Brief Intervention Guide

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

Matua Raki 2012

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Foreword

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

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

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

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

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

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June 2012

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Introduction to the Guide

Who is the Brief Intervention Guide for?

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

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

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

Sections within the Guide

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

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

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

What is brief intervention?

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

In this Guide brief intervention refers to:

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

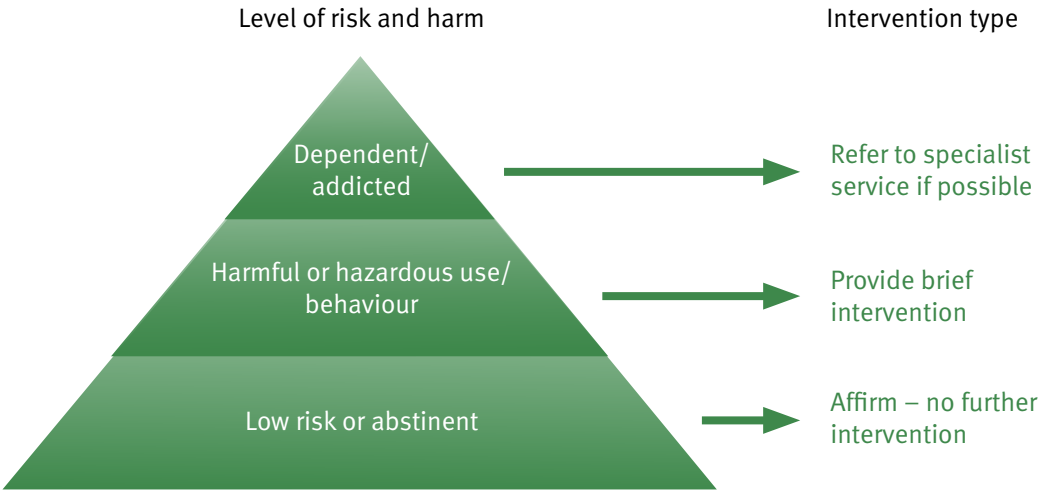
The purpose is to support the person to think about their behaviour, assisting them to make a connection between their behaviour and any associated risks and harms. (adapted from NHS Health Scotland, 2009, and Humeniuk, Henry-Edwards, Ali, Poznyak & Monteiro, 2010b).

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

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

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

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



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

Why offer brief intervention?

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

Harms from use of alcohol, tobacco other drugs and gambling

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

- Alcohol-related harm in New Zealand is estimated to cost $5.3 billion per year, or $14.5 million per day (Alcohol Healthwatch, 2009). Approximately 25% of people who drink alcohol typically drink large quantities when they drink (Law Commission, 2009). A recent NZ report noted that in the previous year one in six adults experienced harm from someone else's drinking (Law Commission, 2010). Alcohol is also closely linked with crime (Wilkins, et al., 2010; New Zealand Police, 2009).

- Tobacco use is the single largest preventable cause of death in New Zealand (Ministry of Health, 2002, cited in Health Sponsorship Council, 2009). On average a regular tobacco smoker in New Zealand will lose 13 years of quality life (Peto, Lopez, Boreham, & Thun, 2006). There are immediate health benefits from stopping for those who are already experiencing harm from smoking and for those who are at risk of harm (Ministry of Health, 2007).

- Cannabis is New Zealand's most widely used illicit drug (Wilkins, Girling & Sweetsur, 2006). A recent survey indicated that 67.1% of cannabis users reported driving under the influence of cannabis in the past year (New Zealand Drug Foundation, 2009).

- New Zealand has the third highest reported proportion of the population using methamphetamine (P) in the world (United Nations Office on Drugs and Crime, 2009). Research indicates that 3.4% of the population (aged 15-45 years) uses methamphetamine, with significant negative impacts on individuals, families, whānau and communities (Wilkins & Sweetsur, 2008).

- Gambling affects one in eight New Zealanders. Each person with a gambling problem affects at least seven others, making this a significant social issue (National Committee for Addiction Treatment, 2010).

- Gambling can be related to criminal activity e.g., a recent New Zealand study suggested that 10,000 people committed illegal activities within the previous year because of gambling (Centre for Social and Health Outcomes Research and Evaluation, 2008). Gambling related crimes can include: illegal gambling, criminal activity to support gambling and family-related offending (Problem Gambling Foundation of New Zealand, 2011).

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

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

> *One-in-five drinkers typically drink enough to double their risk of injury; nearly one-in-three drink over the daily recommended maximum so face a greater than 1:100 risk of dying of an alcohol-related disease or injury.*
>
> (Law Commission, 2010, p. 72)

Brief intervention is part of the spectrum of effective responses

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

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

> *Social workers, youth workers, Probation Officers as well as GPs and practice nurses... have an important part to play in identifying and working to curb risky or hazardous behaviour that might progress to become more problematic. Further, people who have a severe problem but who do not see themselves as having a problem and/or who are not presenting at specialist addiction services may present before these generalists*
>
> (Matua Raki, 2012, p. 11)

Brief intervention evidence base

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

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

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

Key concepts in screening and brief intervention

Screening as a basis for brief intervention

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

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

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

Table 1: Screening result and level of intervention

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

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

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

Before offering brief intervention

Preparation

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

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

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

Box 1. Resources for brief intervention
Alcohol: The Alcohol Advisory Council's resources such as information brochures, booklets and dvds are of high quality and freely available. It is recommended that workers keep a stock of these on hand to give to people who have issues related to alcohol. Web based self-help material on the ALAC website may also be useful. There is also material aimed to support family and friends concerned about someone else's drinking. The ALAC website is available at: www.alac.org.nz.
See also Kina Families and Addiction Trust, **Living Well**, for families seeking help for alcohol and other drug issues. Available at: http://www.kinatrust.org.nz.
Tobacco: The Quitline website, http://www.quit.org.nz/, provides excellent resources to support people to quit smoking. It may be useful to print out or order resources such as **The Quit Book** (available on line at http://www.quit.org.nz/file/new-quit-book.pdf) which has tips for quitting and staying quit. This book can be the basis for a discussion and tips most relevant to the person can be highlighted for quick reference. Quitline also has the **4Ds** card which people can order and take with them to remember the 4Ds: Delay, Deep Breathe, Do something Else, Drink water. The Quitline website also has a free quit smoking service and a texting service that sends people motivational messages and tips. These can be used in addition to face-to-face services.

Box 1. Resources for brief intervention *(continued)*
ADANZ, www.adanz.org.nz or 0800 787797, provides information, assessment, brief intervention and ongoing support to people who use alcohol and other drugs and their family and whānau members. ADANZ also maintains an up to date online database of specialist addiction services across Aotearoa New Zealand
Other drugs: The New Zealand Drug Foundation website provides information on drug effects and harm reduction for a range of drugs, including cannabis and methamphetamine. The website is available at: http://www.drugfoundation.org.nz/drug-information/about-drugs
Gambling: The Gambling Helpline website has helpful information and a range of self-help material, including printable leaflets targeted at identifying a problem, preparing to change, gambling triggers, warning signs etc. More substantial self-help booklets are also available. There is also material aimed to support family and friends concerned about someone else's gambling. This material is available at: http://www.gamblinghelpline.co.nz/Self-help--resources--links_356.aspx

The knowledge base

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

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

Training

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

How to provide brief intervention

Elements of brief intervention: FRAMES

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

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

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

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

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

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

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

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

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

Motivation and brief intervention

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

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

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

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

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

Box 2. Key principles of motivational interviewing
Express Empathy: show acceptance and develop rapport. Ambivalence to change is normal. The worker listens to and accepts what is important to the person. Empathy and rapport make space for gentle challenge.
Develop Discrepancy: Change is motivated by a perceived discrepancy between a person's current behavior and their important personal goals and values.
Roll with Resistance: Resistance is a signal for the worker to respond differently. Avoid arguing for change.
Support Self-efficacy: If a person believes they can change, the likelihood of change occurring is greatly increased. A person's belief in the possibility of change is an important motivator.

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

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

Bring together the stages of change and a motivational response

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

Table 2. Stages of change and motivational responses

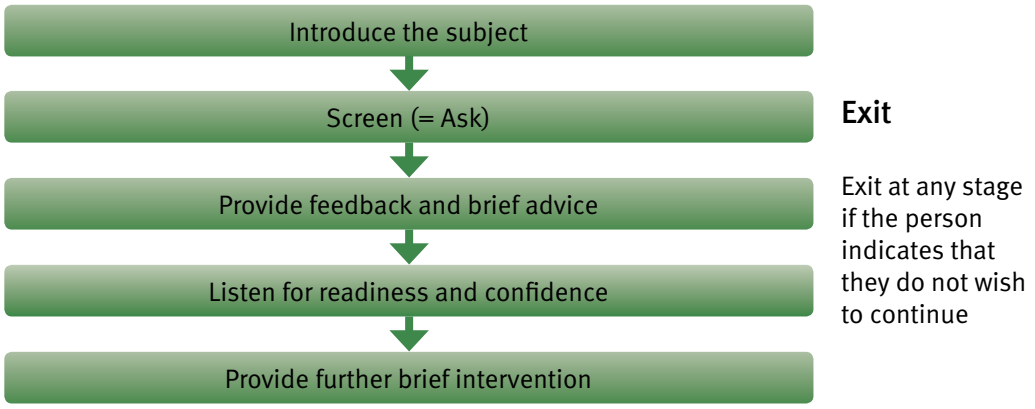
Stage	Response
Pre-contemplation – not thinking about change; don't see a problem "*My grandmother smokes and she's 85 and fit as. Smoking is no big deal.*"	Work towards engendering motivation Provide information and advice (with permission) on the benefits of change
Contemplation – thinking about change;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

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

Stages of brief intervention at a glance

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

Figure 2. Stages of brief intervention



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

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

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

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

Tips are provided for each stage as a further aid.

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

Introduce the subject

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

Objectives

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

Responsibility sits with the person

Empathy: listen and reflect; maintain rapport

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

Tips
Your own values and behaviour are not the focus and should not interfere with your efforts to support people to reduce harm from alcohol, tobacco, other drugs and gambling.
When working with people of cultures other than your own ensure that you convey respect for cultural difference. Use cultural support and expertise to assist in providing an effective service. Pay attention to cultural norms in relation to rapport building. Taking the time to effectively engage with Māori and Pasifika people and building a trusting relationship will increase the likelihood of being able to provide an effective intervention.
With young people: It is generally important to develop rapport before you introduce the issues i.e., by talking about topics other than substance use or gambling. Clarity about confidentiality is especially important to develop trust.

