going to the gym can help you feel good.

4. **Treat Physical illness:** If you're feeling unwell, go see your GP.

5. **Balance your Sleep:** Set a regular sleep routine, be active during the day, wind down for at least 30 minutes before bed, avoid drinking caffeine after about 4pm.

INCREASE POSITIVE FEELINGS

1. **Do at least 1 thing that MAKES YOU FEEL GOOD each day.**

   Write a list of positive activities in the table provided. Include the following in your list:

   - ➜ 2 people you would like to spend more time with
   - ➜ 2 activities you would like to do more often
   - ➜ 2 places where you would like to spend more time
   - ➜ 2 things you don't own but would like to (make sure you can afford them)
   - ➜ 2 of your favorite foods

2. **Schedule pleasant activities in advance** – set days & times to do them in the column provided.

PLEASANT ACTIVITIES I ENJOY	WHEN WILL I DO THEM? *Set the time...*						
	MON	TUES	WED	THURS	FRI	SAT	SUN

STRESS-LESS

Reduce Mental and Physical Tension by trying some of the following:

➜ **1. Exercise 3+ times a week.**
High energy exercises (e.g., running, martial arts or going to the gym) that help you release pent-up tension. Gentler activities like walking or yoga also help you stress less. List three activities that could help you stress less and relax:

1._____

2. _____

3. _____

Try and do one of these activities at least 3 times a week.

➜ **2. Ssttrreettcchh your body** to reduce muscle tension. Try the following

Whole Body: Stand up and stretch as tall as you can, hold your arms up tall and stand on your tippy toes!!!

Neck: Stretch your neck as long and tall as you can – make if feel like a swans neck. Now turn your head to the right side and push your left shoulder and arm down as you exhale extend the stretch even more. Now repeat for the other side.

Shoulders: Rotate your shoulders forward 5 times and backwards 5 times. Now give yourself a bear hug.

➜**3. Give yourself a mini massage!! (or ask a friend).**

Use your very own massage therapist (YOUR HANDS!) to massage your neck and shoulders. Lie on your back and place a tennis ball wherever you feel muscle tension. Try the base of your neck, between your shoulder blades and the small of your back

STRESS-LESS

➜ **4. Self soothe: "Relax by soothing each of your 5 senses:**

Sight:

Hearing:

Touch:

Taste:

Smell:

Add these activities to

➜ **5. Take a brief vacation**.
Go to bed and pull the covers up over your head for 20 minutes, read a book in bed, lie in a park, sit on the beach".

➜ **6. Listen to music mindfully:**
"Listen to your favourite music track or album mindfully - really listen to the music - every beat, every lyric and every instrument. Try to focus on the music. If your mind wanders off, this is ok it's what minds do. Just notice this and gently bring your focus back to the music".

Most importantly just DO SOMETHING to help you STRESS LESS

BELLY BREATHING RELAXATION

➜ **First, sit comfortably in a chair with your head, back and arms supported.** Uncross your legs and close your eyes if that feels comfortable. Put one hand flat on your chest and the other hand over your stomach between your ribs and bellybutton. Remember that you want your bottom hand – the one on your stomach – to move during this exercise, not the hand on your chest – that's why we call it 'Belly Breathing'.

➜ **Now, take a breath in, and hold it as you count to 3.** Don't make this a really deep breath, just breathe in normally, using your diaphragm and hold it in for a count of 3. When you get to 3, breathe out and mentally say the word "relax" in a calm, soothing manner.

➜ **Next, practice breathing in and out slowly in a 6-second cycle.** Breathe in for 3 seconds and out for 3 seconds ("in-2-3, out-2-3"). As you breathe in, use your diaphragm, not your chest. Your hand on your chest should remain relatively still. Every time you breathe out, mentally say the word "relax" in a calm manner.

➜ **Observe your hands as you breathe.** If you are relaxed, the hand over your belly should be moving more than the hand over your chest.

➜ **There is no need to slow down the rate of your breathing – this will happen naturally as you become relaxed.** Try to breathe in through your nose and out through your mouth.

➜ **Continue this process until your symptoms of anxiety, stress, tension or anger are relieved.**

BE MINDFUL NOT MINDLESS

If you find yourself feeling depressed, anxious or thinking about using drugs or alcohol, follow these steps:

➜ **1. NOTICE the thought**

➜ **2. OBSERVE the thought in a non-judgemental way**

➜ **3. Remind yourself:**
'This is just a thought';
'Thoughts are just thoughts, they are not facts"

OR say to yourself: ***'I've had the thought that……..'***

➜ **4. Refocus your attention on what you are doing in the present moment**

➜ **5. Finally, take a moment to see if your feelings change.**

HOW TO IMPROVE YOUR SLEEP

10 TIPS to BETTER SLEEP

1. **Try to have a regular sleep routine** by going to bed at the same time every night and getting up as soon as you wake. Do not nap during the day.

