Brief intervention - Tip sheet

Brief interventions are appropriate for clients presenting at a general health setting and who are unlikely to seek or attend specialist treatment, when contact time and/or resources are limited, and when more intensive interventions are not deemed necessary.

Brief intervention is recommended for clients with a:

- low to moderate dependence on alcohol, amphetamines, opiates or cannabis; or
- dependence on nicotine.

If brief intervention consists of only one session, it should include:

- advice on how to reduce drug use or drinking to a safer level;
- provision of harm reduction information; and
- discussion of harm reduction strategies.

Multiple sessions could include:

- assessment of dependence;
- motivational intervention;
- goal setting; and
- assessment of high risk situations.
-

Brief interventions are not recommended for clients with severe dependence, cognitively impaired clients, complex clients, or clients with poor literacy levels.

FRAMES - Tip sheet

The principles underlying most approaches to brief interventions were systemised by Hester and Miller in what is called the FRAMES model:

- **Feedback:** Give feedback on the risks and negative consequences of substance use. Seek the client's reaction and listen.
- **Responsibility:** Emphasise that the individual is responsible for making his or her own decision about his/her drug use.
- **Advice:** Give straightforward advice on modifying drug use.
- **Menu of options:** Give menus of options to choose from, fostering the client's involvement in decision-making.
- **Empathy:** Be empathic, respectful, and non-judgmental.
- **Self-efficacy:** Express optimism that the individual can modify his or her substance use if they choose. Self-efficacy is one's ability to produce a desired result or effect.

Stages of Change - Tip sheet

The stages of change model suggests that individuals attempting to change behaviour move through a sequence of stages of change:

1. Pre-contemplation – not interested in changing AOD use. Provide harm reduction information and where possible negotiate safer methods of using.
2. Contemplation – starting to think about changing their behaviour. Motivational interviewing is useful for clients in this stage.
3. Preparation – a decision to change has been made. The client is not thinking about putting it into effect. Goal setting, planning, identifying triggers for relapse and problem solving are useful for clients in this stage.
4. Action – clients are changing their behaviour. The counsellor can assist with relapse prevention and management and reinforcing positive changes.
5. Maintenance – clients are focused on maintaining the positive changes. Continue to reinforce the positive changes that have been made and encourage clients to begin working towards their longer-term lifestyle goals.

Clients may relapse for any stage of change to previous one.

Motivational Interviewing – Tip Sheet

Motivational interviewing is a counselling technique that encourages the client to consider the good and less good things about drug use.

Motivational interviewing can be used to explore the functionality of clients' drug use, to encourage ambivalent clients to consider change, and to reinforce motivation for change. Motivational interviewing can also be helpful for establishing the therapeutic alliance, promoting an atmosphere of non-judgemental acceptance of the client.

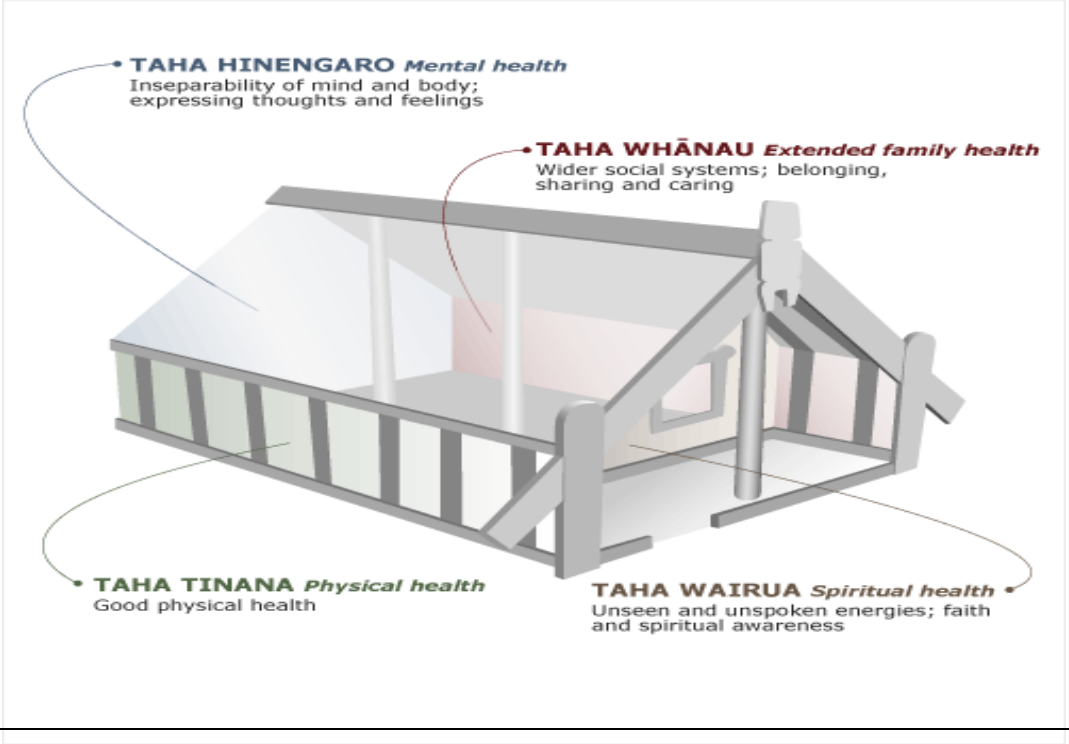
Accept whatever the client says and encourage them to explore their own beliefs and feelings, not what you think they should think and feel.