Screen

Objectives

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

Responsibility sits with the person

Empathy: listen and reflect; maintain rapport

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

Tips
Be familiar and comfortable with the screening questions and/or tools.
Defer screening when other needs are clearly more immediate, for example, the person is intoxicated, highly agitated, in need of urgent medical attention etc.
Emphasise the objective nature of the tool.
Be sensitive to literacy levels and adjust accordingly e.g. work through the tool with the person.
Be sensitive to language issues where English is not the person's first language. Ensure this does not become a barrier.
If the person says no or changes their mind mid-way through the process respect their choice and exit the brief intervention process. Consider whether it could be an option to revisit the issue at a later date and if so flag this as your systems allow.
With young people: Use a screening tool or process that has been validated for use with young people, for example The Substances and Choices Scale (SACS) available at www.sacsinfo.com.

Provide feedback and brief advice

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

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

Responsibility sits with the person

Advice: provide advice

Empathy: listen and reflect; maintain rapport

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

Tips
Brief intervention can stop at this point if there is insufficient time to provide any further intervention.
Check in with the person about how they are finding the process. Make space for them to ask questions.
If the person becomes withdrawn, argumentative or resistant take this as a sign to back up. Avoid arguing and/or persuading, avoid presenting reasons for change, maintain rapport and simply reflect back what the person is saying to you.
If there are indications of dependence or addiction recommend and support referral for further assessment or more intensive assistance.
If there are indications of other health problems, including mental health problems, recommend and support referral to appropriate services.
With young people: look for opportunities to provide positive feedback, focus on their strengths and achievements as much as possible. Avoid the discussion becoming overly problem-saturated (Christie, 2008a).

Listen for readiness and confidence

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

Feedback: about personal risk or level of current harm

Responsibility sits with the person

Empathy: listen and reflect; maintain rapport

Self efficacy: convey optimism about their ability to change.

Action	Example
Check out how the person is responding	"*What are your thoughts about the screening result?*" "*It's a lot to take in. Are you surprised about your score?*" "*I know you weren't necessarily expecting to be looking at this today, but I wonder what you think about how drinking fits in with some of the other issues that have bought you here today?*"
Explore readiness to make changes: - Does change seem to be worthwhile to the person - Are they confident about their ability to change - Try to elicit change talk	"*What are your thoughts at this point? Are there any concerns that you have?*" "*Have you considered cutting down on your drinking?*" "*Can you think of any benefits if you were to stop smoking?*" "*What connections do you see between your drinking and the stresses in your life right now?*" "*On a scale of 1-10, if 1 is not ready at all and 10 is totally ready, how ready are you to make changes in your drinking?.... What are some of your reasons for giving this rating?" OR "why did you rate 5 instead of 3?*"

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

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

Provide further intervention (as appropriate)

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

Feedback: about personal risk or level of current harm

Responsibility sits with the person

Empathy: listen and reflect; maintain rapport

Menu of options: outline options or strategies

Self efficacy: convey optimism about their ability to change

Action	Example
For people who are considering change or wanting support to change, select an appropriate approach (one or more): › Provide information › Goal/s and Menu of options › Build confidence › Enhance motivation	**Provide information**: focus on the benefits of change: "*Would you like more information? I have a dvd here that you could take home. It might be interesting to hear about some of the benefits other people have experienced after cutting back.*" **Facilitate goal setting and explore menu of options**: "*Could you consider setting yourself a goal in relation to smoking?*" "*What are some changes that you are interested in trying out?*" "*Would it be helpful to look at some options that have been helpful for other people? There are some very effective nicotine replacement therapies available to help people quit smoking, they really improve your chances of successfully quitting. It could be helpful to look at whether any of these are worth trying for you.*" "*There are lots of options for cutting down on gambling, you are the best judge of what is likely to work for you. Would it be helpful to talk about some ideas and then, if you want to, set a goal for yourself to try out?*" "*It sounds like the Friday night drinking is your main concern because it is impacting on your performance at Saturday sport. We could explore some practical options and you could make a plan, then if you think it's worth a go you could try it out. If it doesn't work out we could look at some other ideas next time we meet.*"

Tips
Keep it personalised, relevant and achievable. The change goal must be something that is worthwhile and "doable" for the person. Avoid the lure of encouraging goal setting that does not meet these criteria.
Encourage the person to come up with their own strategies and/or explore in detail how strategies will fit into the person's situation. People are more likely to try things out if they come up with their own ideas.
Spend time looking at a range of options. It is important to convey that there is more than one way to address issues and improve situations. This helps generate self-efficacy.
Listen carefully for what the person is prepared to work on at this time and focus on that.

Important considerations

Cultural considerations and brief intervention

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

Working with Māori

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

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

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

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

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

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

Working with Pasifika

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

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

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

Overcoming potential barriers to brief intervention

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

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

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

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

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

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

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

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

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

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

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

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

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

Responding to family and whānau

Resources for family and whānau

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

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

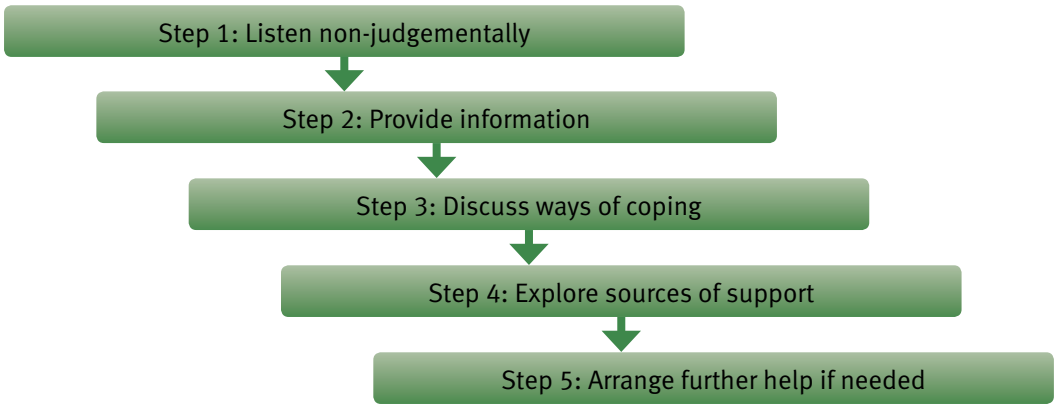
- *Living Well*, for families seeking help for alcohol and other drug issues. Produced by the Kina Families and Addiction Trust.
  Available at: http://www.kinatrust.org.nz
- *Concerned About Someone Else's Drinking*. Produced by ALAC.
  Available at: http://www.alac.org.nz/sites/default/files/useruploads/Resourcepdfs/02209_ALAC_Concerned_About_Someone%27s_Drink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

The 5-Step Method

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

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

Figure 3 The Five-Step method



1. Listen carefully to the experience of the family member/s to develop an understanding of how they are affected. Explore their concerns. Provide reassurance that others also have these experiences. Convey empathy and non-judgement.
2. Provide relevant information about substance use/gambling/addiction as relevant. Provide information about other relevant issues tailored to the concerns raised e.g. child care, financial assistance etc. Targeted information helps family members to gain a sense of having some control in their lives.
3. Explore coping responses. Research associated with the model has identified three broad coping responses:
   - Engaged – Standing up to
   - Tolerant – Putting up with
   - Withdrawn – Withdrawing

   Explore the current responses and discuss what is effective and what is less effective? Explore alternatives.
4. Explore social support. Draw a network diagram to determine current support. Work on strategies to increase positive support and decrease negative support.
5. Explore further options for help and support. Check out further needs, provide information, refer as necessary and arrange follow up if required.

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

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

(Orford et al., 2007).

Brief intervention requirements at an organisational level

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

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

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

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

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

Project initiation

Key actions at the outset include:

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

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

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

Box 3. Inform and educate

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

The information sheet should cover the following:

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

Consulting within the organisation

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

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

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

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

In determining who to consult the following could be considered:

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

Project planning

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

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

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

Box 4. Key considerations in selecting screening methods
› **The make-up of the population/group** to be screened: what are the issues that this population may be experiencing?
› **Whether to screen for single issues or multiple issues**: what is optimal given the needs of service users and the expertise and resources available within the service?
› **Setting**: what is realistic in the service setting i.e. if office based then computer-based or pen and paper and more in-depth screening may be possible. If in the field (e.g. working with homeless population) there may only be opportunity to ask a couple of key questions with record keeping occurring at a later time.
› **Systems for responding to screening results**: the level at which the organisation can respond to those whose screening results are positive and in particular those whose results indicate the potential for a significant problem is an important consideration in selecting a tool. Where workers have time and an ongoing relationship with the service user it may be optimal to use a tool that provides information about presence and levels of problem (e.g. AUDIT or ASSIST); where there is limited time a short screen such as AUDIT-C which focuses on the presence/absence of a problem may be more appropriate.
› **The time available to screen and provide intervention and any associated costs**: what can the service optimally provide?
› **The expertise of the staff**: what level of knowledge and skill is required to screen and respond appropriately based on the screening result?
› **The level of management support**: is there management approval for the process? Do management support staff training and ongoing staff support?

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

Box 5. Data considerations for organisational monitoring
The following measures are suggested for monitoring brief intervention:
› Number of service users in the brief intervention target population: i.e. the number of people that would be expected to be screened.
› Percentage screened: i.e. the number of service users screened divided by the number in the target population. It is recommended that a realistic target is set initially.
› Number and percentage of "positive" screens: i.e. the percentage of service users whose screening results indicate that intervention is required.
› The percentage of "positives" receiving an intervention (including a subset of those who are referred for specialist intervention.

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

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

Implementation

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

Ongoing improvement

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

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Appendix 1

Brief intervention guides for primary health care

Primary health care brief intervention guides: alcohol

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

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

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

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

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

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

Other helpful guides

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

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

Appendix 2

Screening Tools

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

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

Drugs and the Brain

A Beginner's Guide to Stimulants and Empathogens

DrugWatch

Version: 1.3
Original version: 18/03/2014
Revision date: 03/04/2014

Part 1: The lizard brain [1, 2]

The brain controls almost everything we do: from our first breath in the morning to our dreams at night. Very little that we do, think or feel takes place without the brain being in charge.

Much of what the brain does happens on an automatic or *subconscious* level. For example, we blink many times a day without consciously thinking about it, but it is our brain that makes us do this (to clean, protect and moisten our eyeballs).