2. **Do something physical during the day.** Be active early in the morning or late in the afternoon, go out into he sun!

3. **Create a relaxing sleep environment.** Make sure you're not too hot cold. Turn off your phones, computers and TV.

4. **If you worry about things during the night,** set aside problem solving time during the day

5. **Wind down at night.** Do something relaxing at least 30 minutes before bed.

6. **Use your bed only for sleep and sex!** Avoid reading or watching TV in bed.

7. **Avoid drinking caffeine** after about 4pm, and try not to drink more than 2 cups of caffeinetype drinks each day (e.g. coffee, cola)

8. **Avoid alcohol** as this makes you restless.

9. **Avoid smoking cigarettes w**ithin 1 to 2 hours of bed as nicotine is a stimulant

10. **Use sleeping pills as anabsolute last resort and only as directed by your GP**

BREAKING a poor sleep pattern

If you've had long-term problems getting to sleep, you may feel anxious about getting to sleep, making your sleep problems worse.

To overcome this, follow the ***"10 Tips to Better Sleep"*** and take the following steps when you can't get to sleep:

1. **If you cannot fall asleep get up after trying for 15 to 20 minutes. Staying in bed when you are feeling restless and anxious is unlikely to result in sleep.**

2. **Do something quiet and distracting (e.g. cards, reading, warm bath). If your mind is very active or you worry about problems, it might be helpful to try something that requires mental effort (e.g. solitaire, crossword). By distracting yourself from your worries you may feel more relaxed and sleepy.**

3. **Go back to bed only when you feel relaxed and sleepy.**

4. **If you are still awake after a further 15 to 20 minutes of trying to sleep, get out of bed again. Repeat this process until you fall asleep.**

APPENDIX 4: REFERENCES

1. Degenhardt, L., et al., *The management of alcohol, tobacco, and illict drug use problems by General Practitioners in Australia.* Drug and Alcohol Review, 2005. **24:** p. 499-506.
2. Baker, A., F. Kay-Lambkin, and T.J. Lewin, *Co-existing mental health and drug and alcohol problems: Steps toward better treatment, in Clinical Handbood of Co-existing Mental Health and Drug and Alcohol Problems,* A.B.R. Velleman, Editor. 2007, Routledge: East Sussex. p. 1-19.
3. Grella, C.E., et al., *Drug treatment outcomes for adolescents with comorbid mental and substance use disorders.* Journal of Nervous & Mental Disease, 2001. **189**(6): p. 384-392.
4. Australian Institute of Health and Welfare, *2007 National Drug Strategy Household Survey: First results, in Drug Statistics Series number 20.Cat. no.* PHE 98. 2008, AIHW: Canberra.
5. Lubman DI, Hides L, Yücel M, and Tomobourou JW. *Intervening early to reduce developmentally harmful substance use amongst youth populations.* Medical Journal of Australia, 2007. 187 (7 Suppl): p. S22-S25.
6. Patel, V., et al., *Treatment and prevention of mental disorders in low-income and middle-income countries.* Lancet, 2007. **370**(9591): p. 991-1005.
7. Rickwood, D., A. White, and R. Eckersley, *Overview of current trends in mental health problems for Australia's youth and adolescents.* Clinical Psychologist, 2007. 11: p. 72-78.
8. Lubman DI, Hides L, Yücel M, and Tomobourou JW. *Intervening early to reduce developmentally harmful substance use amongst youth populations.* Medical Journal of Australia, 2007. **187** (7 Suppl): p. S22-S25.
9. McCambridge, J. and J. Strang, *The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: Results from a multi-site cluster randomised trial.* Addiction, 2004. **99**: p. 32-52.
10. Hettema, J., Steele, J. & Miller, W. R., *Motivational Interviewing.* Annual Review of Clinical Psychology, 2005. **1**: p. 91–111.
11. Martino, S., et al., *Motivational interviewing with psychiatrically ill substance abusing patients.* American Journal of Addictions, 2000. **9**: p. 88-91.
12. Steinberg, M.L., et al., *Motivational Interviewing With Personalized Feedback: A Brief Intervention for Motivating Smokers With Schizophrenia to Seek Treatment for Tobacco Dependence.* Journal of Consulting & Clinical Psychology, 2004. **72**(4): p. 723-728.
13. Swanson, A.J., M.V. Pantalon, and K.R. Cohen, *Motivational interviewing and treatment adherence among psychiatric psychiatric and dually diagnosed patients.* Journal of Nervous & Mental Disease, 1999. **187**: p. 630-635.
14. Scogin, F.R., A. Hanson, and D. Welsh, *Self-administered treatment in stepped-care models of depression treatment.* Journal of Clinical Psychology, 2003. **59**(3): p. 341-349.
15. Prochaska, J.O., C.C. DiClemente, and J.I. Norcross, *In search of how people change.* American Psychologist,, 1992. **47**: p. 1102-1114.
16. Miller, W.R. and S. Rollnick, *Motivational Interviewing: Preparing People for Change.* 2nd ed. 2002, New York: Guilford Press.
17. Moyer, A., et al., *Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations.* Addiction, 2002. **97**: p. 279-292.
18. Shafii, M., et al., *Comorbidity of mental disorders in the post-mortem diagnosis of completed suicide in children and adolescents.* Journal of Affective Disorders, 1988. **15**(3): p. 227-233.
19. Wagner, B.M., R.E. Cole, and P. Schwartzman, *Comorbidity of symptoms among junior and senior high school student suicide attempters.* Suicide and Life Threatening Behaviour, 1996. **26**(3): p. 300-307.
20. Lewinsohn, P.M., P. Rohde, and J.R. Seeley, *Adolescent psychopathology: III. The clinical consequences of comorbidity.* Journal of the American Academy of Child & Adolescent Psychiatry, 1995. **35**(4): p. 510-519.
21. Kessler, R.C., et al., *Short screening scales to monitor population prevalences and trends in non-specific psychological distress.* Psychological Medicine, 2002. **32**(6): p. 959-976.
22. Sheehan, D., et al., *MINI International Neuropsychiatric Interview, DSM-IV English Version 5.0.0.* 2002: Sheehan DV & Lecrubier Y.
23. World Health Organisation ASSIST Working Group, *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Development, reliability, and feasibility.* Addiction, 2002. **97**: p. 1183-1194.
24. Proudfoot, H., M. Teeson, and P. Dillon, *feeling good? alcohol, drugs and mental health.* 2005, Canberra: Commonwealth of Australia.
25. Carver, C.S., M.R. Scheier, and J.K. Weintraub, *Assessing coping strategies: A theoretically based approach.* Journal of Personality and Social Psychology, 1989. **56**: p. 267-283.