Components of motivational interviewing include the following:

- Explore the good things about drug use.
- Explore the less good things about drug use in more detail.
- Explore which of the less good things concern the client and why.
- Summarise the good and less good things and ask the client's opinion of you summary.
- Enhancing cognitive dissonance. Several methods:
    1. looking back - how do past expectations compare with current situation;
    2. looking forward - compare what the client would like to be doing in the future compared to what they think they will be doing if they keep using; and
    3. exploring the discrepancy between them, a user, compared to them, as a non-user.
- Summarise all of the above and ask the client how it all fits together.
- Encourage the client to make a decision about their drug use before moving to goal setting.

If the client does not want to change, explore harm reduction strategies where appropriate.

Te Ware Tapa Wha - Tip sheet



Harm reduction - Tip sheet

Harm reduction strategies are appropriate for clients who continue to use alcohol or other drugs, or who are likely to relapse. Counsellors are advised to work with clients to develop harm reduction strategies that they are prepared to implement.

Harm reduction strategies aim to reduce the problems associated with AOD use, such as overdose, family violence, aggressive behaviour, driving under the influence of AOD, psychosis, and blood borne viruses.

In determining harm reduction strategies, attention should be given to:

- understanding the functionality of drug use;
- understanding that potential harms can fall into a number of categories; and
- potential risks of polydrug use and interactions of different drugs.

Motivational interviewing can be used to formulate and negotiate the implementation of appropriate harm reduction strategies. The client should explore the following.

1. The good things about continuing to use in the current fashion (sharing needles, using large amounts of the substance, mixing drugs etc).
2. The less good things about continuing to use in the current fashion, and why and how much they concern the client.
3. How the good and less good things about unsafe using practices weigh up.
4. What the client thinks the future will hold if he or she continues to use in the present fashion.
5. How do the good and less good things about safer using, as well as the client's projection of the future weigh up.
6. Summary of all of the above.
7. What does the client want to do, what compromises can be drawn.

After a list of possible harm reduction strategies has been formulated make a contract with the client and help them strengthen their resolution about implementing the agreed upon harm reduction strategies.

Relapse prevention and management - Tip sheet

Goals of relapse prevention are to provide clients with:

- skills and the confidence to avoid, and deal with, any lapses; and
- a set of strategies and beliefs that reduce the fear of failure and prevent lapses turning into full-blown relapses.

Stages in relapse prevention

- Provide a rationale and demystification of relapse
- Enhance commitment
- Identify high risk situations
- Develop coping skills
- Encourage client to take responsibility – without blame, for a lapse
- Explore harm reduction strategies

Relapse management strategies

- Explore and acknowledge any negative feelings of shame, failure and self blame
- Explore what the lapse means for the client in terms of their decision to change – challenge any beliefs about lapses becoming relapses, and normalise the lapse
- Explore in detail the chain of evens that led to the lapse
- Explore what the client could have done differently next time
- Help the client renew their commitment for change

Harm Minimisation / Harm Reduction

(Information from ALAC – A Training resource for Youth Worker Educators)

Approaches to the management of alcohol and other drug use draw on broad philosophies to guide aims, objectives and practice principles.

Currently in the alcohol and drug area, there are two dominant philosophies: harm minimisation and abstinence.

It is important to note that while these approaches can be clearly distinguished in theory, distinguishing them in practice may not be so clear cut.

Harm Minimisation

The philosophy of harm minimisation underpins New Zealand's National Drug Policy (1998).

Three core strategies associated with harm minimisation are demand reduction, supply reduction and harm reduction. These strategies are not mutually exclusive and projects, programmes and policies will frequently emphasise elements of more than one strategy.

Demand reduction:

Demand reduction strategies are designed to deter people from taking up harmful drug use (prevention. Interventions aim to reduce harms for particular target groups, prevention programmes are often based in se4ttings such as youth centre, prisons, school, the workplace, gyms and liquor outlets.

Supply reduction:

Supply reduction strategies aim to control or prohibit importation, production and distribution of AOD. In NZ, the Department of Customs, the Police and MOH are key agencies involved in supply reduction strategies.

Harm reduction:

Harm reduction focuses on reducing harmful consequences of drug use rather than reducing drug use itself. Harm reduction strategies accept that the use of drugs in part of life for many people and its often enjoyable and non-problematic. However, when harms arise from drug use, strategies are employed to reduce harms. The drug user's decision to use drugs is accepted as a fact without judgement.

Abstinence

Earlier and largely discarded theories of drug use tended to support a single goal of abstinence. Abstinence remains an important goal in may programmes and polices concerned with the management of issue related to the use of drugs.

Abstinence promotes no use, arguably the safest options. Abstinence is a straightforward and clear-cut goal and can be highly desirable for some people, for example, where there is server dependence or where the consequences of use are unusually server, such as risk of imprisonment or being excluded from school.

Examples of approaches that have a strong abstinence focus are the 12-steip approach used by Alcoholics Anonymous, the Auahi Kore[3] smoke free programme and 'Just say no" campaigns for preventing drug use.