Buried deep within the human subsconcious brain (also called the lizard brain) are survival instincts:

- To eat (to stay alive)
- To reproduce (to continue the species)
- To respond to threats or aggression (to protect yourself, your family and what you own)

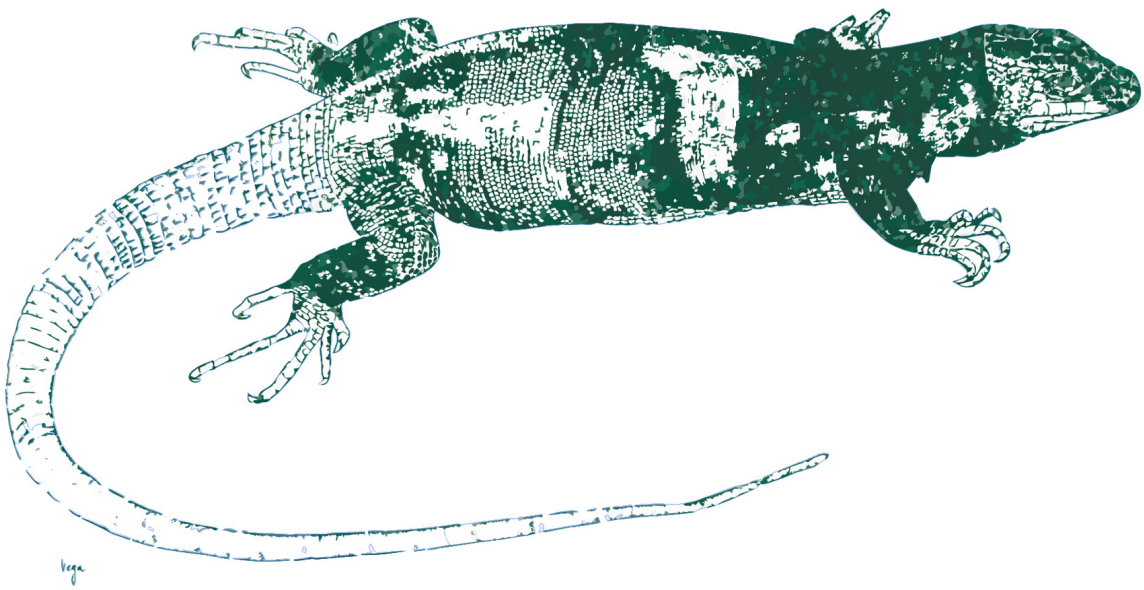
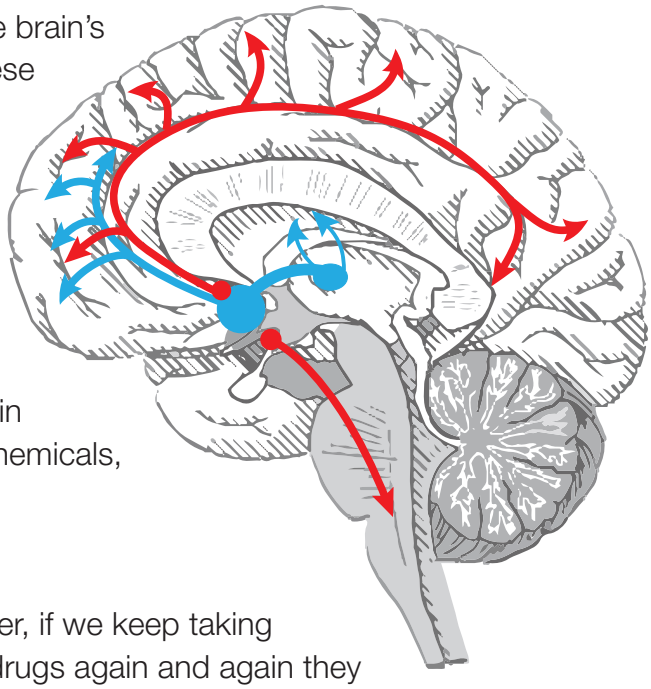


Image credits: see references section at the end of this document

There are certain areas in our brain whose job it is to make us feel good when we do these things, so when we eat, have sex or take exercise our body releases chemicals that make us feel happy or excited. These parts of the brain are connected in networks called **reward pathways** because they release **reward chemicals** when we do something that makes us more likely to survive.

The picture to the right shows two of the brain's reward pathways. There are many of these pathways in the brain; they are like phone or computer networks with information flying along wires.



Drugs that get you high use these reward pathways to make us feel good. They are like pirates taking over a ship: they hijack these parts of the brain and make them release lots of reward chemicals, which is why we feel high or stoned.

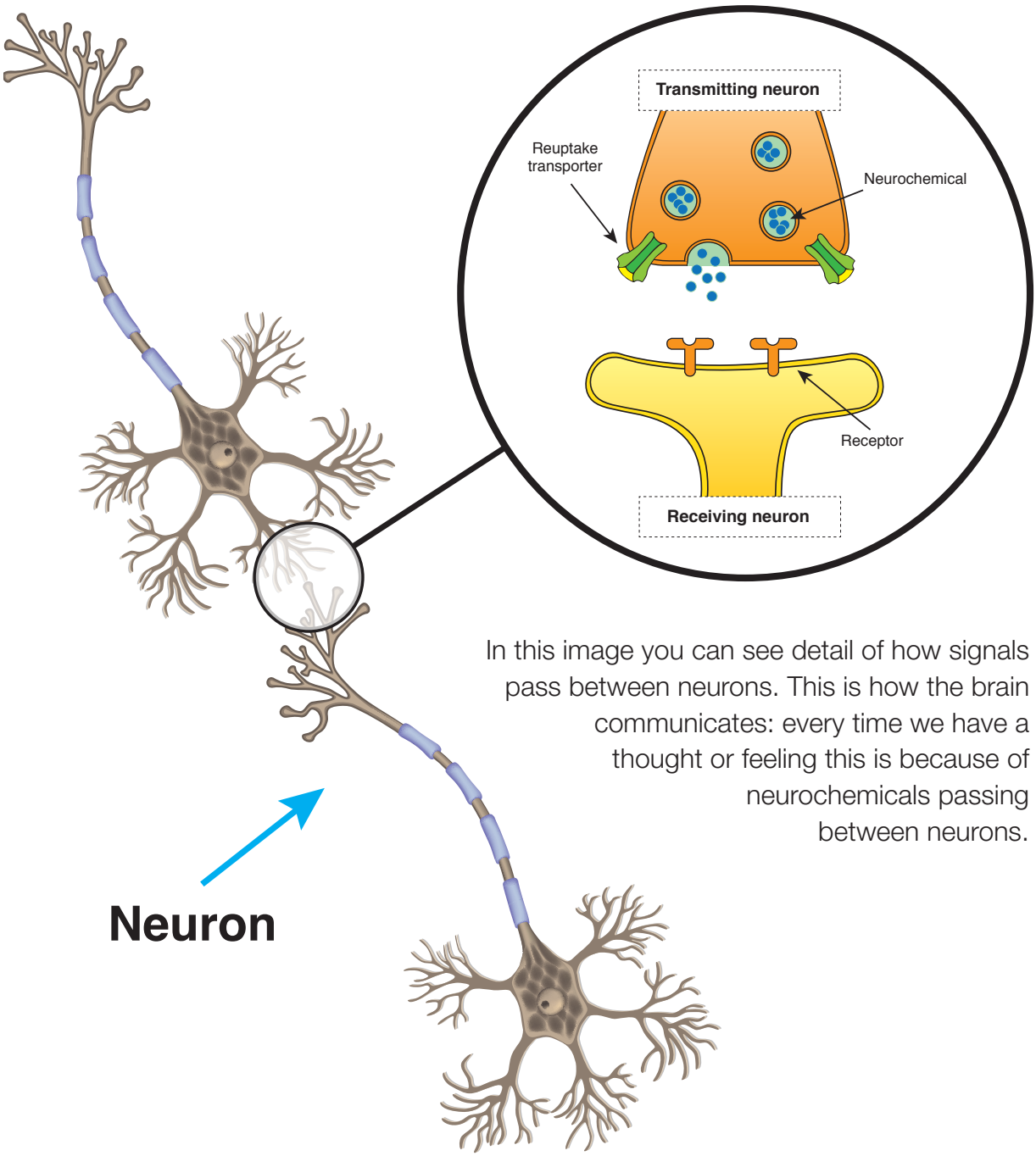
However, if we keep taking these drugs again and again they can take over the reward pathways in the brain until all we want to do is to take the drug. Nothing else makes us feel good any more apart from getting high and this can become a habit.

Once you get to this stage:

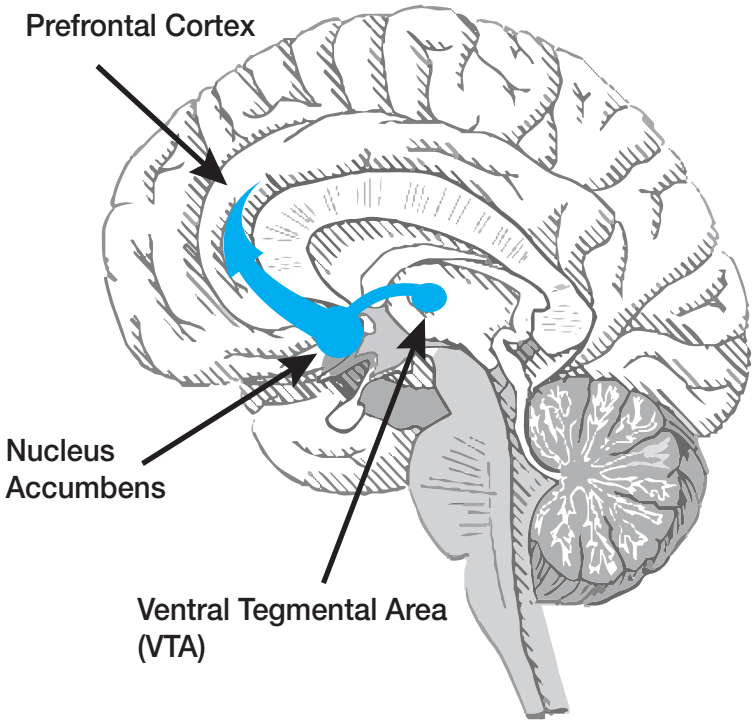
- You might have cravings
- You start to want to take the drug more than doing anything else
- You find yourself keeping using even when you want to stop
- You become more moody and irritable when you can't get hold of it.