26. Linehan, M.M., *Cognitive-behavioural treatment of borderline personality disorder.* 1993, New York: Guilford Press.
27. Persons, J.B., J. Davidson, and M.A. Tompkins, *Essential Components of Cognitive-Behaviour Therapy for Depression.* 2001, Washington: American Psychological Association.
28. Andrews, G., et al., *The Treatment Of Anxiety Disorders - Clinician Guides And Patient Manuals*. 2003, Cambridge: Cambridge University Press.
29. Segal, Z.V., J.M.G. Williams, and J.D. Teasdale, *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse.* 2002, New York: Guilford Press.
30. Hayes, S.C., V.M. Follette, and M.M. Linehan, *Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition.* 2004, New York: Guilford Press.
31. Andrews, G. and T. Slade, *Interpreting scores on the Kessler Psychological Distress Scale (K10).* Australian & New Zealand Journal of Psychiatry, 2001. **25**(6): p. 494-497.
32. Hides, L., et al., *The Reliability and Validity of K10 and PHQ amongst Injecting Drug Users*. Australian & New Zealand Journal of Psychiatry, 2007. **41**: p. 166-168.
33. Lecrubier Y, Sheehan D, and Weiller E. *The Mini-International Neuropsychiatric Interview (MINI). A short diagnostic structured interview: reliability and validity according to the CIDI.* European Psychiatry, 1997. **12**: p. 224-231.
34. Humeniuk R, et al. *Validation of the alcohol, smoking, and substance involvement screening test (ASSIST).* Addiction, 2008. **103**(6): p. 1039-1047.
35. Hides, L., et al., *The reliability and validity of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) in first episode psychosis* Addictive Behaviours, 2009. **34**: p. 821-825.
36. Heather, N. and S. Rollnick, *Readiness to Change Questionnaire: User's Manual.* 2000: Centre for Alcohol & Drug Studies, Newcastle City Health NHS Trust, and Centre for Clinical Psychology & Healthcare Research, University of Northumbria at Newcastle.
37. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders IV Text Revision (DSM-IV-TR).* 2000, Washington: American Psychiatric Association.