Part 2: The reward pathways [2, 3, 4, 6, 7]

The brain is a big network made partly of **neurons** (nerve cells). It uses chemicals called **neurochemicals** (nerve chemicals) to send and receive signals between these neurons.



In this image you can see detail of how signals pass between neurons. This is how the brain communicates: every time we have a thought or feeling this is because of neurochemicals passing between neurons.



The picture to the right is a simple version of part of the brain's reward pathway that controls some of our moods and attitudes.

When this reward pathway is activated (for example by food, water or sex), information travels from the VTA to the Nucleus Accumbens and then up to the Prefrontal Cortex.

The VTA uses an important chemical called **dopamine** to send this information. Dopamine controls things like what is important to us, what gives us pleasure, how we feel, how we learn and what motivates us. Dopamine gets stimulated by many drugs and is part of what makes you feel high, and how much you feel you want or need a drug. It is often linked to stimulants, so amphetamine (speed) and cocaine are typical drugs that raise dopamine levels. As the levels of dopamine increase in the brain, other areas get stimulated, including the Prefrontal Cortex. The Prefrontal Cortex is very important, especially where drugs are concerned, as it controls a number of different functions, including:

- Behaviour *(controlling your actions, acting in an appropriate way)*
- Development of conscience *(knowing right from wrong and doing the right thing)*
- Decision making *(gathering information before making a decision)*
- Impulse control *(being able to control your feelings)*
- Focus *(being able to stay on track with a project until it's finished)*

People who have problems with the Prefrontal Cortex can experience:

- Short attention span
- Problems with impulse control *(being impatient, 'kicking off')*
- Poor organisation and planning skills
- Hyperactivity
- Emotional problems *(such as shutting down, withdrawing from people)*
- Misreading situations
- Being dishonest
- Problems with learning
- Short term memory problems
- Anxiety
- Serious mental health problems *(such as psychosis)*

Using drugs changes the way that this part of the brain grows, develops and works. Young people can develop problems with drugs more easily as the Prefrontal Cortex can still be growing and developing when people reach their early twenties.

Part 3: Neurochemicals [1, 2, 3, 4]

Dopamine is a neurochemical that the brain uses to send messages to its different parts. Different neurochemicals control different parts of the brain.

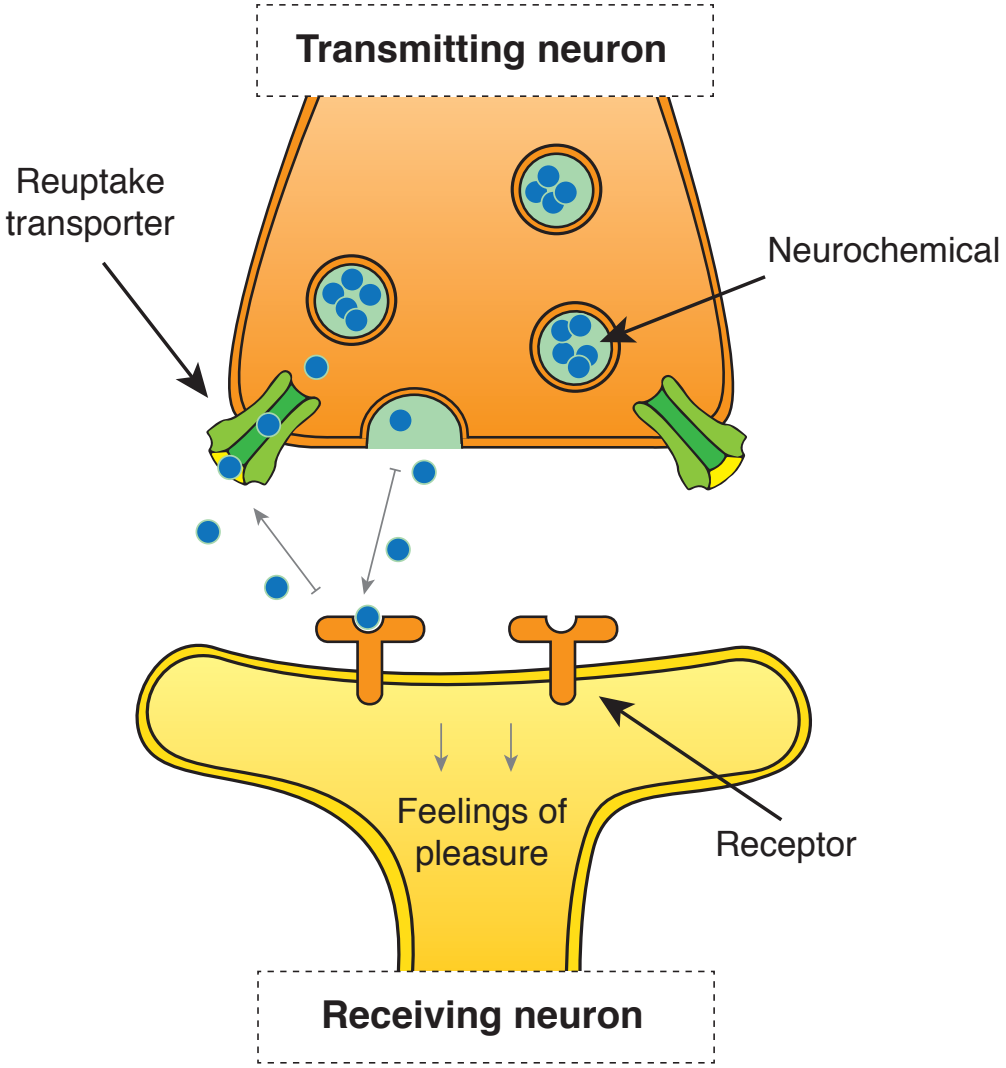
Neurochemicals are like the various types of messages found in a phone network, for example phone calls, texts, emails or instant messages.

Here are some more examples of neurochemicals:

Neurochemical	What it does
Noradrenaline	How awake or aroused you feel, attention span and confidence.
Adrenaline	Similar to noradrenaline and also controls energy.
Dopamine	Motivation, wants, pleasure, love and the reward pathway. This is a big part of what makes you want to take more of a drug.
Serotonin	Memory, emotions, wakefulness, sleep, mood (depression), sexual activity and temperature. It is associated with euphoria (happy feelings).
GABA	Controls impulses, muscle relaxation and arousal and slows down the brain. Plays a big part in sleep and 'feeling good'.
Endorphin	The senses, especially pain, emotional and physical distress. A lot of the high you get from exercise comes from endorphins.
Histamine	Involved in sleep and waking patterns and inflammatory response (for example allergic reactions).

Part 4: How a drug affects your mood [1, 2, 7, 8, 9, 10, 15]

When you do something that triggers the brain's reward pathway (for example, taking exercise), neurochemicals are released by the **transmitting neuron**.

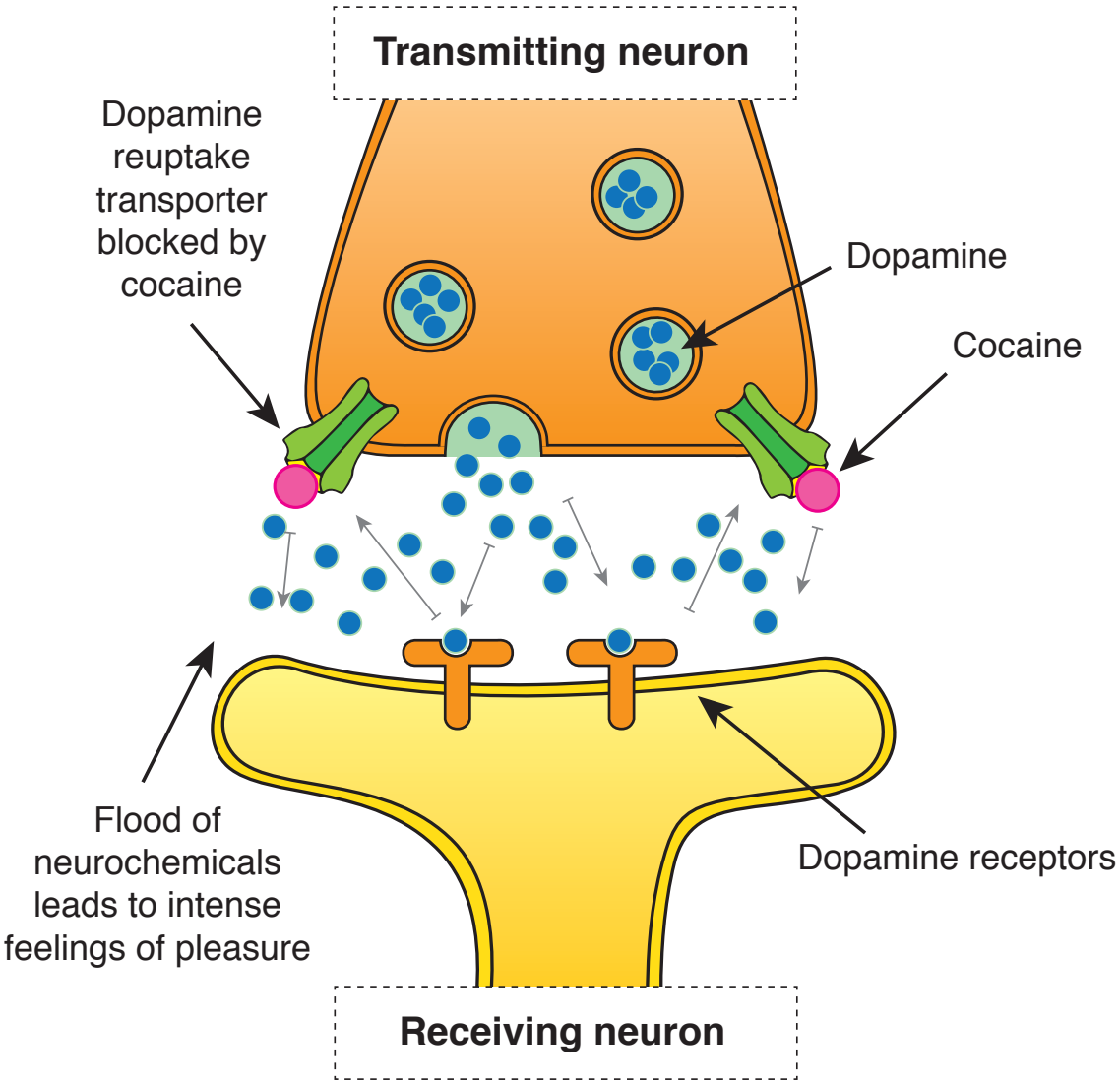


Some of the neurochemicals land on the **receptors** on the receiving neuron, and this is what sends out feelings of pleasure to other parts of the brain. Most of the extra neurochemicals are absorbed back by travelling through the **reuptake transporter**, ready to be used again if necessary. Some neurochemicals do not get absorbed, and this is thought to play a part in **drug toxicity** (poisoning, or overdose).

We will now look at what happens when you take certain stimulant and empathogenic drugs.

Cocaine

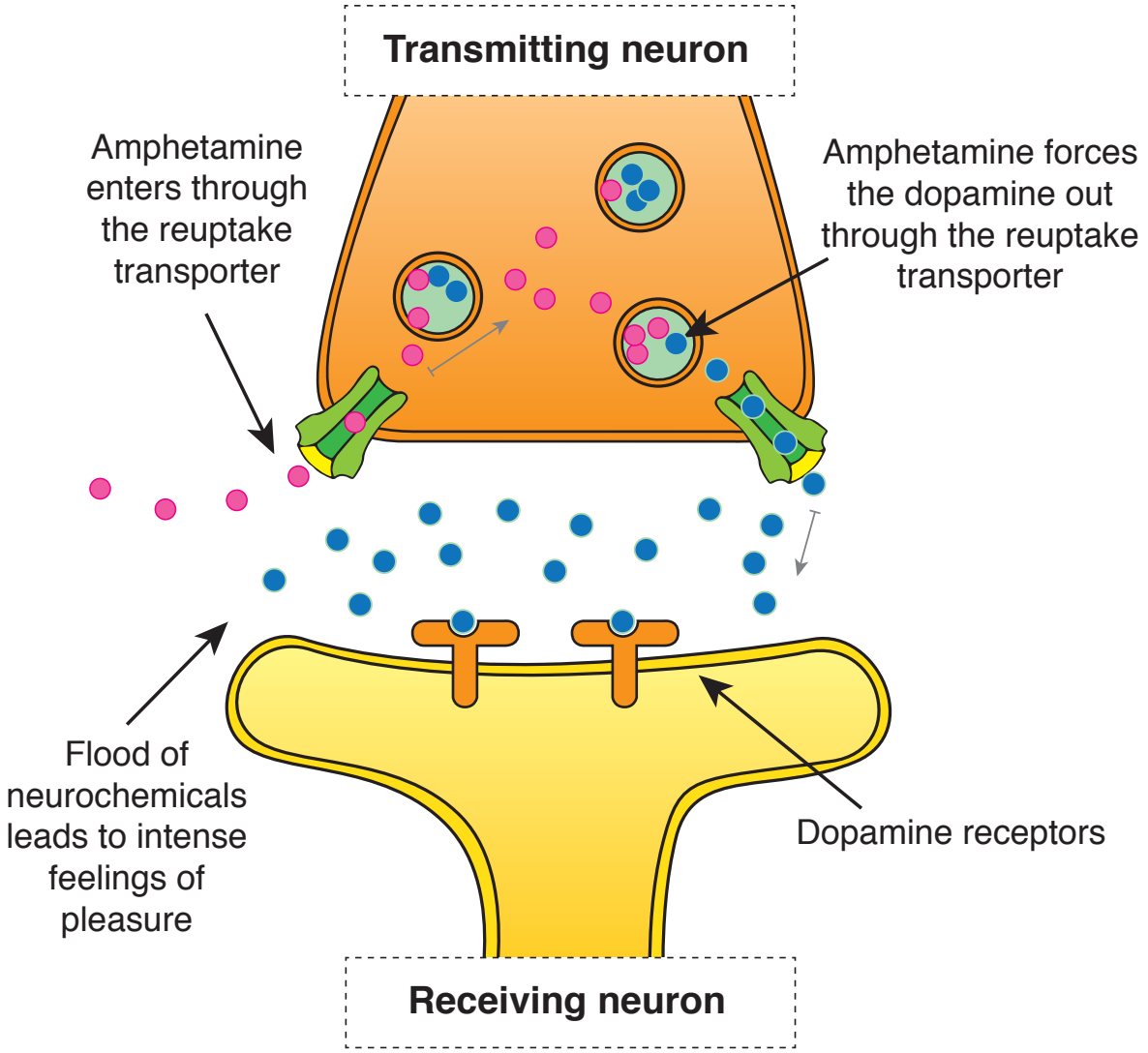
When you take cocaine it affects the neurons in two ways. Firstly it stimulates the transmitting neuron to send out lots of dopamine. It also blocks the dopamine reuptake transporter which means that the extra dopamine that has been released ends up flying around your brain, triggering and stimulating the dopamine receptors which is why you feel high.



If you keep on using stimulant drugs over and over again you can use up all your dopamine (this is called dopamine depletion). This can lead to problems including depression and other mental health issues, issues with learning, hyperactivity, cravings, dependency or addiction and problems releasing dopamine in the future.

Amphetamine (speed)

Like cocaine, amphetamine increases the amount of dopamine in the neurons, but it works in a different way. The amphetamine molecule is similar in shape to dopamine and it can enter the transmitting neuron through its reuptake transporters. It then forces the dopamine molecules out through the transporters. This can be toxic, and can lead to life-threatening hyperthermia (overheating).



If you find yourself doing stimulant drugs too often you can become tired, run down, low in mood and possibly have mood swings and some paranoid thoughts. The best thing that you can do is to **take a break** and allow your body to recharge. Plenty of sleep and food can help your body and mind to recover.

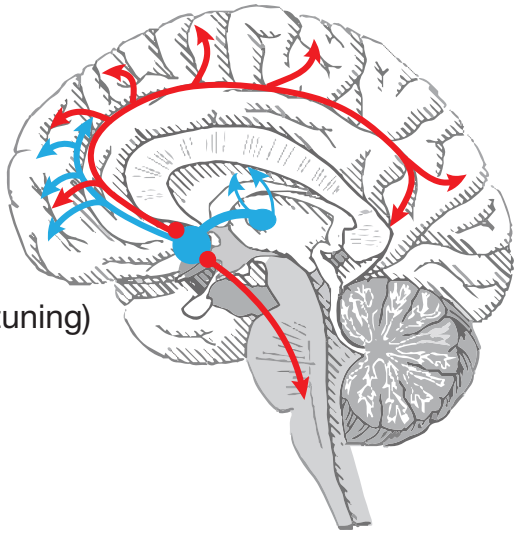
MDMA (ecstasy)

Although MDMA causes the release of dopamine, another neurochemical it stimulates is called **serotonin**. Serotonin is an important neurochemical that helps you to feel relaxed and controls mood, appetite and sleep. It is serotonin that gives MDMA a lot of its 'loved up' feeling and this is why ecstasy is called an **empathogen** (empathy is when you place yourself in someone else's shoes and feel what they are feeling).

Dopamine pathways

Functions

- Reward (motivating)
- Pleasure, euphoria
- Motor function (fine-tuning)
- Compulsion
- Re-dosing



Serotonin pathways

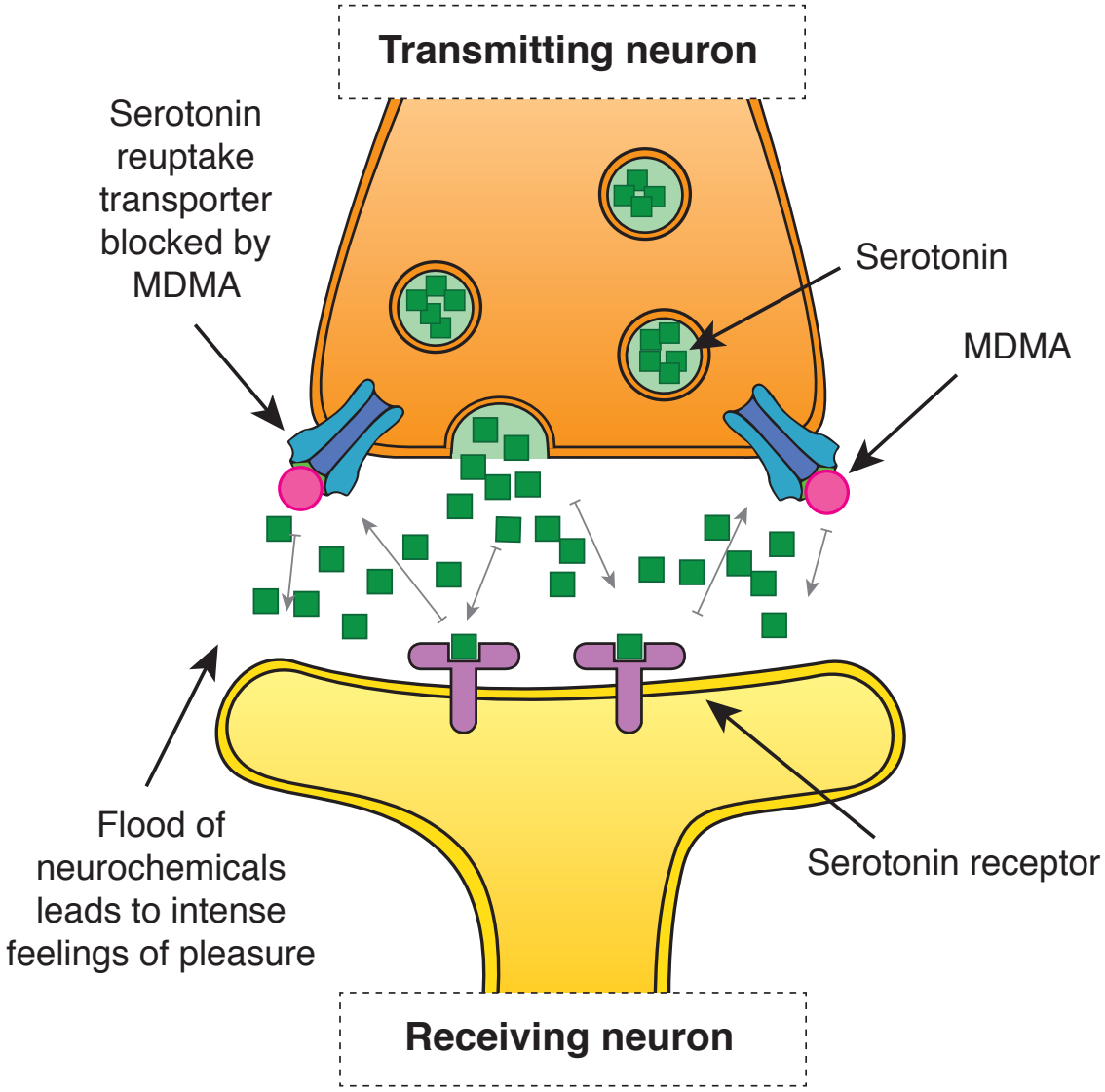
Functions

- Mood
- Memory processing
- Sleep
- Cognition/thinking
- Appetite

When you take empathogens they release serotonin in your brain, but can leave your serotonin levels very low afterwards and can also lead to life-threatening hyperthermia. If you take more drugs to try to get that good feeling back you might find your body can't produce the high, a bit like trying to flush a toilet twice in a row!

Using up your stores of serotonin is partly the reason why you might feel down, angry, sad or upset a few days after taking empathogens. And it is not just low levels of serotonin that causes problems; very high levels can lead to a medical condition called Serotonin Syndrome which can be fatal (see page 13).

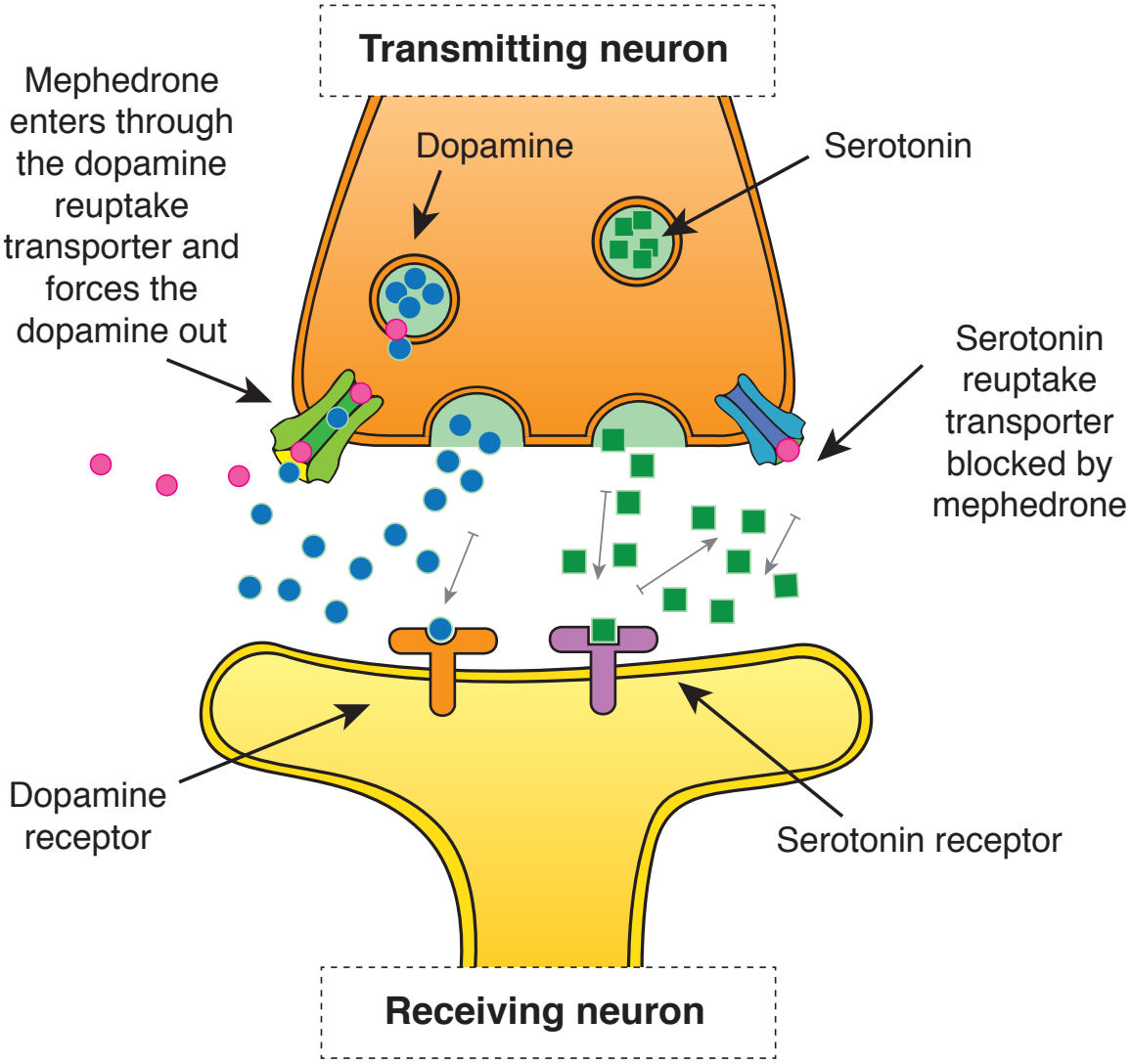
When you take MDMA it affects the neurons in two ways. Firstly it makes the transmitting neuron send out lots of serotonin. It also blocks the serotonin reuptake transporter, and it is this extra serotonin flooding the area between the neurons that leads to the 'loved up' feeling.



Mephedrone (bubble, mkat)

Mephedrone is a powerful drug that greatly increases both dopamine and serotonin levels, and in animal studies caused about a 500% increase in dopamine and a 900% increase in serotonin. This makes it both a stimulant drug and an empathogen. As the effects of the drug start to wear off, serotonin levels drop quite quickly which is why people want to take more and more of the drug (this is called 'redosing').

As mephedrone is a relatively new drug we are not completely sure what it does in the brain. It acts mostly like amphetamine, but also affects serotonin levels.



Serotonin syndrome[16]

This is a medical condition caused when your body releases too much serotonin. It can occur in a lot of different situations, one of these is when you take recreational drugs that effect your serotonin levels. It can kill you if not recognised and dealt with both quickly and effectively.

Symptoms include: agitation, anxiety, overheating, shivering, restlessness, twitching, high blood pressure, flushed skin, stomach noises, vomiting, diarrhea, dilated pupils and mental distress.

If someone you are with is showing some of these signs **call an ambulance immediately**.

While waiting for the ambulance do what you can to **cool the person down** and **calm them down**. It is dangerous to restrain people in this state.

For further information on Overdose & Emergencies see DrugWatch Information Sheet.

Part 5: How drug use can lead to dependency [2, 3, 4, 5, 7]

The drugs that have the strongest effect on your brain are stimulant drugs (like speed, cocaine and mephedrone) and opiate drugs (like heroin). The way you take a drug also affects how likely you are to become dependent. In general, the quicker and stronger the drugs affects you, the more your dopamine levels 'spike'. This is why injecting and smoking drugs can be more likely to lead to dependency than eating or swallowing them.

When you first start taking a drug you only need a relatively small amount to get you high. But if you keep on taking it your brain can get used to all the extra reward chemicals and you need to take more and more to feel that same high. This is called **tolerance**.

Your brain gets used to these extreme levels of reward chemicals, and so normal activities that you used to enjoy (like exercise, eating a nice meal or spending time with your family) no longer make you feel happy.

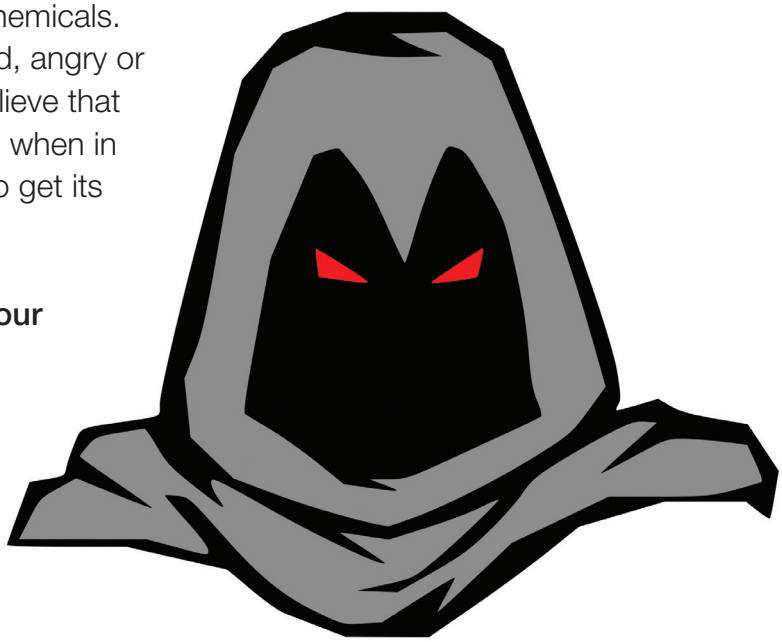
You might find yourself feeling **bored** the whole time... unless you are taking drugs. This is because your brain is getting used to the extreme 'spikes' in reward chemicals.

When you aren't taking drugs the levels of these chemicals drop and your brain starts wanting more.

It sends out warning messages around the brain and these messages get sent out to different parts of the body. You can feel these in different ways, some people feel edgy, angry, anxious, stressed, tearful, shaky, sweaty or as if they have a knot in their stomach... these feelings are called **cravings**.

Part 6: Cravings [11, 12]

Cravings can be very sneaky. They are the brain's way of trying to get you to take drugs so that it can balance out your reward chemicals. They often make you feel agitated, angry or stressed and it is very easy to believe that you are feeling upset with people when in fact it is just your brain wanting to get its happy chemicals back.

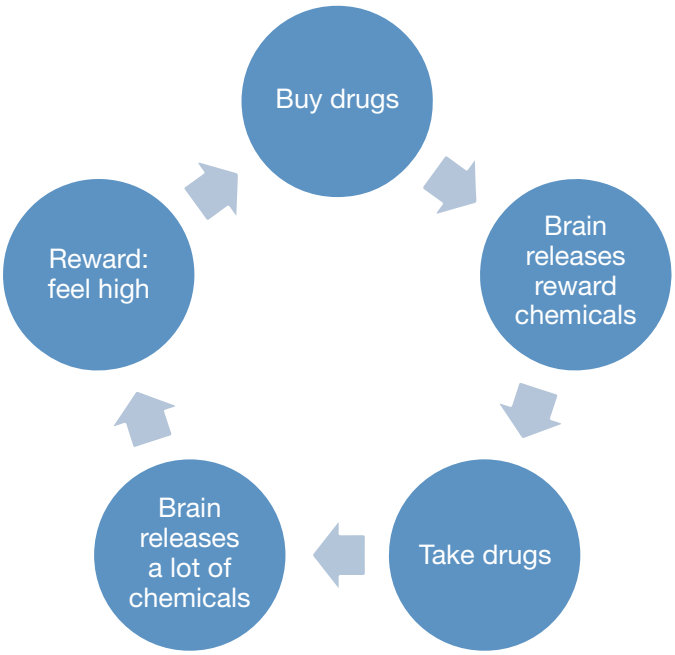


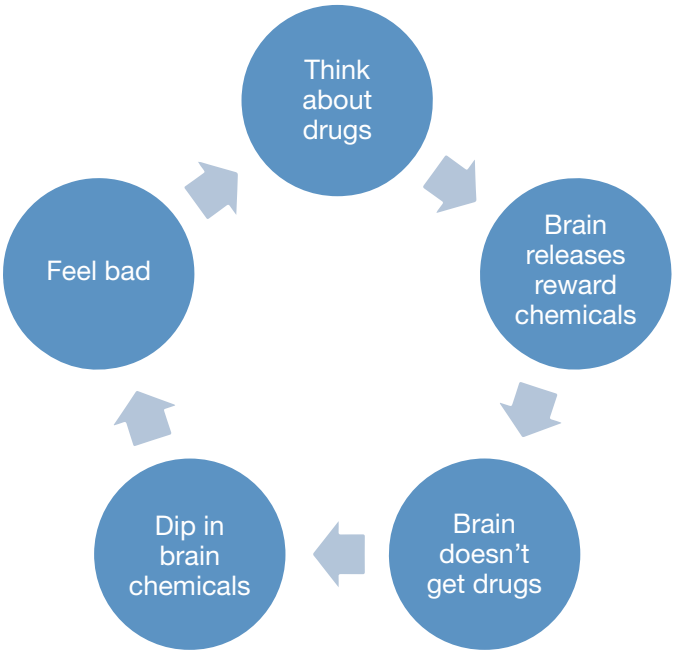
If you don't learn to **recognise your cravings** you can often behave in ways that might be out of character, for example getting into arguments with people and 'kicking off' for no reason. There are lots of reasons that people have cravings, and different people feel them in different ways. This is something that your drugs worker can help with, as we all react differently to cravings and have our own ways of coping with them.

Cravings can come in many forms: for example it can be as simple as thinking about drugs on Friday morning before you are due to go out that night, a very strong, tense, angry feeling if you can't get hold of any drugs when you were expecting them, the ache for more when your supplies are running low, or the tingle you might get in your stomach when you've been off drugs for a few days and think about them suddenly. These feelings are all caused by neurochemicals (mostly dopamine) being released in your brain.

Lots of things can make you crave drugs. These are called **triggers**. Triggers can be thoughts, feelings, sights, sounds, smells, places or situations. Examples could be: it's a hot day and you see a beer glass, or someone walks past you and you smell cannabis smoke.

When you use drugs regularly you train your brain to get a big reward when you take them. Think about how you feel when you are just about to buy drugs, and when you have just bought them. Your brain releases reward chemicals like dopamine even before you've taken the drug because you have trained it to know that it will soon get a big reward (see picture on the right).





When you have a craving your brain thinks it's going to get drugs, so it releases some reward chemicals. When it doesn't get the drugs it was expecting your levels of reward chemicals drop, and you can feel bad, stressed, frustrated, sick or angry.

If you don't learn to interrupt or control your cravings you can find them taking over your thoughts, and if you keep giving in to them it can become more and more difficult to resist taking drugs.

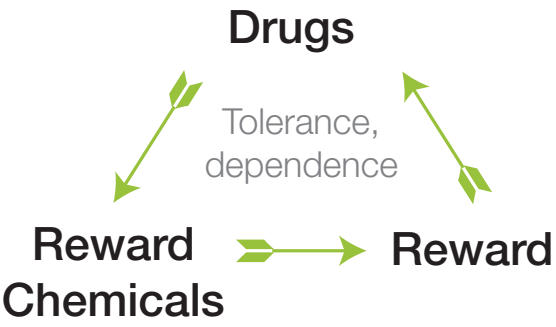
Part 7: What is dependency? [5, 6, 13, 14]

Being dependent on a drug is when you feel you *have* to take it, when you can't stop or cut down, and when you keep on using even when you know the drug is causing you problems.

If we think back to the reward system in the brain. Firstly you are motivated to do something for survival (for example, eat) and then your brain releases chemicals which are your reward. This ends the reward process.

Motivation → **Reward Chemicals** → **Reward**
food, career, sex etc.

When we take drugs we change the way this pathway works; taking drugs give us 'free' reward chemicals. This can cause problems as it can create a loop which can lead to dependency, when the drugs become the motivation and survival instinct.



Dependency is when drugs take control over your behaviour. It usually begins with casual or recreational use ('every now and then' or 'just at weekends') and ends when you feel you have to take them.

Some people can use drugs without problems, and others become dependent very easily. There are many reasons why this might happen: it might be something in your brain, something in your personality, something in your upbringing or maybe a combination of these things. At the moment, no one knows why.

Part 8: Are drugs becoming a problem? [17]

Working this out isn't simple, and admitting it isn't easy because we all want to think we're in control. Below are some of the things that can suggest that your drug use is becoming a problem. If you have answered yes to three or more of the following questions in the past year it suggests your drug use might be becoming a problem and that it might help to speak to someone about it.

Do you need more ..... to get high, or get the effect you wanted?

Do you have any signs of physical withdrawal, or do you find yourself thinking about ..... a lot when you don't have it?

Do you find yourself taking more ..... in a session than you'd originally planned, or find yourself taking it for longer sessions?

Do you find yourself wanting to cut down or stop taking ..... ?

Do you spend a lot of time scoring ..... or recovering from a ..... session?

Have you stopped, or cut down activities such as school, college, training, work, hanging out with friends or family because of your use of .....?

Have you kept on using ..... despite knowing that it is causing ongoing problems to your physical or mental health?

Has using ..... caused you troubles with the law (police, YOT, probation)?

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Page 6 *Network*: converted to vector and edited in Adobe Illustrator by Mark Adley. Based on the image http://odak.co.uk/business-users/virtual-private-networks-vpn. Kind permission to use the image was given by email, subject RE: Message from ODAK webpage form, sent by Aytekin Yelden [aytekin@odak-online.com] Tue 21/01/2014 17:01.

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Drugs and the Brain: A Beginner's Guide

This guide was written and designed by Mark Adley, in collaboration with UK DrugWatch and N2L. Mark is a drugs worker in the North East of England and the creator of the **Drugs Wheel**, a new psychoactive substance awareness model (available at www.thedrugswheel.com) designed to illustrate the wide range of new substances that are available.

N2L (Never Too Late) is a confidential service for young people under 18 who live in North Tyneside and are experiencing difficulties in relation to the use of drugs and alcohol.
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Email: n2l@northtyneside.gov.uk

N2L NEVERTOOLATE
Young People's Drug & Alcohol Service

UK DrugWatch is an informal online professional information network established by a group of professionals working in the UK drugs sector. The aim of the group is to raise/establish standards for drug information, alerts and warnings. It is currently an unfunded, bottom-up initiative that works in the spirit of mutual co-operation. A list of current members, and a selection of drug briefings can be found here.

DrugWatch

A special thanks to Colin Davidson, neurophysiologist from TicTac Communications, Ltd., for invaluable advice.

A pocket guide to brief intervention and behaviour change

Introduction

How often do you try to encourage someone to change lifestyle behaviours such as smoking, poor dietary habits, inactivity, alcohol misuse, illicit drug use or risky sexual practices and your advice gets a blank look that says the person is not interested.

Making any lifestyle changes can be difficult and some people will need encouragement and support.

In these situations using brief interventions may be helpful.

Considering the burden unhealthy behaviours have on the health, wellbeing and our society delivering brief interventions is a priority. (Making Life Better 2013-15)

This pocket guide will explore how people change and highlights the basics of delivering brief intervention.

This pocket guide will not replace training but will support the training you have received on brief intervention for alcohol use, smoking, physical activity, *Health for Life* etc.

All front line workers in health and community settings should be familiar and confident to deliver opportunistic brief interventions to encourage healthy behaviour.

Encouraging change

Many people make lifestyle changes without any type of formal help. Others need support.

We all can be **ambivalent** about change, that is, we can have reasons for making changes but equally reasons against it.

Ambivalence is normal and its resolution is central to making any change.

NICE (National Institute for Health and Care Excellence) has two guidance papers that this pocket guide draws from:-

Ambivalence is not reluctance to do something but conflict about choosing between two courses of action.

Each side has costs and benefits.

Ambivalence must be engaged rather than overridden.

- Behaviour change: NICE public health guidance 6 Issues October 2007
- Behaviour change: individual approaches NICE public health guidance 49 Issued: January 2014.

A **behaviour change intervention is defined as a** '*single or multiple sessions of motivational* ***discussion*** *focussed on increasing the individual's insight and awareness regarding specific health behaviours and* ***their*** *motivation for change.'*

Behind any intervention, NICE suggests using a recognised model of change.

Models of behaviour change

Two models of change may be helpful in delivering brief interventions.

The Stages-of-Change Model (Transtheoretical Model)

This model recognises that different people are in different stages of readiness for change.

It is important not to assume that people are ready for an immediate or permanent behaviour change.

By identifying a person's position in the change process, a worker can better match any intervention to the client's stage of readiness for change. The Stages of Change Model, can be particularly useful with people who do not see anything wrong with their behaviour or ambivalent about change.

NICE does recognize this model helps to understand the experience of behaviour change, but does not accurately explain and predict such change.

A second model could be helpful. (See COM-B Model)

The Stages of Change and interventions		
Stage	**Definition**	**Intervention elements to be emphasized**
Precontemplation	The person is not considering change in the near future, and may not be aware of the actual or potential health consequences of continuing the behaviour.	**Feedback** from the results of screening. **Information** about the hazards or benefits of change (increase awareness).
Contemplation	The person may be aware of consequences but is ambivalent about changing.	**Listen** to the person. Use **feedback** to elicit concerns. Emphasize the benefits of changing. **Help them weigh up pros and cons of change.** **Give choice** of a goal that works for them.
Preparation	The person has already decided to change and plans to take action.	Help them make a plan, set goals considering possible setbacks and support.
Action	The person has begun to make a change.	**Build confidence** and **self efficacy**. Help them stick to their plan.
Maintenance	The person has achieved a period of change.	Give **Encouragement**. Help them see rewards of change.
Relapse	The person resumes previous behaviours .	Explore efforts, learn from the experience, **build confidence** to try again.

Capability, Opportunity and Motivation (COM-B Model)

For any change in behaviour to occur, a person must:-

- Be physically and psychologically capable
- Have the physical and social opportunity. People may face barriers to change because of their income, ethnicity, social position. For example, it is more difficult to have a healthy diet in an area with many fast food outlets, no shops selling fresh food and with poor public transport links if you do not have a car
- Be more motivated to adopt the new behaviour.

This is known as the COM-B model (Michie et al. 2011d).

Identify specific behaviour change techniques.

NICE defines ***Behaviour change interventions*** as sets of techniques, used together, to enable change.

NICE would recommend that any change intervention identifies the specific ***behaviour change techniques*** (BCT's) being used in that intervention. (Michie et al. 2013).

Some examples of BCT's include:-

- Self-monitoring of behaviour: monitor and record their behaviour(s) such as a drinks or activity diary
- Information about health consequences written or verbal about health consequences
- Credible source: verbal or visual communication from a credible source in favour of or against a behaviour.

What is a brief intervention?

A brief intervention is a short, time-limited interaction/conversation.

The guided nature of the conversation, delivered in a motivational style, distinguishes a brief intervention from basic information giving although providing information and written self-help materials for an individual to take away can be part of a brief intervention.

The aims of brief intervention are to:-

- Engage with those people not yet ready for change
- Increase the person's perception of real and potential risks and problems associated with a particular behaviour
- Encourage change by helping the person to consider the reasons for change and the risks of not changing.

There are two levels of brief interventions:-

Brief Advice typically last no more than 5 or so minutes.

Extended Brief Intervention is based on brief motivational approaches typically lasting 20-30 minutes.

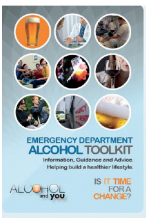
The common thread between them is the brevity of the intervention, the focus on education and motivation (as opposed to actual treatment) and the ability to be delivered by non-specialist.

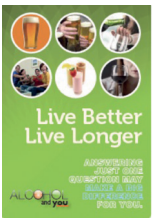
Brief advice

Brief advice' involves structured advice lasting 5 or so minutes, commonly delivered by non-specialist working in front line settings.

Simple brief advice should include 'feedback' from screening. (See screening and brief intervention section)

The *Alcohol and You Partnership* in the South Eastern HSC Trust has produced three alcohol brief advice tools specific for community settings, emergency departments and mental health settings.





They can be downloaded from the Alcohol and You website at www.alcoholandyouni.com or from the South Eastern HSC Trust's website under the Healthy Living tab. (Behaviour change)

‘Extended’ brief advice

In common with ‘brief advice’, ‘extended brief intervention is usually delivered in one session but, unlike brief advice’, is extended to 20-30 minutes to allow for interaction and motivational enhancement through use of motivational interviewing.

It also can include follow up sessions.

Motivational Interviewing

Motivational Interviewing is a conversation style that has been found effective in supporting change.

Characteristics of Motivational Interviewing

- Guiding more than directing
- Dancing rather than wrestling
- Listening as much as telling
- Collaborative conversation
- Evoking from persons their concerns
- Honouring of person’s autonomy.

Source: S. Rollnick, W. Miller and C. Butler Motivational Interviewing in Health Care. 2008

Training is essential to build competence in using motivational interviewing.

A Pocket Guide to Motivational Interviewing is available as a reminder after training to support practice.

Components of a brief advice

The acronym FRAMES captures the elements of a brief intervention.

- **Feedback**: about personal risk or impairment.
- **Responsibility**: emphasis on personal responsibility for change
- **Advice**: respecting their right to choose what is right for them
- **Menu**: alternative options for changing and the person setting their own goals
- **Empathy**: listening reflectively without cajoling or confronting; exploring the person's reasons for change as they see their situation
- **Self-efficacy**: an interviewing style which enhances peoples' belief in their ability to change.

Confidence to change is equally important as the importance to change.

If the person is not confident they run the risk of talking themselves out of change.

Screening and Brief Intervention

Screening is the first step. How does screening differ from assessment?

Screening is a process for evaluating the possible presence of a particular problem. The outcome of screening is normally a simple yes or no.

Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

Screening presents the opportunity to provide feedback and highlight the possible benefits of change.

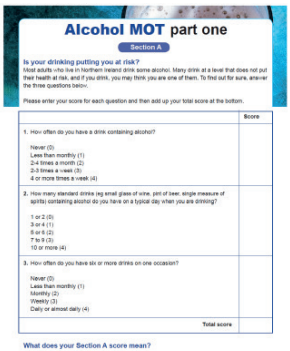
Screening should always be offered with permission.

With alcohol use, the AUDIT questionnaire is the preferred resource for screening as it gives well defined cut of scores for differing levels of risk.

The Alcohol MOT from the Public Health Agency has been developed using the advice of Rose et al (2008) who encouraged a two stage approach.

- Use the AUDIT C initially (The first 3 questions of the AUDIT that look at consumption)
- Followed by the full AUDIT for those scoring in the hazardous range of the AUDIT C.

Other forms of screening include spirometric screening of chronic obstructive pulmonary disease (COPD), CO moderating, waist circumference 37" for a man - 32" for a woman and body mass index, smoker's health check etc.



Alcohol MOT part one

Section A

Is your drinking putting you at risk?

Most adults who live in Northern Ireland drink some alcohol. Many drink at a level that does not put their health at risk, and if you drink, you may think you are one of them. To find out for sure, answer the three questions below.

Please enter your score for each question and then add up your total score at the bottom.

	Score
1. How often do you have a drink containing alcohol? Never (0) Less than monthly (1) 2-4 times a month (2) 2-3 times a week (3) 4 or more times a week (4)	
2. How many standard drinks (eg small glass of wine, pint of beer, single measure of spirits) containing alcohol do you have on a typical day when you are drinking? 1 or 2 (0) 3 or 4 (1) 5 or 6 (2) 7 to 9 (3) 10 or more (4)	
3. How often do you have six or more drinks on one occasion? Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)	
Total score	

What does your Section A score mean?

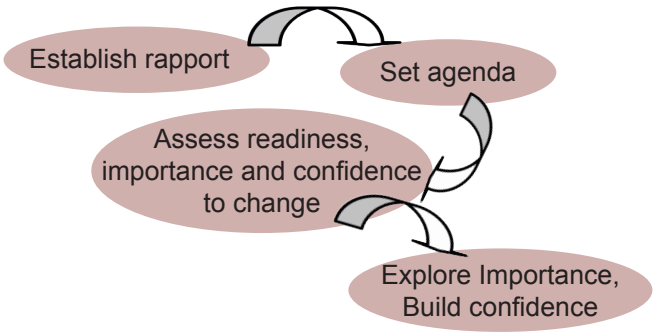
The way the intervention is delivered is equally important as content

- Additional research is telling us the way we talk to someone about chance can greatly influence their motivation to change. (Miller, Rollnick, 2013)
- Telling people what to do is often ineffective
- Creating a safe atmosphere to explore change is vital
- Ambivalence to change, often seen as resistance, is a common response
- Talking about change is a good indication for a positive prognosis regarding change.
- Ambivalence and arguing against change suggests a poorer prognosis
- A motivational approach using Motivational Interviewing presents the practitioner with a way of working that facilities change through exploring and resolving ambivalence. It requires empathetic listening and eliciting “change talk”

- Presenting information in a neutral manner without imposing it allows people to make their own decisions about the information they receive preferred resource for screening as it gives well defined cut of scores for differing levels of risk.

The way in which you talk with people can substantially influence their personal motivation for behaviour change.

Key tasks in talking to people about behaviour change



Throughout the process is an exchange of information and reducing resistance.

Source: Rollnick, Mason and Butler, 1999

Using information

Always ask permissions to give advice

Use Elicit-Provide-Elicit

Elicit they want it/ are ready for it

Provide it neutrally

Elicit again: "what do you think of that? "

The 4 A's & 2 R's Approach in smoking cessation

Ask: all smokers about their smoking at every opportunity

ADVISE: all smokers to stop

ASSIST: smokers to stop

ARRANGE: a follow up

RECOMMEND: using smoking cessation aids

REFER: to further sources of support

What is less helpful with just relying on advice?

Traditionally, health practitioners have encouraged people to make lifestyle changes through giving advice. While this works with some people, it has its limitations.

Premature problem-solving is likely to lead to resistance for example:-

- “I’ve tried that and it doesn’t work”
- “Yeah, but... I really need the cigarettes to calm me down.”

In one study of more than 4000 smokers:-

- 42% were not thinking about quitting at all
- 40% were thinking about quitting but “on the fence”
- 18% were actually preparing to quit smoking. (Kottke,1988).

Educational approaches about how to change were relevant only to 18% of those who are ready and willing to change.

Providing education to those not ready to change is interventional “mismatch” in that the person feels pressure to do something about which they are ambivalent. Education in these circumstances can have a paradoxical effect on motivation, actually reducing, rather than increasing, motivation to change.

A different approach as presented in this guide is needed for the other 82% of people who are not ready to change.

There is something in human nature that resists being coerced and told what to do. Ironically, it is acknowledging their freedom to choose and not change that sometimes makes change possible

Resources

A Nudge in the Right Direction was developed as a tool to help workers have conversations about lifestyle change with clients they are working with. It is a general tool that can be applied to any lifestyle or behaviour change.

The Big Five: Taking Control of your Health through lifestyle Changes provides information about the benefits of change and build motivation to change activity levels, eating habits, drinking, smoking and build emotional health.

They can be downloaded from the South Eastern HSC Trust's website under the Healthy Living tab. (Behaviour change)
http://www.setrust.hscni.net/pdf/A_nudge_in_the_right_direction_(4).pdf

The specific behaviour change techniques (BCT's) have been mapped for both **A Nudge in the Right Direction and The Big Five.**

A self help web site is available from the Alcohol and You Partnership at **www.alcoholandyouni.com**.

For more information on brief intervention see:-

http://www.who.int/substance_abuse/activities/sbi/en/

http://www.bmj.com/content/346/bmj.e8501

http://ranzetta.typepad.com/files/clarifying-alcohol-brief-interventions-2013-update.pdf

http://www.phorcast.org.uk/document_store/1286787041_KbjK_ltphn_obestity_review_level_1.pdf

http://www.nice.org.uk/guidance/ph1

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